

I. PROJECT IDENTIFICATION

1. PROJECT TITLE
DEVELOPMENT PROGRAM GRANT FOR DIRECT RELIEF FOUNDATION (DRF)

2. PROJECT NO. (M.O. 1095.2)
 YES NO

3. RECIPIENT (specify)
 COUNTRY **WORLDWIDE**
 REGIONAL INTERREGIONAL

4. LIFE OF PROJECT
 BEGINS FY **1976**
 ENDS FY **1978**

5. SUBMISSION
 ORIGINAL REV. NO. DATE
 CONTR./PASA NO.

II. FUNDING (\$000) AND MONTHS (MM) REQUIREMENTS

A. FUNDING BY FISCAL YEAR	B. TOTAL \$	C. PERSONNEL		D. PARTICIPANTS		E. COMMODITIES \$	F. OTHER COSTS \$	G. PASA/CONTR.		H. LOCAL EXCHANGE CURRENCY RATE: \$ US (U.S. OWNED)		
		(1) \$	(2) MM	(1) \$	(2) MM			(1) \$	(2) MM	(1) U.S. GRANT LOAN	(2) COOP COUNTRY (A) JOINT (B) BUDGET	
1. PRIOR THRU ACTUAL FY												
2. OPRN FY 1976	174	72					102					
3. BUDGET FY 1977	187	92					95					
4. BUDGET 11 FY 1978	174	98					76					
5. BUDGET 12 FY												
6. BUDGET 13 FY												
7. ALL SUBQ. FY												
8. GRAND TOTAL	535	262					273					

9. OTHER DONOR CONTRIBUTIONS

(A) NAME OF DONOR	(B) KIND OF GOODS/SERVICES	(C) AMOUNT
N/A	N/A	N/A

III. ORIGINATING OFFICE CLEARANCE

1. DRAFTER Maurice D. Kohan, PHA/PVC/OPNS	TITLE Project Manager	DATE 8/12/75
2. CLEARANCE OFFICER Cleo F. Shook, PHA/PVC/OPNS	TITLE Associate Director	DATE 8/14/75

IV. PROJECT AUTHORIZATION

1. CONDITIONS OF APPROVAL

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- John A. Ulinski, Jr., PHA/PVC
- William Alli, PHA/PRS **W.ESA, 8 Aug 75**

2. CLEARANCES

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LA/MRSD	<i>[Signature]</i>	8/4/75	AFR/DP	<i>[Signature]</i>	8/4/75
EA/TD	<i>[Signature]</i>	8/4/75	PPC/DPR	<i>[Signature]</i>	8/4/75
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3. APPROVAL AGENCY OFFICE DIRECTOR

(Mrs.) Harriett S. Crowley
 Acting Assistant Administrator for PHA

4. APPROVAL AID (See M.O. 1095.1, 1975)
 SIGNATURE: _____ DATE: _____
 ADMINISTRATOR, AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT PAPER FOR A DEVELOPMENT PROGRAM GRANT
FOR
DIRECT RELIEF FOUNDATION

JUNE 1975

DIRECT RELIEF FOUNDATION

DEVELOPMENT PROGRAM GRANT PROPOSAL

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INTRODUCTION

The Direct Relief Foundation of Santa Barbara, California, was founded in 1948 for the express purpose of improving the health services and health status of poor people on a self-help basis in the most medically deprived areas of the world. Where such health services do not exist, Direct relief Foundation provides assistance for their establishment.

Direct Relief Foundation (DRF) concentrates its resources on two primary activities: Medical Relief International Program (MERIT) and Aesculapian International (AI)

MERIT collects and distributes the pharmaceuticals, medical supplies and hospital equipment. Over \$49 million worth of goods have been shipped during the past ten years to more than fifty countries

Each shipment is sponsored by the recipient facility or a benevolent individual or group here or abroad.

AI arranges for provision of volunteer medical personnel (physicians, dentists, nurses, paraprofessionals) to health institutions (clinics, hospitals, educational facilities) in medically deprived areas overseas. Most of the volunteers have assisted in developing health services as well as teaching personal hygiene, family planning and nutrition.

Through the AI program, DRF has established a cooperative network with existing health facilities throughout the world. DRF volunteers have been able to provide excellent curative and preventive health services.

Much of the success of this program - 130 volunteers this year alone - is the tradition of a close relationship with in-country organizations and personnel who already serve in the health area. In addition, DRF's self help philosophy has undoubtedly increased its receptivity as well as productivity.

II. RATIONALE

A. Development Program Grant Proposal

1. Background

Direct Relief Foundation proposes to develop the capabilities of less developed countries to improve the health status and economic capacity of the poor within a defined target population. With the assistance of an AID Development Program Grant, Direct Relief Foundation will specifically be aided in the planning and development of: preventive health programs, including health education and family planning training; improved methods of providing medical supplies and pharmaceuticals; viable programs to increase the productivity of the native population.

Direct Relief Foundation trustees believe that in order to effect a significant and lasting improvement in the health and economic levels of less developed countries, a comprehensive approach is vital. To this end, Direct Relief Foundation (DRF) proposes to research and develop bold and innovative health delivery and economic development programs in three selected countries.

DRF has 26 years of experience in assisting the poor in over eighty countries throughout the world. During the past ten years, efforts

of the Foundation have reached nearly 50 million people with \$49 million worth of pharmaceuticals, medical supplies, hospital equipment and volunteer professional services.

As a result of the experience, DRF has engendered a high level of respect, trust and confidence from health professionals and foreign government officials for its efficiency and dependability. DRF has demonstrated an ability to determine priorities and recognize factors which provide project stability and enhance modernization. DRF has a long-established reputation of maximum efficiency in the direct people-to-people approach. Its operation of less than 15 percent administrative costs places it in a unique status as a charitable, voluntary agency. DRF is non-religious, non-sectarian and non-political.

Through DRF's contacts and involvement in the neediest areas around the world, it seeks to extend the scope and increase the impact of its present activities by bringing about improvements in less developed countries. It is the aim of the Direct Relief Foundation to make all such programs self-sustaining to the greatest extent possible.

Direct Relief Foundation has the experience to plan and develop programs which will meet these identified needs in selected target areas.

The human and physical resources DRF will contribute to this project come from its active Board of Trustees and its two major programs, Medical Relief International (MERIT) and Aesculapian International (A.I.)

Experience

- 26 years of continuous and expanding activities.

Material Resources

- Pharmaceutical supplies
- Medical and hospital supplies and equipment
- Surgical instruments
- Laboratory equipment and supplies
- Medical texts
- Food supplements

(Licensed premises for these activities by the California Board of Pharmacy and registered with the Federal Drug Administration)

Human Resources

- Approximately 5,000 volunteers, collectors, deliverers, processors and pharmacists
- Volunteer physicians, dentists, nurses and technicians to serve long and short-term assignments overseas
- Direct Relief Foundation Trustees, Officers and International Advisory Council (47 members)
- Direct Relief International Board of Trustees, Officers and Board of Advisory Trustees (51 members)
- Direct Relief Foundation Medical Task Force (5 members)
- Wings for DRF (200 members)
- Members of the International Health Activities Committee of Womens Auxilliary to the American Medical Association
- Executive Director with ten years of executive management and legal experience; expertise in economic and manpower programs
- Director of Programs with 26 years experience in development and implementation of all phases of DRF activities

Supportive staff, in the office and warehouse, of dedicated employees who implement the continuity of DRF activities (15 members)

Able to hire necessary staff to implement Development Grant, including executive managers, staff with extensive medical, economic and foreign service background and expertise.

DRF assistance to health institutions (hospitals, clinics, orphanages, medical and paramedical educational facilities) has produced information and data concerning medical problems and needs of many medically deprived and less developed areas of the world. Reports from local physicians and hospital administrators in foreign nations as well as DRF Volunteer medical and paramedical personnel have generated a considerable amount of information regarding the health and economic status of these areas. This information includes the cultural, geographic and economic variables that affect the ability of region or country to cope with these problems and needs.

