Senator Kennedy. Surely.

Mr. Mendenhall. The Vietnamese and the United States Mission set up a joint task force at the end of March to work out the implementation of the land reform program. One of the things this task force has done is to simplify the administrative procedures for transferring of land and issuance of title. It used to take as much as 12 to 18 months for the papers to proceed through the bureaucracy from the village up to the central office. It is now down to where our people estimate that it will take 3 months.

We certainly will continue to be involved in this task force in the implementation of the land reform program.

As I indicated, our dollars are not going to be made available directly for payments to landlords. They will simply be made available for imports through our commercial import program machinery as the demand for imports arises, because of the additional piasters of the Vietnamese Government being injected into the economy through the payments to the landlords. We have a very careful system of control through our commercial import program.

Senator Kennedy. But eventually that money will go into the Saigon government, will it not?

I mean, after they pay their piasters out to the landlords, we are going to reimburse them, are we not?

Mr. Mendenhall. We will make dollars available under the commercial import program to importers for commodities that are brought in and sold on the commercial market, just as we do under our present commercial import program.

Senator Kennedy. You mean the money would not even go to the Government; it will go to the importers?

Mr. Mendenhall. The importers buy the dollars with the piasters at the legal rate of exchange. The piasters constitute what is known as the counterpart funds. That fund is used to help finance items in the Vietnamese budget.

Mr. Hannah. I think, Mr. Chairman, to assure you of this, that as this moves forward, at least so long as I play a role in the administration, we are going to make certain that whatever contribution we make is expended for the purposes that we envision. Of course, this has hurdles to get over before it is going to become a fact, but this is going to be worked in, I assure you of that.

Senator Kennedy. I would hope so, because the experience that we have had in terms of recent—as of a year ago, in January—in terms of the degrees of corruption over there, it was just absolutely heartbreaking. Fifty percent of the materials that went on over was ending up in the black market. We had as high as 40 percent of piaster payments not getting distributed to the refugees themselves.

We heard your testimony and others that progress has been made. And I think all of us are realistic as to what the problems are. But I think when we begin on embarking a new land reform program that is going to be subsidized by taxpayers' funds, that a new program certainly ought to have the kind of scrutiny which any such program rightfully deserves.

Mr. Hannah. We expect to provide the scrutiny. And, of course, we are conscious of the fact it is going to be scrutinized by you and
your colleagues and others. It has to be able to stand that sort of continuing study. We will try to make it that way.

The staff of the CORDS Refugee Directorate has increased steadily in numbers and in capability to work effectively in the field. The numbers have increased from 55 in 1966 to 96 in 1967 to 116 in 1968. Of the 116 positions authorized for fiscal year 1969, 109 were filled as of April 30.

For the immediate future we plan to continue our efforts to help the Vietnamese Government upgrade the existing camps and to accelerate the reestablishment of the refugees by either returning them to their original villages or by resettling them in new locations.

Recent substantial improvements in security in many parts of the countryside have made it possible for large numbers of refugees to return home and we expect this return-to-village movement to pick up momentum during the remainder of this year. Those refugees whose original hamlets remain insecure can expect to be resettled in place by upgrading their present temporary camps into resettlement hamlets, or to be resettled in new locations as suitable, secure sites become available. As I pointed out earlier, 295,000 refugees were reestablished during the first 5 months of this year.

The CORDS Refugee Directorate has set a goal of 600,000 refugees to be reestablished during 1969, and, if present trends continue, this goal should be reached. If the present low level of generating new refugees is maintained, the overall total of temporary refugees should be reduced from 1.3 million at the beginning of 1969 to well below 1 million by the end of this year.

Going on to the conclusions on page 23—

Senator KENNEDY. I heard from a responsible high official within the administration that there was going to be a cutback in civilian personnel in Vietnam. Would you care to respond to that?

Mr. HANNAH. There has been a substantial cutback, as you know, in the last year or two, due to the fact that the Congress has not granted the amount of money that my predecessors thought were necessary. We are trying to reduce the number of direct-hire personnel that are involved in headquarters, to get more thought of these people out in the field where the problems exist. But it is my own guess, Senator, that when peace comes the Agency for International Development will probably be more greatly involved in Vietnam as the military will be less involved.

So I would not mislead you into believing that the coming of peace or of a reduction in the level of military activity will necessarily mean a reduction of AID activities unless the Congress or the administration changes the role of our agency, I would guess we are going to have no less substantial role in a year or two or three than we have now.

Senator KENNEDY. Well, do I understand you right, then, that other than the financial limitation placed on you by Congress over the AID personnel in Vietnam, there is no contemplated reduction in civilian personnel in Vietnam?

Mr. HANNAH. We hope to continue to increase the effectiveness of the people we have so that we can get the job we are now performing accomplished with fewer people.

But, Mr. Mendenhall, since you live with this more closely than I, what is your response?
Mr. Mendenhall. Senator, we had some 2,400 authorized AID funded positions in Vietnam at the beginning of 1968. They are now down to some 2,100.

At the same time the total number was coming down, the number of refugee positions authorized was increased from 96 on January 1, 1968, to 116 by mid-1968, and it has remained at 116. I would not anticipate and Dr. Hannah I do not think you would, that there would be any reduction in the refugee positions.

There is a personnel review in process in the U.S. Mission in Saigon at the present time and that may result in some further cuts in overall civilian personnel. But my guess would be no reduction of refugee personnel.

Mr. Hannah. Let me conclude this statement by reiterating a point those of us in AID must always remember. We are not the Government of South Vietnam. Our mission is to help the Vietnamese—to give them support and to prevent a forcible conquest of the country—to enable the people of South Vietnam to determine their own form of government and to do so without coercion.

As we carry out this mission, we must remember that, while it might be easier to do their work for them than to assist them to assume their own responsibilities, we must resist that temptation.

As our military forces now seek to have the Vietnamese Army take over greater responsibility, so should we be careful not to do too much unilaterally in the nonmilitary sphere. Our efforts should continue to stress the need for Vietnamese action and, whenever possible, to help them to improve their capabilities.

This is not said to minimize any delays and disruptions that have occurred and that may still occur. It is meant to be a simple statement of a fact with which we must live if we are to leave a Vietnam capable of managing its own affairs.

And that is the basic philosophy, sir, of the Agency for International Development at this time.

Senator Kennedy. Thank you very much, Mr. Hannah.

Just a couple of final questions. Would you give us at least some idea of the priority that you personally placed, your Agency places on the other war in Vietnam? What sort of priority should that have?

Mr. Hannah. When you say the "other war" I am not sure that I understand.

Senator Kennedy. Civilian side. I support winning hearts and minds.

Mr. Hannah. Well, the personal commitment is the fundamental war. It has been my feeling for a long time that we win few wars on battlefields. We lose them there sometimes, or we have the alternative where we might lose them. But in the end the kind of war that is significant is what we do to encourage the local people to have aspirations to develop what they have in human resources so that they may utilize whatever the nation may have in other resources for the improvement of their own people. Thereby that may have the maximum opportunity in determining the course and pattern of their own society.

So if I understand your question, it is this other war which matters most; the war for the minds and hearts of the civilians—not to accomplish other objectives, but to make out of their country the kind of a place that will be satisfying for them to live. And this is always
at least with the hope that tomorrow will be better than yesterday, and that there will be a better situation for the children and their grandchildren than there has been for the older generation.

This is the basic philosophy that I hold. And it should be the fundamental role of the Agency of International Development, wherever it operates, Vietnam or elsewhere.

Senator Kennedy. I think the highlight that you place, particularly in terms of the Vietnam struggle, is extremely relevant and important. I suppose, I move to the additional question of whether in terms of our own priorities in Vietnam, whether this war—the civilian war, or the battle for the hearts and minds of the people—given the kinds of priority that are necessary to be successful, and given the limited period of time that you have been able to serve as the administrator of this Agency, would you be able to give us any kind of insight as to the attitude within the administration on this question?

Mr. Hannah. Well, I think the emphasis that I place on it is supported by the people higher up in our Government. It certainly is by the Secretary of State and by the President.

We recognize that the shooting war necessarily has priority, and that we must play the role we have as effectively as we can.

But we must also make it clear at every opportunity, as I tried to in my comment a moment ago, that the war could be lost on the battlefield but that that it is not going to be won there. Whether we succeed or fail is going to be determined largely by our success in creating this attitude in the Government of Vietnam and by encouraging them to provide the kind of a climate that will allow their people to make of their country one that will want to resist Communist aggression, and one that will provide the maximum number of people—hopefully all—a role in determining the course in government and society and their economic, and political systems.

Senator Kennedy. I suppose even if we are able to achieve what the President has stated are our limited objectives over in Vietnam, as we move on into the hopefully peaceful resolution of that conflict, the importance of your work and the battle for the hearts and minds becomes of much greater importance and significance; because the final irony would be if we achieved a stalemate or conclusion to that conflict, and then find that the people who had been caught in the crossfire of this conflict, who had suffered so tragically and brutally from that barbaric war, and in the conclusion, free elections were to fail, that the central government did not care about them as individuals or as a people, and turned to the other side.

This would be, I would imagine, one of the great tragedies.

Mr. Hannah. If this is permitted to happen, then the American families that have lost sons or brothers over there, or have had them returned grievously wounded and permanently handicapped, have paid a tremendous price for very little. Whether this one is going to be won or lost still has to be determined, for while we can provide a military shield for a time, unless something is encouraged to happen behind that shield, we cannot for long carry on that kind of a situation.

And, of course, my reaction to this war is the same as most American parents. I happen to have a son who is an officer in the infantry over there. We are paying a very heavy price, and we have a responsi-
bility to do what we can to see that the war off the battlefield is won.

Senator Kennedy. I could not agree with you more. The purpose of this committee is recognition that ultimately and fundamentally this conflict will be decided by the people in that nation and country. It has always appeared to me that if we put a lesser priority on really identifying with the legitimate aspirations of the people in that nation, then if the central government is going to put a lesser consideration on their aims toward the future, I think it will be a very hollow solution to that conflict, no matter how it is worked out. If we are going to see all of these people, refugees, the war casualties, resettled refugees, which in effect is almost half of that country, if we go back to the period of 1960 to date, we do feel their central government, or even the Thieu and Ky government in the last 23 months, are sufficiently insensitive to the needs of these people where they will never gain the kind of support. And ultimately, that is going to be the tragedy for those you have pointed out who have lost their lives and their families.

So when you and those in your agency do your work, and Mr. Nutter and those that work so closely with him, placing the emphasis and the priority on this other battle, I think you serve our overall policy well.

Mr. Hannah. Thank you very much, Mr. Chairman. I would like to make just one comment, and that is that it takes a great deal of courage on the part of the people in a government to advocate the measures that we urged them to espouse that are politically unpopular.

I refer particularly to the action recently taken by the Prime Minister in indicating that they are going to impose much higher taxes, particularly on imports of luxury goods. Of course there has been a great commotion in the Parliament over there, but this is the action we are insisting that they take in order that they keep some sort of control on the rate of inflation.

When they do it in response to our urging, it would be helpful if some of our people give them a little credit for courage instead of holding them up as lacking the support of the people.

I have a great respect for the old general, the prime minister, for although he is well along in years, he has a real understanding of their problems and a real desire to do something about it, even if it means his political sacrifice. I am only saying, I think we ought to give him a little credit for what he is trying to do.

Senator Kennedy. I respect the point. I wish we had a better example than saying that increasing the tax of luxury goods was a difficult and unpopular thing among the South Vietnamese people, because I would certainly think that the million South Vietnamese who are under arms and slugging around in those jungles out there, would not find that an unpopular issue, since just a few rich South Vietnamese have made all too much from the backs of these South Vietnamese and the American taxpayers.

Mr. Hannah. I agree wholeheartedly. I am saying that in this land-reform business, there are going to be some tough political decisions that are going to have to be made. We are going to have to insist and to encourage them. Whenever we have an opportunity, if they are making progress, express some appreciation.
Senator Kennedy. I want to thank you, Mr. Hannah, and Mr. Nutter, for your appearance. You have been extremely responsive. I respect completely, as I mentioned in the opening statement, that this is a new challenge for both of you. It is a matter which has been of great interest to the committee.

I think by your statements and your commitments, Mr. Hannah, at the end, you indicated all so well your own very high commitment to these efforts.

This is extremely reassuring, given your own kind of a background and experience, and your abilities.

The members of this committee look forward to working with you and your staff people along the common lines to see if we can be of help and assistance.

