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UNITED STATES ECONOMIC ASSISTANCE TO VIET NAM, 1954-1975

VIET NAM TERMINAL REPORT

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U.S. ASSISTANCE TO PUBLIC HEALTH PROGRAMS
INTRODUCTION - VIETNAM, 1954-75

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From the earliest involvement of the U.S. Government in economic assistance to Vietnam, health sector assistance was of interest. Beginning in 1950 with the Special Technical and Economic Mission to French Indochina, and soon after to the Associated States themselves, the U.S. funded projects aimed at expanding medical care to the people of Vietnam. The initial effort was rather narrowly focused on establishing medical education facilities in Saigon and providing nursing advisors to the schools of nursing in both Hue and Saigon. It was not until 1954 when the new government of South Vietnam was formed, that U.S. assistance efforts became a major, concerted effort aimed at development of a comprehensive national health care program which could be sustained by the Vietnamese.

The scope of the U.S. assistance program in public health became much broader and of an emergency nature as the war intensified in the mid-1960s. The impact of war upon the people of Vietnam had been profound in terms of creating a sizeable refugee population and magnifying the public health/preventive medicine and curative/surgical needs of the populace. Therefore, provision of assistance in public health and medical care, particularly for the refugees and civilian casualties of the war, became an important part of the war effort of both the Governments of Vietnam and the United States.

Whereas in 1963 it was estimated that 80 percent of the rural population was receiving some type of health service from the government, by 1965 this coverage had regressed to 30 percent. At the same time, civilian casualties with war related injuries and refugees were being generated at increasing rates. Given the inability of the medical system and its facilities to cope with this situation, a rapid expansion of U.S. medical assistance was undertaken. The traditional advisory elements of U.S. assistance remained, but a large

new input of operational personnel was added. A step-up in the supply of medicines and equipment was necessary to support the effort, together with repair and expansion of existing medical facilities and the construction of new facilities. Arrangements were made for the U.S. Department of Defense to provide support to help deal with the war generated situation. Other nations increased their help in public health as well. Total U.S. and Free World medical personnel assistance peaked in 1968 at over 1,500 people. The USAID dollar budget alone that year was over \$27.0 million.

As the GVN became increasingly capable of meeting public health staffing requirements with its own people, USAID began phasing out the considerable numbers of U.S. personnel engaged in operational activity, and began shifting to an advisory effort at high levels of the Ministry of Health organization. By 1974, the USAID public health program budget was about \$7.0 million and declining. However, during this period USAID and the Ministry of Health began to develop plans for expanded programs, which would involve major U.S. support, in preventive medicine at the community level and in rehabilitative medicine for war victims. Detailed plans of action for these programs were being developed at the point of the communist takeover.

1951-1955: A period of transition and groundwork for modernization

The public health system under which American advisors found themselves operating in the beginning was patterned after the French colonial system. The French and graduates of the French medical school dominated the medical community. The greater majority of the hospitals in use at the inception of American assistance were built in the period 1925 to 1935, were located in the urban areas, and were accessible mainly to the French and well-to-do Vietnamese. It was during the French administration that the system of

provincial medical care was established under the administration of a Ministry of Health. District clinics were established and staffed and in many of the provinces hospitals were built. Most of the rubber and tea plantations owned by the French also furnished medical care of sorts to the plantation workers. This plantation medical care, being the only care available to large numbers of Vietnamese and at an extremely low level, contributed much to the poor image of French medicine in Indochina. During this period of adjustment and transition, civil programs competed with military for both funds and personnel and came out a poor second best. Village health workers were not paid, district health services were not adequately staffed and the province hospitals, most over thirty years old, continued to deteriorate, being barely adequate as housing much less capable of furnishing an environment for medical care.

As mentioned above, the earliest U.S. assistance in 1951 was specialized in nature and was administered through the Special Technical and Economic Mission to the French in Indochina . This program was designed to improve nursing and midwifery services in Vietnam. Nursing advisors were assigned to the schools of nursing in Hue and Saigon and curricula were modernized and training and facilities expanded. In spite of a successfully developing program of nursing education, the demands for competent nursing services continued to increase. This was based upon an increased public demand and the expansion of government health programs.