In this activity, DRF has found that the problems vary from one area to another and from one country to another only in specific details. The universal needs include:

- a preventive health program which includes health education and family planning training;
- a method to provide useful medical supplies and pharmaceuticals, including identification of need, provision of goods and evaluation of utilization;

a viable means of increasing the productivity of the native population including increasing personal income and community resources.

Direct Relief Foundation recognizes that modernization of less developed countries is complex and requires the raising of certain physical indicators such as health, nutrition, education, and energy. DRF experience indicates such modernization must proceed through successive steps which are preconditions for increasing the countries' standards of living.

Available statistics indicate the low accessibility to health care (10 percent of the population) is a major obstacle to improving the productivity and the standard of living in ten developed countries. Conversely, DRF's experience indicates that improved availability of health resources does not necessarily result in a higher standard of living. DRF proposes a project to increase the standard of living through a combined effort of capacity building in health delivery and economic resources. The project to the extent possible will be structured to capitalize on both DRF experience and on available health and economic resources in the selected less developed countries.

2. Purpose

The purpose of the AID Development Program Grant is to increase the capability of the Direct Relief Foundation to improve the health and economic status and resources of needy people in selected less-developed countries, stressing preventive health programs which

include health education and family planning training, systems of providing medical supplies and pharmaceuticals and development of a viable means of increasing productivity of the native population.

Such increased capability will allow the Direct Relief Foundation to provide:

1. Identification of nine areas of need in selected less-developed countries and establishment of three Health Resources Centers in at least three of these areas;
2. Identification and training of 30 local community health workers skilled in first aid, family planning, nutrition, sanitation and referral;
3. Development of comprehensive systems providing medical supplies and pharmaceuticals to at least 25 countries currently being served by Direct Relief Foundation;
4. Identification, improvement and/or development of locally produced marketable goods in six market areas;
5. Development of three locally-supported organizations for internal upgrading.

B. Methodology

It is important to note that throughout the work effort, the philosophy of the Direct Relief Foundation will continue to be one of helping the target populations and countries to increase their internal capacities to assist themselves. Whenever possible local human and material resources of the target areas will be utilized. All programs will endeavor to use the talent and knowledge of those who will derive the benefits.

Critical to the success of the project is the interrelationship between economic upgrading and (increasing of productivity) of the target populations and the delivery of the health resources. As the economy is stimulated, the family unit will have more time and resources to allocate to medical care and to participate in health education programs. Conversely, a healthier family unit will enable the economic productivity to be supported without interruption due to ill health. This interrelationship will be achieved through a series of orderly steps involving the planning and development of the DPG and, later, the direct operational contribution of DRF.

DPG staff will conduct as part of its methodology, a health status and economic analysis of several potential target areas. After test area selection, program staff will develop a two phase economic development plan for each area.

The initial phase will integrate economic development as it relates to increased productivity of the very poor with a rudimentary understanding of preventive health care. Achievement will be predicated on increasing the productivity of the target population and development of outreach clinics from an existing base known to DRF. Economic and health related techniques to be used will be planned by DPG staff and delivered through the Health Resources Center with staff and facilities provided and recruited by DRF.

Phase two will involve advanced economic development assistance and implementation of health training programs at the local level. This will require detailed analysis of potential markets in the test areas, evaluation of products designed to take advantage of opportunities identified in the market study, development of a guaranteed loan program to provide stimulus and encouragement for local manufacturing of products and in turn local productivity.

DPG staff will develop a health plan for the target areas. To implement the plan, DPG resources will be used to recruit and train staff who will be responsible for programs relating to the health education and delivery portions of the plan. Staff will review DRF's pharmaceutical and medical supply system in order to provide the most effective system for the target area.

The Health Resources Center will be the delivery system for the health/economic plan developed by the DPG. It will provide for the delivery of primary health care including preventive medicine, and health education, family planning,

immunization, sanitation, and nutrition by means of a horizontal organization which emphasizes outreach through trained persons from local villages and communities.

1. Identification of Need Areas

Nine areas of need will be identified in three less-developed countries. Target site criteria which maximize the concepts and purposes of the grant will be developed. Appropriate data, including demographic and morbidity statistics will be collected from such agencies as the World Health Organization, the United States Department of State, Agency for International Development, and the Department of Health, Education and Welfare as well as appropriate government and private agencies within the less-developed countries.

Using this data, selection criteria will be discussed with AID officials. Based on the experiences of DRF in Asia, Africa and Latin America and in accordance with AID policy, three less-developed countries will be selected.

A list of typical countries with background information and a brief synopsis of DRF experience is provided as follows:

a. DOMINICAN REPUBLIC

(1) Background

Per capita income is less than \$400 per year; poor health resources in country, although government and population would be cooperative.

(2) DRF Experience

Has well organized affiliate; 50 hospitals, clinics and dispensaries served; DRF programs sponsored by American Institute of Free Labor and Fundacion Dominicana de Desarrollo.

b. HAITI

(1) Background

Low standard of living; densely populated; very poor health and medical standards; population may be difficult to assist.

(2) DRF Experience

Has worked with ten recipient institutions.

c. HONDURAS

(1) Background

Very low standard of living; low coverage of medical programs.

(2) DRF Experience

Has own representative in country; twelve hospitals served; contacts with government, Rotary.

d. INDIA

(1) Background

Extremely low standard of living; poor health and medical coverage; cooperative government and population.

(2) DRF Experience

Hundreds of hospitals served; contacts with many local groups and organizations, several of which have recently initiated contacts.

e. LESOTHO

(1) Background

Per capita income is \$90; medical and health facilities inadequate and low quality; government and population cooperative.

(2) DRF Experience

None; recent contact from self-help group requested assistance.

f. BANGLADESH

(1) Background

In extreme need; little to no medical program.

(2) DRF Experience

Eight recipient institutions served; some contact with local government and Rotary in Dacca.

After selection of three less-developed countries, site visits will be made by Development Grant Staff. Their exploration of the needs of the countries as well as discussions with government, private organizations and the local population will produce recommendations for designation of nine target areas within the three target countries. Specified selection criteria will be used to make the final decision. The criteria will totally integrate the need to provide preventive health programs, a delivery system for medical supplies and pharmaceuticals, and a means of increasing the productivity of the native population.

The initial site visits will also concentrate upon analysis of sites for development of Health Resource Centers (HRCs). Though the actual establishment of each HRC will not be funded by the Development Program Grant, it is important to integrate this concept into the overall program direction. Each HRC will be associated with a health facility capable of dispensing basic health care.

The center will be organized as a resource for pharmaceutical and medical supplies as well as a provider of primary health care, preventive medicine (including hygiene, nutrition and sanitation) and health education.

This will be achieved primarily through an outreach program maintained by trained community people and volunteers recruited by DRF's AI program. As stated in Section 2, below, community people will have been trained by trainers who are supported by DRG efforts. Outreach will include provision of actual medical services as well as health education.

The HRC will also be used as a provider of information to increase productivity and as a base for development of linkage of economic development with health outreach and training.

Selection and methodology for the establishment of the Centers will be based on local attitudes, laws, customs, and need as well as the existing relationship of DRF to the area. Documented procedures will be developed in conjunction with an ongoing solicitation effort through the new Sister Hospital Program and/or Foundations. While it is not possible at this time to estimate the annual level of funding for the Health Resource Centers, sufficient discussions have already been held with various individuals and organizations to indicate sufficient interest and funding for support purposes in addition to existing resources in the A.I. and MERIT programs.



Throughout the planning and development phases of all the programs, Direct Relief Foundation will receive assistance and advice from the University of Southern California. The USC Center for Health Services Research is uniquely qualified to provide data retrieval, analysis and evaluation for the programs. The Center staff has had extensive experience in the health manpower area and will work closely with the USC Schools of Business and International Relations as needed.

2. Training Program for Community Health Workers

Direct Relief Foundation proposes to plan, develop and operate an educational program to train community health workers in a ratio of one worker to five hundred people. Training will provide skills which include first aid, family planning, nutrition, sanitation and referral. The outreach delivery concept will be emphasized throughout the development and operation of the program. The plan will also include continuing education and retraining for health paraprofessionals.

