We will probably get back to Mr. Klein, but I would like to get Dr. French, while we are talking here about some of these health issues.

First, let me say that the general health problems of South Vietnam are those which are common to most poor, underdeveloped, tropical countries, basically in six categories: infectious disease problems; parasitic disease problems; malnutrition; environmental conditions of the populace, especially relating to their living conditions and the practices of general hygiene and sanitation; the effects of Westernization, especially those effects brought about by mechanization, leading to a disproportionate incidence of accidents; and lastly, problems which are peculiar to the mores and social conditions inherent in the population in question.

The latter have to do with the age range within the population, the agricultural way of life, and so forth.

By way of examples of some of these changes and what effect they have on health problems in South Vietnam, if one looks at the combined effects of natural accidents, especially having been increased by Westernization, and those other accidents which are related to warfare, and combine these with the effects of infectious and parasitic diseases, one finds that in 1970 this combined effect represented one-fourth of the total morbidity of the population of South Vietnam; this morbidity rate being shared equally between the effects of trauma, whether it be warfare or other kinds of accidents, on the one hand, and infection on the other.

**Mortality Rates**

If one looks at mortality in 1970 in South Vietnam, one finds that over 49 percent of the deaths in that country were related to the combined effects of accidents, warfare and infection, and again, the accidents and war were about equal to the effects of the infectious disease problems.

Two years later, in 1972, there had been little change and, in fact, the combined morbidity effect had increased, apparently slightly, although I think that this increase was not real.

At the same time, however, we find that there was a significant drop in mortality, a full 6 percent over that 2 year period, and I think this was related primarily to the improvement in the overall ability of the medical care system of that country to cope with its almost overwhelming problems.

**Hospital Admissions**

At this point I would like to inject some additional statistics about the hospital population of Vietnam.

In the period between 1967 and 1973, the hospital population or the admissions to hospitals increased from 470,000 a year to approximately 800,000 per year, which was almost a doubling. Casualties, however, resulting from warfare as a component of this hospital admission rate went from 46,000 to a projected figure of about 42,000 over the same period. In other words, 10 percent of the hospital admissions in 1967 were related to warfare, and we find that in 1973, we come up with a projected figure which runs somewhere between 5 percent and 6 percent.
So there is a considerable burden which still exists, upon the hospitals and medical care systems of this country related directly to warfare.

Senator Kennedy. But the total numbers are pretty close to the same, are they not? The difference between 46,000 and 42,000?

Dr. French. Yes. However, the hospital admissions doubled; although the total number stays the same, they doubled.

Senator Kennedy. But in relationship to the number of people that are actually war-related casualties, it is at a similar level as last year.

Dr. French. That is right. This is not talking about military hospitals; these are civilian hospitals.

THE BURDEN OF WAR ON HOSPITALS

I think the important thing to recognize here is that there is a considerable burden still being exerted on the civilian medical care system by warfare.

We had an opportunity to view this firsthand in a couple of instances. Particularly, this was seen in Quang Nagai, where we visited a large provincial hospital supported in part by the government of New Zealand and their excellent medical team. We saw numerous casualties which had been admitted to that hospital, children, adults, all ranges and ages of life, who had been injured and maimed by the continued effects of warfare, and we have some pictures that might be entered into the record of these individuals.

The major implication of the morbidity and mortality information which I have just given, is that preventive measures could be most productive in improving the health status of this land. One needs to say little about the prevention of war casualties being directly related to the cessation of warfare and, of course, much is known about the prevention of other accidents, whether they be in industry, on the farm, related to motor vehicles or secondary to other Western inputs which, until relatively recently, were foreign to this country.

Prevention, again, plays a major role in approaching the infectious, parasitic, enteric, and pulmonary disease problems. These are eminently responsive to early diagnosis and prevention and the recognition of this fact and the combined efforts of USAID health personnel and the indigenous health structure of the country of South Vietnam has resulted in a dramatic change in the evolution of the input of assistance and consequent development of the medical care system of that country.

I would like to mention at this point that a number of the original input USAID funds into the health system was related to trying to change the medical education system and the hospital system of that country in the direction which it has taken in the United States, namely, towards the creation of many specialists and highly specialized hospitals and institutions which have extremely high costs but limited value in terms of reaching the lower echelons of needs at the interface between the ordinary population and the medical care system.
TURN-ABOUT IN USAID PUBLIC HEALTH SUPPORT

In 1972, however, there was a complete turn-about, which was under the combined efforts of USAID health personnel and the Ministry of Health personnel. A convention or meeting was held. Other health representatives from developing countries were brought in and as a result of this meeting, a major decision was made to change the primary investment into health, rather than being at the top with limited effects at the bottom, changing around this investment in the direction of community health, community medicine and trying to invest most of their efforts into the district levels, the villages and the hamlets.

I believe that the byproduct of this effect over the last 2 years has really been significant, and there has been considerable input and results from this.

However, I want to indicate the following, Mr. Chairman, that this situation, which is a very positive one headed definitely in the right direction, which I believe is going to lead to major changes in the organization of an excellent medical care system, are kind of precarious at this time, and the reason for this is, if we look carefully at the input of funds through USAID into the health programs of this country, we find that they are consistently being cut back at a rate which I think is rather rapid, and one wonders as to whether they will be virtually cut out altogether before the mechanism of the country can, in fact, overtake the full responsibility.

I have a chart here—a couple of charts—which have been made up, which can demonstrate this. [see figures 1–3]
RELATIVE VALUE OF GVN PIASTER*
YEARLY AVERAGE 1966 - 1974
*PIASTERS: U.S. DOLLAR, EXCHANGE RATE

TOTAL U.S. AID/VIETNAM PUBLIC HEALTH SECTOR FUNDING
U.S. DOLLARS & PIASTERS IN U.S. $ 
(ACTUAL VALUE, AS ADJUSTED TO AVG. YEARLY RATE OF EXCHANGE)
DECREASE IN U.S. MEDICAL AID

What we have done here is take the amount of U.S. dollar input over that period. I believe beginning in 1966 or 1967, which has steadily decreased from the U.S. Government. At the same time, there has been a steady increase in piaster input by the Vietnamese Government. It has been suggested that that increase in piasters counterbalances the decrease in dollars.

But if one considers the effects of the inflationary rate and converts the piasters into actual dollars and combines them with the U.S. dollars [chart 3], one can see that we have a steadily decreasing curve in terms of actual input into the health care system as far as the total effort. If we combine the effects of inflation, piasters, and U.S. dollars, there has been a steady decrease.

Senator Kennedy. This is real dollars, then?

Dr. French. These are real dollars. What, in effect, is occurring here, is a steady attrition in terms of input into the health care system. And it is my belief from what I have observed that this has reached a critical point.

I believe that it has reached the danger point, and I think that if it continues much beyond the present time, there is going to be a virtual collapse in terms of the health care system of that country.

Senator Kennedy. Of course, if you look over at these charts [see figure 4, on page 1], you see from 1973, you see the total dollars for Saigon—with the exception between 1972 and 1973—is actually increasing.

And yet, your point is that in terms of the total amount, in real dollars, being expended in the health area is one of declining amounts.

Dr. French. That is right. And my feeling is if we look at this particular humanitarian—

Senator Kennedy. Excuse me, have you seen any projections for next year?

Dr. French. I do not have the projection figures for the coming year's health care program, but I would be somewhat surprised if there was any marked increase in next year's budget that would be particularly earmarked for health.

EFFECTS OF CUTS IN U.S. MEDICAL AID

I would like to mention several components of this health care system which are particularly endangered. There has been a medical logistics and supply system which was developed for this country primarily through our efforts, which works remarkably well. And for the first time in the history of that country, there is an equitable distribution of much needed medications, medical supplies and equipment.

However, the United States input into this system is now at such a low level that it cannot, in fact, maintain itself. There are vehicle and transportation needs and so forth which cannot even be kept up at this point because there are no longer personnel to be paid to main-
tain this system. Therefore, I can see an imminent collapse in terms of distribution of necessary medical supplies and equipment throughout the country.

There was a capital development improvement program for the development of the infirmaries and health facilities for the villages and hamlets throughout the land. This program has just gotten under way. However, unless there is forthcoming a significant amount of aid, this will entirely collapse. And if it does, the entire program, which has its emphasis now at the level of the villages and hamlets, will likewise cease.

