W / Civ Cy
FILE / SUBJ.
DATE / SUB-CAT.
7/74

CR 7/22/74

HUMANITARIAN PROBLEMS IN INDOCHINA

Mr. KENNEDY. Mr. President, last week the Subcommittee on Refugees continued its public inquiry into the crisis of people created by the Indochina war. It met, as we have for nearly 10 years, to review American policy toward Indochina and to make the case again that the humanitarian problems of refugees, civilian casualties, orphans, and war victims of all kinds, must be a matter of vital concern to the American people and their Government.

The subcommittee received the testimony of its recent study mission to South Vietnam and Cambodia, which reported on current American programs to meet the humanitarian needs of the people in these two war-torn nations. The study mission was composed of Mr. Wells Klein, executive director of the American Council of Nationalties Service, and Dr. David French, director of the Office of Community Health Affairs of Boston University's Medical Center. Both have served as consultants to the subcommittee.

I would like to share with my colleagues the text of their report to the subcommittee, because I believe their findings bare heavily on the administration's request for aid to Indochina which is now before the Congress.

Regrettably, their report indicates that there has been very little change in the nature of the problems confronting the people of Indochina, or in the character of American policy toward the area. Despite the rhetoric of peace with honor, there is no peace. The tragedy of Cambodia increases every day. War continues. And the level of human misery deepens.

As Cambodia bleeds, as the human toll mounts with each day of continued war, in South Vietnam the "cease-fire war" has also meant that more Vietnamese have been killed, more refugees have been displaced, and more civilians have been wounded or maimed. In fact, more Vietnamese have died in 1 year of the cease-fire than all American casualties over an entire decade of war. Fighting continues in South Vietnam because our diplomacy has failed to end it.

In Laos, serious questions remain over our policy toward the newly established Provisional Government of National Union. Despite our country's general public support for the cease-fire agreements and the formation of the new government, several indicators suggest that the intent of some of our remaining presence in Laos can only help to perpetuate old relationships and the division of that country. We have gone that route once before, with tremendous cost to our own country and the people of Laos. We must not repeat this mistake and failure of the past. The new government must be given a chance to work.

Meanwhile, the humanitarian needs of the Laotian people remain as great as ever. Tens of thousands of refugees are still crowded on land that will neither support their needs nor give them any hope for the future.

Mr. President, a regional crisis of people remains acute today throughout Indochina—because our aid program has yet to place top priority on meeting the relief and rehabilitation needs of people, rather than the financial requirements of armies and governments. This administration's budget priority remains with the means of war rather than with the tools for building peace.

We are told we have a "moral commitment" in Indochina. And we hear officials say that if Congress does not provide the amount of aid requested, it "will be a violation of the clear understandings the South Vietnamese had from us at the time of the cease-fire."

What understandings? And who made them? And why are they hidden from Congress and the American people? And what about our moral commitment? What is so moral about providing vast quantities of ammunition for Indochina? What is so moral about an aid program that places a priority on fueling war and keeping a war economy afloat, rather than helping to meet the needs of war victims?

We have no moral commitment to any army in Indochina. We have no moral commitment to this or that government—to this or that official or faction. Our only true remaining moral obligations are with the people—to the millions of people in Indochina who cry for help.

We have a moral obligation to help accomplish political goals of the cease-fire agreements. We have a responsibility to remove our assistance to the people of Indochina from the political conflict, by channeling it through United Nations and other international humanitarian organizations. We have a duty to help people, not to buy time for governments too weak to support themselves.

Until these obligations also become the focus and priority of our aid program in Indochina, we are destined to meet again in a hearing next year to find, once again, that peace is still a stranger in Indochina, and that the plight of the people remains as serious as before. Until the violence ends, and political settlements are negotiated, the only "takeoff" we will see is an increase in the number of refugees, civilian casualties, orphans, and other victims of continuing war.

Mr. President, this tragic reality, of an escalating humanitarian crisis in Indochina, is documented in the report of the study mission to the subcommittee, and I ask unanimous consent that their testimony be printed at this point in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

STATEMENT OF WELLS KLEIN, EXECUTIVE DIRECTOR, AMERICAN COUNCIL FOR NATIONALITIES SERVICE, AND MEMBER OF THE SUBCOMMITTEE STUDY MISSION TO SOUTH VIETNAM AND CAMBODIA

Mr. Chairman: It is a pleasure to be here this morning to report to you on the visit Dr. David French and I recently made to Vietnam and Cambodia in our private capacity as consultants to this Subcommittee. As you know the purpose of our visit was to review humanitarian problems particularly in the fields of health, child welfare, and refugee assistance, which have been of concern to this Subcommittee for many years. Because of the shortness of time and the rather large body of data and observations we wish to transmit to the Subcommittee we will confine our testimony this morning to general observations and recommendations to be followed by a more detailed report later in the summer.

VIETNAM

I should have wished to begin this report on a positive note, for there have been some significant achievements in Vietnam this past year in relation to meeting the basic needs of people whose lives have been disrupted by war. Unfortunately, despite these achievements and changes in the specific nature of some of our humanitarian concerns, nothing has happened in broad terms, in the balance, to ameliorate the severity of human suffering in Vietnam. In fact, today the condition of people, the general level of misery, is as bad if not worse, than it was a year ago, and the situation continues to deteriorate.