I want to thank you very much, and your assistants, and Mr. Nutter for your appearance before the committee today.

Mr. Hannah. Thank you very much, Mr. Chairman.

Mr. Nutter. Thank you very much, Mr. Chairman.

Senator Kennedy. The subcommittee will stand in adjournment until 10 o'clock tomorrow morning.

(Thereupon, at 11:55 a.m. the hearing adjourned to reconvene tomorrow, Wednesday, June 25, 1969, at 10 a.m.)
The subcommittee met, pursuant to notice, at 10:25 a.m., in room 1318, New Senate Office Building, Senator Edward M. Kennedy (chairman) presiding.

Present: Senators Kennedy (presiding) and Mathias.

Also present: Dale S. De Haan, majority counsel; Dr. Donald M. Chang, minority counsel, and Mr. Stan Darling, assistant to Senator Mathias.

Senator Kennedy. The subcommittee will come to order.

The hearing today continues the subcommittee's inquiry into civilian casualties, refugees, and related problems in South Vietnam.

Before beginning, I want to welcome to the subcommittee Senator Mathias of the State of Maryland.

Senator Mathias, since his election and appointment to the Judiciary Committee, has exhibited a great interest in the problems of refugees. It has been a continuing interest which he had in the House of Representatives, where he served on the Judiciary Committee. He has recently attended the ICEM meetings in Geneva, so he has been actively following and concerning himself with the problems of all refugees.

At this point, I want to welcome him to this committee, and I look forward to his counsel and to his interest in the problems of refugees and in particular the problems of refugees in Vietnam.

Our first witnesses are two medical doctors, John Levinson of Wilmington, Del., and Thomas Durant of Boston.

Both of these gentlemen have spent a great deal of time in Vietnam over the last few years and just recently traveled there for the subcommittee.

Dr. Levinson, who is in private practice, has served as a volunteer to a number of private agencies working in Vietnam. His first tour was in 1963. As a matter of fact, this last trip of Dr. Levinson's to Vietnam was his sixth trip to Vietnam, and he traveled in 1968 as a consultant with this committee.

Dr. Durant, who is currently assistant director of the Massachusetts General Hospital, served from 1966 to 1968 in the Public Health section of the U.S. Mission in Saigon.

They are professionals and humanitarians, and good examples of the many highly motivated civilians serving in Vietnam, often at great
personal risk to better the daily lives of the South Vietnamese people. All of them deserve high tribute and every support possible from our Government and South Vietnam.

Dr. Levinson and Dr. Durant are presenting a report on their recent field study this morning. I understand they have a brief opening statement and will continue their testimony with slides.

Gentlemen, we welcome you here.

STATEMENTS OF DR. JOHN M. LEVINSON, WILMINGTON, DEL.; AND DR. THOMAS S. DURANT, ASSISTANT ADMINISTRATOR, MASSACHUSETTS GENERAL HOSPITAL

Dr. LEVINSON. Thank you, Senator.

Dr. Durant and I would like to request that our official report on our visit in South Vietnam from April 25 through May 7, 1969, be included in the proceedings of the hearings.

Senator KENNEDY. It will be so included.

Dr. LEVINSON. Thank you, Senator.

(The documents referred to follow:)

JUNE 24, 1969.

Hon. EDWARD M. KENNEDY,
Chairman, Judiciary Subcommittee on Refugees,
Senate Office Building,
Washington, D.C.

DEAR SENATOR KENNEDY: We herewith submit our report on our visit to South Vietnam from April 25 through May 7, 1969, concerning refugees, civilian casualties and social welfare problems.

We are grateful to your staff and to the numerous persons, both American and Vietnamese, who assisted us in gathering information and making numerous on-site visits.

Respectfully,

JOHN M. LEVINSON, M.D.
THOMAS S. DURANT, M.D.
REFUGEE AND MEDICAL SITES VISITED

1. Da Nang Medical Center

The city of 25,000 now has over 300,000 people. The Ministry of Health authorized 600 beds, but it has 750 beds but usually cares for 950 or more patients at a time, plus relatives. 600 or more Civilian War Casualties are treated monthly. This is one of the few Vietnamese hospitals with a blood bank, but it is difficult to get Vietnamese to donate blood, many of the volunteers are too anemic to bleed and often blood found is syphilitic and must be destroyed. Reliance is upon blood 21 plus days old, not usable by U.S. standards and given to the hospital from local U.S. military hospitals upon reaching 21 plus days old . . . that is, expiration date plus. Sanitation is very poor. Early this year sewage overflowed in operating rooms and new system being installed. Hastily constructed temporary wards are in poor repair and rapidly deteriorating. The greatest problem is lack of beds and poor water supply according to the Medicine Chief Dr. Tung. There is little ARVN night support at hospital in spite of plans of the Coordinating Committee for Military and Civil Health.

The medical supply problem is largely solved since last year, but cancer drugs still not obtainable! Recently U.S. advisory team uncovered over 1000 sheets and blankets hidden by Vietnamese staff! The greatest problem according to U.S. medical officer in charge of advisory team is maintenance. This problem was restated in virtually every Vietnamese hospital visited.

2. Da Nang Rehabilitation Center

This is a new and all Vietnamese operation. Case load is heavy and 3 month waiting for amputees to be given prosthesis. No help available for 20 quadriplegics from Da Nang hospital.

3. 55th Evacuation Hospital U.S.A.

This was one of the three new D.O.D. hospital originally planned for Vietnamese C.W.C. It has 320, not 400 beds as planned. It opened April 28, 1968 and is a first rate hospital by all standards. It only handles 45-50 C.W.C. per month and at times C.W.C. must be turned away due to U.S. Military Hospital policy of keeping 35% of beds available for "contingencies". Biggest problem is lack of radio communication to choppers to direct patients to this hospital or provincial hospitals as space available.

4. Hue Central Hospital

1100 beds available vs. 1300 before TET 1968 due to great destruction of area. There is no joint utilization with ARVN, hospital basically clean by Vietnamese standards but maintenance great problem. Shortage of people to teach Vietnamese in nursing, administration and how to run operating rooms. Due to little enemy activity in area in recent months, only 5% of 3000 patients per month are C.W.C.

5. Hue Medical School

Large parts of this destroyed in TET 1968. Building closed not repaired. Plans call for reopening this summer with return of students temporarily transferred to Saigon. We were unable to find any plans for faculty, etc. This is a critically needed facility.

6. Hue Nursing School

The school has reopened in largely destroyed quarters. Library was destroyed by V.C. and N.V.A. at TET 1968, 183 students in 3 year program and 140 in 1 year program. The only other 3 year nursing program is in Saigon.

7. Quang Tri Provincial Hospital

450 beds overcrowded with 1500 patients per month of which 100 per month are C.W.C. 65% of surgery is for C.W.C. Public health is their biggest problem.

8. 3rd Marine Division Memorial Children's Hospital

Although authorized for 15 beds, they have 60 and usual census is 100 children. There are 18 Vietnamese "nurses" . . . all trained locally by U.S. personnel. 15+% of surgery for C.W.C. This is well run by marines under difficult conditions.
9. Cam Lo Refugee Oamp

20,000 people from D.M.Z. live in 5 village units. Conditions vary greatly in camps. Sanitation poor. Families interviewed have received payments. These people will not be able to be resettled till war over.

10. Hoi An Hospital (Quang Nam Provincial Hospital)

120 of 300 plus patients per month are C.W.C. Most surgery sent to Da Nang hospitals. The number one problem is that of water. For 8 plus months a 500 gallon pump has been on order! Although 4 ARVN M.D.'s scheduled to come here by the Coordinating Committee for Military and Civil Health, none had arrived. X-ray is poor as generator is insufficient.

11. Tam Ky Provincial Hospital

On our last visit the wards had 60 beds plus 60 in tents. Today, tents are gone and 240 ward beds occupied by 750 patients per month. 197 C.W.C. in March and 90% of surgery occupied with C.W.C. 70% of patients walk in, or are carried in by "chogey stick". Last year this hospital run by a U.S.A. Captain with one year of obstetrical training. Currently run by excellent team of well trained U.S. personnel. No ARVN M.D. have arrived as scheduled by Coordinating Committee for Military and Civil Health. Major problems are maintenance of water and electrical equipment and shortage of trained Vietnamese personnel.

12. Tiep Cu "Reception Center"

This "reception center" in Tam Ky, in Quang Tin Province by theory keep refugees only 2 months. Last year camp was crowded with 5000 plus people, 7000 in camp in March 69 and now 700 remain. Some of people in camp not refugees but had moved in for shelter. Wells as in all camps visited had no lids and were not clean. Privies were filthy and not functional. Payments in piasters and grain were delinquent, and many people had been there 5-6 months. It should be noted that in Tam Ky district that 40,000 of 100,000 people are refugees.

13. 312th Evacuation Hospital (U.S.A.)

This was the second D.O.D. hospital originally planned for Vietnamese C.W.C. It has 325 beds, and ¼ of patients are Vietnamese. In addition to an average of 240 Vietnamese surgical cases per month during January, February and March 1969 there were 100 Vietnamese medical cases per month. The U.S.A. M.D.'s go to Tam Ky and Quang Ngai on consultation when able. Two Vietnamese ARVN M.D.'s recently assigned here for preceptor ship training which is working well.

14. Quang Ngai Hospital

This 440 bed hospital overflowed with 1450 patients in March of which 532 were C.W.C. In addition 1000 outpatient C.W.C. treated. Enemy action completely destroyed the medical warehouse on September 29, 1968 and although supplies are available storage space is limited and makeshift. The U.S. personnel strongly suspect stealing of supplies at management level by Vietnamese. Although nurses still steal medications and charge patients for suturing wounds, this problem is less than it was 1 year ago. A great problem is that of motivating Vietnamese nurses to give any sort of reasonable patient care and an acute shortage of all personnel exists. 500 cases of Bubonic Plague in the first 4 months of 1968 and only 350 in comparable period in 1969. 50% of secure population i.e., 300,000 have received plague immunizations but only 60% live in secure areas. Few other immunizations given. Entire area quite insecure.

15. Quang Ngai Tuberculosis Hospital

Canadian run, functioning well in spite of great destruction in TET 1968 and subsequently. Destruction almost fully repaired. 80 bed patients plus 100 outpatients daily.

16. Quaker Rehabilitation Center—Quang Ngai

They are rehabilitating 100 plus patients each month with numbers increasing. They could handle 200 patients per month if they had bed space. Many amputees afraid to come in as they lack proper identification papers (that is they are probably V.C.) and are afraid of being held and not allowed to return to their homes. 27 Vietnamese prosthetists are in training but 8 are to be drafted!
17. Batangan Peninsula

On January 13, 1969 an amphibious operation removed 12,718 people from here and killed some hundreds of V.C. All homes were destroyed and in 1 month all people returned to area, houses rebuilt and all payments made to these people who were forcefully removed and resettled. (Spot checks on 8 families confirmed payments all made.) Currently 3 C.A.P. teams, each with 13 marines plus 25 P.F. personnel; 2 R.F. companies of about 200 personnel total; 10 R.D. teams of 20 personnel each team; 400 men of Americal division and 400 ARVN on peninsula to guard this supposedly pacified group of people! This appears to have been a very expensive and questionably effective operation to win "hearts and minds". The houses are of poor quality, cramped together. Most all palm trees destroyed by gunfire. Although people may go and work in fields or go fishing security is poor with curfew at night fall.

18. Ghenh Rang "Temporary Refugee Camp" (in Qui Nhon)

These 4,068 people of 498 families live in 500 houses which is really a beautiful urban area for Vietnam. Most people are employed, have been overimmunized. Houses are of cement, Hondas crowd the streets, schools and medical care adequate. A visit by representatives of our committee to Cathedral Camp in Qui Nhon in 1966 supposedly stimulated this in 1967. No payments have been made to these people although they will eventually by law be paid in spite of comparatively small needs. The U.S. and Vietnamese have agreed on this low priority due to obvious prosperity. Unfortunately the Cathedral Camp which was to be closed after building this, was not, due to large flow of refugees.

19. Cathedral Camp (Qui Nhon)

2,425 refugees ... many here since 1964. Crowded, filthy but most employed. No payments ever made here. Only 3 wells, water dirty. Most have had some immunizations. A large 3 story apartment building here in planning stage. Many Hondas in camp at night lend credulence to prosperity. U.S. advisors feel many of these should not be considered refugees but "urban drift".