There are other programs such as the national laboratory program, which is an excellent program, remarkably well developed to allow for the first time in the history of this country a widespread laboratory evaluation for people who are ill. That system is in imminent danger, likewise, of collapse, unless significant support is forthcoming.

And, finally, there are numerous training and educational programs through the National Institute of Public Health, which likewise will not really get off the ground to maintain this medical care system which is developing at the right place, namely, at the bottom, in the villages and hamlets where it will have the largest impact on the population.

RECOMMENDATIONS

I would like to get to some recommendations in my written testimony, Mr. Chairman, at this point. I do not want to expand upon the first two too much, but I would like to dwell upon the third one to some extent.

First of all, I would like to recommend strongly that there be continued significant input into the general and specific support of the Ministry of Health. This input has been remarkably good. It is involved in the planning and developmental process of the whole health care system.

Second, I would like to strongly recommend continued special project support which relates to those special programs in logistics and supply; the National Institute of Public Health; a newly developing maternal and child health program—and, incidentally, in this regard, 70 percent of the people in this country are either children or mothers—a significant maternal and child health care program. And an important part of that is family planning and other things of this nature which will affect the majority of the population of this country. And lastly, of course, is the facilities development program, which, as I have indicated earlier, is so essential to the development of health care, the important interface between the people and the health care system.

The last recommendation has been touched upon already to some extent, but I would like to further examine this. This is in the area of multilateral aid for the development of the health care program of this country.
MULTILATERAL AID

Multilateral aid for the development of health and social welfare conditions in Southeast Asia has been talked about over the last couple of years but has shown very little evidence of practical development. For this reason, a special effort was made to investigate the current status of this approach, and it would be worthwhile to review this process.

On the way to visiting Southeast Asia, the study mission stopped off in Geneva, where contact was made with the Indochina operational group of the Red Cross, the UN High Commissioner for Refugees, and the World Health Organization. Colonel Douglas Gill, Chief of Operations of IOG, and Mr. Jean Pierre Hocke, the Chief of Operations of ICRC, discussed in some detail the continued function of IOG.

ROLE OF THE IOG

This organization had initially expected to be inoperative after an initial year's function, but finds itself now beyond 1 year and expecting to have to function for an additional 9 months at least. The IOG was set up only on a temporary basis initially as a combined operation of the ICRC and the International League of Red Cross. It was set up for strictly emergency purposes, since the International Red Cross sees itself as operative only under emergency conditions.

At that point, we learned of the virtual dependence upon the IOG for all emergency medical care operations in the country of Cambodia. This subject is taken up in more detail under the discussion relative to the country of Cambodia.

The IOG does not look upon itself as extending indefinitely in its operative approach in the future and is looking to be relieved by some other kind of international emergency and on-going operative entity.

U.N. HIGH COMMISSIONER FOR REFUGEES

We also met with the U.N. High Commissioner for Refugees, Sadrudin Aga Khan, who discussed in some detail his plans for the initiation of a greatly enlarged and strengthened refugee relief program for the Indochina Peninsula. I was particularly interested in the nature of the medical care support that the U.N. High Commissioner for Refugees would anticipate.

He indicated that they were cognizant of extensive medical care needs and that they would call freely upon WHO and UNICEF to assist them in this regard. They felt that there was a good past history of cooperative activity between these three arms of the United Nations, and he felt that this would also operate smoothly in the case of Indochina if adequately supported financially by the various nations through the United Nations, including the U.S.
We also met with Dr. Belleride of the World Health Organization in Geneva, who again indicated the great willingness of WHO to cooperate in a joint effort with UNICEF and the U.N. High Commissioner as indicated to meet refugee and general humanitarian needs in Indochina. Dr. Belleride, however, indicated that the functional structure of WHO was such that all operations must of necessity emanate from the Southwestern Pacific office located in Manila, The Philippines.

U.N. PERSONNEL IN THE FIELD

It is important at this point to review briefly the nature of contacts with various UN officials in Indochina itself. After we left Geneva, upon arrival in Bangkok, Thailand, we met with Mr. Mace, the deputy to the U.N. High Commissioner for Refugees, who had just completed a short tour of South Vietnam at the request of the U.N. High Commissioner for the purpose of program development. We were briefed concerning some of his findings, and it was indicated to us the willingness of the U.N. High Commissioner for Refugees to be cooperative with the United States in terms of developing multilateral support for refugee relief. It was also indicated to us that they were hopeful of having operative programs under way as of October 1974.

Our next interface with U.N. officials was at a luncheon in Saigon held by Mr. Pierre Sales, resident representative of the UNDP. Present at this luncheon was Mr. Paul Nelson, Social Development Advisor for the U.N.; Mr. Jean Jacques Deschamps, UNICEF Program Officer sitting in for Mr. Ralph Eckert; and Dr. Richard Coppedge, WHO representative ad interim and project manager for the National Institute of Public Health project.

At this luncheon, we again broached the subject of the multilateral approach through the UN and specifically utilizing three components of the UN, namely UNICEF, WHO, and UNDP, in addition to the good offices of the U.N. High Commissioner. The conversation indicated that there was strong acceptance of this approach. There had obviously been some contact between Geneva and the UN officials with whom we lunched, indicating that as a result of our recent visit to Geneva there was strong development of a feeling of agreement being possible and wanting to proceed with this approach.

At another luncheon held by Dr. Richard Coppedge, I had an opportunity to speak directly with Dr. Dy, the Director of the Southwestern Pacific Section of the WHO. Incidentally, Dr. Dy flew in from Manila to be present at this meeting. Dr. Dy was the last cog in this wheel, and he indicated that it was his policy and that of the Southwestern Regional Office of WHO to strongly support health and humanitarian developmental projects and that they were giving special preference to the countries of the Indochina Peninsula recently set back by the ravages of war.

He was agreeable to the multilateral approach which would allow the enlargement and development of programs by WHO and indi-
icated that all that was necessary was that the specific country make a formal request for this assistance, and WHO would be more than willing to respond.

Elsewhere in this testimony, Mr. Klein will perhaps enlarge upon some of his meetings with people in UNICEF.

POSSIBILITIES GOOD FOR U.N. INVOLVEMENT

Mr. Chairman, I would like to indicate that these contacts, both in Geneva and in South Vietnam—and later it will be further indicated that these were extended into the country of Cambodia—indicated not only a willingness on the part of the critical divisions of the United Nations to be involved in a multilateral approach, but almost their anxious anticipation that some sort of leadership or push or statement or obvious evidence of wanting to do this would come from the United States, that undoubtedly program possibilities are most possible in that regard.

Senator KENNEDY. This is terribly important, Dr. French. I gather from what you say that, first of all, there is a great willingness, desire and interest, from what you saw, by the various agencies of the U.N.—whether it was the U.N. High Commissioner, or, as you have mentioned, WHO, UNICEF, UNDP—all showed a willingness to take the time to meet with you, and to assume some additional responsibilities in these areas of humanitarian concerns. I gather that was one of your prime observations.

Second, you are an expert in the evaluation of the functioning of different organizations in the health area. And, as one who has been a real spearhead in developing community health programs and actually seeing these programs function, and work effectively in my own city of Boston. I think all of us in that community, as well as those who know you by reputation in other parts, respect your judgment. And, of course, Mr. Klein has had a wealth of experience in looking at refugee programs.

And you come back with a firm impression, in terms of these international agencies, that they have the will and the capacity to get some things done in Indochina.

I am terribly interested in this.

We are talking about international humanitarian programs which may be limited now because of the lack of resources, but programs which, from your professional point of view, could be reasonably expanded and could function and work effectively in carrying out the mandates of their charters?

Do you have any reservations at all about endorsing these international agencies?

Dr. FRENCH. I have no reservations whatsoever. In fact, the record with UNICEF and WHO in other parts of the world has been exemplary. I would feel that they should not only be encouraged, but I got the impression that they were encouraging me and were hopeful that—for instance, in the instance of the U.N. High Commissioner, it was not initially our intent to see him. We had not even remotely dreamed that we were going to see him. We got a command
performance appearance from him and appeared in his offices, he being desirous to try to convince us to take a message back to the United States that they were hopeful we would want to be involved with them in this kind of thing up until that point their not being aware that there was sufficient desire in this direction on our part.

Senator Kennedy. There is something missing here.

Now, we have had, as I have read earlier, the statement of Administration officials saying they want to use these agencies and to involve these international organizations. I personally went around to see the heads of U.N. agencies, probably 5 to 7 years ago, to ask of their interest. And I found uniform interest and willingness and a desire to work, so far as possible, in Indochina.