Mr. Chairman: where we could once consider such matters as refugee care and resettlement, health services, and child welfare, as discreet areas of concern without specific reference to economic considerations, this is no longer possible. Vietnam's deteriorating economy and mounting inflation affect every aspect of humanitarian assistance.

In its simplest terms the basic problem is the continuing war with no end in sight and apparently no interest on either side in seeking a solution except on its own terms, and the eschewed economic structure and utilization of human resources dictated by total preoccupation with military considerations. Thus in 1973 Vietnam suffered a 65% inflation despite our economic aid, and another 26% in the first four months of this year. In ten years Vietnam's urban population has grown from 15 to 45 percent, and with the withdrawal of American forces, with their same 300 million dollars of personal and military spending, unemployment and under employment are rampant in urban areas. With this unemployment, the more than one million men in the armed forces, and the large number of people in government service, more than half of Vietnam's work force is either not working or unproductive in economic terms. In short, Vietnam is in the midst of serious economic depression compounded by an alarming and mounting inflation.

Against this backdrop it is not surprising that malnutrition is increasing alarmingly in urban areas as people are forced by economic necessity to switch from rice and protein rich foods to starchy substitutes. School drop-outs are rising as thousands of families can no longer scrape together the 3,000 piasters or five dollars per year required for school attendance. It is estimated that the number of "street children" has doubled since the beginning of last year, and infant abandonment is clearly rising as a result of economic pressure despite efforts to keep children with their families.

Mr. Chairman, it seems to be generally acknowledged that humanitarian concerns in Vietnam, especially today cannot be viewed, or resolved, outside of the broader economic context. The degree of unanimity on this is reflected in the similar views held by yourself and Ambassador Martin. Obviously there is need for economic stabilization if the people of Vietnam—refugees, children, orphans, the elderly, and the urban poor and destitute are to have any reasonable chance of progression beyond the struggle for sheer sur-

vival. How stability is to be achieved, at what level, with what hard decisions and belt tightening, and with what economic input from the United States, and through what mechanisms; these are the critical policy decisions to which this Subcommittee, the Congress, the Administration, the American people and the GVN must address themselves. Furthermore we must be clear in our own minds as to our obligations and our objectives. We may not agree, but at least let us understand the relationships between the economic, the political and the military in Vietnam. Finally, in considering how some degree of economic stability can be fashioned in Vietnam, we must also consider the needs of our own country caught in the pincers of inflation, and recession, and what some of us feel to be our basic humanitarian obligations in other lands such as the Sahel and Bangladesh where survival, not stability, is the pertinant concern.

Before turning to these questions, I would like to digress and report to the Subcommittee on recent developments in the fields of refugee resettlement and child welfare, particularly because the apparent, if still somewhat tentative, success of refugee resettlement has implications for broader policy.

A year ago, following the 1972 offensive and the upsurge of fighting after the ceasefire, refugee camps throughout Vietnam contained over 600,000 refugees with many additional people in refugee status out of camps. The deplorable situation of these people was documented in our testimony and the Subcommittee report last year.

As of our visit several weeks ago, however, these camps were almost entirely empty with the few remaining thousand refugees scheduled for resettlement in late June or early July. This significant achievement of return-to-village and resettlement was carried out by the GVN with major financial assistance and support from AID. I do not mean to suggest that there are no problems with the resettlement program, for there are many, but the overall direction is appropriate, given that conditions prohibit many people from returning to their original homes, and the program is being handled relatively well.

It was also comforting to note there is no indication that the GVN is using refugee resettlement as a means of expanding territorial control although in some cases this may inadvertently occur. By its nature, resettlement in Vietnam means placing people on previously untilled land. Thus resettlement could possibly be interpreted by the PRG as a move by the GVN to extend its territorial control, but such an interpretation based on present evidence would be both incorrect and most unfortunate, for there is no advantage to either side in making refugee resettlement sites a new focus of armed conflict.

Also, and contrary to the views of our Embassy, we could see no evidence that the PRG or NVA are specifically targeting refugee resettlement sites for military harassment. In Quang Ngai, a good deal of military activity swirls about resettlement and return-to-village locations, but this pattern has been endemic in Quang Ngai for many years. Otherwise, while refugee sites are periodically caught up in the fighting or receive almost random attacks, so do other civilian locations. Main force military activity seems to devolve around strategic objectives and lines of communication rather than population centers.

As mentioned earlier there are many operational problems, some of them serious, in the resettlement program. These include: inordinant delays in land clearing causing a backup of refugees living in totally inadequate staging sites; problems of land title; inadequate support from other ministries; particularly agriculture, public works, and health; fresh water supply and irregation; and insufficient attention to local development projects. Also the GVN and AID have been generally overoptimistic with regard to the period of time refugees will need supplemental assistance before becoming economically viable. Some land areas selected for resettlement seem, at best, marginal, and these people will require considerable assistance not presently budgeted or programed if they are to become self-sustaining.

Yet with all of its problems one must conclude that the resettlement program, if given sufficient follow through, will have significant results in moving large numbers of people out of a squalid state of dependency back to the land and their own homes (whether new or old) where they will once again be economically and socially productive.

