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THE VIETNAM REFUGEE SITUATION 1/26/73

Mr. PELL. Mr. President, Americans have, of course, been deeply divided on the subject of Vietnam, but we have been united in our humanitarian concern for the civilian victims of the long and brutal struggle there. In a country where 48 percent of the population is under the age of 15, it has been inevitable that a large proportion of those victims has been children. Fortunately, with the restoration of a measure of peace in Vietnam, the scenes of bewildered, maimed, and homeless refugees no longer haunt our TV screens. May they never do so again.

But we must not let an attitude of out-of-sight, out-of-mind make us forget the fact that today, despite great effort, there are still some one million Vietnamese refugees, at least half of whom are living in crowded emergency camps under deprived conditions. Children comprise more than 50 percent of the population of these camps.

I was graphically reminded of this yet unhealed war wound, and the magnitude of treatment that it still requires, by a report by the special mission of the International Rescue Committee of New York that examined the refugee situation in Vietnam in April. The report, I believe, objectively describes the problem, measures the needs, and proposes means by which the IRC can make an even more effective contribution to a solution in the fields of resettlement, public health, and child care, especially of war orphans and sick and injured children. Because this commendable report is most pertinent to the Senate's consideration of the allotment of funds for humanitarian relief in Vietnam, I request unanimous consent for excerpts to be printed in the RECORD.

There being no objection, the excerpts were ordered to be printed in the RECORD, as follows:

EXCERPTS FROM THE REPORT OF THE SPECIAL MISSION TO VIETNAM OF THE INTERNATIONAL RESCUE COMMITTEE

INTRODUCTION

The International Rescue Committee started its refugee relief and resettlement work in Vietnam in 1954, when approximately a million North Vietnamese fled to the South. In recent years, IRC has maintained a broad range of operations for refugees and children including day-care centers, a reception and convelescent center for children undergoing reconstructive surgery, a program for in-home day care, medical and public health projects, and training and community development programs. With the ending of hostilities in Vietnam, it semed advisable that a group of IRC board and staff members visit Vietnam in order to conduct a fact-finding survey of needs and conditions, and then to submit recommendations as to whether IRC's existing operations should be continued, extended, reduced or terminated—bearing in mind future trends and possible developments in both Vietnam and the United States.

The Mission was in Vietnam from April 2-April 14. It consisted of Co-Chairman Angier Biddle Duke and Leonard Marks, Mrs. Angier Biddle Duke, Joseph Buttinger, Anthony Duke, Cecil Lyon, Isadore M. Scott and David Sher. Ambassador Kenneth Keating, a Co-Chairman of the delegation, unfortunately was prevented from accompanying the Mission. However, he was of inestimable assistance in back-stopping the study group and maintaining liaison both here and in Vietnam.

The Mission visited refugee camps in An Loi, Phu Cuong, Long Khanh, Da Nanag, Quang Tri, Kontum; day-care centers in Nha Trang and Saigon; the reconstructive surgery hospital of the Children's Medical Relief International and several IRC facilities in Saigon; community development and medical projects. It was briefed by Vietnamese officials, including the Minister of Social Welfare and the Minister of State in Charge of Refugee Resettlement and Rehabilitation, officials of the American Embassy and the United States Agency for International Development (AID), and talked with official and private individuals of varying nationalities in many fields including social service, business, medicine, child care, commerce, diplomacy, churches, the press, etc. The resident IRC staff in Saigon had arranged an inclusive program for the Mision and handled all arrngements for the Mission's work in Vietnm.

Early in its stay the Mission was briefed by Dr. Phan Quang Dan, Minister for Refugee Resettlement and Rehabilitation. Dr. Dan was most anxious that the Mission visit with him Quang Tri, Thua Thien and Quang Nam, the northernmost provinces, where he is actively engaged in resettling refugees in a program which he, personally, considers will prove to be a key to whether or not there is to be peace in Vietnam in the future. Dr. Dan is convinced that during the next few months every effort must be made to forget the trials of the past and to give peace a chance.

REFUGEE CAMPS AND RESETTLEMENT

The tragedy of Vietnam's refugees is a repetition of the tragedy of all uprooted people who have lost their homes, their livelihood and, in many cases, family members. Crowded into emergency camps, deprived of all privacy, they have no roots. The anguish of Vietnam's refugees is especially poignant as the vast majority of them have lived by the soil; now they have no land to cultivate, no communal bond with their fellow villagers. They share one profound hope: to find new roots and begin again. If they lose this hope, they will lose their human dignity. Vietnam's refugee population consists 90% of farmers, 5% of fishermen and 5% of city dwellers.

Some 8 million refugees in a country of 18 million people have been created in Vietnam since the war began. Insofar as official statistics convey an accurate picture of the actual situation, all but approximately one million are considered to have found new homes—some in the communities from which they had been driven, others in new areas because their villages have either been destroyed or occupied by the Viet Cong.