With the arrival of independence in 1954 the role of U.S. government public health assistance expanded, and the responsibility for assisting the RVN Government to revitalize and develop its health program and facilities was given to the United States Operations Mission, Public Health Division (USOM/PHD). The USOM/PHD became the advisor to the new Department of Health. The RVN Department of Health operated all the hospitals in the country with the

exception of a few private hospitals in Saigon and other cities: administered training schools for nurses, midwives, and auxiliary health personnel; controlled the pharmacies of the country, including the manufacturing of drugs, and conducted an environmental sanitation program. The typical provincial health department operated a 250 bed hospital and supervised five district infirmary maternities and 70 village health stations.

For the period 1954-1955 the USOM health and sanitation program in South Vietnam grew to an annual funding figure of close to \$1.0 million, while the GVN was committing about 56 million piasters a year in counterpart funds. By June of 1955, 17 direct hire technicians were employed in the public health program. During this initial period, although the USOM program, which grew out of the STEM program to the Associated States, was relatively ambitious in scope, it could be roughly organized into four major program areas 1) specific disease control programs, 2) environmental sanitation, 3) health training and education, and 4) construction of facilities and commodity support. Nearly half of the dollar cost of the overall program was for technical advisory services in the first three areas.

Principal among the disease control projects was malaria eradication. During the two years 1954 and 1955 it was estimated that seven and a half million people were afforded protection by this project in which the U.S. provided vehicles, DDT, sprayers and personnel costs. A major training component was also a part of the project. Other assistance was provided for control measures against tuberculosis, trachoma and leprosy. In addition, more than three million people were vaccinated during this period with U.S. supplied vaccines, including those for smallpox, typhoid, cholera and plague.

In environmental sanitation the principal USOM emphasis was on water supplied. Materials were furnished for six municipal water supply systems,

including a water treatment plant for the city of Hue. Fifteen other municipal water systems were surveyed to determine needs for expansion and rehabilitation. Efforts were also aimed at rural water systems with the provision of about 2,000 sanitary wells and an additional 2,500 open type temporary wells for refugee camps.

In health education the mission continued efforts begun in 1951, toward development of a national health education program. During the period under discussion, 80 health workers were employed by the Vietnamese Department of Health on funds provided by USOM, of which seven were placed on detail at the Commissioner of Refugees. Meanwhile the mission has helped establish a National School of Nursing in Saigon with a branch in Hue. Buildings and dormitory facilities were built, equipment and teaching materials donated, and full time teaching staff was set up in each unit for counterpart training. A class of 46 students completed its studies in both units in 1956. Vietnamese personnel were also being trained in the U.S.

USOM undertook assistance during this period in the training of laboratory technicians and in the renovation of some 21 laboratories of the Department of Health. Related to this activity, a Health Technicians School was inaugurated with USOM assistance in 1955 with a three year course of study designed to produce rural health technicians who would be on contract to serve the government when their training was completed. Part of this assistance package was construction of physical facilities for the school which began in 1956.

1956-1964: Rural outreach and growing military disruption

In 1956 the directions of the USOM public health program and of the GVN Ministry of Health took a somewhat different tack. A Presidential Decree was issued that year which legally established a Rural Health Program and formalized the health services down to the village level. Where the Ministry of Health

with USOM assistance had originally sought to fill the urgent need for rural medical services with the Health Technicians Program established a year earlier, plans now began to take shape to scale down the training and education requirement for rural health workers. Basically, the curriculum of the Health Technicians Program was altered to accommodate development of a number of categories of health workers at a lower level of capability than originally conceived. One of these categories was the village health worker which eventually became the basic program to meet the needs of the majority of Vietnamese people. In this program, individuals designated by the village council were trained, generally at the province hospital, for a period of six weeks. This training proved basically adequate to enable the health worker to recognize the requirements for use of the village health kits which were given to each new village health station and included basic drugs and first aid materials.

Thus health training and education became the major emphasis of the public health assistance program during the course of the next few years. In fiscal year 1957, when the USOM health program budget rose to over 2.0 million, over half of that was allocated for the category of health education and training. The remaining funds were budgeted for disease control, environmental sanitation and development of facilities, including construction and remodeling. By June of 1957 the number of direct hire technicians employed in the public health program had risen to 32 and four contract technicians had also begun work.