20. Qui Nhon Provincial Hospital

This 450 bed hospital treats 1000 plus bed patients per month. 40% of 500 major operations per month on C.W.C. They average 300 C.W.C. per month. Maintenance is poor, running water only available in O.R. and in the laboratory and frequently they are unable to procure antituberculosis drugs. The New Zealand surgical team strongly requests more Vietnamese physicians to work here.

21. Qui Nhon Rehabilitation Center

Opened April 27, 1969 by Canadians. Very adequately equipped. 60 beds, good personnel.

22. Phu Phong Temporary Refugee Camp (Binh Dinh Province)

1823 refugees have lived here since 1965. No privies are operational, and people won't use them anyway. The 3 wells contain dirty water. The dispensary contains few drugs, but many of people have been immunized. Over 50% of children go to school through 5th grade. Each family has at least 1 person employed. Few have been paid benefits and many have lost their records. No temporary payments in past 2 years! Some few moved away last year, many won't move. This area is to be upgraded and called a "resettlement area". Some have been previously resettled and then returned here, which may explain poor motivation and filth.

23. Bong Son (Impact Hospital)

Formerly this was a 12 bed village dispensary with average daily census of 100 patients for last 2 years having only makeshift O.R. In mid March 1969 new hospital of 100 beds opened with average daily census of 150. Of 430 patients in April 80 were C.W.C. The main problems are those of getting Vietnamese to assume responsibilities and to use toilets.

24. Socker Field Camp (Binh Dinh)

1503 people live in this temporary camp which will be made into a resettlement area. Many have been here 4 years, only 1 of 5 wells has water in it, and there is not a dispensary in the camp. 62 of 204 families have no employment. Only 2 months ago the 1st of temporary payments made. 50% of children get some schooling. Elections held on April 27 were interesting in demonstrating people expected something to be done for them by their elected officials.
25. Trung Luong Resettlement Area (Binh Dinh Province)

These 2256 people displaced from the An Lao valley had no privies and only 3 usable wells of 6 in camp! The dispensary has part time personnel only, 25% of families unemployed and 35% of people had not received full payments.

26. Kontum Provincial Hospital

This 180 bed hospital treats 250 inpatients per month. In February and March 1969 about 100 C.W.C. per month and only 15 in April 1969. The Vietnamese Medicine Chief does all the surgery, and appears to have little relationship with his American counterpart. The American M.D. has had minimal training after an internship, is very passive, claims he only works 2 hours per day and has initiated no projects since being there! Little laboratory work done and the effort is very disappointing. Sanitation poor.

27. Pat Smith's Kontum Hospital

The former hospital 4 miles away was abandoned after being attacked by V.C. in March 1968. Current facilities are in a school and consist of 68 beds, treating 170 inpatients a month and numerous outpatients. Pat Smith caters to the Montagnards, the entire area is humming with activity, and a fantastically good job being done in contrast in Kontum Province Hospital several miles away.

28. Kon Horing (Kontum Province)

This 200 year old village of 7000 people contains 2400 in camp refugees in a resettlement area. On February 23, 1969 and again on March 21, units of the X.V. struck and burned out large areas of the village destroying 80% of rice supply. 53 people, mainly women and children killed and wounded on the 1st attack and 15 on the second, also some kidnapped by enemy. In spite of 2 visits by U.S. refugee director to Salgon no plaster or tin payments had been allocated by my April 30 visit. No death or injury payments had been made. Some emergency commodities had been issued.

A new prefabricated hospital had been erected to be run by a French M.D. but he was recently killed by a land mine, and no medical replacement available.

29. Pleiku Provincial Hospital

This 180 bed hospital treats 400 inpatients per month of which about 30 are C.W.C. One of greatest problems is shortage of Vietnamese personnel as they don't like to work here. (They prefer big coastal cities.) Chief of U.S. Milphap team has only had 1 year of surgical training!

30. 71st Evacuation Hospital (U.S.A.) Pleiku

This 300 bed unit, runs with 260 beds due to personnel shortage. 50=60 C.W.C. treated each month which means 20% of major surgery performed. They handle total of 1200 inpatients per month. As other U.S. hospitals they are limited by ruling to keep 35% beds available for contingencies of mass casualties of U.S. personnel. As other Evacuation hospitals this is well equipped, clean and well run.

31. Plei Ya Lou Resettlement Area (Pleiku Province)

These 1995 Montagnards came from north central Pleiku province. They expressed a desire to leave their homes and come here due to V.C. pressure and taxes. The camp was prepared and ¾ came voluntarily, ¼ followed. Only 1 dirty well in camp and 90 died of intestinal disease this March. Diet poor, much malnutrition and due to meager supplies of fish, rice and salt people forced to eat animal feed and slaughter their animals. People here very unhappy. Before coming here these people never saw G.V.N. and opportunity being lost to win "heart and minds".

32. Plei Ring De (Pleiku Province)

In January 1969, 732 Montagnards were forcibly resettled here from area 40 kilometers away (near the Cambodian border). This was ordered by Lt. General William Peerse (as was Edap Enang and other camps) so that their home area could be a "free fire zone". (General Peerse was commanding General I Field Forces for II Corps and also served as Senior Advisor for II Corps). The displaced Montagnards took all the distributions of rice etc., refused to work in nearby tea plantation and showed no initiative. After 2 temporary resettlement benefits in plantation April 23 all except 37 packed up and walked out! It should be noted that many of them had 2 or 3 times previously left other camps as Edap Enang. It appears that plague in nearby village may have disturbed them, but
since “free fire zone” was not heavily used it seems they decided they preferred the risks at home rather than the camp.

The remaining Montagnards gave many different reasons for staying, i.e., “good food here” . . . “too many N.V.N. in home village” . . . “security better here”.

33. Edap Enang Resettlement Area (Pleiku Province)

This area for 7000 Montagnards prepared in 1966. Many left in 1967 due to food shortages. Most were moved in to allow free fire zones for the U.S. 4th Division as well as to make G.V.N. control easier. A self defense corps has been organized which in last several months has on 2 occasions ambushed V.C. coming in the camp! Only 1000 of current 4897 came voluntarily. Many have not received full payments. More planting this year is a good sign that they may stay.

34. Phu Rom Provincial Hospital (Impact Hospital)

This 60 bed unit opened April 14, 1969. Formerly 35 bed dispensary. 2 large generators for hospital but insufficient fuel to run them. Therefore they turn off at night. Maintenance already a problem. Few Vietnamese work here as they don’t like area. Korean team doing very good job in province for three years.

35. Tuyan District—Hoa Do Hamlet in Phuyen Province

This hamlet of 1500 people rebuilt since destroyed by R.O.K. operation in December 1966. There is a new school and a new dispensary but sanitation poor. This is considered a “B” hamlet and all but 68 of the 286 hamlets in this province have started or have a fully formed self defense corps. It is claimed that 23,000 of 97,000 refugees in this province have returned to village in past 6 months (figures differ from those on official charts). It must be noted that many hamlets located in hills in insecure areas have been relocated, so that vast areas will be empty and entire province will be far from secure even if goal met to pacify all hamlets in province in 1969.

People interviewed complained that the new houses with poorly constructed wood walls did not keep out the rain. They preferred their former homes with mud walls.

36. Tuy Hoa Provincial Hospital

This is a 212 bed hospital treating 250 inpatients per month. 100 bed increase to be started this month after which it will be jointly used by ARVN and MOH. The need will be very great when 91st EVAC Hospital moves away in July 1969. Korean Milphap team runs hospital and is very short of Vietnamese M.D.’s and Vietnamese nurses.

37. 91st Evacuation Hospital (Tuy Hoa)

This 400 bed U.S. Army Hospital was one of the first 2 in Vietnam to accept C.W.C. In the 6 month period Oct. 1968–Mar. 1969 they treated 706 surgical and 309 medical inpatient Vietnamese. 80% of major surgery was on C.W.C. This first rate U.S. installation will accept its last patient June 1, and completely close by Sept. 1, 1969. Most personnel will move up to the 312th Evacuation Hospital in Chu Lai to replace the reserve medical personnel there who are to be sent home. This deactivation is based on the fact that the 173rd Airborne, and the 4th Division have been moved from the area. Three inescapable conclusions present.

1. There will be a lack of necessary hospital facilities in the area for C.W.C.
2. This will be a major blow to the tremendous pacification efforts in Phu Yen province.
3. The propaganda value to the enemy is obvious. The physicians at this hospital are deeply concerned about this deactivation and do not wish to leave Tuy Hoa. There are no known plans on utilization of these excellent medical facilities.

38. Khanh Hoa Province Hospital

This 330 M.O.H. hospital in Nha Trang treats 1200 inpatients per month. Most C.W.C. in area sent to 8th Field Hospital nearby. Supply situation good, with exception of heavy equipment. (Recently they waited 6 months to get badly needed Wangenstein Suction apparatus.) Sanitation very poor.
A major problem is that many Vietnamese (often in as "free students", i.e. observe on wards for up to a year, then take a Civil Service Examination and if they qualify are called "National Nurses". Although they are then paid at a lower scale than nurses formally trained, their salary is increased with size of their family. However many thousands of these "National Nurses" go out to practice medicine in the cities and run essentially a "shot shop"... obviously a poor quality and dangerous type of medicine.

39. 8th Field Hospital (Nha Trang)
This 365 bed hospital averages over 1000 inpatients per month. Only about 5% of case load is C.W.C. Supply situation excellent.

40. Ba Gieng Resettlement Area (Cam Ranh)
6000 people from Quang Ngai and Binh Dinh provinces have been here for 3 years. This is the first inter regional transfer of people and although it is now a most affluent middle class development with good security, the people interviewed wish to return to their original homes when the war is over.
A large 2 story school is being built, there are adequate stores, a fine market place and a gas station. The local pool hall was filled with young Vietnamese teenagers. The people have received all resettlement allowances, largely live in cement dwellings, and must all employed by U.S. Military. The average family with 2 employed makes 35,000 piaster per month. There is no farming or fishing. What happens when the U.S. Military goes???

41. My Ca Resettlement Area (Cam Ranh)
After 1 year of planning this area is rapidly developing into an area similar to the Ba Gieng resettlement area. Although one of the better efforts, the long term economic problems are frightening.

42. Dampaao Hospital in Tuyen Duc Province (Project Concern)
This 50 bed hospital with 20 regional clinics renders a good medical service to Montagnard refugees. No major surgery is done due to lack of sufficient electricity. C.W.C. are given limited care, and along with other surgical emergencies medivaced to Cam Ranh. A major contribution is training of Montagnards as village medical assistants. Security in area is marginal.

43. Lien Khang Hospital in Tuyen Duc Province (Project Concern)
This new unit nears completion and should have a real surgical capability. Funds for this donated by people of Worcester, Mass. as a living memorial to their war dead. Full operation of this 50 bed unit anticipated in July 1969.

44. Tuyen Duc Provincial Hospital in Dalat
This 300 bed well equipped and well run hospital treated 1000 C.W.C. in 1968. They have no running water, lack sufficient staff, are not overcrowded and appear in much better shape than most provincial hospitals.

45. Bao Loc Impact Hospital (Lam Dong Province)
This 100 bed unit opened March 4, 1969. 400 inpatients and 3600 outpatients treated in April. A young Navy Lieutenant just out of an internship is in charge, and no surgery done due to his lack of training. A well equipped operating room is never used! Patients die if medivac not available. This is but one of many hospitals that are ineffective due to lack of surgical personnel.
On the other hand, there are two 50 K.W. generators for this hospital, far in excess to any needs, with a capability of providing power for the entire city!

46. Gia Nghia Hospital in Quang Duc Province
This 20 bed installation was destroyed by enemy action in February 1969. R.F. and P.F. units camped here in the ruins. Area insecure. All supplies formerly by air.

47. ARVN Hospital (Quang Duc Province)
There are 30 beds in a wooden shack with a dirt floor for the ARVN. There are 2 tents with 20 beds for civilians to replace the destroyed Gia Nghia Hospital. The U.S. Milphap personnel have no surgical training and there is not an operating room. The former Vietnamese Medicine Chief was ineffective and has left to study ENT in Nha Trang. Supplies come in poorly, area filthy, security very bad.
48. Khiem Tin Camp in Khiem Duc District (Quang Duc Province)

Over 3,000,000 piasters spent for building alone to house 1200 non-refugees who live 1-2 kilometers away. This almost completed project was ordered by Province Chief, and is officially UNKNOWN by Vietnamese ministry!! The work has been done by R. D. Cadres, public works employees and local people. The justification by the Province Chief is to provide security for the farmers in the valley who only live 1-2 kilometers away!!! Other projects of this nature are in planning stage, and U.S. advisors are powerless to stop this "forced resettlement", a policy that had supposedly stopped months ago.