The apparant success of the refugee resettlement program under the able leadership of Deputy Prime Minister Doctor Phan Quan Dan has led some 600,000 non-refugee families, mostly urban unemployed and poorly resettled refugees of previous epochs, to apply for resettlement under this same program. While it is unlikely that 600,000 families, or over three million additional people could, or would, be resettled in this manner, Dr. Dan estimates (and he has a good track record) that upwards of 1,000,000 people could be returned to the land over the course of the next two or three years. Short of peace, which is the ultimate solution, such a program, if adequately supported, would be a major contribution to economic and social stability, and would begin to bring some semblance of normality to Vietnam.

Unfortunately progress in the field of child welfare has not paralleled that in refugee resettlement. Only in the area of adoption has significant progress been made as measured by services presently available to children. There are now six American and international adoption agencies working in Vietnam. In general they are adequately funded including major support from the U.S. Government. It is important to recognize that intracountry adoption is the best available alternative for only a few of Vietnam's tens of thousands of disadvantaged children, and that those voluntary agencies now engaged in intercounty adoption are sufficient in number and professional competence to handle the problem in terms of the essential criterion—what is best for the children.

Members of this Subcommittee will remember that in previous testimony I have emphasized the need for adequate intercountry adoption services in Vietnam. With the progress made in recent months I must now state just as forcefully that further preoccupation with inter-country adoption, as against other child welfare services, would pose a false issue working to the detriment of those tens of thousands of disadvantaged children for whom Vietnam is, and will always be, home.

Turning now to other aspects of child welfare. It was more than fourteen months ago that this Subcommittee held a special hearing on "Orphans and Child Welfare in Vietnam." Subsequent to that hearing we received many assurances from the Government that child welfare concerns in Vietnam would receive priority attention. You will remember, Mr. Chairman, that shortly thereafter you and I met with Secretary of State Rogers on this same matter, and that during our discussion it was evident that the State Department and AID recognized the urgency of child welfare concerns in Vietnam. In short, it appeared that a long last the children of Vietnam would receive some reasonable attention.

Yet, fourteen months later funds for child welfare services (with the exception of adoption) are only now reaching those voluntary agencies who will actually program these services. The urgency articulated in Washington seems not to have reached Saigon, say nothing of the children who are, by and large, as they were fourteen months ago.

AID funds for child welfare services are being channeled primarily through voluntary agencies. These agencies have the professional staff and experience to provide immediate impact which the Ministry of Social Welfare lacks. Yet, in essentially by-passing the Ministry of Social Welfare to achieve immediate impact, AID is mortgaging the future of services to children in Vietnam. As Dean Dumpson stated in his testimony last year ". . . most of what we can do for children in Vietnam can only be accomplished through Vietnamese institutions. It is, therefore, imperative to strengthen the Vietnamese Government and voluntary agencies at the same time we are addressing ourselves directly to the immediate needs of children." Ignoring this admonition is a serious deficiency in our approach to child welfare. The objectives of immediate impact and of strengthening Vietnamese social welfare institutions are not mutually exclusive.

Another area of great concern which persists in the question of priority given to child welfare by the GVN. In our testimony last year Dean Dumpson and I urged the U.S. Government to ". . . raise the issue of the welfare of children with the Vietnamese Government at the highest level so that child welfare programing will receive equivalent priority on the Vietnamese side." We observed that "at this point the Vietnamese Ministry of Social Welfare is at the bottom of the Government's administrative structure and receives scant support in terms of funds and personnel."

In a separate report submitted to AID last fall after visiting Vietnam at the invitation of Ambassador Martin, Jean and John Thomas recommended ". . . what is needed in the welfare field is the same type of attention from President Thieu as he gave to the refugee efforts. What is most necessary is the enacting of a Presidential decree establishing an interministerial entity for social welfare."

Whatever the mechanism, it is apparent that our approach to child welfare will remain lopsided and inadequate until both we and the GVN are willing to give equivalent priority to this area. We would once again suggest that the Embassy and AID raise the question of child welfare and strengthening the Ministry of Social Welfare at the highest level.

Mr. Chairman, I would now like to return to that basic question which the Congress must shortly face in its deliberations on the Foreign Aid Bill—what should be the level of economic assistance to Vietnam and to achieve what objectives? The Administration has asked for 750 million dollars in FY 1975. This is an amount far in excess of that provided in FY 1974. The rationale for this request is that if we provide a higher level of economic assistance for several years Vietnam will achieve economic self-sufficiency and will no longer be dependent on the United States. This is a seductive argument but I have a strange feeling of "deja vu." I fear we are again being asked to see the light at the end of the tunnel.

In economic terms there is considerable question whether self-sufficiency can be achieved in this time frame particularly in the midst of a continuing war. The World Bank suggests that South Vietnam will be dependent on outside economic assistance and foreign exchange support until at least the 1980's. Furthermore, a significant portion of the 750 million dollars is slated for capital development in one form or another. One must question whether a wartime economy with all its attendent abnormalities is the place to embark on a major program of economic development.

The proposed level of economic assistance to Vietnam must also be viewed in relation

to our own domestic needs, which are considerable and obviously growing worse, and in relation to our economic assistance responsibilities in other areas of the world. Many of the less developed countries could achieve significant economic progress and in some cases reach "take-off" with a continuing fusion of capital on the order suggested for Vietnam.