Of the one million "active" refugees in Vietnam today, 653,000 (115,000 families) are living in 109 refugee camps. An additional 200,000 are temporarily sheltered outside of refugee camps; and 260,000 are officially identified as "in-place cease-fire victims," or refugees whose homes have been destroyed since the cease-fire agreement was signed but have found shelter within their own communities.

The top priority facing Vietnam, and private groups providing supporting assistance, is the resettlement of the 653,000 refugees living in camps. Close to 255,000 of them are in the Da Nang area of Quang Nam province, about 80 miles south of the North Vietnamese border; their villages and homes in Quang Tri province, some 70 miles to the North, were reduced to rubble in some of the bitterest fighting of the war. Most of Quang Tri is now occupied by Communist forces.

Among the most deprived groups of refugees are the Montagnards. At least 50,000 of these darker-skinned mountain tribesmen have been driven from their homes and now are crowded into camps in the hot, flat lowlands. The mortality in Montagnard camps runs several times higher than in other camps; these people find it extremely difficult to adjust, physically and mentally, to an entirely new geographical environment, and thousands, especially the children, arrived severely malnourished and debilitated. Many Montagnards spent weeks and months in the jungles escaping from the Viet Cong, and their chances of ultimate survival were greatly diminished.

Binh Duong province is one of the several areas of high refugee concentration inspected by the IRC Mission. Here live 31,000 refugees (6,060 families) in five camps. One of them in the Phu Van refugee center where 20,000 refugees are crowded into 80 shelters. There are 14,000 children among them. As many as eight people sleep on a six-foot square board. There is one water tap for every 5,000 refugees and two 40-watt bulbs for every 250 inhabitants. Both of these items are considered "luxuries" in terms of overall refugee camp standards.

The government of Vietnam has set a target date of one year for the resettlement of the 653,000 in-camp refugees. It hopes to resettle about 40% of the refugees on "new" lands—that is, six million acres of virgin land and one million acres of war-abandoned land. Housing is a major problem, along with a lack of medical and public health facilities, and child care. But the resettlement priority does not diminish the urgent needs of the out-of-camp refugees and the "in-place cease-fire victims." Or of many older, "resettled" refugees who must have aid in order to survive and rebuild their lives.

MEDICINE AND PUBLIC HEALTH

In the course of its fact-finding survey on medical and public health problems in Vietnam, members of the IRC Mission inspected the facilities operated by private and governmental agencies throughout the country. Some of the United States and Vietnamese officials who were consulted include:

Dr. William D. Oldham, in charge of public health and medicine for USAID (Agency for International Development); Dr. Edward P. Irons, deputy to Dr. Oldham; Dr. Isaiah Jackson, chief of public health and medical care; William E. Paupe, chief of plans; Gardner Munro, USAID administrator of children's programs; Norman Firnstahl, responsible for official U.S. activities for refugee relief and rehabilitation; Dr. Tran Nugoon Phieu, the GVN (Government of Vietnam) Minister of Social Welfare, and his principal staff members; Dr. Phan Quang Dan, Minister of State for refugee resettlement; Dr. Tran Minh Tung, Minister of

Health, Administrators, social welfare workers, doctors, nurses and other medical personnel were also consulted in Saigon and during visits in eight provinces.

The work of American voluntary and governmental agencies has been an essential factor in the development of medical care and public health programs during the many years of war. The continuing participation of private groups is vital to the future of Vietnam, which has been held back from solving its problems by 30 years of fighting and destruction. If not for the war, advances by the Vietnamese would have been dramatic.

In the mid-1960's, the primary thrust of both private and governmental agencies was in the area of *medical* care. At that time, there were just over 1,000 Vietnamese physicians in the country, nearly 800 of them in the armed forces. In addition, paramedical personnel ranks were seriously depleted by the war. There are now 2,100 Vietanmese doctors, and 80% of medical care is provided by paramedicals: nurses, health technicians, pharmacists, laboratory and x-ray technicians, medical aides, etc.)

By mid-1969, an official program was initiated to consolidate many military and civilian health facilities; at the same time, assisted by USAID and voluntary agencies, health-manpower programs were developed resulting in significant increases in the numbers of physicians, dentists, pharmacists, nurses and other health techicians available for assignment to civilian health facilities.

Because of the increasing Vietnamese capability to assume responsibility for the medical care program, basic priority emphasis of U.S. agencies has shifted to "preventive medicine," mainly self-help efforts to establish safe water supplies, sanitary waste removal and sewage disposal, and a generalized program of environmental sanitation and personal hygiene. A significant step in this new direction is the estabilshment of a new category of health worker for assignment to district-level health facilities, with the responsibility for extending a broad range of health services to rural areas. The training period is three years, and the first class of this new category of medical personnel will be available for assignment in mid-1973.