49. Gia Nghia Impact Hospital in Quang Duc Province

One and a half years have been spent on the construction of this installation which is not yet half completed. Supplies must be moved in by air, because of insecurity, and each cubic foot of sand to make cement arrives at a cost of $90.00 (U.S. dollars). It is said that there is no way to use local building materials. As judged by the medical facilities seen in this province there is a critical need for this new installation, which is hopelessly bogged down.

GENERAL OBSERVATIONS

Civilian War Casualties: 1968

The Sub Committee estimated that in 1967 there were up to 200,000 civilian war casualties in South Vietnam. This figure was arrived at after careful study of data available, a country-wide inspection, and the realization that many victims never reached hospitals or dispensaries. It was also known that many thousands of C.W.C. were treated through hospitals and clinics run by voluntary agencies, countless people were treated as out-patients through M.O.H. hospital and dispensary system and not on official records. Lastly, it could never be known how many civilians were killed outright or never managed to secure medical aid.

In 1968 the M.O.H. hospital admission rate for C.W.C. was well over 60% greater than 1967. Certainly improved transportation and communication may account for some increase, thereby, decreasing the number of unknown uncared for at hamlet and village level. However, there were many thousands more cared for through M.A.C.V. hospital system, which in 1967 provided only token care. During a great part of 1968 the pace of the war was markedly increased in all areas with a corresponding greater number of military casualties. C.W.C. have increased in relationship to population densities and proximity to fighting areas.

Brigadier General Spurgeon Neel (M.A.C.V. Surgeon General) states that U.S. military casualties are 1 killed for every 6-7 wounded. The killed to wounded ratio in civilians who are ill protected and in poor general health is certainly much higher. It is obvious that the 4 ingredients that led to a decrease in the morbidity and mortality of U.S. forces are still largely unavailable to the C.W.C. They are:

1. Rapid transport to medical facilities.
2. Surgical capability.
3. Anesthesia capability.
4. Adequate blood bank.

Considering these thoughts, plus the evidence from visiting representative health facilities in most provinces it is undoubtedly true that the yearly number of C.W.C. has again increased. It appears that the best estimate is that approximately 300,000 civilians were killed or wounded in South Vietnam in 1968.

The D.O.D. hospital system

The 3 new D.O.D. hospitals originally planned for C.W.C. have been used for U.S. military personnel and C.W.C. Supposedly a minimum of 1100 beds were to be available for C.W.C. but in spite of lack of adequate personnel and bed shortage in Provincial hospitals, this has not occurred. Increasing utilization of D.O.D. system in addition to providing bed space and good overall care, gives sophisticated medical care completely unavailable at Provincial hospitals. A new program is that of giving preceptorship training to Vietnamese doctors in the D.O.D. hospitals. The D.O.D. hospitals have assumed an important role in pacification program. When it was learned that 91st Evacuation Hospital was closing, it was discussed with Brigadier General Neel. He states that 1200 beds will be closed by this fall, that is 15-16% of U.S. military bed capacity. Furthermore, he maintains that there are still adequate U.S. military medical facilities to help the Vietnamese. This is completely contrary to findings in the field!
Refugee problems

The conditions and needs of these people vary tremendously. A repetitive finding was a lack of trained Vietnamese refugee staff. There appears to be no use of assigning more CORDS personnel at district level if they have no Vietnamese counterparts.

Great pride is taken in the tens of thousands of resettled refugees particularly in I Corps. This entire effort is predicated upon security. No one could state that "security" prevailed because we were stronger or the enemy weaker.

Too many decisions and programs are ill conceived in Saigon, and do not reflect the need and thinking at district level. "Project Recovery" after TET 1968 stated that each head of household who lost his home was to receive 10 bags of cement, 10 sheets of tin and 5000 plasters. The gathering of data and processing up to Saigon, with checking and rechecking consumed a great portion of time refugee advisors felt should have been given to other more pressing projects. By the time some received their tin and cement, the acute need was over, other arrangements had been made by the refugees themselves and many immediately sold these items on the open market. This program finally completed in February 1969.

Many refugee advisors freely state that the escalation of the war, with neglect of "the other war", has caused great suffering and many Vietnamese hate us for this. "Winning hearts and minds" is now an empty phrase with little evidence of this being accomplished.

Although payments to refugees are often slow and some non-existent, the general situation has improved. The MOH/SWR has ruled that the U.S. Province Advisor is to be notified when payments are given to Vietnamese Province Chief. This has literally forced him into more rapid disbursements, and cut down on corruption. Certain Province Chiefs have been replaced with men of greater ability and integrity, and great improvements occurred.

47 "Mobile Teams", of 10 Vietnamese on each team, have been created to help refugees. They are paid on a higher scale than usual MOH/SWR personnel, and they have a special dispensation to allow replacements on team if a member is drafted. Theoretically, the teams are dispersed per need to various provinces and then are under direction of Province Chief. Often they have not worked in this relationship and friction and inefficiency has existed.

Private construction was forbidden post TET until December 1968. This was one of the better benefits to the refugee. However, since the general mobilization order in 1968, a ministry may NOT hire anyone to replace a drafted individual. The problems created are obvious.

Death and injury payments are still slowly administered. (The U.S. government still is billed for damage to coconut trees and the like!)

Many U.S. personnel including people working with refugees insist many Vietnamese in and out of camps are "urban drift", not truly refugees. This argument is given for Qui Nhon where 85% of the peninsula is occupied by ARVN and U.S. military. The civilians crowd the periphera for security, mainly work for military and live in hovels. Often they have money, as attested to by large number of Hondas in camps at night. They refuse to build homes of any value as they don't know when they will be moved out, and they have not titles to land. There is some evidence coming in that once a refugee's homeland is secure he will pack up and return, completely neglecting "the payments" yet due.

In March 1969, a group of out of camp refugees in An Khe approached the U.S. refugee advisor with 250,000 piasters. They had saved this from farming and wanted him to buy a tractor for them. The interesting fact is that they had not received their "payments"! The industrious nature of many refugees often has not been appreciated.

In January 1968, a Vietnamese and U.S. effort sent 38 prefabricated warehouses throughout the country for use in refugee program. Each unit was sent in 7 boxes, each 10' x 10' x 10'. Thirty thousand plasters were allocated to erect each one of these, and a team of experts was to be available, cement and other supplies available on demand. In Pleiku the boxes remain unopened, as the trained personnel never arrived! They know of none of the 38 programmed warehouses that were ever completed.

In 1968 the refugee vocational training program was allocated 30,000 sheets of metal, 4' x 8' x 3/16" for use in 1969. The metal is too heavy for building use, and appears to have very little use at all. At any rate, Pleiku never got their ration at all.
The Electrification Program in refugee camps has been a complete waste and failure. This GYN program, U.S. inspired, was to give refugees electricity who never before had this utility. This was a country wide program which was cancelled in 1969. The monuments to the program are empty generator houses built at a cost of 280,000 piastres each.

Another example of a Saigon conceived program which bears little relationship to the district level need is that of the "Rototiller Program". Six plus months ago 5 large crates arrived in Pleiku containing unasked for, and unneeded rototillers. No spare parts were sent, no gasoline allotment, no personnel to operate and no program organized for use of this equipment. In all likelihood the crates are still unopened.

In Binh Dinh Province there are 1/6 of all refugees in South Vietnam. In 1966, 1967 and much of 1968 no payments made in many camps. Not only was corruption suspected, but it was proven, and Col. Vong was sentenced to death (but never executed) and other officials failed. Since there was no refugee service chief from October 1967-February 1968, no money or supplies given to refugees with few exceptions. Following appointment of a new chief, little was accomplished as there was much friction between him and Province Chief. Program now is still weak due to personality problems. The emphasis in the refugee program has changed from "payments" to "return to hamlet". This change in emphasis was ordered from Saigon and has created much additional paper work and slowed down payments.

The problem of "forced resettlement" has been documented repeatedly in sites visited. This situation exists today in 4 provinces in II Corps, namely in Pleiku, Dak Lac, Quang Duc and Lam Dong.

III CORPS

In III CTZ, Thomas Durant was accompanied by two representatives of the Refugee Directorate; namely, Mr. George Klein, Refugee Chief III CTZ and Mr. Raymond Fontaine, Liaison Officer from Saigon.

Phuoc Long Province

In a briefing, the Refugee Advisor, Mr. Robert Handy, stated that 18,238 refugees were being resettled. All have homes. The refugees are allowed to farm adequate land for the duration of their stay at the refugee sites. No land titles are being distributed. Besides receiving rice for food, the Montagnard refugees obtained rice seed and vegetable garden seed. The newly-appointed province chief sees no need for land reform.

1. Son Trung Site

During the post-Tet offensive of 1968, four hamlets, Son Trung #1, Son Trung #2, Son Thanh, and Bu To were razed to the ground. They were completely rebuilt adjacent to one another at one site. Security was established with barb-wire fences, bunkers, popular forces and self-defense peoples forces. All this was accomplished within 3 weeks' time.

2. Bu Nho Site

In Phuoc Binh District, Son Giang Village, Tu Hien #2 hamlet, Bu Nho site, 1963 refugees (415 families) are being resettled.

In November 1968, these people were told by the VC that they would be taken into the jungle to work for the VC. They immediately requested that they be moved to a secure area by the government. They were moved to the Nguyen Van Cuong Temporary Camp by the government. On February 10 they moved to a newly-constructed permanent resettlement site. Plans are now being made to further assist these people. They are all Montagnards. Presently they have some employment as laborers in Song Be.

The 1969 plan includes land clearance. Moreover, a school and a water system, and latrines are being considered.

3. Dak Son Site

In Phuoc Binh District, Son Giang Village, Dak Son #1 hamlet, 535 refugees (124 families) are being resettled at the Dak Son site.

In December 1967 these people, all Montagnards, were victims of probably the grates VC atrocity of the war. Their village was attacked and burned by NVA soldiers using flamethrowers. An estimated 200 people were killed—most of them burned to death. So these people are strongly anti-VC. They are farmers. The Truong Son Cadre here are excellent. There is an adequate water supply.

The 1969 plan includes vocational training in sewing, a school, and several self-help projects.
**Tay Ninh Province**

In his briefing, the refugee advisor, Mr. Thomas Wajda, informed the visitors that Tay Ninh had 1720 temporary refugees and 10,399 refugees who were being resettled. Mr. Wajda was confident that this resettlement process could be completed by the end of 1969, provided that the MHSVR made commodities and funds available soon. He complained of Saigon's slow response to the SWR Chief's requests. No land titles issued yet in this province.

1. **Phuoc Dien I Site**

In Phuoc Ninh District, Thanh Dien Village, Phuoc Dien I hamlet, 2027 refugees (339 families) have resettled themselves.

This resettlement site was beautifully laid out and established by a Philippine Civic Action Group (Philcag). The homes are constructed of concrete blocks. There are adequate wells. There is nothing lacking for an ideal refugee resettlement hamlet except security. As a result of constant VC terrorism and harassment, almost 300 homes were abandoned, after the roofs had been blown off by the VC. On 27 April 1969, the office of the hamlet chief was demolished by a plastic charge. At night, the VC have easy access to this resettlement hamlet. Both the Province Chief and the PSA, Mr. Appling, are fully aware of this hamlet's insecurity which at this moment does not top the list of priorities.

**Han Nghi Province**

The inspection party did not land at the capital city because on that day, 29 April, President Thieu was presiding over an important celebration, attended by the American Advisory Group. The visitors landed at Duc Hoa and proceeded to the resettlement site called Cau Ca (or An Dan) in Duc Hoa District, Duc Hoa Village, An Dan hamlet. In the absence of the refugee advisor, Mr. Matthew Ward stated that 276 houses had been built of concrete or clay blocks. This is a self-help project.

The water supply is presently inadequate. The people draw water for washing from nearby wells; but they must walk several kilometers for potable water. The 1969 development plan calls for the digging of wells and latrines and a dispensary. Three classrooms are under construction. No land titles issued here yet.

A section of the old temporary remains standing, in order to have a place to receive new refugees.