Our amendment is going to insist upon our support of these agencies. I think that unless we do that, I think we will be making an extremely serious mistake—for the reasons that have been outlined in your and Mr. Klein's testimony.

As one who barely went along with it last time—I think they won the foreign aid program by three or four votes the last time—even though I am very interested and have supported foreign aid every year since I have been in the U.S. Senate—but I, for one, do not see how, given these kinds of unfulfilled assurances and commitments of the past, unless something is changed in the area, I find the other parts of the program of sufficient concern to question my continued support of the foreign aid bill. But I think your statement is very helpful in this area.

SITUATION IN CAMBODIA

Let me just ask you, Dr. French, how do you compare what is happening in the Cambodian situation versus Vietnam, in the health area?
Dr. FRENCH. Fine, I would like to make some comments on that. But may I make one last comment on the U.N. situation?

Senator KENNEDY. Fine.

Dr. FRENCH. While in Indochina, I got several reports from UNDP relative to their assistance both in the Khmer Republic, as well as South Vietnam. There are numerous places along the way where it is indicated that they had held back in their programs of assistance because of the input in the bilateral fashion between the United States and the particular government. For that reason, rather than overlap, they were not developing programs.

There are specific instances which I, for instance, pointed out to your staff the other day where this is alluded to in the UNDP report. So our bilateral aid in a way has held back U.N. development to some extent.

Relative to the Cambodia situation, Cambodia is an entirely different problem. It is a rather sad situation. It is an extremely overwhelming situation.

TWO CAMBODIAS

There are two Cambodias. There is the Cambodia of Phnom Penh, which has swollen from its original 700,000 population to what some now estimate to be 2 million, which is out of a population of the entire country of approximately 7 million people. With this swelling of the population of Phnom Penh, which is surrounded only by a small amount of arable land, completely separated from the rest of the country by any and all transportation means, it becomes readily obvious that all kinds of nutritional and other kinds of problems are being created by the very logistics of the situation involved.

The tremendous influx of refugees into Phnom Penh has created a swelling of the indigent population. What characteristically happens is, the refugees come into temporary situations, whether it be a Buddhist pagoda or any other kind of temporary camp situation they can get into. There is no place for them to go from there, except to disappear slowly but surely into the baseline indigent population, which is now more than doubled.

At that point, they are no longer identifiable in terms of assistance means. And the aftermath has been, since December of 1973, a tremendous accentuation of health problems. This is now evident by obvious and significant numbers of cases of malnutrition of a severe nature in infants and children. I saw there—the only time that I have seen this in Indochina—cases of kwashiorkor in infants that I have not seen any other place in any of the other three countries of Indochina that I visited.

ROLE OF VOLUNTARY AGENCIES

The voluntary organizations have responded tremendously to this need by setting up feeding programs. But it is kind of an overwhelming situation, and considerably more assistance needs to be given to meet that need. There is food input in terms of rice being given by
USAID. However, I would like to indicate that this is considerably diluted by virtue of how it is done.

U.S. rice is primarily bought at prices which are somewhat different, at cost values which are somewhat different in terms of the price and the transportation costs, whereas other rice closer by might have been purchased. I understand—and you are probably more familiar with the political mechanism behind that—but the facts and figures indicate that a considerable amount of money is wasted in that process.

But even though there were adequate inputs of rice, I think the important shortage is in protein foods, which just are not existent for this population.

**INADEQUATE HEALTH CARE SYSTEM**

In terms of the health care system itself, it has been stated—I believe it was stated in the report from the Comptroller General of the United States—that it was reported that there was adequate medical care coverage within the city of Phnom Penh. This is absolutely not true.

There are physicians whose names are listed in the ranks of the coverages of clinics and hospitals, but the amount of money that is payable by the government for their services is so small that they are forced to spend most of their time in the private practice of medicine to support themselves and spend virtually none of their time in these clinic facilities. So the vast refugee population and indigent population which I mentioned earlier is going with little or no health care.

Then the added insult to this whole process is the influx of war injured civilians and soldiers. There is no military hospitalization circumstance in this country. All injuries, civilian or military, must go into the existing civilian hospital system. Large numbers are transported into the city of Phnom Penh.

Mr. Klein and I had a rather nauseating situation, there having been a major battle at Kompong Chanang just several days beforehand involving some 16,000 men. We walked down corridors with stretchers of men with open wounds unattended, filth and detritus, flies and insects and everything there. And there was obviously no medical personnel to meet their needs as yet.

**SITUATION IN THE PROVINCES**

The other side of that—as I said, there are two Cambodias. The other Cambodia is that of the outlying provinces, which are completely isolated and separated from the capital city. Most of the reports that we saw from Cambodia were made by people who visited only Phnom Penh. We were lucky in that we were able to visit two outlying provinces by flying over part of the war area into Kompong Thom and Kompong Chanang.

At Kompong Thom we saw evidences of a tremendous response to trying to handle the refugee problem. Five thousand new hectares of land were being planted in rice. USAID should get most of the
credit for this. USAID has done a remarkable job with agricultural people and other assistance.

In addition to this, the voluntary agencies are out there, too, and they are pitching in not only with the populace, helping to grow food to feed themselves, but they have set up nutrition stations for infants and nursing mothers. There are seven medical teams, which I mentioned earlier.

IOG supports these completely. If it were not for these seven emergency medical teams of IOG, and those of the voluntary agencies, there would be no medical teams in the outlying districts of the country of Cambodia.

This is a country which is in a sad condition and needs considerable assistance.

Last, I should mention conferences with the Ministry of Health officials. The new Minister of Health had only been in his job several days at the time I met with him. He is a young, extremely intelligent man who exudes confidence. You could not help but be confident in him.

For the first time, he is looking at the national budget for health, making the kinds of moves necessary to do significant planning on a national scale, and openly asked for assistance, not in terms of interference by a lot of American health personnel, but assistance from those who have some know-how in terms of planning and organization of health services that might come in to assist him.

Senator Kennedy. That is very, very helpful, Doctor French.

We want to express our very warm appreciation for your testimony and statement, which will be printed in its entirety at this point in the record.

[The prepared statement of Dr. David M. French follows:]

**STATEMENT OF DR. FRENCH**

Mr. Chairman, my name is Dr. David M. French. I am the Director of Community Health Affairs for the Boston University Medical Center and further by way of introduction I might indicate that my basic medical background is in surgery with particular training in pediatric surgery. Of recent years I have become almost completely engrossed in the field of medical care with special interest in the medical care delivery system. In June of this year I visited, along with Mr. Klein, the countries of South Vietnam and Cambodia as a consultant. The observations which I have made are the result of many experiences and a fair amount of detail which cannot be developed perhaps at the time of this oral testimony but much of it will hopefully appear later in a more detailed publication on behalf of the Senate Subcommittee on Refugees.

**SOUTH VIETNAM**

The general health problems of South Vietnam are those which are common to most poor, underdeveloped, tropical countries. Basically, they fall into six categories: (1) infectious disease problems, which includes the very large problem of gastrointestinal infections and infestations, respiratory diseases, and tuberculosis and venereal disease; (2) parasitic disease problems, including malaria and certain special parasitic diseases, such as schistosomiasis; (3) malnutrition, which relates in a larger sense to the whole reproductive process of the population as well as to the basic ability to resist infectious diseases listed above; (4) environmental conditions of the populace especially relating to their living conditions and the practices of general hygiene and sanitation; (5) the effects of Westernization, especially those effects which are brought about by mechanization, leading to a disproportionate incidence of accidents; and (6)
problems which are peculiar to the mores and social conditions inherent in the
population in question. The latter have to do with the age range within the
population, the usually agricultural or rural life led by the population, their
customs and religion, the rate and nature of population growth or decline; and
that all of these must be considered in terms of their effect on the utilization of
medical care.

Although it is not beneficial at this time to go further into the basic disease
and other health problems of underdeveloped countries, it is however, im-
portant to indicate that the superimposition of prolonged warfare over a
period of 30 years can create deprivation and other widespread effects on the
population which have everything to do with its survival and ability to compete
in the modern world.