A related area of program expansion at this time was in higher medical education. In 1957, USOM agreed to assist in the development in Saigon of a medical center consisting of a basic science building and a 500 bed teaching hospital and related facilities to serve as the physical plant of the Faculty of Medicine, University of Saigon. By the end of FY 1959 approximately

\$3.0 million had been obligated for this construction and over \$2.0 million more was requested for FY 1960. A small portion of these funds was being spent on training and upgrading of the faculty. At this point, this construction activity was absorbing most of the public health program funding which reached approximately \$3 million in 1960.

Meanwhile, assistance to rural health service development was achieving some success and it was planned to terminate funding of that activity in FY 1961. In 1960 more than 3,000 village health centers were in operation and 35 of 36 selected provinces had one or more pilot districts organized. It was believed that all the groundwork had been laid so that the government could continue to provide and expand basic health services to rural areas without further USOM assistance.

In addition, the malaria eradication program was making progress, as was the nursing education program. In an effort to provide immediate relief to the acute shortage of nursing personnel in Vietnam, subprofessional education programs, which had been developed in both Hue and Saigon in conjunction with the basic nursing programs, were able to graduate 174 nursing assistants by April 1959. USOM also continued to provide supplies and equipment as well as construction assistance to School of Nursing facilities in Saigon, Hue and Can Tho.

The above description roughly outlines the USOM public health programs as the Cold War began to heat up in South Vietnam. Projects which were making reasonable progress as the decade of the 60s began, plunged headlong into wartime planning as military activity spread throughout the countryside. As the civilian population in the rural areas began to be affected by the mounting insurgency, province hospitals and rural health facilities were hard pressed to provide adequate medical care for civilian war casualties. Consequently,

in the summer of 1962, the USOM established a program which provided surgical teams to selected provincial hospitals and developed a plan for the renovation and/or construction of modern surgical suites in 29 province hospitals. This program of U.S. assistance continued to expand and in January, 1963, fifteen U.S. military medical officers and 107 enlisted men were deployed through out Vietnam to carry out Medical Civic Action Programs (MEDCAP). In the first seven months of operation, more than 840,000 patients were treated by these teams.

With respect to preventive medicine, U.S. assistance to the Vietnamese rural health services had effectively expanded that system. An estimated 80 percent of the rural population were receiving some type of Vietnamese government sponsored health services by 1963. However, from the fall of the government of Ngo Dinh Diem in 1963 to 1965 the intensified enemy action and disruption of administrative and supervisory channels reduced the Rural Health Services to providing medical care only at the district level and in a few secure villages. The population effectively covered regressed to about 30 percent of the total in rural areas.

As hostilities in South Vietnam continued to heighten, it became apparent that the GVN Ministry of Health would require other donor assistance in all areas across the broad spectrum of health services necessary to provide minimally adequate medical care for the people of the country. USAID plans were formulated to greatly increase the numbers of U.S. professional health personnel, medical commodities and other resources to assist in this effort.

Throughout 1963 and 1964, the U.S. mission struggled with the program of surgical teams and surgical suites. It became increasingly clear that the demands were too great on GVN personnel, logistics capability and management to support the teams. U.S. assistance programs moved to fill the gap, and

the role of the U.S. Military Assistance Program continued to grow. The surgical team at Can-Tho was replaced by an Air Force surgical unit and the Navy developed a similar unit at Rach Gia. Both of these military surgical capabilities were added to the USOM Public Health Division effort by the Department of Defense at the request of the State Department. The military teams were technically an improvement over the original teams in that the nursing complement was increased, allowing the medical officers more time to concentrate on surgery and technical problems. In addition, they were able to take on a heavier training schedule for the Vietnamese assigned to the province hospitals. And finally, the military supplemented the team with an administrative officer to handle nagging personnel and supply problems.