Economic assistance obviously has political implications. With the level of assistance proposed for Vietnam we are trying to achieve by economic means what we could not by military—we are caught in the inertia of the past, and are still trying to "win the war". But peace can not be bought. If peace is to come to Vietnam, as it eventually must, then it will result from the resolution or compromise of those basic differences between the contestants which have been generic to the conflict for decades. Nothing will be achieved by the big powers loading their respective sides of the scales with more and more assistance. On the contrary, this dependence on others has the effect of further rigidifving the situation and prolonging the war. Why seek a resolution, why start the long and painful process of identifying possible areas of compromise and reconciliation when the United States, or China, or Russia are always ever present to maintain the status quo?

In advocating both a reduction in, and restructuring of, our economic assistance to Vietnam from that proposed I am not sugesting we have no obligations—we clearly do have. However, our obligations are not to a specific government but rather to the people of Vietnam and to the elusive promise of peace. The objectives of our economic assistance must be the achievement of economic and social stability and the reconstruction of the human and material resources of Vietnam. As a nation we should be willing to underwrite the costs of these programs. However, our commitment to long rang economic development, to a new and more sophisticated economic structure, to industrial parks and the like, these should be held in abeyance until such time as a peace settlement is achieved and such proposals can be judged on their own merits and in relation to similar requirements in other parts of the world.

Over the years you, Mr. Chairman, and this Subcommittee have repeatedly emphasised the need to involve multilateral UN family agencies in programs of humanitarian assistance to Vietnam and other countries of the Indochina pennisula. In the past some of these agencies have evidenced some reluctance to become too deeply involved in Indochina, and our government has hardly played the enamored suitor. At this junction, however, UNICEF, UNHCR and the IOG are each considering significant program expansions in Indochina, while WHO, UNDP and others may be considering similar actions. These initiatives are in keeping with the recommendations of this Subcommittee over many years and, theoretically at least, they are in line with the Administration's policy of encouraging additional economic and humanitarian assistance to the people of Vietnam, Laos and Cambodia.

There is a great deal which can be accomplished, and probably best accomplished, through multilateral assistance. In Vietnam, for instance, the Ministry of Social Welfare desperately needs technical assistence, as well as recognition, if it is to fulfill its mandate. UNICEF is the logical vehicle to provide assistance of this nature. If one considers Vietnam's estimated three percent rate of population increase together with its population structure of an unusually large numbers of young women about to enter their child bearing years, the prospects for economic stability, say nothing of growth in real per-capita income, are alarming. So for political and religious reasons Vietnam has been unwilling to come to grips with its population problem. Yet it must, and on a crash basis, if any economic assistance is to be meaningful. Multilateral assistance in family planning and maternal and child care, through UNICEF and the UN Fund for Population Activities would probably be the most effective and expeditious approach to this critical requirement. If something is not done immediately to control population growth in Vietnam, we automatically shelve any prospect for economic stability.

In both Vietnam and Cambodia UNHCR could provide vital assistance in refugee care and resettlement programs as could WHO and IOG in the health field. The important city-to-farm program in Vietnam would be a logical focus for assistance from UNHCR. In Cambodia, UNICEF and WHO could make important contributions to assisting the Khmer government in dealing with its serious health and nutritional problems.

In each of these program areas "funds in trust" mechanisms as well as "earmarked funds" can be utilized to support multilateral assitance and internationalize humanitarian assistance to Indochina. Yet at the very moment when it finally seems possible to anticipate significant multilateral assistance to the countries of Indochina, our government has taken a major action which, if followed to its logical conclusion, could unravel the entire structure of multilateral assistance throughout the world. I refer, of course, to our recent statement that since the United States provides 25% of UNICEF general funds, no UNICEF general funds should be used in PRG or DRVN areas of Vietnam. Obviously, if this dictate is enforced, then any nation, contributing to any general fund, of any UN agency, could exercise veto power over the entire program of that agency.

Mr. Chairman, I will end my testimony on Vietnam with the following observation. If it is our policy to isolate the PRG, the DRVN and the Khmer Rouge from international contract as was for so long our policy toward China, then our stance vis-a-vis the use of UNICEF general funds has a certain narrow international logic, even though it sets a precedent we may one day regret. If, however, we believe that international contact may open up channels of communication and possibly lead to a lessening of the extreme rigidity which presently characterizes the PRG, DRVN and Khmer Rouge factions, then our policy with regard to the use of UNICEF general funds, and its broader implications is totally unrealistic and reflects a level of political paranoia that borders on the absurd. Do we really believe that our interests will be violated if UNICEF provides assistance to children in these areas, or are we simply caught in the same inertia of the past with its tunnel vision?

CAMBODIA

The situation in Cambodia is markedly different from that in Vietnam in almost every respect, and comparisons between the two countries are not generally fruitful. During the four years of war in Cambodia a good half of the some seven million population have been displaced to some degree. The American Embassy estimates that there are currently upwards of 1,200,000 registered and unregistered refugees in the approximately 20% of the land area presently controlled by the government. These refugees represent approximately 23% of the total population under government control.

Since early 1973 the refugee population almost doubled its previous size. To quote a recent Embassy report: "The refugee problem has been compounded by a commensurate drop in production as refugees moved from the land into and around urban areas. This in time has led to shortage of many basic food stuffs and is one of the contributing factors in the hyperinflationary situation which exists in Cambodia today." The report goes on to say that "The key to the refugee situation then is not only to provide immediate assistance but also to resettle as many of the refugee population as possible on productive land."