By way of examples I would like to quote the following figures. If one looks
at the combined effects of natural accidents, especially having been increased
by Westernization, the accidents of warfare and combine these with the effects
of infections and parasitic diseases, one finds that in 1970 this combined effect
represented one-fourth (¼) of the total morbidity of the population; this
morbidity rate being shared equally between the effects of trauma on the one
hand and infection on the other. If one looks at mortality in 1970 in South
Vietnam one finds that over 49% of the deaths in that country were related to
the combined effects of accidents, warfare and infection, and again the accidents
in war were about equal to the effects of the infectious process.

Two years later, in 1972, there had been little change and, in fact, the com-
bined morbidity effect had increased to 28.7% while at the same time the effect
of mortality had dropped somewhat from 49.3% to 48%. If one considers the
increasing capacity of the Vietnamese health system to record and digest its
own statistics, I think it would be safe to assume that the apparent increase
in morbidity has little meaning. However, at the same time, the drop in mor-
bidity over that period of time by a full 6% is significant and indeed represents
an improvement in the overall ability of the medical care system of that
country to cope with its almost overwhelming problems.

The ability to cope with the combined problems of war, accident and infec-
tion in Vietnam have been related to an extremely capable and astute in-
digenous population which has benefited by a considerable input in terms of
know-how and money from the American influence in that country over the last
8 years from 1966 to 1974. It is hardly justifiable that such involvement came
about because of warfare; nevertheless, this side benefit did result from this
unfortunate experience. At the outset the U.S. military was primarily involved
in the backup and in fact much of the front-line medical care delivered in South
Vietnam. However, over the past year and one-half, this has dramatically
dropped off to zero (0) and during that period of time we have witnessed an
extremely good symbiotic relationship between USAID public health input and
the rapidly evolving medical care system of South Vietnam. The major implica-
tion of the morbidity and mortality causes in this country as stated above is
that preventive measures could be more productive in improving the health
status of the land.

One needs to say about the prevention of war casualties being directly re-
lated to the cessation of warfare and, of course, much is known about the
prevention of accidents whether they be in industry, on the farm, related to
motor vehicles or secondary to other Western inputs which, until relatively
recently were foreign to the major part of the population of this country. Pre-
vention, again, plays a major role in approaching the control of infectious, para-
sitic, enteric, and pulmonary disease problems. These four categories of disease
are eminently responsive to early diagnosis and prevention and the recognition
of this fact in the combined efforts of USAID health personnel and the in-
digenous health structure of the health structure of the country of South
Vietnam has resulted in a dramatic change in the evolution of the input of
assistance and consequent development of the medical care system of that
country. The early input of AID support made through a contract with the
American Medical Association to support medical education in South Vietnam
started that country's development in the general direction which finds our own
country headed in at the present time, namely, an overabundance of super-
specialization enshrouded in multiple hospitals, requiring a considerable amount
of the Gross National Product to support them.
At the same time it becomes difficult to measure the widespread benefit to the total population of such a major investment at the top. The medical education program instituted by the American Medical Association (AMA) went about a complete reversal in 1972 and at the present time the main productive output in terms of health education and in terms of investment in the medical care system is entirely geared to the level of the districts, villages, and hamlets throughout the whole expanse of the country of Vietnam. The development of widespread use of paraprofessionals, the ability to undertake systems of identification and recording of health problems and the general education of the populace relative to hygiene, nutrition and sanitation has to a great extent evolved from this medical care system, especially through the Ministry of Health's development of the National Institute of Public Health.

I feel that it is especially important at this time to make a plea for continued and appropriate backup and assistance for the medical care system in the country of South Vietnam until they have matured to the point of being able to continue under their own steam, adequately backed up by their own economic system. Current cutbacks in economic aid through USAID are grossly endangering this support and it becomes a question of what is the appropriate method to give adequate support to the health care needs of such a developing country.

I am in perfect agreement with you, Mr. Chairman, that such support should be multilateral in type with the United States government paying its fair share of the burden. Later on in this testimony I shall go into greater detail as to our investigations of the possibility of such a multilateral approach through the mechanism of various components of the United Nations.

INTRODUCTORY COMMENT TO THE RECOMMENDATIONS FOR VIETNAM

In order to put the following recommendations in the proper context, it is appropriate at this point to make some overall observations relative to the current status of the medical care system development of South Vietnam.

The medical care system of South Vietnam was jolted out of the Dark Ages by the impact of the war, especially in its latter stages over the last 8 years, where marked involvement by the United States occurred. It should be kept in mind that the Vietnamese people have been involved in almost constant conflict for the past 30 years with various nations. An entire generation has come up under the impact of various degrees of deprivation, accentuated by the constant impact of war. The major impact of military involvement on the part of the United States since 1966 in particular saw the introduction of large numbers of medical personnel from the United States both as part of the military as well as part of various volunteer efforts.

At its zenith this involvement was noted in every province of South Vietnam, at least in each of the provincial hospitals and in many instances at even district hospital levels and below. Since war casualties were handled not only by military installations but also to some extent in civilian hospitals, no fine line was ever drawn as to the extent of involvement of US military personnel in medical care delivery. Likewise, at times of lull in the fighting, US military medical personnel, as well as other US military personnel, often engaged in voluntary medical care support for the adjacent civilian population. USAID during this same period developed a programmatic approach in the public health area which added to the input of military and voluntary health personnel from the United States and with the passage of time the USAID input became more and more heavily in terms of impacting on the evolution and modernization of the medical care system of the whole country of South Vietnam. The Ministry of Health and the Ministry of Education were particularly involved in this process and the evidence is quite clear cut at this time that a warm and symbiotic relationship existed between USAID health personnel and these two agencies of the Vietnamese government.

Likewise, the same excellent relationships apparently existed throughout the lower echelons of the health care system although initially the major impact was at the top. It is my observation that the development of the health care input of USAID was allowed to proceed with a minimum of interference on the part of those components of the American government that were primarily interested in the political aspects of the conflict in Vietnam. Evidence of this
political conflict and its support are still very apparent in almost every other aspect of American involvement in Vietnam, but the health aspects seem to remain almost completely free of domination or interference by political forces.

It is also interesting to note that health personnel involved with major responsibilities in South Vietnam have evolved considerably from what must have been their normal state in the United States in that they ultimately became convinced of the need to make a major investment at the level of the interface between the individual person in Vietnam and the medical care system. For this reason an initial major investment in medical education for the purposes of developing highly trained specialists and a topheavy hospital-oriented medical care system similar to that of the United States was halted.

A major conference was held in 1972 with input from outstanding consultants from other developing countries which led to a reorientation of emphasis for the medical care system with a major commitment to the field of community medicine and the training of community medical care practitioners who would be spread throughout the length and breadth of the land. In addition, a major commitment was made to train other kinds of medical care personnel likewise to be distributed throughout the length and breadth of the land to work at the district, village and hamlet levels in order to make a major impact in the area of public health and preventive medicine.

Since that time this reorientation or new approach is in evidence everywhere and the public health personnel of USAID and the Health Ministry and Educational Ministry as well as the government of Vietnam are to be commended for this approach which is already beginning to show signs of payoff in terms of impacting on the health care needs of this country. There is evidence of increasing utilization of health care services in this country as a result of positive experiences by the populace which had previously been heavily dependent upon a traditional medical care system. The unfortunate thing is that as success mounted in this rational approach to the development of medical care, cutbacks in support both in terms of direct funding by USAID and personnel input from USAID appear to be endangering the continued successful development and could perhaps prevent full maturation of a system which undoubtedly would ultimately be able to stand on its own two feet.

I would like to indicate, Mr. Chairman, that this situation is particularly precarious in terms of the medical logistics and supply system which has been developed allowing the broad distribution of pharmaceuticals and other necessary medical supplies throughout the country, the capital development and improvement of the district level and below health facilities (MTD and MD), the development of the Under Six Program which is a special maternal and child health program dependent upon the expansion of the capabilities of midwives, the National Laboratory Program which is on its way to developing a standardized system of laboratory support for the entire country, including the training of necessary personnel, and the multiple programs in the process of developing through the emerging National Institute of Public Health.

It seems to me to be unquestionable the nature of this humanitarian aid in the medical care field and it would seem that it would be important to reorder priorities such that support could be maintained in an adequate amount to assure its continued development and maturation. The accompanying chart which takes into account the reduction of US funding input, the increase of the government of Vietnam funding input as well as inflation relative to the piaster shows that in actuality there has been a steady but slow decrease in overall funding input into the medical care system of Vietnam.