**Binh Duong Province**

On 30 April, the inspection party arrived in Binh Duong Province. They were met by the refugee advisor, Mr. Roger McNiere. He stated that, in his province, there were 5190 refugees engaged in the process of resettlement. Major problem with them was delay in payments due to Saigon red tape.

1. **Gadsden Site**

In Chau Thanh District, Phu Cuong Village, Bong Dau hamlet, 996 refugees (158 families) have been resettled.

This is a well-developed, permanent resettlement site. All facilities are superior. This was a special project sponsored by Gadsden, Alabama. Much U.S. military assistance was also given. The people are well off—most of them working at the U.S. 1st Division installation nearby. When money in lieu of rice payments are made this site will be completed. No other facilities are necessary. No land titles issued here yet.

2. **Lai Thieu Site**

In Lai Thieu District, Binh Nham Village, Binh Hoa hamlet, 3,100 refugees (548 families) have been resettled.

Binh Hoa is a permanent resettlement village. The majority of these refugees are the often publicized "Ben Suc refugees" who were generated during operation Cedar Falls in January of 1967. The majority of the others are voluntary refugees who come mostly from northern Binh Duong province. This village is relatively well off. The International Rescue Committee has been active here for 2 years. The YMCA has a community center here. The economic well-being of the people is good. There are a variety of village businesses. However, a poultry project begun a year ago is not doing well. No land titles yet.

3. **Kien Dien Site**

In Ben Cat District, An Dien Village, Kien Dien hamlet, 2077 refugees (431 families) are presently being resettled.
This is a permanent resettlement site. The hamlet has been in the VC sphere of influence in the past. However, this is an APC and R.D. program hamlet, and emphasis is being placed on the development of the hamlet. Recently the new Popular Self Defense Group has repelled two VC attacks on the hamlet (January 1969). Farming is the main occupation and there is adequate land. The people here are fairly self-sufficient. No land titles issued yet.

In the same hamlet, 120 refugees (25 families) who had been living in the Michelin rubber plantation and who had to be evacuated before a military campaign, freely chose to return to Ben Cat District where they had originally lived. While waiting for the MHSWR to assist these people, the Civic Action Team of that area built homes for these people in Long Nguyen hamlet. The houses are constructed of wood and covered with aluminum sheets. The CA Team is also feeding them with rice which was grossly contaminated and unfit for human consumption. No payments here yet.

**Binh Tuy Province**

During the briefing, the Refugee Advisor, Mr. Dan Ruffino, stated that in his province, 10558 refugees are receiving resettlement assistance.

1. *Tam Tan Site*

In Tam Tan District, 1551 refugees (389 families) have been completely resettled. The refugees live in large concrete block houses. They earn their livelihood by fishing and farming.

The purpose of this trip was to show the kind of homes that are planned for the resettlement of 1400 other families throughout the province. The MHSWR is being asked to supply the cement and roofing needed to complete this plan. An exception to the present policy of giving money instead of cement will have to be made, inasmuch as there is no cement available on the local market in Binh Tuy province.

**Health Facilities Visited**

**III Corps**

1. *Phuoc Long Province Hospital*

Capt. Di Bartolomeo MILPHAP discussed problems of joint utilization implementation. The ARVN Medical Officer presently was spending most of his time in a private practice that he set up in Song Be. Very active hospital wards jammed with CWC. A rather dilapidated Quonset hut kit had arrived to be set up for the additional beds needed when the ARVN, MOH joint utilization plan is implemented.

2. *Tay Ninh Province Hospital*

Miss Helen Leibiz the head US AID nurse states supplies good. Province is not included in joint utilization yet. Only 3 MOH MD's at MOH hospital and 8 ARVN MD's at ARVN hospital.

Interviewed two small children wounded by river boat H & I—Shot in daytime around noon. Mothers stated they had received no payment yet.

Wards crowded: plenty of CWC.

3. *Ben Cat District MID*

A small TB clinic run by US Army MD—sees 300 cases/week. Has had trouble with supply of INH and streptomycin. Medecin Chef unwilling to cooperate with supplies—considers it a US run operation. No BCG immunization done—school or maternity.

4. *Vung Tau Province Hospital*

Australian team probably pulling out because of political issue of joint utilization. Australian Embassy thinks there will be too much flak at home if Australian doctors are taking care of South Vietnamese wounded Soldiers as well as civilians. Medecin Chef still considered to be illegally collecting fees for surgery done by Australian team.

5. *Bin Tuy Province Hospital (IMPACT)*

Beautiful hospital run by KOPHAP team. Very secure province, very little action, beds filled with patients not really requiring hospitalization.
That itinerary listed only one refuge site in IV CTZ: namely, Thanh Phu in Kien Hoa Province. The rest of the itinerary was composed of hospital facilities.

Dinh Tuong Province

In the absence of the Refugee Advisor, Ray Fontaine briefed Doctor Durant on the refugee status of the province.

A total of 20,187 refugees (2,886 families) have been completely resettled. Seventy-three new temporary refugee families have received one month's rice allotment. And soon 3,000 displaced persons, who are residing outside of refugee centers, will obtain the money-equivalent of one month's rice. Moreover, 143 families, who have returned home, have already received assistance to rebuild their homes. The SWR Chief, Mr. Bui Dinh Quac, who is energetic and efficient, plans to resettle 700 more families in their native village.

Kien Hoa Province

In a briefing, James Smath, the Refugee Advisor, stated that in this province there are 4,280 refugees in temporary status, 100 in resettlement process, and 6,840 displaced persons who are living outside of established refugee centers.

In January 1968, when Senator Edward Kennedy visited Kien Hoa, he proceeded to Thanh Phu District and Village. There, in two adjacent hamlets, he found refugees housed in substandard temporary quarters. At that time, it was planned to resettle these people elsewhere. Subsequently, several attempts were made to induce these refugees to establish themselves elsewhere; but they chose to remain in these temporary houses until they would be able to return to their native village. Consequently, each refugee received the resettlement allowance of six month’s rice and he was given assistance to repair his home. No land titles issued here yet.

1. Thanh Tri Ha Site

In Thanh Tri Ha hamlet, 2 concrete-block classrooms are being constructed in order to alleviate the crowded conditions in the hamlet school. Alleged to be completed in May.

2. Thanh Qui Site

In the Thanh Qui hamlet, refugee resettlement, a drainage problem exists because the two rows of houses were built in a depression. A raised sidewalk had been recommended. The Refugee Advisor stated the money has recently been received for this purpose and that the sidewalk will be completed in May.

Vinh Binh Province

The Refugee Advisor, Mr. James Tully, informed the visitors that this province numbered 480 refugees in temporary status, 5,779 in the process of resettlement, and 3,910 displaced persons who are residing outside of recognized refugee sites.

Mr. Tully stated that the biggest obstacle to the implementation of the refugee program lay in the inefficiency or inertia of the SWR Chief, Mr. Ly Van Hol. "He is afraid to leave the province town," said Mr. Tully. Mr. Richard Holdren, Refugee Chief of IV CTZ, remarked that Colonel Nguyen True Long, Inspector of IV. CTZ, was presently in Saigon to report upon the SWR Chief and to request a replacement.

Bao Lieu Province

The acting Refugee Advisor, Mr. Tom Maher, stated that in this province 300 refugees are receiving temporary allowances; another 1818 are getting resettlement assistance, while 5,380 displaced persons are living the best they can outside of established refugee centers. Some 170 families have returned to their native village.

Chuong Thien Province

Captain Richard Children, who, as Civic Action officer, is responsible for refugee relief, informed Doctor Durant that the refugee rolls list 810 persons in temporary status, another 2,008 in resettlement process, and 7,650 living outside of refugee centers. He stated that, because of poor security, there was no refugee movement back to native villages.
Kien Phong Province

The Refugee Advisor, John Tierney, informed the visitors that the April report of this province showed 14,530 refugees in temporary status, none in resettlement process, and 13,120 displaced persons scattered here and there outside of refugee centers.

John Tierney stated that after seven months of inertia, the SWR Chief, Mr. Dao Trong Tam, had finally begun to disburse funds to the refugees. When Doctor Durant expressed dismay that a SWR Chief could be guilty of gross neglect without being removed, Ray Fontaine assured him that the MHSWR was approached many times on this subject. The answer had been that Mr. Tam could not be replaced because of scarcity of personnel, but that he would be pressured into action.

At long last, during April, Mr. Tam began to disburse funds.

When Doctor Durant suggested that a Refugee Mobile Cadre Team be called to assist the SWR Chief, John Tierney added against it at least for the present.

There much as the last Cadre Team, who made the census of refugees in late 1968, had exposed the inertia of the SWR Chief, it seemed unlikely that Mr. Tam would be disposed to accept the assistance of another team.

Until Mr. Tam can be replaced by a more competent person, he will need constant encouragement or goading from the MHSWR.

Chau Doc Province

The Refugee Advisor, Mr. Eugene Yokes, stated that the refugee rolls of this province listed 5,580 persons in temporary status and none in resettlement process. Besides these refugees, another group of persons had been assisted by the MHSWR and CORDS/Refugee. These are the war victims. For example, during February 1969, some 1400 homes were damaged or destroyed. All 8,000 victims received compensation for their losses. Moreover the 111 wounded and the families of 37 persons killed during the attacks are receiving a token compensatory payment.

An Giang Province

The New Life Development Chief, Mr. William Gadwin, explained the refugee situation. Because of its good security, this province has no refugees of its own. However, some 10,000 persons who have sought refuge from neighboring provinces, are scattered here and there in An Giang province, subsisting without assistance from the MHSWR. Some 400 displaced persons are living in one temporary camp, awaiting resettlement.

Health Facilities Visited

IV Corps

1. My Tho Province Hospital

Visited with Dr. Barr and Dr. Fithugh. Wards overflowing with CWs. Interviewed woman shot by riverboat H & I on March 30 in Kim Son district—states she has received no compensation payment.

2. Visited ARVN hospital next door which also was overflowing with CWs. No joint utilization planned in this province. ARVN hospital better maintained because of more personnel

Both hospitals have been mortared frequently during past months.

3. Vinh Binh Hospital (Phu Vinh City)

Staffed by Airforce MILPHAP team. One of the few that had some surgical training. CWs average 120-200/month. Wards—typical Medevac—complications to Can Tho. 40 deliveries/week, Some BCG being given. No supply problems.

4. Can Tho Province Hospital

Dr. Khu and John Yann toured the overflowing wards of this 500 bed province hospital. 86% CWs. MILPHAP team here also has an orthopedic trained surgeon as MOC, and has a thoracic surgeon also. BCG used here for newborn.

5. Can Tho ARVN Hospital

Large military hospital—well staffed—well kept—many personnel, but also almost completely filled with many casualties. Malaria now in delta brought by NVA. 600 beds—650 patients.
6. Cao Lanh Hospital (IMPACT Hospital) (Kien Phuong Province)
   Staffed by energetic KOPHAP team—totally frustrated by
   1. Construction stopped in hospital in October, 1968—dispute with con-
      tractor by OICC and U.S. AID.
   2. Medecin Chef—active practice in town uses many beds for his private
      obstetrical patients.
   50-80% CWC's. Supplies poor due to poor understanding of the requisition
   system. Medecin Chef is on detached service from ARVN to have joint utilization
   ARVN hospital—very poor—merely 6 sheds.

7. Chau Doc Hospital (CORE Unit of IMPACT hospital)
   Staffed by Navy MILPHAP team with Pediatrician as Senior Medical Officer.
   1. Elective surgery being done instead of more urgent cases. To receive report
      from Dr. Barr, i.e., small boy with grenade injury to hand needing debridement
      had been in hospital several days with no debridement yet while elective cases
      being done in O.R.

8. An Giang Hospital (Long Xuyen Province)
   Province Hospital staffed by Australian Surgical Team. Long Xuyen is one of
   the most pacified provinces in South Vietnam. Very few CWC's—mostly Honda
   accidents filling surgical beds. Ward facilities in poor shape—ceiling caved in
   from rain.
   Supplies in fairly good shape.

9. Bao Lieu Province Hospital
   Staffed by 3 MILPHAP Capt's fresh from their Internship with no surgical
   experience whatsoever. Supplies, water and electricity in fair shape. Wards—
   moderate amount of CWC's. Selected for joint utilization.

10. Vi Thanh Hospital (IMPACT) (Chuong Thien Province)
    Staffed by effective KOPHAP team, many of whom speak fair Vietnamese.
    Recently opened—marked increase in number of CWC's because population now
    aware that good care is available. (See attached report).