In spite of the constant struggle with security and the growing pre-occupation of the GVN and USOM with civilian war casualties, efforts at a regular program of development of medical and public health services in South Vietnam continued during the war years as conditions allowed. During 1963 and 1964, for example, the malaria program continued a large scale spraying campaign visiting over 1.2 million homes every six months. At this point, the malaria index for certain provinces had dropped from over 7% to less than 1% through these efforts. Six malaria advisors were actually stationed in the provinces with four to six more backing them up in Saigon. In addition, USOM played a large role in fighting a cholera epidemic in 1964 by providing technical assistance and over \$1.8 million worth of intravenous fluids and vaccines and airlifting supplies to the provinces hit by the epidemic. Meanwhile training of village health workers and nurses continued. By 1963-64 80% of Vietnamese nursing instructors had received training in the United States.

1965-1969: massive emergency build up and integration with Military Assistance

During the year 1965 the USOM program of public health assistance underwent rapid and dramatic changes, largely in response to pervasive and intense

military activity. U.S. military forces began a build-up that would eventually reach 500,000 troops. Of necessity, the highest priority of the program became medical care, curative in nature, rather than the program of preventive medicine and health education which had seen reasonable progress in the recent past. As mentioned above, by 1965 intensified fighting meant that less than 30% of the rural population were now being reached with government health services. Furthermore, as the Vietnamese medical personnel were increasingly drafted into military service, the staffing shortage at civilian installations became acute. The four U.S. surgical teams operating in 1964 in Nhatrang, Danang, Can Tho and Rach Gia were simply not enough assistance of the Ministry of Health to handle a growing problem of civilian war casualties plus basic health services in the provinces.

During 1965 USOM's personnel levels in public health grew more dramatically than dollar levels (although FY 1966 also saw a skyrocketing financial commitment). In FY 1965 the program grew from its approximately \$3.0 million per year of the early 1960s to almost \$6.0 million. At the same time, by the end of that fiscal year, the staff of USOM's Public Health Division had grown to 82 direct hire and 30 PASA employees, the latter being primarily Public Health Service and Defense Department technicians. The program was reorganized during the year into two basic projects: Medical Education and Health Development. The medical education project continued to train doctors and dentists, construct necessary facilities, and provide equipment for the training program. The health development project essentially incorporated all other activities of the public health program. It included 80 of the 82 direct hire personnel mentioned above and all of the PASA people (those on loan from other U.S. government agencies). It consisted of the following nine subactivities: 1) Hospital

Development, which provided direct augmentation of operating personnel to beef up civilian medical care in the provinces; 2) Rural Health, designed to link up the fragmented government health services system with the growing system of USOM and U.S. military medical services; 3) Malaria Control, which at this point was forced to abandon the objective of eradication and work simply to contain the disease sufficiently to avoid a major health problem; 4) Health Education, designed to strengthen health education and awareness among the public with special emphasis on refugee areas; 5) Communicable Disease Control, which was newly designed to improve surveillance and control measures, including immunizations, aimed at a number of major diseases; 6) Urban Sanitation, to expand and systematize refuse collection and disposal in Saigon and surrounding urban areas; 7) Medical Logistics, to establish and maintain a logistics system to support all the activities of the Ministry of Health, which at that point was called the Commissariat of Health; 8) Training, to support GVN civilian health programs by training of new Vietnamese sub-professional health personnel; and 9) Nursing Education to continue to provide nursing personnel to government hospitals.

Meanwhile in the growing effort to expand medical capability at the provincial level, the U.S. decided to commit additional military medical resources to the USOM program. In May 1965, the Office of the Secretary of Defense directed the military departments to develop a medical program for increasing the medical presence of the Vietnamese government by utilizing U.S. military mobile medical teams throughout South Vietnam. A detailed plan was developed for the purpose of providing expanded health and medical service for the civilian populace, developed jointly by USOM and the Military Provincial

Hospital Augmentation Program (MILPHAP). Composed of three doctors and 10-12 other medical personnel, the teams were based at provincial hospitals and worked for the province medicin chef. In mid-1965 there were eleven medical teams (four of which were American) assigned as indicated below. The introduction of MILPHAP would go a long way toward achieving the goal of a team of each of the 43 provincial hospitals in the country.