To provide a point of reference for discussion of present conditions permit me to quote from my own testimony to this subcommittee a little over a year ago. At that time I said "To summarize the refugee situation, the prognosis is dismal. Neither our government nor the Cambodian Government have any organized refugee program. Adequate housing, sanitation, and medical service are either nonexistent or in short supply. Increasing numbers of refugees are being generated by an accelerated level of military activity and intensified American bombing. The repression on both sides is increasing with the government losing its precarious control and relying more and more on American intervention. And in the midst of this are a million refugees, half of them children. They are receiving virtually no assistance and face malnutrition, serious food shortages and, in some areas, the real specter of starvation.

While the military and economic situations have further eroded and the conditions of refugees are certainly no less serious than a year ago, the recent responses of the United States and Khmer governments to the refugee problem are encouraging. Because of statutory limitations on the number of official American personnel who can be in Cambodia at any given time and because the voluntary agencies represent an excellent resource, the U.S. Government has contracted with World Vision, CARE, and CRS to provide emergency refugee assistance, medical services and resettlement assistance particularly to the refugee population. Though these agencies in their programs reflect different priorities, and their programs are at different stages of development, each is operational and making a significant contribution. Together they utilize 47 international staff and 141 Khmer staff. In addition, the Indochina Operations group of the International Red Cross (ICRC & LICROSS) has five highly effective medical teams operating in Cambodia.

On its part, the Khmer Government has begun the difficult task of reorganizing its response to the refugee crisis. The new Minister of Refugees, M, Kong Orn appears both concerned and competent. He faces a difficult ask and deserves all the support that the U.S. Government can provide. Although the present government structure is clearly inadequate to deal with the enormity of the Khmer refugee problem, a reality recognized by both governments, it is, nonetheless, important that U.S. Government and private agency efforts be undertaken in consultation and coordination with the Khmer Government. This is a matter of both principle and practical effectiveness.

In response to a suggestion from the American Embassy the Khmer Government has recently organized the Resettlement and Development Foundation, a semi-autonomous body where membership is drawn from the Khmer business community. With U.S. funding the R.D.F. will concentrate on refugee resettlement. Although it only received its first funding in April the Foundation is already at work in Phnom Penh, and Kompong Thom.

While the unfortunately belated responses of the United States and Khmer governments are quite clearly insufficient to meet the enormity of the refugee problem, a positive beginning has been made and both governments appear to be moving forward as rapidly as their respective circumstances permit. Yet obviously, much more is needed, and it is to be hoped that future planning and program expansion will reflect the same

energy and commitment that presently characterize U.S. and Khmer efforts.

Some specific recommendations may be in order:

While the U.S. Embassy now has six positions allocated to refugee personnel, an additional two or preferably three slots are immediately needed, particularly in view of the increasing logistical support both the voluntary agencies and the Resettlement and Development Foundation will require. In addition, if one or two additional voluntary agencies are interested in working with the refugee problem, and if they are professionally competent to do so, they should be encouraged to participate in the program with substantial U.S. funding.

In closing these summary remarks on the refugee situation I would like to briefly comment on our policy in Cambodia. While I deplore the circumstances and decisions which led to our deep involvement in Cambodia, I have the impression that our Embassy is searching for alternatives and for a resolution of the current conflict. We seem to be looking to the future rather than to the past, and this is an encouraging sign in the midst of an otherwise depressing scene.

Finally, though I do not suggest changing the ceiling on U.S. government personnel in Cambodia, an interpretation of the law or a statement of Congressional intent which would exclude U.S. voluntary agency personnel working in Cambodia on humanitarian programs under U.S. government contract from inclusion in this ceiling would be very helpful. It would permit voluntary agencies to use their personnel in the most effective manner without impinging on the intent of the ceiling.

Testimony of Dr. David French

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

SOUTH VIETNAM

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

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

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

Two years later, in 1972, there had been little change and, in fact, the combined morbidity effect had increased to 28.7% while at the same time the effect of mortality had dropped somewhat from 49.3% to 43%. If one considers the increasing capacity of the Vietnamese health system to record and digest its own statistics, I think it would be safe to assume that the apparent increase in morbidity has little meaning. However, at the same time, the drop in mortality over that period of time by a full 6% is significant and indeed represents an improvement in the overall ability of the medical care system of that country to cope with its almost overwhelming problems.

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

The major implication of the morbidity and mortality causes in this country as stated above is that preventive measures could be most productive in improving the health status of the land. One needs to say about the prevention of war casualties being directly related to the cessation of warfare and, of course, much is known about the prevention of accidents whether they be in industry, on the farm, related to motor vehicles or secondary to other Western inputs which, until relatively recently were foreign to the major part of the population of this country. Prevention, again, plays a major role in approaching the control of infectious, parasitic, enteric, and pulmonary disease problems.

These four categories of disease are eminantly responsive to early diagnosis and prevention and the recognition of this fact in the combined efforts of USAID health personnel and the indigenous health structure of the health structure of this country of South Vietnam has resulted in a dramatic change in the evolution of the input of assistance and consequent development of the medical care system of that country. The early input of AID support made through a contract with the American Medical Association to support medical education in South Vietnam started that country's development in the general direction which find our own country headed in at the present time, namely, an overabundance of superspecialization ensconced in multiple hospitals, requiring a considerable amount of the Gross National Product to support them. At the same time it becomes difficult to measure the widespread benefit to the total population of such a major investment at the top.