11. 29th Evac. Hospital (DOD Hospital)
    Opened June '68—one of the DOD hospitals originally planned for GVN
    civilian use. Capacity—237 beds with potential expansion to 303.
    65—70% occupancy rate, 125 average census. 20—25 average Vietnamese census
    but these are RE/FF, CIDG and PRU. Very few civilians as such, allegedly
    because GVN doctors refuse to refer patients to 29th Evac. Most civilians arrive
    by chopper. Hospital unaware of Rehabilitation Center being built 2 miles down
    the road.

12. Saigon Hospital
    New wing constructed last year still unopened due to personnel shortage.
    Few CWC's here except at times of rocket attacks. Most surgical beds over-
    flowing with Honda accidents. Probably the most efficiently run hospital in
    the country. Electricity and water good, plans to improve laundry and kitchen.

13. Cho Ray Hospital (Saigon)
    1200 bed largest teaching hospital in South Vietnam.
    New plastic surgery section built for Dr. Barsky's Children's Medical Re-
    habilitation Institute just completed (30—40 beds) scheduled to open shortly.
    Many Honda accidents filling surgical beds and some CWC's referred from
    Provinces.
    Neurosurgical unit built by Japanese soon to open.
    Major rehabilitation of electricity, water and sewage systems of this hospital
    still hogged down in red tape of US AID and GVN. For example, the kitchen
    and central supply building whose construction began in 1964 is still function-
    less as the contract for electricity and water goes through its 18th revision in
    2 years.

14. Cho Quan Hospital
    The only communicable disease hospital in South Vietnam which also has
    approximately 200 bed mental hospital, 250 bed leprosarium and 50-75 bed prison
    hospital.
This hospital has totally inadequate basic utilities, i.e., water, electricity and sewage. Plans to rehabilitate this hospital have been scrapped with no immediate alternatives proposed yet. This is the main hospital for the care of cholera and plague in the country.

15. Nguyen Van Hoc Hospital (Gih Dinh)

New 500 bed teaching hospital under construction for two years, alleged to be nearing completion soon.

The problems of staffing this hospital under existing conditions is yet to be solved.

SPECIFIC FINDINGS—REFUGEES

1. An increased emphasis has been placed on the refugee program in 1968. When one considers that the official number of refugees as of March 31, 1969 was 1,446,630 plus the one million people over the last year who were excluded from this figure and known as “war victims”, it is apparent that the problem is still overwhelming.

2. Many dedicated U.S. personnel and many South Vietnamese continue to work improvements in the program.

3. The Ministry of Social Welfare has been combined with the Ministry of Health, under the direction of Dr. Tran Van Luy. Although there is no question as to his ability and dedication, the tremendous responsibilities are overwhelming.

4. An overall analysis of the payments to refugees disclose that there has been an improvement over 1967, but continued bureaucratic delays persist in many areas.

5. Land reform continues to be tokenism at best, with no evidence of land titles distributed in any of the refugee sites visited.

6. Forced resettlement, although contrary to stated GVN and US policy as of winter of 1968 continues.

7. Lack of schools, sanitation and potable water are major problems of most refugee camps.

8. Lack of security and increasing dependence upon US presence for employment hampers the return to village program. The long term economic and social future of this agricultural country is endangered by development of permanent refugee urban ghettos.

9. It is most obvious that the average refugee has not left his home for political reasons, but has fled for survival. Whether in camp or out of camp he tends to view GVN with pragmatic indifference.

10. Post TET, Saigon housing reconstruction has shown significant results in GVN, Canadian and British projects, while the US AID sponsored project has hardly broken ground.

SPECIFIC FINDINGS—HEALTH

1. The outstanding accomplishment in the health field is a functional and adequate medical supplies system. Fill rate on drugs average 90% throughout the country and none of the gross delays of one year ago exists.

2. The number of civilian victims increased in 1968 to approximately 300,000.

3. The DOD hospital system, though expanded to care for CWC, has never accomplished the goals recommended. The proposed decrease of 1200 beds in the DOD system will further hamper these efforts.

4. Milharp teams frequently continue to lack surgical experience and maturity, and lack specific orientation to the health problems that they will face.

5. Nine impact hospitals were planned and programmed in 1967. One has been cancelled, six have become operational only in recent months, in one construction ceased in October 1968 due to bureaucratic red tape and one hospital appears to be 1½ years from completion.

6. The Military and Civilian Health Coordinating Committee, organized on August 23, 1968, has yet to implement more than token use of facilities and personnel.

7. There has been a major increase in immunization, predominantly for plague and cholera, BCG and Sabin immunizations are practically non-existent. Lack of refrigeration and poor records remain serious problems. The incidence of plague and cholera have decreased, but the relationship to immunization is problematical due to the cyclical character of these diseases.

8. GVN continues to fail to realistically budget for maintenance of health facilities. Structural failures and non-functioning equipment cause breakdown
in large areas of health facilities. Almost a complete lack of trained Vietnamese personnel in this critical area.

9. Insufficient emphasis has been placed on training medical paramedical personnel at all levels.

10. Little salary change since 1961 makes it extremely difficult to draw competent motivated personnel to health field.

11. GVN personnel policy states that no one can be hired to replace or fill the position of someone who has been drafted. This unrealistic policy in face of general mobilization of a year ago has further endangered already critically inadequate staffed facilities.

12. Rehabilitation facility capability has increased over 100% better in past year but still most inadequate.

13. No adequate blood replacement system exists in MOH Hospital System—they continue to rely on outdated U.S. blood.

14. Contracts to improve basic utilities, i.e., water, electricity, and sewage in three of largest Saigon hospitals after two years are still bogged down in U.S. AID red tape.

15. Few of the excellent and realistic recommendations of the Medical Appraisal Team of September, 1967, have been implemented.

Dr. Levinson. We are grateful to you and your committee and staff and to the many persons, both Americans and Vietnamese, who have assisted us in gathering information and making numerous on-site visits.

Yesterday, Dr. Hannah, who so recently inherited AID's obligations in South Vietnam, stressed that the AID commitment might even increase with the withdrawal of U.S. combat forces. There are great responsibilities that remain, not only to the Vietnamese, but to the U.S. troops who have fought and died there as well as to all of the citizens of our country.

Yearly we have learned of new programs for old problems with little mention of past failures. Tremendous changes will be needed to increase the efficiency of programs while decreasing corruption and waste at all levels. Educational efforts must be stressed rather than strictly providing services as we look to phase out our programs.

Yesterday, Dr. Hannah complimented this committee for its past efforts in constructive criticism on the refugee problem, civilian war casualty and health problems in South Vietnam. It is in this same light that we wish to present our critical findings today.

Rather than learn from endless official briefings in Saigon, Dr. Durant and I largely gathered our data on a visit to over 100 refugee camps, hospitals, as well as talking with the people in villages and hamlets and in their clinics.

I hope we will have reasonable luck with our mechanical problems and I am sorry this first slide is not too effective.

Senator, what I would like to do is go through a portion of the places I visited, with the aid of slides, and make some comments.

The first slide, I think, we can skip. Basically, what I tried to show here is the route that Dr. Durant and I took. We left Saigon after a brief stay there. I visited I and II Corps while Dr. Durant visited III and IV Corps. My comments will be limited at this point to I and II Corps.

The first picture here is at the Da Nang Medical Center. This is a 750-bed hospital which usually cares for some 950 patients daily. The blood bank is one of the few in the country, and most hospitals in this country are still relying on outdated U.S. blood, that is, blood that is over 21 days from collection, is not felt usable by U.S. standards but the Vietnamese must rely upon it.
In spite of our DOD hospital program to take care of Vietnamese, the halls of hospitals are often crowded, as you can see.

The sanitation was very poor, and prior to my arrival, the sewage had overflooded in the operating rooms and a new system was being attempted.

The burn cases are very frequent in Da Nang. Fortunately, these did not appear to be napalm burns, but those from gasoline used as cooking oil. These people need a great deal of help.

There are many additions put on the Da Nang Hospital over the years.

Senator Kennedy. Could you give us any estimate of the people that you saw there in that hospital that are the result of war casualties, what percentage? Do you come to that, Dr. Levinson?

Dr. Levinson. I would hesitate to say the number at the Da Nang Hospital on this visit. I think it probably was in the neighborhood of 15 to 20 percent. It was lower than it had been because of the decrease in military activity in that area. But certainly it was far, far higher in previous times.

The greatest problem they had at Da Nang was that of maintenance. I think this was explicit in the shack called an orthopedic ward, that was put on 4 years ago, and it is rapidly deteriorating.

Now, we proceeded up to Hue.

Senator Kennedy. Before leaving Da Nang, as you remember, we were there in 1968, and they had that sort of tent structure or shack outside of the hospital in which they had a number of orthopedic cases. In many instances, the patients themselves would be waiting 8 to 12 months for any kind of treatment.

I was wondering if that building still exists, or whether it has been eliminated, and what the delay is as far as surgical treatment at the present time.

Dr. Levinson. Those buildings still exist, and the slide I showed you, Senator, was the front of one of those buildings. It was not well detailed in this slide. But there has been some increase in the effectiveness of getting people with orthopedic wounds treated more rapidly, but there is still a long waiting list.

A rehabilitation center run strictly by the Vietnamese is now in operation at Da Nang and doing a good job. But as with all rehabilitation efforts in the country, they are woefully inadequate for the long line of people waiting for prostheses.

This slide at Hue, I think, is most illustrative. In the lower portion, you can see the farm areas, but there are no homes there. There are no homesites even left and these were destroyed by the Tet offensive in 1968.

The sandy areas above are areas where mass graves were found.

We speak with great pride of the great number, the tens of thousands of people that have been resettled in I Corps, and this is certainly true. I saw many people who had been resettled but the great question that remains unanswered is: are they resettled and secure because the enemy has chosen not to strike, or are we more powerful in the area. Nobody seemed to feel we were more powerful in the area. But many of these homes close to Hue, these homesites, could not be used again, as you can see here.
The Hue Hospital here used to be an institution of something over 1,500 beds. It is now 250 beds short because of the Tet offensive. It has never been rebuilt. You can see large areas of destruction remaining.

As we look to the future, education seems to be their one hope. There is a medical school in Saigon, which through the help of the AMA, a long, tedious road has been followed, but it looks like we are on the way to having a very fine school there. The medical appraisal team several years ago recommended that the school here in Hue be upgraded, but with the Tet offensive, the students fled, were enrolled in Saigon, and I have been told as of July 1 this school would be reopened.

This picture I took at the beginning of May showed it in no way changed since the Tet offensive of the year before; and I wonder if this school will reopen. I could find no listing of a staff or anything of the sort.

We were told that Can Tho should be evaluated down in the Delta for another medical-school site. I know of nothing that has happened in that regard.

This rather strange photograph is the nursing school at Hue, which is one of the two 3-year nursing schools in the entire country. Mass destruction occurred at Tet, mannequins were placed in the window by the VC for us to shoot at. All of the books were burned, as the VC used them for cooking their rice and there seemed to be scant funds available, and Aid for Industrial Medicine, Inc., a small agency in Wilmington, Del., supplied some of the money to rebuild this. I do not understand why governmental funds were not available.

We proceeded to Tam Ky.

You may recall, Senator, at Tam Ky there were some 60 beds last year and 60 beds in tents. Fortunately, that area has been upgraded tremendously. There were 240 beds there in operation and this illustrates again the shortage of Vietnamese doctors, with a nurse suturing wounds, as is commonplace in this country; 90 percent of the surgery here in Tam Ky was done on civilian war casualties. They were in a very difficult area.

I think one of the most distressing places we visited last year was that of the Tiep Cu reception center in Tam Ky. This is a Quang Tin Province and, by theory, the Tiep Cu refugees are there only 2 months. Last year the camp was crowded with some 5,000 or more people.

There were 7,000 in March of this year, but only 700 remained at my visit at the end of April. Some of the people in the camp were not refugees but had moved in for shelter.

Wells, as in all camps visited, had no lids on them and were filthy. Privates were filthy and nonfunctioning. Payments in piasters and grain were delinquent and many people had been there some 5 to 6 months, despite the fact it was an area to keep them only 2 months. It should be noted, however, in Tam Ky district that 40,000 of the 100,000 people there were refugees.

Senator Kennedy: Have you any impressions about the effectiveness of distribution of piasters? We were there in 1968; we received estimates in terms of the percentage of food that was to go to the refugees. The best estimate we had was 50 percent of it was ending up on the black market and nothing going to the refugees, and that significantly,
40 percent of the piaster payments were never getting to the refugees themselves.