Initial efforts will be focused upon the development of an overall training plan. Included will be consideration of training methodology and location of training. It will be necessary to draw upon experience of individuals throughout other organizations who have developed similar programs in the past, e.g., Project Concern, Lutheran World Relief Medical Assistance Program.

The emerging Sister Hospital Program of DRF whereby a U.S. health facility sponsors a foreign facility, will provide additional invaluable assistance from medical and paramedical personnel in outlining the best approach. In addition, participants in the ongoing DRF Aesculapian International Program (A.I.) which places medical personnel overseas will provide an excellent resource.



Grant Staff will plan and prepare a training syllabus, manuals and other training aids based on indepth onsite study of the local needs, access to health institutions, analysis of the health status of the population and local customs, and other essential factors. Criteria for selection of thirty potential community health workers will be developed and tested. Throughout the preparation process, discussion of procedures will be held with community groups within the target areas.

AID Development Program Grant monies will be utilized in the program development and testing stages; actual implementation of training programs will be funded by DRF through the MERIT, A.I. and Sister Hospital Programs.

Medical and paramedical personnel recruited through the A.I. program will provide much of the training support. As currently envisioned, each training site will be located in close proximity to the Health Resource Centers. Training Development Teams will be composed of a training coordinator, a physician and several paraprofessional or professional volunteer health personnel, both native and foreign (e.g., registered nurse, health educator, licensed vocational nurse).

Several training modes have already been explored. Discussions with Project Concern, Duke University, and village training programs in Iran have indicated several alternatives.

The barefoot doctor concept is currently being used in Iran where individuals with six years of formal education undergo six months of medical training to become village health aids. With more than 40,000 rural villages needing primary health care and education, the rudimentary skills of health workers will undoubtedly be of significance.

Models are also available on the rural domestic level.

Duke University has developed a successful outreach program which serves rural areas of North Carolina. Persons with only seven years of formal education are identified and trained in the availability of medical services and methods for preventive and referral health care. Outreach services are centered around the individual's local community. DRF and DPG staff plan to integrate many of these concepts and training materials into their own program.

3. Plan flexible Medical Supply System for each target area.

In order to ensure that each HRC is equipped with and appropriate quantities of pharmaceuticals and medical supplies, program staff will plan a comprehensive system for delivery and evaluation of goods to be utilized in each of the nine target areas in three counties.

To achieve this, initial efforts of Program staff will concentrate upon review of DRF procedures for donating medical supplies and pharmaceuticals. A thorough review will include examination of the methods used by DRF to determine need, the methods utilized to transport goods, the system of receipt of shipments in foreign nations, and a thorough

analysis of the present utilization of goods shipped and received.

A review will be made in the nine target areas of previous DRF donations as to their speed of shipment and usefulness. This will include input by local officials, medical staff and community people.

Based on these reviews and other appropriate information sources, a comprehensive system will be planned for the effective donation and utilization of medical supplies and pharmaceuticals into target areas. Program staff will evaluate the new techniques and results in target areas in terms of whether the actual need was met and to what extent the shipment was cost beneficial. The length of time from request to receipt of goods will also be scrutinized. A critical part of this evaluation will be comments and assessments by members of the target community.

DRF's regular staff will utilize, when appropriate to the MERIT program, delivery and evaluation methods planned and tested by DPG staff. In this manner, DRF will strive to initiate more efficient and effective medical supply systems in at least 22 of the countries presently being served, in addition to the three target countries.

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4. Productivity enhancement and economic development.

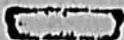
Phase one will involve the development of a plan by DPG staff to increase the productivity of a target area population as well as the exportation of the plan to IIRC's by DRF staff and volunteers.

Though the planning and development of IIRC's will be a primary goal, it must be reiterated that the effectiveness of the centers depends on their availability and response to the needs of the area. Individuals who are extremely poor are not able to be concerned about their health status. The income-health interrelationship is critical to the understanding of how economic development should be pursued.

Phase I envisions increasing the productivity of the local population, thus seeking to break the chain of low income leading to poor health status which in turn causes low productivity and leads again to low income.

As soon as the nine target areas have been selected, staff will study the economic basis of the poor and marginally poor of the area. Consultant expertise will be used to identify areas where volume and quality can be improved without altering the basic local approach. Emphasis will be placed upon the individual producer (farmer, fisherman, etc.).

From this study DRF and DPG staff with consultants will develop plans for each of the nine target areas to increase



individual productivity. Upon completion of these plans and initiation of HRCs in the target areas, HRC staff and volunteers will implement these plans through HRC outreach programs. At all times, an effort will be made to integrate the health goals of the HRC with the individual plans to increase productivity.

Phase II will be a broader effort to upgrade the economy of several of the target areas. In six of the nine target areas, program staff will develop plans to identify at least one locally produced marketable product, encourage efficient production of the product, and develop an effective marketing approach for the product. Staff will study economic factors of the areas to identify a product or products which are in need of development and which can be effectively marketed.

In selecting the products for which a development plan can be written, primary consideration will be given to the customs, ideas and abilities of the local community. Identification of potential markets for the products will involve study of export/import laws, transportation modes, foreign exchange regulations, competitive markets, and analysis of domestic and/or international factors which may effect successful sale of the goods.

Potential areas of production and marketing will be visited in order to discuss tentative marketing approaches with the communities. Based on input from each target area, detailed and tailored market plans will be developed.

Actual implementation of the development and sale of the locally produced Goods will be integrated into ongoing programs and efforts of DRF DRF Staff will research the ways in which the Foundation's contracts and programs, such as the Sister Hospital Program, can be utilized to promote the economic capacity of each target community.

In the context of this proposal, it is expected that the DPG will allow DRF to conduct the analysis of the economic basis of the poor, to identify areas where volume and quality can be improved and develop plans to increase productivity. This will be done by short term consultants with funding estimated at 10% of the yearly budget. The implementation phases one and two, based on this analysis, if advisable, will be funded from other DRF resources.

DRF staff will determine the feasibility of a program to guarantee loans to stimulate increased production and improved marketing of target area products. Survey will be made to: (a) locate potential guarantors both in the United States and in target area countries, (b) locate lending institutions willing to make business loans and (c) determine extent of guarantee which will be required.

DRF will coordinate the loan program if it is determined feasible.

In three target areas, Program staff will encourage the development of locally supported community groups to provide direction and advice for internal upgrading - in terms of both health and economic status.

Each group will be created from an existing community organization, if one is available and interested. The composition is projected to include community leaders and individuals interested in the health and economic status of the area (e.g., local health professionals).

These local organizations will be involved in all aspects of the development programs in their communities. It is envisioned that these groups will be especially closely linked to the development of the Health Resources Centers so as to provide continuity of support and assistance during and after their establishment. Each organization will be involved in the identification and selection of potential community health workers, development of training materials, and all of testing of the training program. Their ideas and recommendations will be solicited regarding an improved methodology and utilization of medical supply and pharmaceutical shipments.

In addition, the role of the community organizations will include advice and assistance regarding the best approach to increasing productivity and marketing locally produced goods. Their knowledge of local customs and attitudes will be invaluable to this process.

These community groups will be an essential element in the development and determination of success of the program. Direct Re: Ho

Foundation firmly believes that without enthusiastic cooperation and participation of these groups, it will be exceedingly difficult to achieve the projected goals. Every effort will be made by DPC staff to ensure that the best possible community groups are organized.

6. Establishment of Health Resource Centers

a. Typical Health Resource Center (HRC)

An HRC would initially be housed in a local hospital or clinic. It would require working space for one training coordinator, one physician, at least three volunteer professionals and paraprofessionals and one economic development specialist.

The volunteer training coordinator would implement the health education program provided by DPC staff. This would include organization and training of foreign and local volunteers into training teams to travel to various parts of the target area to develop an outreach program as well as provide services directly at the HRC. In addition to health education, the teams will give information on available health services to the community and information and training on hygiene, nutrition, sanitation, and family planning.