The medical education program instituted by the American Medical Association (AMA) went about a complete reversal in 1972 and at the present time the main productive output in terms of health education and in terms of investment in the medical care system is entirely geared to the level of the districts, villages, and hamlets throughout the whole expanse of the country of Vietnam. The development of widespread use of paraprofessionals, the ability to undertake systems of identification and recording of health problems and the general education of the populace relative to hygiene, nutrition and sanitation has to a great extent evolved from this medical care system, especially through the Ministry of Health's development of the National Institute of Public Health.

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

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

Introductory Comment to the Recommendations for Vietnam

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

The medical care system of South Vietnam was jolted out of the Dark Ages by the impact of the war, especially in its latter stages over the last 8 years, where marked involvement by the United States occurred. It should be kept in mind that the Vietnamese people have been involved in almost constant conflict for the past 30 years with various nations. An entire generation has come up under the impact of various degrees of deprivation, accentuated by the constant impact of war.

The major impact of military involvement on the part of the United States since 1966 in particular saw the introduction of large numbers of medical personnel from the United States both as part of the military as well as part of various volunteer efforts. At

its zenith this involvement was noted in every province of South Vietnam, at least in each of the provincial hospitals and in many instances at even district hospital levels and below. Since war casualties were handled not only by military installations but also to some extent in civilian hospitals, no fine line was ever drawn as to the extent of involvement of US military personnel in medical care delivery. Likewise, at times of lull in the fighting, US military medical personnel, as well as other US military personnel, often engaged in voluntary medical care support for the adjacent civilian population.

USAID during this same period developed a programmatic approach in the public health area which added to the input of military and voluntary health personnel from the United States and with the passage of time the USAID input became more and more heavily in terms of impacting on the evolution and modernization of the medical care system of the whole country of South Vietnam. The Ministry of Health and the Ministry of Education were particularly involved in this process and the evidence is quite clear cut at this time that a warm and symbiotic relationship existed between USAID health personnel and these two agencies of the Vietnamese government.

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

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

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

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

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

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

VIETNAM

Recommendations

A. Continued General and Special Support of MOH

1. Planning and Program Development—

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

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

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

B. Project Support

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

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

3. MCH Program Development—A major area of program development since 65–70% of population is either children or mothers.

a. Under Six Program—been developed via AID, MOH, and National Institute of Public Health, needs funding input to make it a reality at district, village and hamlet level.

b. Family Planning—population growth now at dangerous level of 3%/year, outstripping economic growth capabilities. Government support is feasible.

c. Special Manpower Development—especially in training of midwives to assume role in basic child care under six years.

4. Facilities Development—

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

C. Multilateral Aid for Development of Health Program

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

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

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

We also met with the UN High Commissioner for Refugees, Sadruddin Aga Khan, who discussed in some detail his plans for the initiatation of a greatly enlarged and strengthened refugee relief program for the Indochina Peninsula. I was particularly interested in the nature of the medical care support that the UN High Commissioner for Refugees would anticipate and he indicated that they were cognizant of extensive medical care needs possibilities and that they would call freely upon WHO and UNICEF to assist them in this regard. They felt that there was a good past history of cooperative activity between these three arms of the United Nations and he felt that this would also operate smoothly in the case of Indochina if adequately supported financially by the various nations through the United Nations.

We also met with Dr. Belleride of the World Health Organization in Geneva who again indicated the great willingness of WHO to cooperate in a joint venture with UNICEF and the UN High Commissioner as indicated to meet refugee and general humanitarian needs in Indochina. Dr. Belleride, however, indicated that the functional structure of WHO was such that all operations must of necessity emanate from the Southwestern Pacific Office located in Manilla, The Philippines.

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

Upon arrival in Bangkok, Thailand, we met with Mr. Mace, the Deputy to the UN High Commissioner for Refugees who had just completed a short tour of South Vietnam at

the request of the UN High Commissioner for the purpose of program development. We were briefed concerning some of his findings and it was indicated to us further the willingness of the Office of the UN High Commissioner for Refugees to be cooperative with the United States in terms of developing multilateral support for relief. It was also indicated to us that they were hopeful of having operative programs underway by October of 1974.

Our next interface with UN officials was at a luncheon in Saigon held by Mr. Pierre Sales. Present at this luncheon were Mr. Paul Nelson, Social Development Advisor for UN, Mr. Jean Jacques Deschamps, UNICEF Program Officer sitting in for Mr. Ralph Eckert, and Dr. Richard Coppedge, WHO Representative *ad interim* and Project Manager for the National Institute of Public Health Project. At this luncheon we again broached the subject of multilateral approach through the UN and specifically utilizing three components of the UN, namely, UNICEF, WHO, and UNDP, in addition to the good offices of the UN High Commissioner. The conversation indicated that there was strong acceptance of this approach. There had obviously been some contact between Geneva and the UN officials with whom we lunched, indicating that as a result of our recent visit to Geneva there was developing a feeling of agreement there, as well.

At yet a later luncheon held by Dr. Richard Coppedge, I had an opportunity to speak directly with Dr. Dy, Director of the Southwestern Pacific Section of the WHO. Dr. Dy was the last cog in this wheel and he indicated that it was his policy and that of the Southwestern Regional Office of WHO to strongly support health and humanitarian developmental programs and that they were giving special preference to the countries of the Indochina Peninsula recently set back by the ravages of war. He was agreeable to the multilateral approach which would allow the enlargement and development of programs by WHO and indicated that all that was necessary was that the specific country make a formal request for this assistance and that the WHO would be more than willing to respond.