Were you able to form any kind of impression about the degree of black marketeering in refugee goods? Has it changed much? Were you struck by any change?

Dr. Levinson. Yes; I think there are some changes. It was my general impression that the grain, the tin, the cement, the piasters, all of these things given to the refugees were arriving more satisfactorily than previously. But I think by any conservative standard, there is waste and corruption still at most levels.

One of the better new decisions was that of the Minister of Health and Social Welfare, Dr. Tran Van LuY who has now ordered whenever piasters are sent to the Vietnamese Province chief for distribution to the refugees, his American counterpart is notified of the timing and amounts that arrive. This gives the Americans leverage to say to the Province chief, when are you going to distribute these goods and moneys, and this has given us a little tighter control. I think it is far from perfect.

The 312th Evacuation Hospital, this was the second DOD hospital originally planned for the Vietnamese civilian war casualties. It has 325 beds and one-third of the patients were Vietnamese on my visit.

In addition to many surgical cases, they cared for some Vietnamese medical problems.

You may recall sitting in this building for several hours for a conference on Quang Ngai. That building was destroyed on September 29, last year. It was the warehouse for this tremendous hospital. It has not been rebuilt and they are suffering accordingly. It is a 440-bed hospital that had 1,450 patients in March, of which 532 were civilian war casualties.

The U.S. personnel strongly suspect stealing of supplies at management level by the Vietnamese; although nurses still steal medications and charge patients for suturing wounds when they are not to; this problem is somewhat less than a year ago.

A great problem is that of motivating Vietnamese nurses to give any sort of reasonable patient care, and an acute shortage exists of personnel at all levels; 500 cases of bubonic plague were seen in the first 4 months of 1968, but only 350 in comparison this year.

Senator Kennedy. Now, you have 440 beds and 1,450 patients. Is it averaging about three in a bed at that hospital?

Dr. Levinson. No, sir. What we mean by this is that during the period of March, there were 1,450 patients admitted. There is an average of well over one patient a bed. However, let me stress that, I do not remember a Vietnamese hospital I have ever been in and seen more than occasionally empty beds, and usually there are two or three in the bed.

Senator Kennedy. Usually people say the reason for two or three in the bed is, that culturally they like to stay together.

Is that your experience?

Dr. Levinson. I never remember hearing of this great togetherness before the war.

Senator Kennedy. One of the other distressing observations that we made in talking with a number of these provincial hospitals, is that some of the doctors would not take some of the cases that came in to
the provincial hospitals unless the Vietnamese were able to pay something in addition themselves.

And in many instances, the doctors in the provincial hospitals would send the ones that were unable to pay to the military hospital, the DOD hospital, or the impact hospitals which now exist, and require the individuals who were wounded to pay something even though obviously they were not supposed to.

Also, there was a very limited kind of nursing care and the nurses were so underpaid that this procedure was generally accepted in most of the hospitals that we went to, I believe.

Does that practice still continue, or were you able to form any kind of opinion about that?

Dr. Levinson. In Quang Ngai, where we heard most about this accusation, it still exists but to a lesser degree. I do not think we can say that all of these ills have been cured, but there have been some changes in this direction.

Unfortunately, the nurses know how to suture up many of the minor war wounds and they capitalize upon this ability, and if the patient has plaster, they will do it. If the patient does not have plaster, they will wake up the American volunteer doctor and ask him to do the suturing.

The next photograph is the Quaker rehabilitation at Quang Ngai. They rehabilitate about 100 or more patients per month, with the numbers increasing. They could handle many more if they had bed space, but again, they do not have this.

They made an interesting statement to me that many amputees are afraid to come in for care as they lack proper identification for patients, that is, they are probably VC and are afraid of being held and not allowed to return to their homes. I certainly gained the impression that once this war is over that thousands of people that need prosthesis will come out of the hills and appear for help. So the problem will be even greater at that time.

It was distressing to note that there were 27 Vietnamese prosthetists in training but eight of these were to be drafted and they had no control over the situation.

Yesterday, we heard about the operation at Batangan Peninsula. I had the opportunity to visit there and I would like to make a short statement on this.

On January 13, of this year, amphibious operations removed 12,718 Vietnamese from their homes, and some hundreds of VC were killed. All of the homes were destroyed and bulldozed to the ground and in 1 month, all of the people returned to the area, houses rebuilt, and all payments made to these people that were forcibly removed and resettled.

I did a number of spot checks and found out they had been indeed paid their allowances in tin and grain and plaster. We have approximately a thousand U.S. and Vietnamese personnel guarding these 12,000 people that are supposedly now good Vietnamese citizens. It is interesting that the claim we have won the hearts and minds. They are out on the peninsula but we have to guard them heavily, we have to bring them in out of their fields by nightfall. Actually, we have very little control over these people, and I gained the impression they are
not pleased at all with what we have done to the peninsula, destroying their homes and the entire area.

This may shock you, but this is a refugee camp. It shows the great variety of types of things we find. This is Ghene Rang temporary camp, in Qui Nhon. These 4,068 people and 498 families live in 500 houses, and it is really a beautiful urban area. Most people are employed, have been overimmunized, if anything. Houses are of cement, Hondas crowd the streets, schools and medical care are adequate.

A visit by representatives of this committee to the Cathedral camp in Qui Nhon in 1966, supposedly simulated this effort in 1967. Unfortunately, the Cathedral camp, which was to be closed after building this, is still open.

Supposedly, the people in these hovels were to be moved several miles, to the last place you saw, but due to the great concentration of refugees, this camp continues to take more and more people in it.

We visited through these crowded alleyways last year. There are 2,400 refugees there, many since 1964. There are only three wells, the water was filthy, most refugees had had some immunization.

Senator KENNEDY. One of the things that impressed me—maybe Dr. Durant would respond to this—is that particularly, as in Saigon, so many of the refugees moving into these urban areas are taken off the refugee lists after a period of time, and they are put on into the urban category. You mentioned in your report, I guess, "Urban Drift."

Actually, they are really no more than moving them from one list onto another, but once on the GVN list or the AID list, they are no longer considered refugees any more, because they have moved into these urban areas.

Could you just reach that point, or will you develop it later on, Dr. Durant?

Dr. LEVINSON. I think Dr. Durant will be saying more about that. This is very true. One of the greatest problems with this urban drift is these people are employed in the various menial jobs at U.S. military camps, and what happens to them after it is all over, one does not know. Virtually none of them have title to the land in these camps. They are afraid to go and put up a decent home because they may be moved off this land and then what?

So, we have created an urban problem of great magnitude.

Now, this is another camp we visited together last year. This is the Phu Phong temporary refugee camp in Binh Dinh Province. I could have used last year's picture; there is no change. There were 1,800 refugees in there from 1965. No privies were operational, three wells contained dirty water, and no temporary payments had been made in the past 2 years, so none had been made since before our last visit to this camp.

Senator KENNEDY. Where are those payments going?

Dr. LEVINSON. Nobody seems to know. There are many stories, the Province chief loans the money out and makes great capital on this, and some of these are diverted to his own private ventures.

Senator KENNEDY. It is always of interest because you remember in 1968, as we went on through those refugee camps, I do not think we found one in which the people were using the wells. Then we go on back for our final briefing in the hamlet evaluation system, and they talk about the many wells in these refugee camps, and I do not think
we ever saw one that was functioning or working. They talk about
the common privies in many of these refugee camps, and yet we never
saw any of those functioning, public showers or other kinds.

Certainly, this picture and the traditions in that camp would sus­
tain that observation; although I guess from what you mentioned
earlier, in the earlier pictures that there has been some progress made
along these lines in some of the other areas.

Dr. Levinson. Not too much progress has been made, as you sug­
gested, as far as the privies go. This is a great public health educa­
tional problem. Many of these people, of course, or vast majorities,
ever used privies previously and they have not been trained properly
in the use and benefits of these today.

In the Montagnard country, the people do not want water from
wells. They will walk miles to get water flowing from the stream. This
is a cultural thing with them and they do not understand how the well
water can be good.

Actually, they are not too far off when you consider the type of wa­
ter in most of the wells. Frequently on the listing one will get from
Saigon, you will hear we have so many wells in a camp, and you speak
to an adviser in the camp and he says, “Well, I certainly agree we do
have 20, but there are only three functioning.”

There is a great disparity between reality and statistics.

Pat Smith, a legendary soul up in Kontum runs an awfully fine
hospital, something that both the Vietnamese and Americans should
look at. Her hospital 4 miles out of town was shot up by the
VC at the Tet offensive; they moved into a school in Kontum 4 miles
closer, for security reasons. It was a beehive of activity. It was clean,
productive, the laboratory was functioning, and that great thing that
we seem to lack throughout Vietnam, “motivation” was found by her
acceptance by the people in her great dedication.

Now, this is Kon Horing in Kon Tum Province, a Montagnards
area. You can see these brown areas where they are going to put up
streets and houses, and off to our right is the village. It is a 200-year­
old village of 7,000 people, containing 2,400 people in refugee camps
and resettlement areas.

On February 21 of this year, and again on March 21, units of the
NVA struck and burned out large areas of the village, destroying 80
percent of the rice supply; 53 people, mainly women and children,
were killed and wounded on the first attack and 15 on the second.
Also, some were kidnapped by the enemy.

In spite of two visits by U.S. refugee directors to Saigon, no plaster
or tin payments had been allocated by my April 30 visit. No death
or injury payments had been made. Only some emergency commodi­
ties have been issued. A new prefabricated hospital had been erected
to be run by a French physician, but he was killed by a landmine the
week before the opening, and there is no medical care available.

These are some of the people waiting there, hopefully, to get some
tin.

Senator Mathias. Doctor, did you get any information that the
payments had been made to local officials, and were not distributed!
Was there any information of that sort?

Dr. Levinson. This is a thing always very difficult to prove. It is
hoped that through Dr. LuY we will be advised when payments have
reached province level and that we will be able to implement these payments. It is very hard to document corruption, but everyone speaks of it, and when you know it has gone to the province level and the people have not gotten it, somewhere in between, something happened and it appears, it has disappeared.

Senator MATHIAS. How far down can you trace it?

Dr. LEVINSON. Well, you usually cannot trace it past sometimes down to a sector level, but usually at province level, and the Americans are very touchy because, after all, they come up with, "Well, we cannot go too far; you know we are guests and we are only advisers, we cannot prosecute." So we have a very tenuous reign here.

This is another example of forced resettlement, something that was supposedly stopped late last year, in Plei Ring De in Pleiku.

In January of 1969, 732 Montagnards were forcibly resettled here from an area of 40 kilometers away, near the Cambodian border. It was ordered by Lt. Gen. William Peerse in order to prepare "Free-fire zones."

When I was there on April 25, all but 37 people of an initial 732 had packed up and gone home. They had gotten their allowances for moving there and they decided, well, conditions in the camp were poor, they would rather take their chances at being shot at by the U.S. Forces in the area than living in the poor conditions in the camp.

Here is that camp as it exists. You may say it looks better than most, but as I say, there was well water that was dirty and they had to walk several miles to get a stream to get water which culturally was acceptable to these people.

Senator KENNEDY. That is not Edop Enang?

Dr. LEVINSON. No, sir; very close to Edop Enang. It is an area where several thousand Montagnards had settled, but a very similar situation existed. Many people in here had been at Edop Enang previously.

Senator KENNEDY. Are there any refugees in Edop Enang now?

Dr. LEVINSON. Yes.

Senator KENNEDY. Are they the ones who were moved just prior to the time that they were supposed to harvest their crops, and who then left in great numbers, back into what was recognized as a free fire zone?

We would find they would show up in these provincial hospitals as civilian war casualties.

Dr. LEVINSON. Exactly. And it was interesting that there have been waves of people in and out and some of the same people evidently have lived in Edop Enang on and off over the years and at present in Edop Enang, there were 4,897 refugees out of which 1,000 came voluntarily. The rest were forced into there because their home areas were declared free fire zones.

Now, you spent considerable time discussing impact hospitals yesterday, and of the original nine programed, this is one of the six now functioning. As you know, they are all at least a year late in opening.

This is the 60-bed unit in Phu Bon that opened this April 14, formerly there had been only a 35-bed dispensary there. There are two large generators for this hospital, but they did not have enough fuel to run them; and the other impact hospitals I visited, they seemed to have
enough fuel in their budgets but the generators were so large, they were siphoning off the electricity for private use in the area.