VIETNAM

Recommendations

A. Continued General and Special Support of MOH

1. Planning and Program Development:
   a. Development of health education system—not only the medical school at Saigon, but also helping the medical school at Hue and the new private medical school in Saigon. Additionally via the National Institute of Public Health develop medical support personnel training and education to increase the realization of a program of preventive medicine and public health. Specifically, these include the laboratory, medical logistics and
supply systems, pharmacy, epidemiology and field survey, midwifery, sanitary and environmental and health education personnel.

b. Support and consultative services directly to the Ministry to increase their capabilities nationwide.

2. MOH support to assist in development of capability to carry out ongoing evaluative methods capable of feedback into operating medical care system.

B. Project Support

1. Logistics program—This is in danger of AID support cutback leading to collapse.

2. National Institute of Public Health—An existing well run and developing multilateral project through the UN destined to play a significant role in the country’s health care future. Advise continued support towards its completion and of ongoing programs.

3. MCH Program Development—a major area of program development since 65–70% of population is either children or mothers.
   a. Under Six Program—been developed via AID, MOH, and National Institute of Public Health, needs funding input to make it a reality at district, village and hamlet level.
   b. Family Planning—population growth now at dangerous level of 8%/year, outstripping economic growth capabilities. Government support is feasible.
   c. Special Manpower Development—especially in training of midwives to assume role in basic child care under six years.

4. Facilities Development

Completion of development of MID (district) facilities and further development of MD (village) facilities strongly recommended. Project in danger of extinction because of funds lack—AID.

C. Multilateral Aid for Development of Health Program

Multilateral aid for the development of health and social welfare conditions in Southeast Asia has been talked about over the last couple of years but has shown very little evidence of practical development. For this reason, a special effort was made to investigate the current status of this approach and it would be worthwhile to review this process.

On the way to visiting Southeast Asia the Senate team stopped off in Geneva where contact was made with the Indochina Operations Group, the UN High Commissioner for Refugees and the World Health Organization. Col. Douglas Gill, Chief of Operations, IOG, and Mr. Jean Pierre Hocke, Chief of Operations, ICRC, discussed in some detail the continued function of the IOG. This organization had initially expected to be inoperative after an initial year’s function, but finds itself now beyond one year and expecting to have to function for an additional nine months. The IOG was temporarily set up as a combined operation of the International Committee of the Red Cross and the International League. It was set up for strictly emergency purposes since the International Red Cross in effect sees itself as operative only under emergency circumstances. At that point we learned of the virtual dependence upon the IOG for emergency medical care operations in the country of Cambodia and this subject is taken up in more detail under the discussion relative to the country of Cambodia.

The IOG does not look upon itself as extending indefinitely in its operative approach into the future and is looking to be relieved by some other kind of international emergency operative entity.

We also met with the UN High Commissioner for Refugees, Sadruddin Aga Khan, who discussed in some detail his plans for the initiation of a greatly enlarged and strengthened refugee relief program for the Indochina Peninsula. I was particularly interested in the nature of the medical care support that the UN High Commissioner for Refugees would anticipate and he indicated that they were cognizant of extensive medical care needs possibilities and that they would call freely upon WHO and UNICEF to assist them in this regard. They felt that there was a good past history of cooperative activity between these three arms of the United Nations and he felt that this would also operate smoothly in the case of Indochina if adequately supported financially by the various nations through the United Nations.
We also met with Dr. Belleride of the World Health Organization in Geneva who again indicated the great willingness of WHO to cooperate in a joint venture with UNICEF and the UN High Commissioner as indicated to meet refugee and general humanitarian needs in Indochina. Dr. Belleride, however, indicated that the functional structure of WHO was such that all operations must of necessity emanate from the Southwestern Pacific Office located in Manila, The Philippines.

It is important at this point to review briefly the nature of contacts with various UN officials in Indochina, itself.

Upon arrival in Bangkok, Thailand, we met with Mr. MacE, the Deputy to the UN High Commissioner for Refugees who had just completed a short tour of South Vietnam at the request of the UN High Commissioner for the purpose of program development. We were briefed concerning some of his findings and it was indicated to us further the willingness of the Office of the UN High Commissioner for Refugees to be cooperative with the United States in terms of developing multilateral support for relief. It was also indicated to us that they were hopeful of having operative programs underway by October of 1974.

Our next interface with UN officials was at a luncheon in Saigon held by Mr. Pierre Sales, resident representative of the UNDP. Present at this luncheon were Mr. Paul Nelson, Social Development Advisor for UN, Mr. Jean Jacques Deschamps, UNICEF Program Officer sitting in for Mr. Ralph Eckert, and Dr. Richard Coppledge, WHO Representative ad interim and Project Manager for the National Institute of Public Health Project. At this luncheon we again broached the subject of multilateral approach through the UN and specifically utilizing three components of the UN, namely UNICEF, WHO, and UNDP, in addition to the good offices of the UN High Commissioner.

The conversation indicated that there was strong acceptance of this approach. There had obviously been some contact between Geneva and the UN officials with whom we lunched, indicating that as a result of our recent visit to Geneva there was developing a feeling of agreement there, as well. At yet a later luncheon held by Dr. Richard Coppledge, I had an opportunity to speak directly with Dr. Dy, Director of the Southwestern Pacific Section of the WHO. Dr. Dy was the last cog in this wheel and he indicated that it was his policy and that of the Southwestern Regional Office of WHO to strongly support health and humanitarian developmental programs and that they were giving special preference to the countries of the Indochina Peninsula recently set back by the ravages of war. He was agreeable to the multilateral approach which would allow the enlargement and development of programs by WHO and indicated that all that was necessary was that the specific country make a formal request for this assistance and that the WHO would be more than willing to respond. Elsewhere in this testimony Mr. Wells Klein will enlarge upon conversations which he had with the UNICEF people in New York City, but I think it is safe to say at this point that there was no lack of agreement at any point and in fact it would be safe to say there was nodding enthusiasm as we continued to pursue the subject of multilateral support through the UN throughout our trip.

Mr. Chairman, I am convinced that the proper initiate exerted at this point would receive immediate response by the four agencies which we interfaced with from the United Nations.

CAMBODIA

Only three days were spent in this sad and beleaguered country, allowing but a minimum of information gathering. In addition very little prior information is documented regarding the function and organization of the health care system.

The problems of Cambodia are vastly different from those of Vietnam though they share the common denominator of war. These differences are:

1. No prolonged U.S. military presence.—Much of the progress underway in Vietnam was an unplanned by-product of U.S. military presence. This along with planned medical support not only of the military but of necessity of the civilian side of medical care resulted in a strong infusion of Western know-how, not just into the medical-technical armamentarium of Vietnamese medicine, but also into the organizational, structural, and educational aspects of the medical care system. All of this was supported over the last 8 years with a
vast input of American dollars. The latter albeit disproportionately small compared to dollars sunk in direct military aid, nevertheless in the setting of Southeast Asia this represented a major quantum jump.

Much can be said in criticism of the lack of planning as much of the early U.S. input into medical care development occurred. This obviously came about as a result of U.S. objectives which were not initially designed to help the Vietnamese medical care system. It would be interesting to study the amount of waste in humanitarian terms of this investment of U.S. know-how and dollars resulting from the preoccupation with military concerns.

Camodia is certainly blessed in that the magnitude of destruction that would have accompanied a U.S. military presence did not occur. At the same time, however, there has been a spin-off of U.S. know-how and dollars into the modernization and upgrading of her medical care system which floods itself swamped by combined demands of a growing population's day to day needs and the continued added burden of military and civilian war casualties.

2. Peculiarities of War and Geography.— At present there are two major divisions of population and land for which the Khmer Republic finds itself responsible. There is a large urban population in the city of Phnom Penh which has swelled in size over the last four years of war, beginning in 1970, from approximately 700,000 to estimates which are now at least 2 million people. Currently Phnom Penh although remaining isolated is surrounded by a relatively small amount of arable land before reaching a perimeter which is the interface between the two political forces which are currently involved in the struggle for the control of Camodia.

The second population group is that which exists in the outlying pockets of land which are widely interspersed throughout the eastern and some of the southern part of the land of Camodia containing the remainder of the 80% of the population of this country. The total land controlled by the Khmer Republic is about 20% whereas the population controlled is about 80%. This separation between the central government and its resources in the capital city and the remainder of the country in outlying pockets which are inaccessible much of the time by ordinary means creates an insurmountable logistical problem relative to any concerted health care effort which the Cambodian government, using their current resources, might be able to overcome.