The physician will provide technical assistance in all training and education programs as well as primary health care on an outreach basis. In addition, he will be responsible for implementation of the medical and pharmaceutical supply program developed by DPC staff.

The volunteer professionals and paraprofessionals will train health education workers and provide the nucleus for delivery of basic health care.

The economic development specialist will work out of the HRC to implement phases I and II of the plan developed by DPC staff.

It is anticipated that some target areas will be covered by mobile units from the HRC. However, geographical considerations of certain target areas may mitigate in favor of HRC satellites located in one or more locations in a target area.

b. Implementation of the HRC

Operation of HRCs will commence in the third year of the project and will be accomplished with non DPG staff and resources. At least one HRC should be in place and operational at DPG's end and one HRC in place and operational in each target country within one year of DPG's end (four years from commencement of project).

As provided in the grant application methodology, shortly after selection of the three target countries, DPG staff will specify criteria for selection of the nine target areas. "The criteria will totally integrate the need to provide preventive health programs, a delivery system for medical supplies and pharmaceuticals, and means of increasing the productivity of the native population." Inherent in this criteria will be a suitable physical location for the HRC. DPG staff in this selection process will contact local hospitals, clinics and other resources for receptiveness to establishment of the HRC.

1. FACILITIES

After selection of the nine target areas, regular DRF and DPG staff will continue specific negotiations for establishment of the HRC facility. Specific provision will be made for necessary space according to DPG estimations

of needed staff size. The DPG staff person assigned to contact the test areas will determine the necessity for satellite HRCs.

Special costs relating to construction, renovation or supplying the HRC will be handled principally through the U.S. hospital sponsoring the target area hospital and regular DRF resources. Medical supplies for the target area hospital will be provided through DRF's Merit Program. Special needs of each area (such as mobile units) will be provided by means of fund raising contacts of DRF (such as service clubs).

Volunteer staff will man the HRC upon the availability of training, educational and medical supply material. This should occur in at least one target area during the duration of the grant. Volunteer staff, utilizing the plans prepared by DPG staff for this area, will put the HRC into operation.

2. STAFF

Staff for HRCs will be recruited by DRF's Aesculapian International program. At the present time, AI has approximately 400 doctors, professionals and para-professionals requesting assignment. Transportation of volunteers will be provided by the individual, the host or sister hospital or regular DRF resources.

In addition host hospitals under the sister hospital program will provide interim staff for the HRCs.

Special effort will be made by DRF to recruit volunteers to implement the economic development program. DRF is presently in the process of cooperating with the University of California at Santa Barbara in an agricultural training program which not only will provide a group of trained volunteers who might be suitable for work in the HRC, but has presented DRF with a listing of persons interested in non-medical volunteer work -- some of whom have substantial economic backgrounds.

During the development of an HRC, efforts will be made to obtain volunteer staff and support from the local population. As outlined in the methodology, such local staff will be essential to maintain an effective and ongoing program once the center is established.

C. TRANSITION AFTER GRANT

Upon completion of the project, DRF intends to continue and expand the activities initiated under the AID grant. This will be accomplished through a combination of volunteer staff and local resources which will result in continuation of the work in program target areas. DRF will provide necessary headquarters staff and services to support a continued effort. (Revenue for headquarters staff participation will be generated through Direct Relief International, DRF's new fund-raising corporate entity.)

In order to provide this desired transition to self-sufficiency, the following must be accomplished in the target areas:

- Training of local health professionals to assume responsibility for operation of the Health Resource Centers.
- Provision for continued outside volunteer support for HRCs.
- Technical and financial support for continued operation.
- and outreach of the HRC to other regions of the country.
- Support from community, local government or outside funding agency for implementation of economic plan.

1. Goals

At the termination of the DPG, effort to continue operations initiated through the project must be maintained and expanded not only in the target areas, but at DRF.

The project application spell out the means
by which the volunteer efforts will continue overseas. In addition, DPG staff at DRF must be maintained at project end. This is necessary:

- (1) To provide staff support for continuing efforts in DPG target areas;
- (2) To explore new programs and techniques in medical relief and economic assistance;
- (3) To improve techniques of traditional DRF programs; and
- (4) To provide ongoing evaluation and administrative support for all DRF programs.

To achieve this, the four professional staff and two clerical staff funded by the DPG will continue as a part of DRF's regular programs. Estimated annual cost is as follows (based on DPG budget proposal, 1975 cost scale):

Program and Planning Officer	\$ 24,000
Program Evaluation	22,000
Program and Budget Specialist	15,000
Program Data and Information Officer	15,000
Two Clerk Typists	16,000
Facilities, Services and Miscellaneous	28,800
Travel	<u>7,200</u>
	148,000
TOTAL	202,400

2. Fund Raising

Immediately upon AFD grant approval a special committee will be established to raise funds for staff continuation. This committee will be chaired by DRF Board Chairman Earl W. Brian, M.D. Its membership will include DRF Advisory Trustees, prominent supporters of DRF, and well known members of the medical and health community.

This committee will have as its goal at least \$100,000 available annually for continuation of DPG staff. Fund raising targets and methods are as follows:

SUPPORT FROM HOST HOSPITAL

Target: \$20,000 annually, commencing 7/78

Method: Each of the 20 sister hospital host hospitals will be asked to provide \$1000 per year for program staff support of the effort. The committee will work with DRF to assure that 20 host hospitals are in the program by DPG end.

CONTRIBUTIONS FROM REGULAR DRF RESOURCES

Target: \$20,000 annually, commencing 7/78

Method: \$20,000 per year will be set aside from DRF regular funds.

SPECIAL FUND RAISING

Target: \$18,000 annually, commencing 7/78

Method: A special fund raising effort will be developed to encourage 10 to 18 contributors to support the continuing DPG effort. It is anticipated that \$30,000 will be raised by 7/78.

SPECIAL PROJECTS

Target: \$20,000

Method: Several hospital and health foundations will be contacted to support a portion of the DPG staff effort. These sponsors will be able to share in the results of health delivery studies completed by staff.

Total goal for year ending June 1979 is \$78,000, with \$30,000 accumulated during the three year effort.

The committee will also explore other sources of funding such as private foundation and public grants and support from target area hospitals and institutions.

3. Recent Cash Contributions to Direct Relief Foundation

	<u>Restricted</u>	<u>Unrestricted</u>	<u>DRT</u>	<u>Total</u>
1972	\$186,037	\$ 60,681	\$ -	\$246,718
1973	\$244,821	\$ 39,716	\$ -	\$284,537
1974	\$185,245	\$ 57,856	\$ -	\$243,101
1975 (Budgeted)	\$175,000	\$ 50,000	\$ 25,000	\$250,000

D. Direct Relief Foundation Evaluation Plan

Program staff will submit a program and evaluation report on the results of the Development Program Grant every six months beginning the seventh month of the grant.

Such reports will include progress towards program goals, compliance with timetable, and comments from target area community officials on the program.

During the last month of the program, a final evaluation report will be submitted which includes assessment of success in achieving the goal and the stated End of Program Status, review of the impact on the effectiveness of the programs of Direct Relief Foundation, review of the impact on the target areas (utilizing comments from target area officials and communities), and suggested ideas for future innovative techniques and programs.

The evaluation component of the project will be formulated on the premise that the project design and evaluation are interrelated and inseparable. DRF staff subscribe to the AID concept that the development assistance process is a series of causitive (means-end) linkages

which trace the transformation of resource inputs into planned development change. The evaluation of the project will be designed to provide information for making program changes in order to make the project perform better and attain the stated purpose.

Evaluation as a process of on-going measurement will focus on the measurement of certain planned project outputs:

1. Expanded development staff and facilities.
2. Additional planning budget and evaluation capability.
3. Improved medical supply and delivery system.
4. Developed capacity to provide health education and economic development programs.