One of the problems we ran into repeatedly in the highlands was a lack of personnel; because the Vietnamese do not like to live there. They like to live in the cities, so you could not get the Vietnamese to take jobs where desperately needed. You can see by the inside of this, ceiling fans, clean, certainly one of the better institutions we saw.

From the air this is not very clear, but it is the 91st Evacuation Hospital in Tuy Hoa, which we also visited last year. It is a 400-bed Army hospital, one of the first two in Vietnam to serve civilian war casualties. In the 6-month period from October 1968 to March of this year, they treated 706 surgical and 309 medical inpatient Vietnamese. Eighty percent of their surgery was done on civilian war casualties.

The great problem, as far as I could see, was as of June 1 of this year, I was told that the last Vietnamese or American patient would enter and this hospital would be completely phased out as of September 1. Most personnel will be moved up to the 312th Evacuation Hospital in Chu Lai to replace the reserve medical personnel there who are to be sent home. This deactivation was based on the fact 173d Airborne and the 4th Division have been moved from the area, so the hospital is not needed.

Three inescapable conclusions present:

1. There would be a lack of necessary hospital facilities in the area for civilian war casualties. We heard yesterday, I might add, that the Provincial hospitals could care for them, but I would say the Provincial hospital several kilometers away cannot care for them, there are wounded there lying in the halls.

2. This effort will be a major blow to the great pacification effort going on in Phu Yen Province.

3. The propaganda value to the enemy appeared quite obvious.

Further tracing this down, going through the echelons to General Neel in Saigon, who commands all of our medical efforts in the military, I was amazed to learn that 1,200 U.S. military hospital beds are to be closed and phased out by October of this year. This is a decision that I was told was reached early this year. We are told that there are approximately 8,600 hospital beds for all U.S. military in the country. This means a 15-percent decrease in bed capacity.

When we decrease this bed capacity, when we furthermore will not allow the last 35 percent of the beds in a military institution to be used—we are holding them for contingencies—we realize that the first effort we have deescalated in Vietnam has been the health effort, and also the care of civilian war casualties, often casualties created by U.S. Forces. I do not understand this at all.

Senator Kennedy. Besides the 91st Evacuation Hospital, what other hospital beds are being closed down?

Dr. Levinson. Senator, you may recall that the three DOD hospitals your committee was so interested in originally, that were to open, were to allow 1,100 military beds for the Vietnamese. At no time have more than about 800 beds at any one time ever been used for the Vietnamese.

Eight hundred and fifty is the top figure.

Actually, what is happening—all U.S. military hospitals around the country were taking in a certain number of Vietnamese, often the
more sophisticated and difficult cases, on a referral or an overflow basis. I heard the statement made that they never turn people away. I saw people that were turned away. It is up to the helicopter pilot or what is available, as to where they go. The fact is that most hospitals have wounded but as we decrease the number of hospitals, the beds available are going to be fewer and fewer.

It just happens to follow mathematically.

Senator Kennedy. What is going to happen to those centers? Are they just going to evacuate them?

Dr. Levinson. Nobody seemed to know, and I found great concern by the enlisted men and the officers that they were going to leave this first-rate institution that cost us millions to build, and nobody knew what it would be used for.

Senator Kennedy. Is there any reason—even if we were evacuating—it could not be turned over to the South Vietnamese, perhaps to a limited extent staffed by them or MILPHAP teams, and still continue to provide services to civilian war casualties?

Dr. Levinson. I think this would be a very logical and helpful move. The one thing against that, we are told, is the maintenance problems would be too difficult. But I think this again is an educational process, and we have got to train people in this country. I do not think that it is that difficult to train some basic maintenance personnel if the reward is going to be better facilities for the care of their people, not only now, but for the future.

Senator Kennedy. I suppose it depends where you are going to spend the money, on maintenance or somewhere else.

Dr. Levinson. I think it would be a little better spent here. As I said several years ago to your committee, rather than leaving jet strips and bunkers and tanks there as monuments, I think a hospital would be a better monument to the American war effort.

You mentioned the black market. I could not resist putting this in. These are all American commodities. This is right on the main street in Dalat. There is nothing but American chewing gum and cereal, and crackers, and so forth and so on. There is no hiding the black market in Vietnam.

Senator Kennedy. Are any of these items that would normally go to refugees?

Dr. Levinson. Oh, no, these are not refugee items. These are PX goods. I think Dr. Durant will have some comment on the PX.

It might be of interest to you, on arrival in Vietnam we were treated very cordially and issued PX cards to use while we were there. I was amazed that during my 2 weeks' stay in Vietnam I could have gotten, I think, 12 bottles of liquor and six cases of beer, several different kinds of cameras, movie projectors and four refrigerators. It was interesting also that as I got out at the smaller provinces, and I ran out of film on one occasion, well, they did not even have film.

It points out the truth and the irony that boys out in the field that deserve the PX and all the privileges and goodies do not get them, but the "fat cat" back in Saigon, he can get them, he can sell them to the bars in Saigon. All of the bars in Saigon, if you ask for Vietnamese beer they look at you like you are rather peculiar, because they have very fine American beer, Dutch beer, and so forth available. The PX has been indeed abused.
Senator Mathias. What are the price levels in the PX?

Dr. Levinson. The price level to the American dealing in there?

Senator Mathias. Yes.

Dr. Levinson. I just bought a toothbrush and tooth paste and they were quite reasonable, and the other items appeared quite reasonable, too. I guess I did not take advantage of the great opportunity.

Senator Mathias. Lower than the American?

Dr. Levinson. Oh, yes. The black market price?

Senator Mathias. No; PX prices.

Dr. Levinson. No; they are lower than you will buy them here at home, by far. We subsidize their efforts.

Senator Mathias. Notwithstanding the transportation?

Dr. Levinson. We write that off, I am told.

Senator Mathias. That is contributing to it.

Dr. Levinson. These last few shots show what happens to the things on paper.

This is an impact hospital in Bao Loc, and let me tell you about it.

It is a 100-bed unit first opened on March 4. Four hundred inpatients and 3,600 outpatients treated in April. A young Navy lieutenant just out of internship is in charge and no surgery is done due to his lack of training. He is a capable young man but he has had no surgical experience. A well-equipped operating room has never been used; patients die if Medivac helicopters are not available.

I might interject at this point, General Humphreys, many years ago, asked for some fixed-wing aircraft and helicopters for civilian war casualties. These have never been granted. You have repeatedly questioned this, Senator Kennedy.

In addition, many of these hospitals do not have effective surgical personnel.

Those are a nice group of instruments. Each one of those little instruments costing $10 to $25, hanging on the rack, polished, never have been used, because no one knows how to use them.

It amazed me, when I learned that as of March of this year, the U.S. Military Establishment had 16,323 physicians, and I am told by our people in Vietnam that we cannot come up with people with surgical training to run those hospitals. I do not think we can continue just to give away services. But it appears to me in our military establishment there must be some man with some interest and dedication that can be motivated to go out to one of these little places and take up the challenge of doing some surgery in the bush.

I am told, “Well, you can’t take a major or colonel who had sophisticated surgical training and put him out there.” I do not know why; volunteer physicians have done this for years and I think we are making a mistake not putting proper personnel here.

Senator Kennedy. What about “Operation Vietnam”? Is that continuing now, placing doctors, and at what level?

Dr. Levinson. The American Medical Association?

Senator Kennedy. Yes.

Dr. Levinson. This is continuing.

I do not know the current staffing problem but I have heard they have run into an increasing problem getting volunteers for this. But something approaching 600 American doctors have volunteered for 2 months or more in the field work.
Now, the reason for this impact hospital in that area is obvious. In this area, it is even more obvious. You are now looking at Ghia Nghai Hospital in Quang Duc Province, a 20-bed medical infirmary dispensary, as it is called, and as of February it was completely shattered by the North Vietnamese Army. So that is what is left.

So this is what happens. This is a Vietnamese military hospital of some 30 beds, and it is a wooden shack, with a dirt floor, and no surgery. And the civilians have been camped right across the dirt path in two tents. So that is the hospital available for the people in that entire province.

So then we move on to a masterful piece of inactivity and inefficiency. This is an impact hospital that was to be done, as you know, a year ago this past March. So we are a year and a half late now, and I think another year and a half is a conservative estimate when it will be done.

Supplies in this area have to be brought in by air, because of security. The airstrip will not take more than a two-engine Beechcraft, and it is kind of difficult to imagine but that pile of sand there is almost worth its weight in gold. I have been told by several of our officials that that sand cost $90 per cubic foot, brought in by helicopter. You cannot use the roads and you cannot bring in big-supply aircraft. So it is virtually impossible to get anything going.

This is the Ghia Nghai impact hospital that they still laboriously work upon.

Now, the last couple of slides here; this is another camp of forced resettlement and this is Kheintin Camp in Khiem Duc District, in Quang Duc Province. Over three million piasters have been spent for building alone, to house 1,200 nonrefugees—may I emphasize, nonrefugees—who live 2 kilometers away.

It is an almost completely unknown project which was ordered by the province chief and is officially unknown by the Vietnamese Ministry. The work had been done by R.D. Cadres, public works employees and local people. The justification by the province chief is to provide security for the farmers in the valley who live only 1 or 2 kilometers away.

I took the first picture, I turned around and took the second. He is going to move those people into those newly-built homes, granted some of them a little better than the ones here, you might think. But the people are jammed together. They were happy out here, tending their fields, but we say we cannot give them security so we are moving them in. Not “We,” but the Vietnamese province chief is doing this entirely on his own. This is another example of forced resettlement.

Senator Kennedy. As I understand, most of the Corps chiefs are military men and most of the province chiefs are military men at the present time. Is that your impression?

Dr. Levinson. I believe most of the Vietnamese province chiefs are military people.

Senator Kennedy. The decisions which affect civilians are being decided either by military men or former military men that have transferred into sort of a civilian status. But they have a military attitude and concept with regard to the movement of both troops and people generally.
One of the things I was impressed by was a sort of a lack of sensitivity toward civilians, and this kind of dislocation really reflects this again. You have the military commanders and colonels—they do not think anything really of moving people and dislocating people and uprooting people.

Once again, it is one of the intangible factors, but has terrific impact, I found. I am sure it would be in this case here.

Dr. Levinson, I could not agree more. One has the impression that the military—there was a Colonel Tung in command here, and you felt the Colonel felt these people were all of lesser rank and that is the way it was going to be.

I am finished with the slides now. I would like just to cover several statements and then go on to Dr. Durant's testimony.

If I may dwell a minute on civilian war casualties, just to emphasize our methodology on arriving at these numbers yesterday.

The subcommittee estimated that in 1967 there were something approaching a hundred and seventy-five to two-hundred thousand casualties. This figure was arrived at after careful study of data available, a countrywide inspection, and the realization that many victims never reached hospitals or dispensaries.

It was also known many thousands of civilian war casualties were treated through hospitals and clinics run by voluntary agencies, French rubber plantation hospitals, VC hospitals, and so forth, and countless people treated as outpatients, but not on official record.

Lastly, it could never be known how many civilians were killed outright or never managed to secure medical aid.

In 1968, the Ministry of Health's hospital admission rate for civilian war casualties was over 80 percent greater than 1967. Certainly improved transportation and communication may account for some increase in people treated there by decreasing the number of unknown, uncared for at the hamlet and village level. However, there were many thousands more cared for through the M.A.C.V. hospital system than in 1967, which provided only token care.

During a great part of 1968, the pace of the war was markedly increased in all areas with accordingly greater numbers of military casualties. Also C.W.C.'s, that is, civilian war casualties, have certainly increased in relationship to the escalation of the war.

Now, if we say that we are giving better care to the casualties, I would caution that if there is something like a 50-percent increase in the number of civilians killed or wounded, I do not think that our medical aid and expertise has increased accordingly 50 percent. So I would daresay that the problem is the same or worse than it has been previously.

Now, Brig. Gen. Spurgeon Neel stated the U.S. military casualties are, one killed for every six or seven wounded. The killed-to-wounded ratios in civilians who are ill protected and in poor general health is certainly much higher. It is obvious that the four ingredients that led to the decrease in morbidity and mortality in U.S. forces are still largely unavailable to the civilian war casualties. That is, rapid transport to medical facilities, surgical and anesthesia capability, and blood banks.

Considering these thoughts, plus the evidence from visiting representative health facilities in most provinces—and I would add that