The few reports which we have been able to evaluate through U.S. government sources or through those of the United Nations have almost invariably dealt with the city of Phnom Penh and have not at all divulged any information relative to the outlying areas wherein perhaps 2/3 of the population of Cambodia now resides. Our team was lucky in being able to visit two of these outlying areas, one at Kompong Thom and the other at Kompong Chhanang. The latter area had been the site of a major battle involving some 16,000 troops only four days prior to our arrival and we had an excellent opportunity to see the impact of war casualties on a badly-divided and poorly developed medical care system. Kompong Chhanang is a provincial capital which has a provincial hospital.

The provincial hospital was visited and we had the opportunity to see the Swedish surgical team which has been stationed there since 4 March 1974. The surgical team works under the direction of the Cambodian staff leadership and consists of one surgeon, one operating room nurse, one nurse anesthetist, and one intensive care nurse to maintain postoperative care for surgical patients. In the period of time since the surgical team has been present they have admitted 129 surgical patients and done 171 operations. During the early period up through May war activities in the area were at a low level and the major portion of the surgery was relative to assistance of civilian medical care needs, both of an acute nature as well as cases of longer standing status. Since the beginning of June, however, there has been a steadily increasing amount of war activity in the area and since the 10th of June only acute war injuries involving both civilians and military personnel have been handled by the surgical team. No civilian activities have been allowable and all of their surgical beds have been totally filled.

In addition to their surgical activities the team has undertaken the training of Khmer nurses, working in tandem with other nursing personnel on the surgical team such that they might ultimately take over these responsibilities. Had it not been for the presence of the Swedish surgical team it is estimated
that at least 80% of the surgical cases handled since the beginning of increased hostilities on the 10th of June would have had to go to the hospitals in Phnom Penh. It is important to note that this, likewise, is somewhat of a logical problem since it is impossible to transport other than by means of airplanes and there is some question as to the nature of the survival of many of these patients had such an evacuation been necessary.

A second point to be made in this regard is that the conditions in the hospital of Kompong Chhanang appeared to be considerably better than those seen in two of the major hospitals in Phnom Penh. The staffing was considerably better, primarily because of the presence of the Swedish team in the provincial capital, whereas in the capitol city of Phnom Penh, physicians were in exceedingly short supply, having to divide their time between their private practices and the governmental practice which is carried out in the several hospitals of the capitol city. The exceedingly small amount of pay given by the government for the latter activity requires almost all physicians to spend the overall majority of their time in their private practices and, as a consequence, large numbers of patients appear to be receiving minimal or no care under exceedingly overcrowded and unsanitary, literally filthy, conditions.

3. Problems of Nutrition.—Again, the problem is divided into two major components: first are the nutritional problems of the capitol city, Phnom Penh, and secondly are the problems which are to be found in the outlying provinces.

Since April of 1974 at the establishment of the Resettlement and Development Foundation, there has been notable activity in some of the outlying provinces relative to the reclamation for agricultural purposes of land. We had an opportunity to visit such a site in the area surrounding Kompong Thom where there is underway the cultivation of 5,000 hectares of rice. We were given an interesting briefing by the provincial military staff, indicating how they had maintained a sufficient perimeter around the provincial capitol of Kompong Thom within which active cultivation of rice has been made possible. Much of the land under cultivation in this area is virgin land and it is expected that these early crops will be of high yield although replanting will necessitate the utilization of fertilizer which is in exceedingly short supply, not only in this country but in the world market.

The cooperative efforts between the AID staff and the governmental staff of the Khmer Republic and local officials has been exceedingly good. In addition, cattle raising is underway at an increased level as is the harvesting of fish which are in exceedingly good supply in nearby streams. In addition, a significant program to supplement the feeding of infants with milk was observed. The Catholic Relief Society has established several of these units throughout the area which works in conjunction with the mothers of the children involved and successfully distributes large quantities of milk which is obviously a needed food supplement. Nursing traditionally at the breast occurs for a period of about three years in this society, but the borderline nutritional status of the mothers seriously compromises the amount of milk available to the infants. The CRS supplementary feeding program has not worked to discourage breast feeding but is given as a supplemental nutritional assistance.

It should be noted at this point that nutritional deficiency is exceedingly widespread in Cambodia. Although it was seen to exist to some extent in the provincial areas of Kompong Thom and Kompong Chhanang and in this instance primarily in the first three years of life, it was nowhere as nearly dramatically seen in these rural areas as it was in the city of Phnom Penh. Large numbers of children in Phnom Penh are currently suffering severe nutritional damage. The government has been unable to respond to these nutritional needs which have been primarily accentuated by the swelling population of this capital city. An opportunity to chat with some of the staff of World Vision gave us an opportunity to hear about some of their supplementary feeding operations in the city of Phnom Penh. They have identified as the major medical care problem in children, in particular, malnutrition. There are occurring on a regular basis distinct clinical cases of kwashiorkor and it was the distinct impression of these physicians that other effects of nutritional deficiency were becoming widespread, relating to the growth and development of the children in general as well as in such areas as crippling of the immunity protection system.

In addition we were given information to indicate that the steadily increasing price of food within the capitol city of Phnom Penh which is related to a
rampant inflation is such that the number of malnutrition cases is bound to increase since more and more people will find it more and more difficult to purchase high protein foods. It should be indicated at this point that USAID activity in Cambodia has been directed toward relief of the food deficiency problem. 90% of the rice land which is potentially arable is now lost because of military action. This has led to the importation through USAID of some 40 million tons of rice per year. A considerable problem exists, however, in the distribution of this rice which can be transported up the Mekong River to Phnom Penh but distribution out of Phnom Penh to the surrounding provinces is considerably problematic since railroads and highways have been cut and until recently the Tonle Sap have remained closed.

The cost of living over the past year has increased some 300%. The cost of meat, alone, has doubled since December (1973) and even the price of vegetables is considerably on the increase. It is estimated that approximately half of the war refugees of the country are currently in Phnom Penh and estimates range as high as 1.2 million people being in this category. Approximately 2/3 of the refugees in Phnom Penh are cared for by their families or some official program, according to USAID estimates. The other 1/3 refugees are dependent primarily upon the voluntary agencies, an estimate of the number being cared for in this regard currently being approximately 388,000.

The USAID rice supplementation program should be reviewed in some detail since it is beset by a number of problems relating to world trade costs and legal entanglements relative to United States law and regulations.

4. The Organization and Function of the Medical Care System.—Within recent weeks a new Health Minister has been installed in the person of Dr. Kim Vien. Dr. Kim Vien is a young, energetic cardiologist who is dedicated to the updating and modernization of the medical care system of his country. The following problems were identified as currently coming under his purview for special attention:

(1) The shortage of hospital beds

Dr. Kim Vien indicated that there were approximately 7 million people in the entire country including approximately 2 million who live within the city of Phnom Penh. For this entire population he estimated the existence of perhaps 9,000 beds, including military beds, with a total capacity using the halls and other space within hospitals to bed down approximately 10,000 people. This leaves us with a figure of approximately 700 persons per bed and this, along with the fact that the average length of stay of patients is estimated to be considerably longer than in the United States, creates a considerable problem. The Health Minister is anxious to undertake studies to arrive at an equitable estimate of beds and distribution of these beds in various institutions that would be ideal for his country.

(2) Supply shortage

Cambodia is considerably beset by the problem of the shortage of medicine, equipment and other kinds of medical supplies that would be necessary to operate an up to date medical care system. Dr. Kim Vien indicated that currently some medicines and supplies were coming through the International Red Cross and through gifts from other countries, however, again, he does not have the means for accurately recording this input nor estimating the need, overall, for the country. He feels that the lack of medical supplies and of hospital beds is most severe in the capital city of Phnom Penh and although present in the outlying provincial areas is not as acute. My observations in Kompong Chhanang and Kompong Thom would tend to confirm the Minister's impressions. Dr. Kim Vien is much aware of the fact that medical care problems of the capital metropolitan area are considerably different from those of the outlying provinces. He has identified the capital area's problems as they relate to nutrition, availability of medical care personnel, and environmental and public health problems being of primary importance.

At the same time he feels that the major problem in the provincial areas is the accentuation of their normal baseline medical care problems by the war situation. This overloading by the war of the provincial areas has received little assistance from the outside world and it is important to note that if it were not for the Indochina Operations Group (TOG) outside assistance would be virtually nonexistent. There are at present 7 medical teams functioning
ununder the auspices of IOG in this country but it is obvious that the widely scattered pockets of warfare in the provincial areas dictate the need of much more assistance on a short-term basis than the 7 medical/surgical teams currently in that country can provide.