These outputs will be the focus of the evaluative process because they are hypothesized to result in the attainment in project purpose; and are assumed to be the result of certain managed inputs (i.e., if specified inputs do not produce the desired output, project management will be re-examined)

The evaluation process will be designed to the extent possible to quantitatively measure the attainment of the project outputs. Where outputs cannot be measured quantitatively, institutional or human behavior patterns will be used to verify attainment of project outputs

As a result of the DPG, DRF should benefit significantly in achieving its own goals. Although not a specific part of the program evaluation, substantial progress toward the following DRF outputs should have been achieved by the program end:

1. Recognition of local government support, local customs and local health resources in all-DRF programs.
2. Recruitment, training and placement of doctors and medical staff consistent with accepted standards.
3. Established liaison and support of local health professionals.
4. Established liaison with local community leaders.
 - a. Documentation of local health needs and resources.
 - b. Establishment of community development and selection process for community health organizations.
5. Adjustment of pharmaceutical and medical supply information consistent with finds of health need survey.
6. Implemented continuing education and retraining program for local health professionals in the use of pharmaceuticals, medical supplies, and health education materials.
7. Initiated health education and training programs in family planning, nutrition, sanitation and referral.
8. Trained community educators in family planning, nutrition, and sanitation counselling, and as referral agents.
9. Produced a measurable increase in the number of acute and chronic conditions treated by local health professionals.
10. Produced a measurable increase in the number of community members obtaining health education services.

11. Established initial liaison with alternative rudimentary health delivery systems in the country.
12. Provided for financial support for the continued operation of the Health Resource Center.
13. Documented the community economic resources and made assessment of economic potential.
14. Completed a plan for creation or increased capacity of the community economic output.
15. Obtain financial technical support for implementation of the economic development plan.

E. The Role of Women in Direct Relief Foundation

Women play an essential part in the operations of DRF - from the policymaking Board of Trustees to key positions on its staff. In addition, millions of women in over 80 countries have been the recipients of DRF's medical supplies and services.

1. Board of Trustees - of six members, two are women:

Elisabeth Zimdin (Vice President)
109 Rametto Road
Santa Barbara, California.

Eileen R. Weatherholt (Secretary)
420 West Queen Street
Inglewood, California

2. Direct Relief Staff

a. Of thirteen full time and part time staff, eight are women.

b. Of eleven "professional" or "policy" assignments, seven are filled by women:

Executive Assistant to the Executive Director--Liz Beuoy

Director of Assignments, Aesculapian International--Ruth Miller

Manager, Aesculapian International--Viola Reed

Manager, Export Department Medical Relief International--Noni Crawford

Correspondent Medical Relief International--Liz Beuoy

Office Manager--Noni Crawford

Contributions Liaison--Ilse De Mott

c. Of four clerical, bookkeeping or warehouse assignments, three are filled women:

Bookkeepers--Mary Mealy
Edith Doud

Clerk-Typist--Barbara Hood

d. Of DRF's 3000 or more volunteers, the vast majority are women.

3. In fiscal year 1974 alone, it is estimated that DRF has serviced almost one million women through its Medical Relief International and Aesculapian International Programs.

III. PROJECT NARRATIVE

A. Program Goal

1. Statement of the Goal

The broader objective to which this project contributes is the development of capabilities of local institutions within less developed countries to improve the status of health services and the economic capacity for a defined target population, to benefit the poor.

2. Measurement of Goal Achievement

- a. Capabilities of existing institutions will have been improved and expanded.
- b. Available local participation will have been enhanced.
- c. Increased understanding of all aspects of health delivery systems will have been developed.
- d. An integration of local products with a viable economic market will have taken place.

3. Means of Verification

Goal achievements will be verified by documentation from Direct Relief Foundation, reports, field visits, and USAID site visits and reports.

4. Assumptions

Assumptions for achieving the goal targets are:

1. That the established relations between Direct Relief Foundation and selected countries will continue.
2. That a responsible LDC organization, government or private, realizes the need and requests assistance from DRF.
3. The basic local human and material resources are available.

B. Project Purpose

1. Statement of Purpose

The purpose of this grant is to have a Direct Relief Foundation providing services to improve health and economic status and resources of needy people in selected LDC's, stressing preventive health programs which include health education and family planning training, methods of providing medical supplies and drugs, and development of a viable means of increasing the productivity of the indigenous population.

Once the additional Program Planning and Evaluation staff is in place, priorities and specific programs will be defined in terms of quantifiable and measurable indicators. Country selection will be based on an analysis of four major factors:

- a. Identification of suitable health and economic problem solving programs.
- b. Establishment of appropriate agreements with selected host country institutions, private and government.
- c. Availability of local support.
- d. A.I.D. priorities and concurrences.

2. End of Project Status (EOPS)

Direct Relief Foundation intends to maximize its program performance in a wide spectrum with the following results at the end of this DPG period:

- a. 9 areas of need will have been identified and Health Resource Centers will have been established at least in 3 of these areas.
- b. Thirty local community health workers, trained in first aid, family planning, nutrition, sanitation and referral.

c. Six market areas which produce local marketable goods will have been identified, improved, and/or developed.

d. Three locally supported organizations for internal community upgrading will have been developed.

3. Means of Verification

The accomplishment of the above indicators will be verified by DRF documentation, reports, field visits, USAID site visits, visits to DRF headquarters by appropriate A.I.D. personnel and by technical outputs reviewed by appropriate A.I.D. offices.

4. Assumptions

In order to obtain the conditions for the project to achieve its purpose, it is assumed that, a) DRF's approach proves to be valid and viable; b) current DRF funding support will be expanded to achieve institutional purposes, and c) the major target populations will accept DRF and its method of approach.

C. Project Outputs

1. Outputs and Output Indicators

The outputs to be obtained from the grant and its indicators will be:

a. An expanded development staff and facilities. Program staff will have been increased by 5 professionals and 2 clericals, and additional space for added staff will have been leased.

b. Additional planning, budget and evaluation capability. With the addition of the professional staff, and clerical and logistics support, the planning, budgeting and evaluation systems will be operative.

c. Improved medical supply and delivery system. An indicator will be a designed delivery system, including monitoring controls, evaluation method, etc., applicable worldwide.

2. Means of Verification

The project outputs will be verified by review of the payroll records, accounting records and the instruction documentation for supply and delivery program; by the training manuals for health education program, the market design for local marketable products and by site visits and USAID reports.

3. Assumptions

The listed outputs are dependent on several factors, such as that the DPG is funded at the level requested and that qualified personnel are available.

D. Inputs

1. Inputs from A.I.D.

A Development Program Grant

2. Inputs from Others

a. DRF Constituency

b. Foundations and Agencies

c. Corporations and Churches

d. Service Clubs

e. U.S. and host country hospitals.

3. Baseline Data

A baseline data will be developed during the first six months of the grant.

Timetable

	MONTHS	1	6	12	18	24	30	36
1. IDENTIFICATION OF NEED AREAS ● Study possible areas; identify three countries ● Contact areas ● Visit areas; further define need; identify nine target areas ● Develop HRC concept ● Discuss HRCs with target areas ● Assist DRF to establish HRCs								
2. TRAINING PROGRAM FOR COMMUNITY HEALTH WORKERS ● Prepare training procedures ● Discuss procedures with communities in target areas ● Prepare training materials ● Discuss training materials with communities of target areas ● Assist DRF with training materials								
3. DEVELOP MEDICAL SUPPLY SYSTEM ● Review existing DRF procedures ● Discuss old methods in test areas ● Prepare and review new methods ● Field test new methods in target areas								
4. DEVELOP MARKET GOODS ● Study markets in test areas ● Visit production and market areas ● Develop plan ● Assist DRF with plan								

metable. continued

MONTHS	1	6	12	18	24	30	36
5. DEVELOP LOCAL ORGANIZATIONS <ul style="list-style-type: none"> ● Integrate concept into ERC plan ● Discuss with community in target area 							
6. EVALUATION OF PROGRAM <ul style="list-style-type: none"> ● Ongoing ● Final 							

Implementation Plan (Cont. Inced)

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V. ILLUSTRATIVE ESTIMATED BUDGET