Medical Team Program - May 1965

<u>Locations</u>	<u>Province</u>	<u>Origin</u>	<u>Arrival Date</u>
Cantho	Phong Dinh	USAF*	4-65*
Nhatrang	Khanh Hoa	USPHS	12-62
Qui Nhon	Binh Dinh	New Zealand	12-62
Danang	Quang Nam	USPHS	1-63
Tay Ninh	Tay Ninh	Philippines	9-64
Long Xuyen	An Giang	Australia	10-64
Gia Dinh	Gia Dinh	Italy	2-65
Rach Gia	Kien Giang	USN	3-65
My Tho	Dinh Tuong	Philippines	5-65
Thu Dau Mot	Binh Duong	Philippines	5-65
Kontum	Kontum	Philippines	5-65

* Preceded by a USPHS team in Cantho from 11-62 to 4-65

To further meet the urgent need for doctors, AID contracted in 1965 with the American Medical Association for a program of Voluntary Physicians for Vietnam. AID financed the travel and per diem costs of some 200 volunteer physicians from U.S. private medicine each year under this program until _____. The usual tour of duty for these physicians was 60 days, and they were assigned to work at civilian hospitals along with the U.S. or other donor medical teams.

Thus, as the build-up in health and medical assistance proceeded into 1966, the USOM program became increasingly dependent on Department of Defense personnel. Basically, the health services available to the Vietnamese civilian population through direct U.S. support broke out into four distinct categories: MEDCAP, Medical Civic Action Program, treatment by ARVN, U.S., and Free World military personnel; MILPHAP, described above; (speciality or medical teams of U.S. and Free World civilian personnel; and Saigon hospital services. It

should be noted that U.S. and GVN operations in each of these categories were designed to be mutually supporting, and wherever local conditions permitted, they actually operated in the same physical facilities as integrated units.

The joint AID-DOD-Free World Assistance (FWA) programs were coordinated roughly along the following lines:

(A) Direction and Control:

1. Operational control of MEDCAP activities was effected through respective ARVN, MACV and FWA military commands.

2. MILPHAP and U.S. military specialty teams were administratively the responsibility of MACV. Day to day operational control of medical activities was vested in USOM as the agency responsible for advising the GVN in civilian health matters.

3. U.S. civilian teams and advisory personnel (AID and PHS) were under control of USOM.

4. Control of FWA teams rested with the parent country in cooperation with GVN and in accord with various inter-country agreements.

5. GVN civilian health and hospital services were controlled by the Commissariat of Health.

(B) Logistical Support:

Resupply of medical commodities was financed by AID while direct support of MEDCAP and MILPHAP was effected through the ARVN/MACV medical supply system. AID supported FWA medical and specialty teams through the Commissariat of Health medical supply system.

(C) Salaries and Administrative Support:

1. Personnel, initial equipment and transportation costs of MILPHAP teams and other DOD medical personnel were centrally funded by agreement between AID/W and DOD/W. Administrative support of U.S. military personnel was the responsibility of MACV.

2. Civilian personnel (AID & PHS) salaries and administrative support were AID responsibility.

3. FWA teams received salaries and most administrative support from home country with assistance from GVN Commissariat of Health for housing, interpreters and hospital facilities. USOM provided administrative support

wherever the Commissariat of Health was unable to do so.

In FY 1966, with emphasis generally as outlined above, the public health program of USOM which now became known as USAID, reached an obligation level of \$26.8 million. Although far below authorized strength, public health personnel levels amounted to 176 direct hire personnel, 27 PASA technicians, and 39 contract personnel. This does not include medical personnel under any of the U.S. military or FWA activities. Most of the total cost was associated directly with provincial hospital assistance and the necessary equipping and logistics involved in that effort.

Over the period of the next two years, 1967 and 1968, with annual budgets similar to that of 1966, numbers of U.S. civilian and military personnel under USAID's public health program continued to grow. Public health assistance was among the largest programs of the U.S. Mission at this time reflecting, of course, the increased tempo of the war especially as growing numbers of U.S. forces were introduced. By January 1968, there were 628 U.S. civilian personnel recorded on project records in public health. This was made up of 319 direct hire, 41 PASA, and 268 contractor personnel. Most of these (449) were associated with the two priority activities, Provincial Health Assistance and Medical Logistics. In addition to U.S. personnel there were 264 Third Country Nationals (TCN) all but 20 of whom were under contract and virtually all of whom were associated with the above two activities. It has been reported that total U.S. and Free World medical personnel assistance peaked in 1968 at over 1,500 people.