(3) Planning and budgeting for the development of a national health program

It was indicated that approximately 28% of the national budget is currently going into health care. In 1973 this amounted to 1,086,006,700 Rielis out of a national budget of approximately 48 billion Rielis. Dr. Kim Vien indicated that his current studies lead him to desire to triple the amount of the national health budget for 1974 and that he felt that he could justify an increase of the health budget to a sum which would equal approximately 10% of the national budget.

This matter is currently under debate before the national legislature and the Health Minister was hopeful that he would at least be able to double the health budget over the amount of last year. He pointed out the fact that the increasing cost of fuel alone was creating considerable problems for their health care system, especially in regard to any development or support of the health care system outside of the capital city of Phnom Penh. When asked what sort of cost figure could be applied to meeting the current overall needs of the nation relative to the health care system, he stated that it would amount to approximately 16 billion Rielis.

Taking into account current input from the government of the Khmer Republic as well as outside input through voluntary agencies which might total as much as 4 billion Rielis, one would still have a deficit of approximately 12 billion Rielis in terms of what is envisioned as necessary to develop a significant operative health care system in this country under current monetary conditions.

Recommendations

1. MOH Support Operation:
   a. AID and multilateral funding.
   b. Full survey of medical care system and resources (American University Medical center team): (1) Phnom Penh; (2) outlying provinces.
   c. Development of MOH Medical Care Planning Operations Group—U.S. input (University Medical Center, APHA and WHO).
      (1) Short term development plan.—prop up baseline civilian medical support needs plus added war casualty input through (a) expansion IOG teams for present, (b) later development of international med-surg teams via UN auspices—UNHCR, WHO & UNICEF.
      (2) Long term development plan.—(a) consultative input and backup of MOH and its outlying subdivisions—multilateral organization (UN)—U.S. input (University Medical Center, APHA and AMA (educational)) WHO input—various other national consultative input.

2. U.S. Commitment of Foreign Aid Funds via Multilateral Channels (UN):
   a. Training and education of medical and allied health personnel.
   b. Development program for district, village and hamlet medical aid teams and facilities.
   c. Supplies and equipment and logistics system for maintenance and distribution.
   d. Develop MOH program to include—family planning, nutritional supplementation, midwifery program development, and health education, immunization.
   e. Emphasis on development of a national, aggressive environmental and preventive health program.

Senator KENNEDY. This has been a very helpful contribution to our continuing oversight of these humanitarian programs in Indochina.

As you know, we have been following this closely, and we will continue to do so. We have been trying to take the study mission’s recommendations and implement them, working with the administration where possible, and to implement them by legislation whenever necessary.
I think your findings will be of great value and assistance to us in carrying forward our effort to focus attention on these humanitarian problems and to do a good deal about them.

We are going to take a recess now until about 2:15.

We again apologize to our witnesses from the executive branch who have come here earlier. But we must now recess until 2:15 p.m. There will be two votes in the Senate back to back, I think 10-minute votes, so we will try to get started at 2:15 or 2:20, or shortly thereafter. We will recess until then.

[Whereupon, at 1:15 p.m., the subcommittee was recessed, to reconvene at 2:15 p.m. the same day.]

AFTERNOON SESSION

Senator Kennedy. The subcommittee will come to order.

Our next witnesses represent the executive branch. We would like to welcome Mr. Robert Wenzel, who is director of the Vietnam Working Group, and the Hon. John Murphy, who is the deputy administrator for the Agency for International Development. Mr. Wenzel will be lead-off witness with a general statement concerning our policy toward Indochina, and I understand that Mr. Murphy and a number of people in the field and the Agency are here. We welcome your appearance here this afternoon.

We want to thank AID and the Department of State for all of the help they have provided to our study mission. They have been in the field, and they have said that the U.S. Mission and AID personnel made every effort to assist them, and for that we are grateful. We want to thank Mr. Murphy for getting his statement to us last evening. That is very helpful to us, gentlemen.

Mr. Wenzel, do you want to start?

STATEMENT OF ROBERT H. WENZEL, DIRECTOR, VIETNAM WORKING GROUP, ACCOMPANIED BY LLOYD M. RIVES, DIRECTOR, LAO AND CAMBODIAN AFFAIRS, DEPARTMENT OF STATE AND

STATEMENT OF JOHN E. MURPHY, DEPUTY ADMINISTRATOR OF THE AGENCY FOR INTERNATIONAL DEVELOPMENT, ACCOMPANIED BY GARNETT A. ZIMMERLY, DEPUTY ASSISTANT ADMINISTRATOR, SUPPORTING ASSISTANCE BUREAU, DR. WILLIAM D. OLDHAM, ASSISTANT DIRECTOR FOR PUBLIC HEALTH, USAID SAIGON, AND DONALD GOODWIN, DIRECTOR, OFFICE OF TECHNICAL DEVELOPMENT SUPPORTING ASSISTANCE BUREAU

Mr. Wenzel. Mr. Chairman, I would like to introduce, on my left, Mr. Lloyd Rives, who is accompanying me, who is the director of Lao-Cambodian affairs in the Department of State.

Mr. Chairman, I would like to address a few brief remarks which will restate the administration’s basic policy toward Indochina, and relate our AID programs to that basic policy. We continue, as the basic policy in the administration, to work purposefully toward a stable peace in Indochina, thereby to contribute to the development of detente throughout the world, and to what Secretary Kissinger
has termed “the worldwide structure of peace.” We continue to believe that the Paris peace accords, achieved in January of 1973, provide a good basis for that stable peace which we envisage.

CEASEFIRE AGREEMENT IMPLEMENTATION

We recognize that these peace accords have not been completely implemented, by any means. Nevertheless, we feel that some progress has been made in the movement toward this peace. For example, we have heard testimony this morning about the level of fighting in Vietnam and Cambodia. In Vietnam, there is indeed serious fighting going on, but it is at a level at about one-third the level prior to the peace accords. Another example of some movement toward accommodation between the parties is the fact that a total of some 37,000 Vietnamese prisoners have been exchanged by each side over the past 18 months.

Nevertheless, we recognize there are still major deficiencies in the implementation. We ask ourselves why, and the answer is very clear. It is primarily due to a very fundamental and major violation on the part of North Vietnam. In brief, it appears to us that North Vietnam has not yet given up its basic policy of a military option for the achievement of its objectives.

Senator Kennedy. Has the South?

Mr. Wenzel. No, sir. I would be glad to address that right now. Certainly, both sides have been guilty of violations. There is no question about that. We do feel that any analysis of the cease-fire situation in the past 18 months produces the judgment that the great bulk of the violations is on the side of North Vietnam. The South has responded militarily frequently, usually in reaction to military action by the North Vietnamese.

One or two very basic statistics, I think, should prove the case. The North has put into South Vietnam some 130,000 new troops in 18 months, in total violation—

SHIFT IN POPULATION CONTROL?

Senator Kennedy. It is my understanding, in reviewing testimony given the Armed Services Committee on April 9th, that the area controlled by the South has actually increased since the cease-fire, and total population control has increased. I am certainly willing to grant that there have been violations by the North. But I believe there have been violations from the South as well.

Here is the testimony of Major General Caldwell, before the Armed Services Committee: he indicated that North Vietnamese combat troops in the South remain at approximately the same level they were at the time of the cease-fire, 150,000 troops, and rather than losing territory to North Vietnamese aggression, General Caldwell testified that, except for immediate post-cease-fire “land grabs,” the “overall change in land territory has ... not changed adversely to the South Vietnamese ...” In fact, he testified that the South Vietnamese forces have increased their control of territory and population.
That is before the Armed Services Committee. This is just so we understand we are getting one thing in the Armed Services Committee, and now something else here.

Mr. WENZEL. Our understanding is there has been no appreciable change in population control or in control of inhabitable land in the country. But I would reiterate that there has been this major influx of troops from the North, which we see as a very unhappy signal.

I have been attempting to sketch out here what we would call the background realities that we see, and it is on the basis of these realities, as we see them, that our policies are framed. A central facet of these policies is our continuing economic and military assistance programs for the area. We believe that as long as this military threat from North Vietnam remains in being, and it is a very serious threat, that we will have to continue.

OPEN-ENDED COMMITMENT?