	<u>First Year</u>	<u>Second Year</u>	<u>Third Year</u>
Program and Planning Officer	24,000	25,300	26,665
Program Evaluator	17,000	18,150	19,358
Program and Budget Specialist	15,000	16,050	17,153
Program Data and Information Specialist		15,000	16,050
Two Clerk-typists	16,000	17,400	19,070
Miscellaneous Writing and Bookkeeping	12,000	13,000	14,000
Special consultants	24,000	39,000	9,000
Travel			
Out of United States	23,490	7,200	14,400
Inside United States	3,000	5,000	7,000
Facilities, Services and Miscellaneous	24,800	25,800	26 800
Equipment:	<u>10,000</u>	<u>-</u>	<u>-</u>
TOTALS	<u>\$174,290</u>	<u>\$186,900</u>	<u>\$174,496</u>

SUPPLEMENT TO BUDGET

1. Program and Planning Officer - Salary provides for approximate 5% annual cost of living increase, plus \$300 per year merit increase.
2. Program and Budget Officer - Salary provides for approximate 5% cost of living increase, plus \$400 per year merit increase.
3. Program Evaluator - Salary provides for approximate 5% cost of living increase plus \$300 per year merit increase.
4. Program Data and Information Specialist - Salary provides for approximate 5% cost of living increase, plus \$300 per year merit increase for year two and year three of program.
5. Two Clerk-Typists - At \$8,000 per year, with approximate 5% annual cost of living increases, plus \$300 per year merit increase.
6. Miscellaneous Project Writing and Bookkeeping - Provides \$7,000 for special technical writing and translation (875 hours at \$8.00 per hour) and \$5,000 for bookkeeping \$1,000 hours at \$5.00 per hour) with \$1,000 per year cost of living increases.
8. Special Consultants - Provides for first year representation in test areas (1 days in each demonstration area at \$80.00 per day, total \$2,400) and special support in certain technical areas such as public health, nutrition, family planning, dental hygiene (126 days first year at \$100 per day; 300 days second year at \$100 per day).
9. Travel

	<u>First Year</u>	<u>Second Year</u>	<u>Third Year</u>
Program Director*	\$ 7,830	\$ -	\$ 7,200
Program and Planning Officer*	7,830	-	-
Program Evaluator*	7,830	-	-
Program Data and Information Specialist	-	7,200	7,200
Travel in U.S.	3,000	8,400	10,000

*Travel and 21 days per diem to three test areas

10. Facilities, Services and Miscellaneous

Annual Rent	\$ 12,000
Janitorial and services	1,200
Utilities	1,200
Telephone and Telegraph	4,200
Copies and Supplies	4,200
Miscellaneous	2,000
(5% inflationary increase at \$1,000 per year)	<u>\$ 24,800</u>
11. Equipment

Desks, chairs, accessories for five professional staff	\$ 4,600
Desks, chairs, typewriters, accessories for two clerical staff	2,400
Miscellaneous equipment for DRF office	3,000
	<u>\$ 10,000</u>

VI. JOB DESCRIPTIONS

Program and Planning Officer

Under the direction of the Executive Director, the Program and Planning Officer shall be responsible for the conduct of the Developmental Program Grant, including compilation of procedures, manuals, statistics, evaluation material, coordination of field data and test efforts and maintenance of the program budget. He will supervise program staff and, with the Executive Director, be responsible for grant compliance and budget. The Program and Planning Officer shall essentially have experience in administration and/or operation of operation of health maintenance and preventive health programs plus experience in supervision, program writing, evaluation, fiscal responsibility, budget and federal grant operation and compliance.

Program Evaluator

Under the direction of the Program and Planning Officer, the Program Evaluator will study and evaluate existing procedures and delivery systems, prepare and manualize new evaluation techniques, and evaluate progress of the program. The Program Evaluator shall possess broad knowledge of evaluation techniques and experience in governmental grant operations related to preventive health programs and health maintenance.

Program and Budget Specialist

Under the direction of the Program and Planning Officer, the Program and Budget Specialist will write program materials, directives and manuals, compile statistics and program documentation, review budget procedures and provide grant fiscal controls. The Program and Budget Specialist shall possess knowledge of governmental grant operations and experience in program writing and budget control.

Program Data and Information Specialist

Under the direction of the Program and Planning Officer, the Program Data and Information Specialist shall be responsible for data collection, information gathering and personal contact with test areas in the second and third year of the program. The Program Data and Information Specialist shall coordinate collection of data with efforts of other program staff. This Specialist shall possess experience in dealing with peoples and programs in developing nations, knowledge of data collection techniques and knowledge of health and economic development programs.

Clerk-Typist

Under the direction of the Program Director or the Program and Planning Officer, the Clerk-typists shall perform clerical tasks in support of the project for the Program Director, the Research Officer and the technical staff. Clerk-typists shall type at least 55 words per minute and be competent in clerical skills.

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: _____
From FY _____ to FY _____
Total U. S. Funding _____
Date Prepared: _____

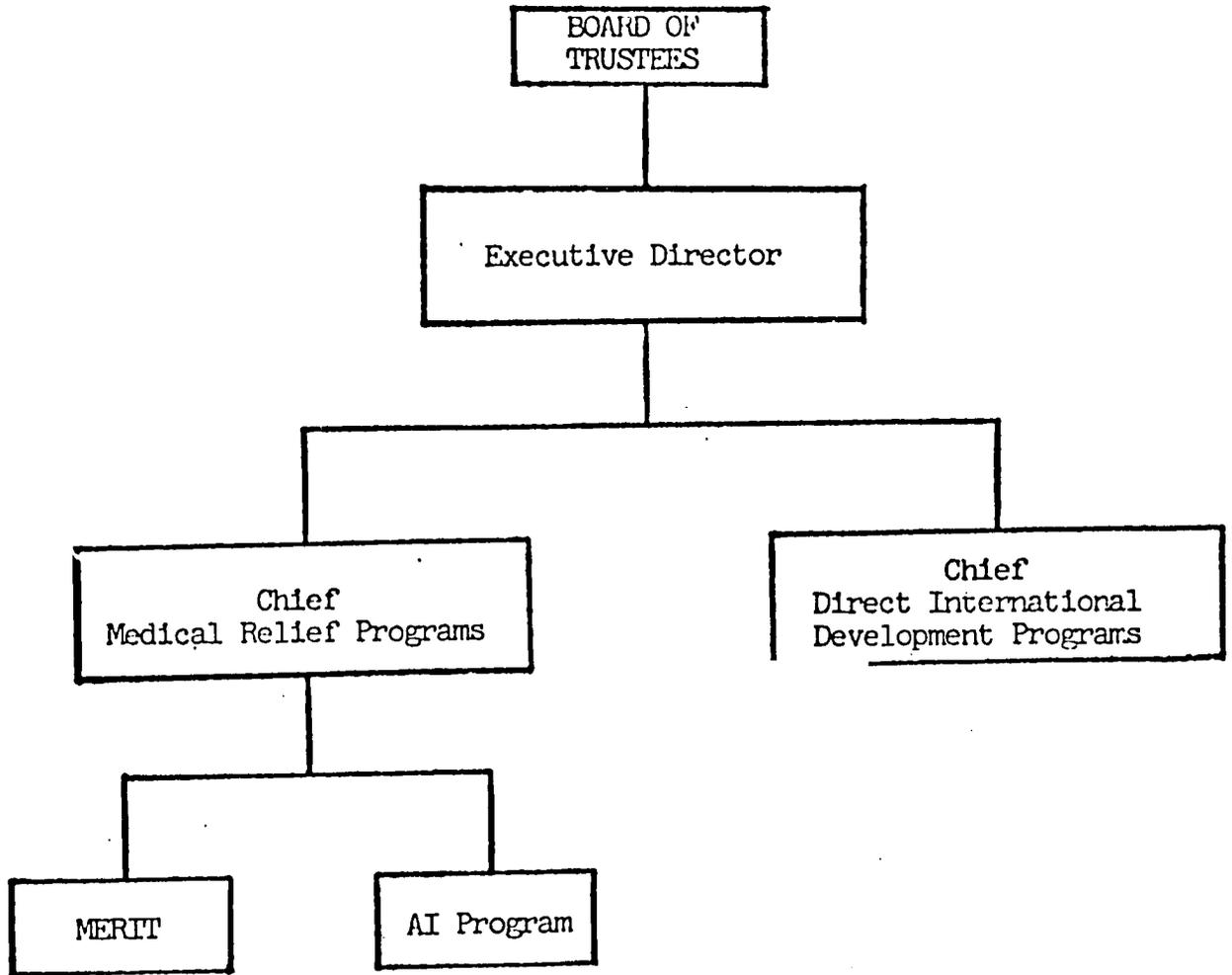
Project Title & Number: Direct Relief Foundation Development Program Grant