The offensive in the Spring of 1972 interrupted this shifting of priorities and resources. Provincial hospitals in Binh Long and Quang Tri were completely destroyed in addition to the loss of a Binh Dinh district hospital, 46 district-level maternity-infirmary dispensaries, and more than 150 village-level health facilities.

Today, U.S. health sector activities involve a broad-based advisory participation in health programs, as well as the carrying out of specific project objectives in areas of medical education, training and logistics, public health, preventive medicine, rehabilitation and population/family planning. It is reported that 59 family planning clinics are now operational.

The major U.S. effort in public health and preventive medicine during 1972 and the first part of 1973 was devoted to supportive assistance of the VN Ministry of Health in refugee camps. No significant outbreaks of communicable diseases occurred during this period. Medical training programs resulted in the graduation, during 1972, of 199 new physicians from Saigon University, an additional 26 from Hue University. The training of dentists, nurses and paramedical personnel has also made impressive strides, with broad American support.

It is the conviction of the Mission that the private American factor in the medicine and public health fields is of extreme importance to the Vietnamese people if the massive refugee problem is to be solved. Private American assistance should involve both short-term objectives—such as providing medical, surgical and health services to alleviate immediate refugee problems and suffering—and a longer-term program designed primarily to make it possible for the Vietnamese to assume full responsibility for a rehabilitation program for their country.

THE CHILDREN OF VIETNAM

No group of Vietnamese war victims is in greater need of help than the children, who comprise 48% of the country's 18 million inhabitants. These boys and girls under the age of fifteen have been surrounded by death and violence during their entire lifetime. Among the children, millions, literally, are sick, wounded, orphaned, undernourished, displaced and homeless. The number of Vietnamese children whose American fathers have abandoned them is about 15,000, according to the best figures available to Vietnamese and American authorities. Some estimates run as high as 25,000. The most deprived of this group are the some 1,800 children of black-American fathers.

There is no reliable count of Vietnamese war orphans (those who have lost both or one parent). There are between 300,000 and 700,000 of them. Children make up 50% of the population in refugee camps. Visits by the IRC Mission to many refugee camps make this figure entirely credible. The makeshift shelters, some crammed with a hundred or more refugees, are swarming with children, as are the surrounding outdoor areas and dispensaries (i.e., where a refugee camp is fortunate enough to have a medical facility).

That the children are generally lively, alert and curious, is not due to the aid which has reached them from outside. There has not been very much of that. But in Vietnam, one's existence, even one's personal identity, is submerged by the family. Hence the resilience of the children. It is a common sight to observe a girl of four walking hand-in-hand with two younger siblings; a boy of five carrying a younger sister on his back while he keeps his eye on a still younger brother. One hardly ever sees children quarreling or fighting. A sick child is rarely "left" at a hospital or dispensary by a mother—who will spend the night on a chair beside her child, or more often on the floor, rather than deprive the young one of her presence and personal care.

American observers can only marvel at the behavior of children (generally between the ages of two to six) at day-care centers. They are absorbed in their play and educational activities. The simple but nourishing food has given them back much of their mental and physical health. Good hygienic training has helped in this process of restoration. The warm relationship between supervisory personnel—all of them Vietnamese—is derived from the mutual respect that exists between adults and children. This is a way of life built into the people's culture, requiring no harsh words or discipline.

The IRC Kieu Mau center in Nha Trang, for example, is for pre-school children from three to six. Only needy parents are permitted to enroll children, and at no cost. School hours are from early morning to late afternoon and the curriculum consists of recreational and educational periods, exercise, meals, a shower, nap, general hygiene care and training. The IRC staff consists of a supervisor, three teachers, three caretakers, two cooks and one laborer. An essential benefit of this and other children's centers is that of enabling Vietnamese mothers to work, and thus to support their families. This is extremely important in the case of war widows.

Anthony D. Duke was the member of the IRC Mission who concentrated his attention on the problems of Vietnamese children. Mr. Duke is a founder and President of Boy's Harbor, an organization for disadvantaged and troubled children in the New York area. Some of his observations follow:

When you go to Vietnam, you are quickly impressed with child-preponderance. I discovered this while travelling throughout that war-beleaguered country earlier this month, and for good reason: 48% of the population is under 15 years of age.

Refugee statistics, war-victim figures, in-camp numbers, out-of-camp numbers, resettlement data, the hospitalized, the wounded, the maimed . . . statistics reach out to you from whatever pages you may be studying. But when you visit refugee camps, the numbers come to life, and your memory is indelibly affected by the smiles and laughter and sometimes tears of the children you see and meet. In the camps, the clinics, hospitals, convalescent centers, day-care facilities and home-day-care centers, you meet thousands of hopeful children. Their spirit in general is remarkably good, though it varies with area conditions and is greatly affected by the kind of care available to them and their elders.