Elsewhere in this testimony Mr. Wells Klein will enlarge upon conversations which he had with the UNICEF people in New York City, but I think it is safe to say at this point that there was no lack of agreement at any point and in fact it would be safe to say there was nodding enthusiasm as we continued to pursue the subject of multilateral support through the UN throughout our trip. Mr. Chairman, I am convinced that the proper initiative exerted at this point would receive immediate response by the four agencies which we interfaced with from the United Nations.

CAMBODIA

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

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

1. *No prolonged U.S. military presence*

Much of the progress underway in Vietnam was an unplanned by-product of U.S. military presence. This along with planned medical support not only of the military but of necessary of the civilian side of medical care resulted in a strong infusion of Western know-how, not just into the medical-technical armamentarium of Vietnamese medicine, but also into the organizational, structural, and educational aspects of the medical care system. All of this was supported over the last 8 years with a vast input of American dollars. The latter albeit disproportionately small compared to dollars sunk in direct military aid, nevertheless in the setting of Southeast Asia this represented a major quantum jump.

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

Cambodia is certainly blessed in that the magnitude of destruction that would have accompanied a U.S. military presence did not occur. At the same time, however, there has been no spin-off of U.S. know-how and dollars into the modernization and upgrading of her medical care system which finds itself swamped by combined demands of a growing population's day to day needs and the continued added burden of military and civilian war casualties.

2. *Peculiarities of war and geography*

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

The second population group is that which exists in thhe outlying pockets of land which are widely interspersed throughout the eastern and some of the southern part of the land of Cambodia containing the remainder of the 80% of the population of this country. The total land controlled by the Khmer Republic is about 20% whereas the population controlled is about 80%.

This separation betwen the central government and its resources in the capitol city and the remainder of the country in outlying pockets which are inaccessible much of the time by ordinary means creates an insurmountable logistical problem relative to any concerted health care effort which the Cambodian government, using their current resources, might be able to overcome.

The few reports which we have been able to evaluate through U.S. government sources or through those of the United Nations have almost invariably dealt with the city of Phnom Penh and have not at all divulged any information relative to the outlying areas wherein perhaps two-thirds of the population of Cambodia now resides.

Our team was lucky in being able to visit two of these outlying areas, one at Kompong Thom and the other at Kompong Chhanang. The latter area had been the site of a major battle involving some 16,000 troops only four days prior to our arrival and we had an excellent opportunity to see the impact of war casualties on a badly divided and poorly developed medical care system. Kompong Chhanang is a provincial capitol which has a provincial hospital.

The provincial hospital was visited and we had the opportunity to see the Swedish surgical team which has been stationed there since 4 March 1974. The surgical team works under the direction of the Cambodian staff leadership and consists of one surgeon, one operating room nurse, one nurse anesthetist, and one intensive care nurse to maintain postoperative care for surgical patients. In the period of time since the surgical team has been present they have admitted 129 surgical patients and done 171 operations. During the early period up through May war activities in the area were at a low level and the major portion of the surgery was relative to assistance of civilian medical care needs, both of an acute nature as well as cases of longer standing status.

Since the beginning of June, however, there has ben a steadily increasing amount of war activity in the area and since the 10th of June only acute war injuries involving both civilians and military personnel have been handled by the surgical team. No civilian activities have been allowable and all of their surgical beds have been totally filled. In addition to their surgical activities the team has undertaken the training of Khmer nurses, working in tandem with other nursing personnel on the surgical team such that they might ultimately take over these responsibilities.

Had it not been for the presence of the Swedish surgical team it is estimated that at least 80% of the surgical cases handled since the beginning of increased hostilities on the 10th of June would have had to go to the hospitals in Phnom Penh. It is important to note that this, likewise, is some what of a logistical problem since it is impossible to transport other than by means of airplanes and there is some question as to the nature of the survival of many of these patients had such an evacuation been necessary.

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

3. *Problems of nutrition*

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

Since April of 1974 at the establishment of the Resettlement and Development Foundation, there has been notable activity in some of the outlying provinces relative to the reclamation for agricultural purposes of land. We had an opportunity to visit such a site in the area surrounding Kompong Thom where there is underway the cultivation of 5,000 hectares of rice. We were given an interesting briefing by the provincial military staff, indicating how they had maintained a sufficient perimeter around the provincial capitol of Kompong Thom within which active cultivation of rice has been made possible.

Much of the land under cultivation in this area is virgin land and it is expected that these early crops will be of high yield although replanting will necessitate the utilization of fertilizer which is in exceedingly short supply, not only in this country but in the world market. The cooperative efforts between the AID staff and the governmental staff of the Khmer Republic and local officials has been exceedingly good.

In addition, cattle raising is underway at an increased level as is the harvesting of fish which are in exceedingly good supply in

nearby streams. In addition, a significant program to supplement the feeding of infants with milk was observed. The Catholic Relief Society has established several of these units throughout the area which works in conjunction with the mothers of the children involved and successfully distributes large quantities of milk which is obviously a needed food supplement. Nursing traditionally at the breast occurs for a period of about three years in this society, but the borderline nutritional status of the mothers seriously compromises the amount of milk available to the infants. The CRS supplemental feeding program has not worked to discourage breast feeding but is given as a supplemental nutritional assistance.