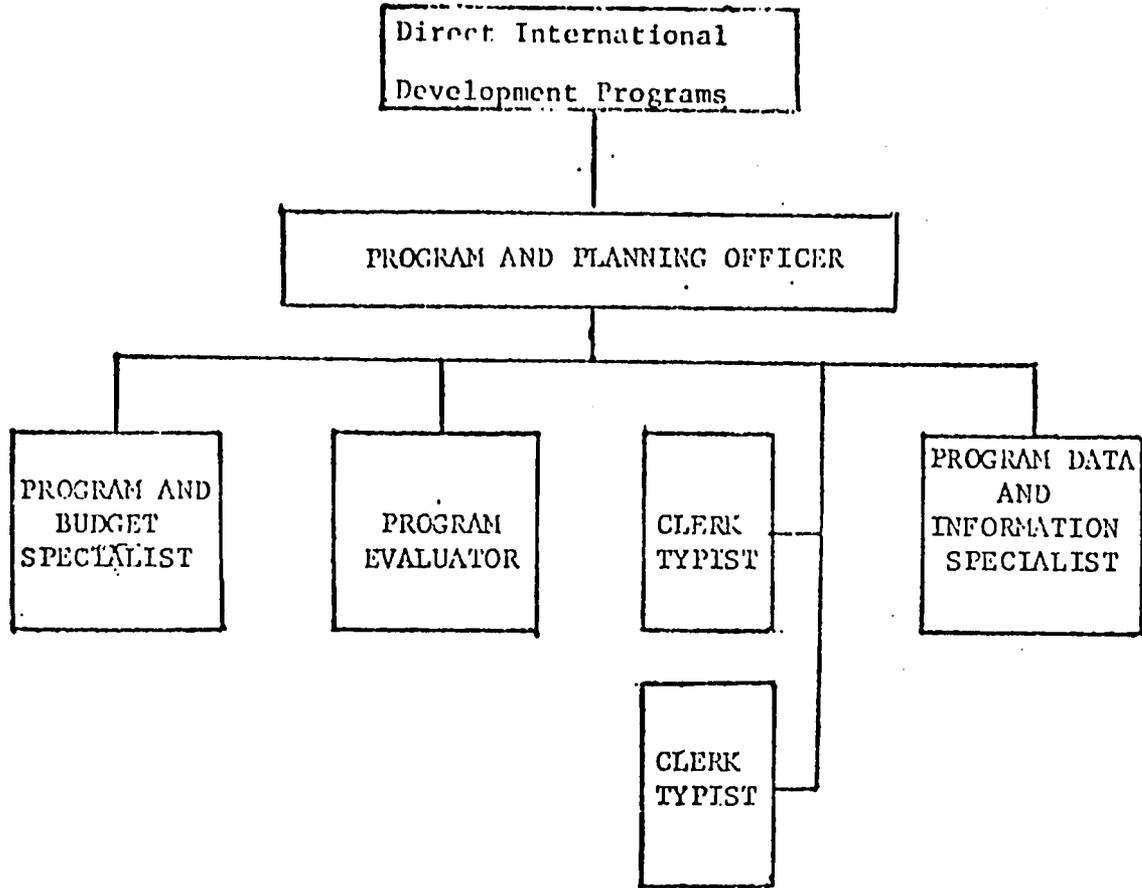
NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The broader objective to which this project contributes: To develop the capabilities of local institutions within less developed countries to improve the health services status and economic capacity to a defined target population for the benefit of the poor.</p>	<p>Measures of Goal Achievement: 1. Capabilities of existing institutions will have been improved and expanded. 2. Available local participation will have been enhanced. 3. Increased understanding of all aspects of a health delivery system. 4. An integration of local products with a viable economic market will have taken place.</p>	<p>Direct Relief Foundation documentation, reports, field visits, USAID site visits and reports.</p>	<p>Assumptions for achieving goal targets: 1. That the established relationships between DRF and selected countries will continue. 2. That a responsible LDC organization, government or private realizes the need and requests assistance from DRF. 3. The basic local human and material resources are available.</p>
<p>Project Purpose: An operational DRF providing services to improve health and economic status and resources of needy people in selected LDC countries, stressing preventive health programs which include health education and family planning training, methods of providing medical supplies and drugs, and development of a viable means of increasing productivity of the indigenous population.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status. (EOPS) 1. 9 areas of need will have been identified and HRCs will have been established in at least 3 of them. 2. 30 local community health workers trained in first aid, family planning nutrition, sanitation and referral. 3. 6 market areas which produce local marketable goods will have been identified, improved and/or developed. 4. 3 locally supported organizations developed for community upgrading.</p>	<p>DRF documentation, reports, field visits, USAID site visits. Visits to DRF Hq. by appropriate A.I.D. personnel. Technical outputs reviewed by appropriate A.I.D. office.</p>	<p>Assumptions for achieving purpose: 1. DRF approach proves to be valid and viable. 2. Current DRF funding support will be expanded to achieve institutional purposes. 3. The major target populations will accept DRF and its method of approach.</p>
<p>Outputs: 1. Expanded development staff and facilities. 2. Additional planning, budget and evaluation capability. 3. Improved medical supply and delivery system.</p>	<p>Magnitude of Outputs: 1. Program staff increased by 5 professional and 2 clerical personnel; additional space leased for added staff. 2. Planning, budgeting and evaluation systems operative. 3. Designed delivery system, including monitoring controls, evaluation methods, etc., applicable worldwide.</p>	<p>1. Payroll records. 2. Accounting records. 3. Instruction documentation for supply and delivery program. 4. Training manual for health education program. 5. Market design for local marketable products. 6. Site visits and USAID visits.</p>	<p>Assumptions for achieving outputs: 1. That the DPG is funded at the level requested. 2. That qualified personnel is available.</p>
<p>Inputs: 1. DPG from A.I.D. 2. DRF constituency (Mailing list). 3. Foundations and Agencies. 4. Corporations and Churches. 5. Service Clubs. 6. U.S. and host country hospitals.</p>	<p>Implementation Target (Type and Quantity) (Budget) (Implementation Plan)</p>		<p>Assumptions for providing inputs:</p>

VIII. DIRECT RELIEF FOUNDATION ORGANIZATION

A. Organizational Structure

All DRF activities are directed from Santa Barbara where the headquarters and warehouse are located. Following is DRF's organization chart. If the A.I.D. grant is approved, it would be functionally located in the Direct International Development Branch.





Legal Basis

DRF is a non-profit, charitable organization incorporated under the laws of the State of California. It has been granted tax exempt status by the United States Internal Revenue Service [REDACTED]

DRF is governed by the Board of Trustees composed of five members and a chairman. They generally meet ten times during each year.

1. Earl Brian, M.D., Chairman of the Board

Center for Health Services Research
USC School of Medicine
2025 Zonal Avenue
Los Angeles, California

Citizen: United States
Former Secretary of Health and Welfare, State of California, with
45,000 employees and \$6 billion budget;
Associate Professor of Community Medicine and Public Health, USC.
[REDACTED]

The Chairman is responsible for the management and control of corporate affairs.

2. Dennis G. Karzag
717 Knapp Drive
Santa Barbara, California

Citizen: United States
Experienced in overseas relief work since 1948; Director of Programs,
DRF; background in construction, warehousing, farming, tree culture,
food service, nutrition, real estate.