Some flavor of the magnitude and importance of providing medical care to the civilian population of South Vietnam at this period, especially when the vast majority of Vietnamese medical personnel had been drafted into military service, can be seen in the attached tables showing hospital admissions

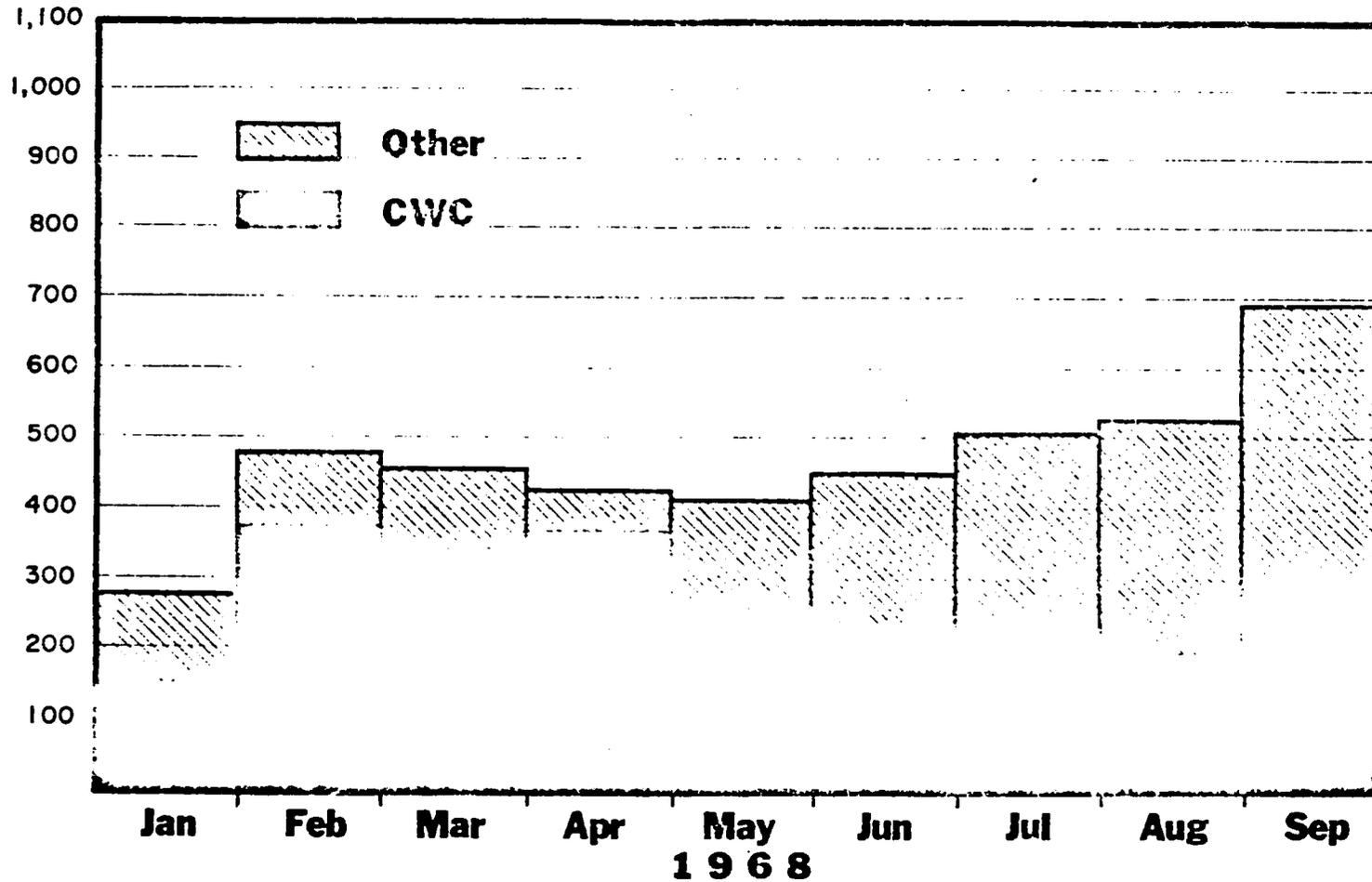
including civilian war casualties for a nine month period from November 1967 through July 1968, and a second table showing civilian occupancy of DOD hospital beds. The figures, of course, reflect only a part of the crushing demand on civilian medical resources since the majority of civilian war casualties were not actually admitted to hospitals but were treated in out patient status whenever possible.