It should be noted at this point that nutritional deficiency is exceedingly widespread in Cambodia. Although it was seen to exist to some extent in the provincial areas of Kompong Thom and Kompong Chhanang and in this instance primarily in the first three years of life, it was nowhere as nearly dramatically seen in these rural areas as it was in the city of Phnom Penh. Large numbers of children in Phnom Penh are currently suffering severe nutritional damage. The government has been unable to respond to these nutritional needs which have been primarily accentuated by the swelling population of this capitol city.

An opportunity to chat with some of the staff of World Vision gave us an opportunity to hear about some of their supplementary feeding operations in the city of Phnom Penh. They have identified as the major medical care problem in children, in particular, malnutrition. There are occurring on a regular basis distinct clinical cases of kwashiorkor and it was the distinct impression of these phyicians that other effects of nutrtional deficiency were becoming widespread, relating to the growth and development of the children in general as well as in such areas as crippling of the immunity protection system.

In addition we were given information to indicate that the steadily increasing price of food within the capitol city of Phnom Penh which is related to a rampant inflation is such that the number of malnutrition cases is bound to increase since more and more people will find it more and more difficult to purchase high protein foods. It should be indicated at this point that USAID activity in Cambodia has been directed toward relief of the food deficiency problem. 40% of the rice land which is potentially arable is now lost because of military action. This has led to the important through USAID of some 40 million tons of rice per year.

A considerable problem exists, however, in the distribution of this rice which can be transported up the Mekong River to Phnom Penh but distribution out of Phnomh Penh to the surrounding provinces is considerably problemmatic since railroads and highways have been cut and until recently the Tonley Sap have remained closed.

The cost of living over the past year has increased some 300%. The cost of meat, alone, has doubled since December (1973) and even the price of vegetables is considerably on the increase.

It is estimated that approximately half of the war refugees of the country are currently in Phnom Penh and estimates range as high as 1.2 million people being in this category. Approximately ⅔ of the refugees in Phnom Penh are cared for by their families or some official program, according to USAID estimates. The other ⅓ refugees are dependent primarily upon the voluntary agencies, an estimate of the number being cared for in this regard currently being approximately 388,000.

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

4. *The organization and function of the medical care system*

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

(1) The shortage of hospital beds:

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

(2) supply shortage:

Cambodia is considerably beset by the problem of the shortage of medicine, equipment and other kinds of medical supplies that would be necessary to operate an up to date medical care system. Dr. Kim Vien indicated that currently some medicines and supplies were coming through the International Red Cross and through gifts from other countries, however, again, he does not have the means for accurately recording this input nor estimating the need, overall, for the country. He feels that the lack of medical supplies and of hospital beds is most severe in the capitol city of Phnomh Penh and although present in the outlying provincial areas is not as acute.

My observations in Kompong Chhanang and Kompong Thom would tend to confirm the Minister's impressions. Dr. Kim Vien is much aware of the fact that medical care problems of the capitol metropolitan area are considerably different from those of the outlying provinces. He has identified the capitol area's problems as they relate to nutrition, availability of medical care personnel, and environmental and public health problems being of primary importance.

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

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

It was indicated that approximately 2.8% of the national budget is currently going into health care. In 1973 this amounted to 1,036,006,700 Riels out of a national budget of approximately 48 billion Riels. Dr. Kim Vien indicated that his current studies lead him to desire to triple the amount of the national health budget for 1974 and that he felt that he could justify an increase of the health budget to a sum which would equal approximately 10% of the national budget.

This matter is currently under debate before the national legislature and the Health Minister was hopefully that he would at least be able to double the health budget over the amount of last year. He pointed out the fact that the increasing cost of fuel alone was creating considerable problems for their health care system, especially in regard to any development or support of the health care system outside of the capitol city of Phnom Penh.

When asked what sort of cost figure could be applied to meeting the current overall needs of the nation relative to the health care system, he stated that it would amount to approximately 16 billion Riels. Taking into account current input from the government of the Khmer Republic as well as outside input through voluntary agencies which might total as much as 4 billion Riels, one would still have a deficit of approximately 12 billion Riels in terms of what is envisioned as necessary to develop a significant operative health care system in this country under current monetary conditions.

Recommendations

1. MOH Support Operation

a. AID and multilateral funding.

b. Full survey of medical care system and resources (American University Medical Center team).

(1) Phnom Penh.

(2) outlying provinces.

c. Development of MOH Medical Care Planning Operations Group—U.S. input (University Medical Center, APHA and WHO).

(1) short term development plan—

Prop up baseline civilian medical support needs plus added war casualty input through (a) expansion IOG teams for present, (b) later development of international medsurg teams via UN auspices—UNHR, WHO & UNICEF.

(2) long term development plan—

(a) consultative input and backup of MOH and its outlying subdivisions—multilateral organization (UN)—U.S. input (University Medical Center, APHA and AMA (educational)) WHO input—various other national consultative inputs.

2. U.S. Commitment of Foreign Aid Funds Via Multilateral Channels (UN)

a. Training and education of medical and allied health personnel.

b. Development program for district, village and hamlet medical aid teams and facilities.

c. Supplies and equipment and logistics system for maintenance and distribution.

d. Develop MCH program to include—family planning, nutritional supplementation, midwifery program development, and health education, immunization.

c. Emphasis on development of a national, aggressive environmental and preventive health program.