3. Robert K. McGill, President
15-410 Grand Avenue
Elsinore, California

Citizen: United States
Rancher; experienced in business management, livestock, land develop-
ment, overseas relief work.

4. William McGill
15-410 Grand Avenue
Elsinore, California

Citizen: United States
Real estate broker; experienced in ranching, livestock, foodgrowing.

5. Eileen R. Weatherholt, Secretary
420 West Queen Street
Inglewood, California

56.

Citizen: United States
Airline hostess; interest in international medical relief.

6. Elisabeth Zimdin, Vice President
109 Rametto Road
Santa Barbara, California

Citizen: Italy
Experience in overseas relief work for 34 years; wife of
William Zimdin, founder of DRF

(Reuben J. Irvin, Treasurer - not a member of Board
20 E. Carrillo Street
Santa Barbara, California

Citizen: United States
Chairman of the Board, Santa Barbara National Bank)

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The Medical Task Force and the International Advisory Council are among the several groups which advise the Board and the entire Foundation.

The Medical Task Force is composed of six physicians who have had practical experience in supervising delivery of health services to medically deprived areas:

1. G. L. Ashor, M.D., Los Angeles, California
Past Medical Director of AMIGOS DE LAS AMERICAS, experienced in reviewing and evaluating preventive medical services in Central America.
2. James C. Carey, Jr., M.D., F.A.C.S., Santa Barbara
Past President, Mission Doctors Association; past Medical Director of AMIGOS DE LAS AMERICAS, experienced in review and evaluation of training for development of preventive and curative medical services in Africa and Central America.
3. J. M. de los Reyes, M.D., Los Angeles, California
Vice President, International College of Surgeons, broad experience throughout developing nations in field of health, emphasis on preventive care.
4. David P. Hansford, M.D., Rep. Medical Officer
Department of State, American Embassy, Bangkok, Thailand, experienced in evaluating medical services delivery systems in Africa and the Far East.
5. Alfred B. Swanson, D.C., Grand Rapids, Michigan
Experienced in health facilities of Far East, excellent analysis of health needs.
6. Paul Williamson, M.D., Laurel, Mississippi
Service in Central America, Africa, South Asia; emphasis on evaluation, utilization of supplies

Several of the nearly fifty members of the Direct Relief Foundation

International Advisory Council should be noted:

1. Dr. James H. Boren, Washington, D.C.
PARTNERS OF THE ALLIANCE with vast experience in development programs in Latin America.
2. Porter Briggs, Executive Secretary, Federation of American Hospitals, Little Rock, Arkansas. Experience in institutional delivery of health care.
3. L.C. Jaime R. Fernandez, Santo Domingo, Dominican Republic.
DRF Affiliates in the Dominican Republic and Director de Recursos Materiales of FUNDACION DOMINICANA DE DESARROLLO.
Experience in medical relief and development programs.
4. Lucia Holguin de Vazquez, Bogota, Colombia. President, DRF Affiliates in Colombia; President, Colombian Volunteer Ladies.
Experience in preventive medicine and development work.

Personnel

1. Headquarters

- a. Executive Director: Peter Rank, effective January, 1975
(See Resume, Appendix-III).
Reports to Board of Trustees; is responsible for overall management of DRF, including responsibility for and direction of Direct International Development programs.
- b. Director of Programs: Dennis G. Karzag.
Responsible for day-to-day supervision of MERIT and A.I. programs.
- c. Office Manager: Noni Crawford.
Reports to Director of Programs; supervises clerical staff in business office.
- d. Administrative Assistant: Liz Beuoy.
Assistant to Executive Director; Program Officer for MERIT.
- e. Manager, A.I.: Viola Reed.
Manager of A.I. program.
- f. Director of Assignments, A.I.: Ruth Miller
Responsible for A.I. assignments.
- g. Contributions Liaison: Ilse DeMott.
Part-time.
- h. Book-keepers: Edith Doud, Mary Mealy.
Part-time.
- i. Clerical: Two part-time.

2. Warehouse

- a. Warehouse Manager: Helmuth Gunther.
Reports to Director of Programs; responsible for maintenance and shipment of medical and pharmaceuticals supplies.
- b. Manager, Pharmaceutical Department: William Chachakos, Pharm.D.
Reports to Warehouse Manager; responsible for maintenance of pharmaceutical inventory and Quality Control Program.
- c. Warehouseman: One full-time.

3. Volunteers

The headquarters boasts more than 100 volunteers working at the warehouse and the central office. Thousands of volunteers throughout the nation collect medical supplies and equipment for DRF activities; transportation of goods is provided by Wings for Direct Relief, a special project of the Ninety-Nines, a nationwide group of women pilots.

Additionally, hundreds of volunteers serve in DRF activities in foreign countries. More than 100 foreign Rotary Clubs have assisted DRF in its work in their countries. DRF's A.I. program, in the past year alone, provided 130 volunteers, estimating that the program reached 551,000 persons with a value of services priced at \$1.1 million.

IX. DIRECT RELIEF FOUNDATION BUDGET - FISCAL YEAR 1975

DRF's budget for Fiscal Year 1974-75 (October 1, 1974 to September 30, 1975) is provided. Estimated value in medical supplies and assistance is \$2.5 million. Administrative costs to provide these goods and services is \$292,000 or 11.6 percent. This cost includes shipment of goods and fund-raising activities.

DEPT OF HEALTH FOUNDATION BUDGET

1975 Fiscal Year
(Revised)

PROGRAM SERVICES

Medical Relief International ¹ (estimated wholesale price ²)	\$1,475,600
Aesculapian International ¹ (estimated value of services ³)	1,079,435
	<u>\$2,555,035</u>

ADMINISTRATION

Salaries and benefits*	124,566
Rent and utilities*	27,500
Communications*	9,000
Transportation*	10,000
General operating expenses*	35,904
Shipping expenses*	75,000
Volunteer services ⁴	<u>198,377</u>
	\$ 480,374
 TOTAL:	 \$3,035,382

*Indicates cash expenditures

F O O T N O T E S

¹Estimated for fiscal year based on 30% reduction from first half of fiscal year 1974-75.

²MERIT pharmaceutical shipments are valued by our pharmacist according to wholesale listing in catalogues provided by manufacturers. (All shipments have exact totals of products sent.) MERIT medical supply shipments are valued by our warehouse equipment man according to normal market value.

³AI value of placement time is computed as follows:

Physician specialist	- \$300/day
General Practitioner and dentists	- \$200/day
Nurses and medical technicians	- \$ 35/day

⁴Volunteer services:

Clerical (MERIT/AI) 1,863 @ \$3.50	\$ 6,520.00
Trustees	
Chairman 300 hrs. @ \$60	18,000.00
Members 1,140 hrs. @ \$15	17,100.00
Processing Plant 6,612 @ \$3.50	23,142.00
Director of Programs	18,000.00
Assistant to Chairman 250 @ \$25	6,250.00
International Health Activities of Women's Auxiliary to American Medical Association 2,833 @ \$5.00	14,165.00
Advisory Council 3,600 @ \$10	36,000.00
WINGS 592 @ \$100	<u>59,200.00</u>
	\$198,377.00

X. REPORTING AND EVALUATION

A. DRF will report progress to AID/W in accordance with the Implementation Work Plan.

B. The evaluation schedule which is proposed will consist of the following three types:

a. Informal status analysis to be performed by PHA/PVC Project Managers as regular monitoring practice, with frequency as determined by the reporting from DRF.

b. A non-intensive (meaning a regular PAR) evaluation performed by an AID/W team prior to the end of the first and second years of the grant. This evaluation will be adequate to gauge progress and identify bottlenecks. Furthermore, it will determine if continuation of the grant is justified.

c. At the end of the grant, if the record of the grant should indicate the necessity of an intensive evaluation to determine possibilities of replication elsewhere, or continuation of support to the same institutions, outside consultants will be engaged to make an evaluation outside the AID/W influence.