IRC's approach and methodology, as observed by me, are outstanding both from a humanistic and technological viewpoint. Each facility I saw had special merit—mainly, it would seem, because of the quality and dedication of personnel and the sensible in-training programs conducted to assist Vietnamese personnel in becoming the eventual operators an in a sense proprietors of each project.

Let me comment on some of the children's facilities I visited while in Vietnam:

The Children's Dispensary in the An Loi Refugee Camp, in Bien Hoa Province, has 16–20 beds, a devoted team of nurses, and IRC supported doctors who visit the dispensary on a regular basis. This camp, with 11,000 Montagnard refugees accustomed to mountain living, is seemingly more crowded than Phu Van. The death rate is higher, I suppose, because here in the hot plains of Bien Hoa these mountaineers find themselves completely out of their element. IRC's Director for Vietnam, Carroll Morris, has a beautiful relationship with staff, refugees and with children wherever he goes. This dispensary takes care of very sick children—their mothers sit and watch them—the Montagnards don't seem to recognize illness until very late in the game; hence the dispensary cares for desperate cases.

At "Mary Lou" Refugee Camp in Kontum we met Dr. Brian Ryan, who looks after thousands of refugee children and also tends the sick at Dr. Pat Smith's 100-bed (with 600–700 patients) hospital. Although going into and through that overly, overly crowded hospital was a cultural shock, I soon learned that lots of human suffering was being alleviated. This hospital, literally bulging with humanity, treats war wounds, TB, plague, and just about every other illness and defect known to man.

The IRC Reception and Convalescent Center for the Barsky Hospital (Children's Medical Relief International) is a remarkable and cheerful place, teeming with children who are being cared for prior to plastic and other surgery, and who convalesce between surgery and going home. There are around 100 young patients there, with every conceivable need for surgery. The atmosphere is extraordinary, and after a while, the visitor notes more the smiling, hopeful eyes of the patients rather than the missing limbs or other serious deformities. Again, I was struck with the quality of all personnel I met.

Vinh Hoi Day Care Center—I visited this excellent center and went over records and case history files and methods employed by Mrs. Phu and others involved.

I also visited two different types of Home Day Care Units. The first was a middle-class family unit, run by a woman who had graduated from a school for Home Day Care Center personnel. The children, eight in number, are fed, clothed, and cared for while their mothers work. Later I visited another Home Day

Care Center with Mrs. Phu and Mr. Morris, this one being in the heart of Saigon's poorest area. Most impressed with the results of IRC's training program for this operation. The in-put here of assistance where needed generates possibilities for parents who otherwise might be totally handicapped.

I met with Dr. Tran Minh Tung, Minister of Health, who particularly commended the Barsky Unit and IRC's Reception and Convalescent Center. He declared the great need for programs to help handicapped children.

Dr. Uyen, head of Planned Parenthood Association of Vietnam, who had formed The Family Happiness Association in 1965, told us that the Association initially used the term "child spacing" instead of "birth control" because of tendency to associate birth control with abortion. In a survey, 80% of people interviewed favored family planning. There are now more than 60 family planning units throughout Vietnam. With the poor, IUD (Inter Uterine Device) is favored. Catholics favor the rhythm method, accept the pill, but don't like IUD, which signifies abortion. Some wives don't like vasectomy because it allows husbands too much sexual freedom.

The principal USAID advisor on children's programs underscored the official position in support of the Vietnamese policy that the best way of helping American-fathered children is to help *all* needy children. The development of community social services, particularly day-care, is extremely important and it is important, he stressed, that IRC should continue its own work.

CONCLUSIONS

The basic conclusions reached by the IRC Mission follow.

1. Although a cease-fire exists in Vietnam, or at least a partial cease-fire, the winding down of hostilities in no sense permits the abandonment of assistance to Vietnam's war victims.

2. The Vietnamese are a spirited and capable people. Given a chance to work in peace, they can develop viable social and economic structures.

3. The Vietnamese people, in order to achieve these goals, must have increased help, especially from the United States which has had so large a role in the war.

4. The nature of such assistance should have as a major underlying objective the encouragement and development of self-sufficiency. Aid should be essentially supportive, not self-perpetuating; only the people themselves can rebuild their own society with their own human resources.

5. An expansion of humanitarian assistance by private American voluntary agencies is of utmost significance.

6. It is the view of the Mission that the funding of the current IRC program for uprooted refugees and children in South Vietnam must be increased to $1,000,000. The expanded program should cover three basic interrelated areas: 1) Refugee resettlement and community development. 2) Public health and medical services. 3) Child care with emphasis on war orphans, sick and wounded children.