Senator KENNEDY. Well, how long? Five more years, and at what level? Say the military threat stays about the same as it is now. How long are we going to be there? Is it open-ended?

Mr. WENZEL. Senator, there has been much concern, I know, expressed in the Congress about the seeming open-endedness of the American aid program in the area. Secretary Kissinger is very much aware of this concern. He has promised, in recent testimony, to provide to the Congress multiyear aid projections for Vietnam, in which he will attempt to sketch out and show to the Congress how we perceive our aid programs running in the next few years. These projections are in the final stages of completion, and I understand they will be submitted to the Congress very shortly.

I can say, in general terms, that we will show the Administration's belief that our aid programs can be substantially phased down over the next few years, if various assumptions hold true, and various things happen. One of the basic caveats is the attaining of levels of aid which we are seeking for fiscal year 1975. We feel that if these levels can be achieved—1976 would also be a high-level AID year—and if these levels can be achieved over the next 2 years, we would envision a very definite phasedown in the following 3 or 4 years.

AID FROM THE "OTHER SIDE"

Senator KENNEDY. Do you have any information on what is being provided by the other side, in economic or military aid?

Mr. WENZEL. We have not very good data on that subject. We have some indications, I think it is fair to say, that the data is not precise. Our sense is that Hanoi's allies are providing them with very substantial levels of aid, particularly in the food area. There have been tremendous shipments of food to North Vietnam over the past year. It is very difficult to quantify that. I do not think we have a good quantification of that.

Senator KENNEDY. The C.I.A. or military intelligence must have some figures. Can you tell us whether it is going down or going up?

Mr. WENZEL. We do have some figures, Senator. It is a question
of their reliability. I think the data we are obtaining today is perhaps not as full as we obtained some years ago, and our resources were much greater than they are today. We do have data. I question its completeness and accuracy, but it would give an indication of the thrust of this, which is quite substantial.

Senator Kennedy. Well, you can tell us what the data is, even with the kind of caveats that you put on it?

Mr. Wenzel. I do not have the figures today, so we would attempt to provide these for the record.

Senator Kennedy. Thank you.

[The material referred to follows:]

**SOVIET AND CHINESE ECONOMIC AID**

Our best estimate at the present time is that in calendar year 1974 Soviet and Chinese economic aid to North Vietnam will total in the range of $1.0 billion to $1.2 billion, at world market prices. The projection, of course, is not a firm figure and will be subject to revision during the course of the remainder of the year. If the projection holds true, such aid in 1974 will be approximately double that of 1973.

Mr. Wenzel. I would like to add a note. We were talking primarily about Vietnam, but I would like to add a note on Laos and Cambodia. We are most encouraged by the formation of the new Provisional Government of National Union in Laos. We fully support this government. In Cambodia I would note, as I believe one of our witnesses mentioned this morning, the Cambodian Government has very recently, on the 9th of July, proposed unconditional peace negotiations. We fully support this initiative, these efforts on the part of the Cambodians to determine their own future; but we feel that as long as the Cambodian people and the Cambodian Government remain under attack by a portion of its population under foreign control and direction, we will have to continue to provide adequate military and economic resources to that country.

Finally, sir, I would like to touch on our proposed economic aid programs, and attempt to relate this—

**SITUATION IN LAOS**

Senator Kennedy. You have gone through Cambodia. Are you going to touch on Laos, too?

Mr. Wenzel. I mentioned in passing what our policy and posture is. As you know, they have a new Provisional Government of National Union. We are supporting this government. It is still in its early stages. We believe it is a viable institution, and will continue to develop along those lines. That is about as much as I can say.

I should add this, perhaps. We are continuing our programs in Laos, and these are being provided through this new government.

May I say just a few words now—

Senator Kennedy. Before leaving Laos, in the Secretary's letter to me of March the 25th—I will make it a part of the record; my letter to him and his response [see appendix I]—he indicated "we have supported the Royal Lao Government and, when it is formed, we will look with great sympathy on the Government of National
Union. We welcome a peaceful and neutral Laos, and where appropriate, we will continue to encourage the parties to work out their remaining problems."

I am sure you saw the General Accounting Office report on Laos, which shows that almost all of our aid goes to one faction. And the Pentagon’s director of the Military Assistance Program to Laos told the House Foreign Affairs Committee that the national security objectives in Laos were “to secure a balanced force which is of sufficient size and strength to maintain survival of the politically neutral Royal Lao Government, and the independence of the people, and to encourage pursuit of these objectives consistent with U.S. interests.”

Admiral Peet did not spell out in his statement that a balanced force meant giving military aid exclusively to former Royal Lao forces. And our GAO report on Laos said, “the objective remains essentially”—this refers to the village health program—“the objective remains essentially the same as we reported in our last report; that is, to provide essential medical assistance to displaced people and to provide medical care in support of the Lao Government and AID rural development programs, which promote Government influence throughout the country”—“Government” meaning the former Royal Lao Government.

So, we are a little confused whether you are carrying through what the Secretary of State has indicated as our support of the Government of the National Union, or whether you are continuing, as Rear Admiral Peet mentioned, and as the GAO indicates, to aid only the former Royal Lao faction. Help me understand.

Mr. Wenzel. Mr. Chairman, may I ask Mr. Rives to comment on that?

Mr. Rives. Mr. Chairman, as the Secretary said, we recognize the Provisional Government of National Union, and we support that government, the formation of that government, and its development. Because of that, our aid is given to that government today. In point of fact, the aid given to that government presently is still distributed only in what is now called the Vientiane side. This is because these are ongoing programs, and because also we have had no request from the provisional government, from any part, for a shift of our aid to the other zone.

In our relations with the new government, we maintain normal relations. The ambassador sees the foreign minister, and our AID director sees the Minister of Planning on a regular basis; both of these gentlemen are Pathet Lao ministers, and they have specifically requested us to continue our assistance as it is. We are not changing programs.

As concerns Admiral Peet’s statement, it is true that our military aid does go to that side; and as he said, we have done this, and expect to continue doing this, until the Provisional Government has settled into what could be called a permanent government. One of the aims of the cease-fire in Laos, and the accords, is to reunify the country, which we assume means eventual reunification of the armed forces of both sides. However, the Pathet Lao forces continue to be
supplied and control their zone, and the former royal government forces also exist in their zone; and we believe it is only fair that during the transition period, both sides should be able to maintain an equilibrium.

**TRANSITION PERIOD IN LAOS**

Senator Kennedy. Perhaps you could tell us a little bit about the transition period. **How long is this transition period?**

Mr. Rives. We do not know. The accords do not specify a length of time. So far, the government has been formed, the ministers have been named, and their deputies, and they are just beginning to function. The Joint Commission for the Implementation of the accords is beginning to function. They are designed, that commission is designed, to maintain the peace and division of forces as they exist. But beyond that, there has been very little progress made.

Senator Kennedy. We are going to continue to support the Royal Lao military forces, then, until there is a complete integration?

Mr. Rives. We expect to, as long as they ask us to do so.

Senator Kennedy. That is not the same as supporting the Government of National Union, is it, if you are supporting just one faction of the Government of National Union?

Mr. Rives. I believe we are supporting the Government of National Union.

Senator Kennedy. By recognition, but not in terms of military assistance. You are supporting only the Royal Lao forces.

Mr. Rives. We are supporting part of it.

Senator Kennedy. Part of it. But it is a distinction with a difference, I believe.

Mr. Rives. I believe we are doing so at the Prime Minister's request, and I assume that the other side is being supplied.

Senator Kennedy. And that will be the situation with regard to our economic aid, as well?

Mr. Rives. Our economic assistance goes to the government of National Union as a whole, and it is up to them to decide how they wish to distribute it.

**AID TO THE PATHET LAO?**

Senator Kennedy. How much of that is expended in the areas controlled by the former Royal Lao government versus the Pathet Lao?

Mr. Rives. To date, probably none.

Senator Kennedy. Has there been any American economic aid—even humanitarian aid—to the Pathet Lao areas?

Mr. Rives. Not to the Pathet Lao areas, no.

Senator Kennedy. No humanitarian assistance at all?

Mr. Rives. Not that I know of, not from us.

Senator Kennedy. What would happen if the Pathet Lao asked us for some kind of humanitarian assistance? What is our policy?

Mr. Rives. Our policy is that this would be discussed with them.

Senator Kennedy. It would be what?

Mr. Rives. Discussed with them. We would see what they asked for, and where, and we would see what we could do.