The FY 1967 USAID returned to organizing each of the subactivities which had been consolidated under the Health Development Project into separate projects. Nevertheless, 90% of the funding in public health during 1967 and 1968 was devoted to the Provincial Health Assistance Project and Health Logistics Support (Medical Logistics) Project. The former continued to provide direct medical care to civilians and the latter provided all supplies and equipment maintenance to support that medical care effort.

The massive infusion of assistance provided an extensive capability by the end of Calendar Year 1968. By June of that year a total of 44 PHAP (MILPHAP and FWA) teams were operating in all 43 provinces and the Saigon Prefecture as compared to 30 teams in 28 provinces two years previously. PHAP teams also increased their activities in support of district health centers. Regular support at the district level was provided in 31 provinces just before the Tet offensive as compared to 19 provinces six months earlier. Coverage regressed during Tet, but by the end of 1968 25 provinces were again receiving regular PHAP support in their secure districts. FWA medical teams at that point consisted of the following: two teams from New Zealand, two teams from the Swiss Red Cross, four teams from the Philippines, four teams from Australia, and one team each from Spain, Canada and Iran.

Other activities under the Provincial Health Assistance Project included construction of hospitals and surgical suites, renovation of a number of other

Chart IV
DOD HOSPITAL BEDS OCCUPIED BY GVN CIVILIANS
 Average by Month



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CHART 11SUMMARY OF CIVILIAN WAR CASUALTIES

November 1967 to July 1968

<u>MONTH</u>	<u>Admission to MCH/SWR Hospitals (All Causes)</u>	<u>Admission to MCH/SWR Hospitals (CWC Only)</u>	<u>Admission to DGD Hospitals (All Causes)</u>	<u>Admission to DGD Hospitals (CWC Only)</u>
<u>1967</u>				
November	46,204	4,601	11,109	281
December	37,519	4,790	13,124	314
<u>1968</u>				
January	31,522	5,919	16,265	642
February	29,017	12,139	20,473	694
March	35,370	8,943	18,092	764
April	35,971	6,483	19,295	616
May	39,826	8,944	27,051	688
June	37,836	7,200	22,513	552
July	39,589	5,630	21,698	559
	<u>326,194</u>	<u>64,651</u>	<u>169,820</u>	<u>5,111</u>

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civilian hospitals and health facilities, and the opening of a plastic surgery center in Saigon by Children's Medical Relief International concurrent with construction of a permanent facility at the Cho Ray Hospital. Nursing advisory assistance and health worker training also continued under this project. In addition, construction and renovation of rural dispensaries and maternity centers proceeded, although much disrupted, as was the entire construction program, due to security conditions.

During 1967-68 funding for the Health Logistics Project also skyrocketed, reaching over \$12 million in FY 1968. As noted above, this was the primary support activity for the program in the provinces. The rapid expansion of U.S. and Free World operational assistance necessitated a corresponding increase in the supply of medicines and equipment to support the effort. The Ministry of Health had established a Directorate of Logistics in 1966 to be responsible for construction and maintenance support of all Ministry of Health medical facilities and programs and organizations of supply operations. USAID had supported the progressive development of these activities from the beginning. The Directorate of Logistics came under increasing pressure as the medical program grew and the increase in medical supplies was accompanied by a large U.S. input of operational and advisory personnel to help the Ministry of Health establish its logistic facilities, develop a procurement capability, set up supply procedures, and improve its capabilities in vehicle and medical equipment maintenance and repairs.

To improve rapidly the capability for providing adequate medical commodity support to Ministry of Health facilities and the U.S. and Free World teams working in them, a Department of Defense, AID, and General Supply Agency Agreement was negotiated which authorized USAID/Vietnam to procure the required medical material from the U.S. Army Medical Depot, Ryukyu Islands. This

arrangement was designed to shorten the procurement and shipping time for medical supplies to meet emergency requirements. It also reduced significantly the size of the medical supplies to meet emergency requirements. It also reduced significantly the size of the medical supply pipeline and allowed some reduction of medical supply and equipment inventories which had to be stored in Vietnam.

Under this arrangement, which is documented by a Department of the Army/ USAID Memorandum of Understanding of May 25, 1967, USAID was billed for 50 percent of the value of the medical material at the Department of Army standard price plus an accessorial charge of 22 percent. Army Operating and Maintenance funds were used for the remaining 50 percent of the standard price. This arrangement was to continue until FY 1975.

An additional effort at relieving the mounting pressure on medical care resources during 1968 was the introduction of the concept of joint utilization which came about in the following manner. During the same years that various U.S. and Free World teams were augmenting the Ministry of Health staff, USAID funded a sizeable construction and modernization program at the provincial hospitals as mentioned above. Twenty-nine surgical suites were built, and wards, water, power and sewage disposal were added at eleven major hospitals. In addition, in 1968-69 eight new hospitals were built in remote areas of Vietnam. The Vietnamese military hospitals received almost no attention during this same period. Although they were officially designated as hospitals, they were in reality little more than simple wards. In late 1967, at the request of the Vietnamese surgeon general, MACV considered a proposal for \$18 million to construct a new military hospitals. The proposal was reduced to \$12 million in early 1968.

After the second VC offensive in May 1968, MACV and USAID health advisors

discussed the overall staffing/facilities situation at length. These discussions led to the concept of joint utilization which in simplest terms was the combined use of the military medical staff at the understaffed but physically more sophisticated civilian health facilities. In support of the concept of joint utilization, MACV agreed not to fund the military hospital construction proposal. In August 1968 meetings were informally initiated with military and civilian counterparts. An ad hoc committee was officially tasked by both Defense and Health Ministries in October 1968 to formulate a plan for a unified medical service utilizing integrated facilities in 26 provinces and 187 districts.

The committee submitted three reports to the Ministries of Health and Defense for their approval. The first contained the principles of coordination to be carried out in the jointly utilized facilities and outlined the ward construction program necessary to meet the increased workload in 12 provincial hospitals. A second report outlined logistical support for jointly utilized province/sector hospitals and district/subsector dispensaries. The third report enumerated administrative principles and operating procedures to be used by the integrated facilities.

The three reports were approved by the Ministers of Health and Defense and the Prime Minister. In July 1969 the Military and Civilian Health Coordinating Program (MCHCP) Committee was formed, officially initiating joint utilization. The committee was composed of three members from the MOH and three from the MOD, with the ministers of Health and Defense serving as ex officio members.

This committee set the date of implementation of various phases of the program of joint utilization. The committee not only had the power to make recommendations, but also to issue instructions to the physician, military or civilian depending on seniority, in charge of joint utilization at the

provincial level.

Implementation was to proceed in four phases:

Phase I - assignment of military medical/paramedical personnel to 13 provincial MOH hospitals.

Phase II - construction of additional wards and assignment of medical/paramedical personnel to 13 additional MOH hospitals.

Phase III - assignments of subsector military personnel to each of the 187 district health facilities included in the joint utilization program.

Phase IV - construction of a new hospital in Go Cong Province which is to be operated by the Ministry of Defense but accept both military and civilian patients.

Because of the successful implementation of the joint utilization program, the requirement for MILPHAP Teams was reevaluated during Phase I (September-December 1969) and recommendations were made for 21 percent reduction.

Beyond personnel requirements, certain very basic decisions which affected the so called post war situation were made by adopting the joint utilization concept. Most important of these were: 1) the decision not to construct a separate system of military hospitals, and 2) the decision not to establish a separate military medical logistical system. The initial impact, particularly of the second system, would throw a major burden on the civilian side from the operational and funding point of view. In addition, it should be noted that the program helped to strengthen the civilian government, since most of the hospital directors chosen under joint utilization were civilians, became seniority was the determining qualification. When the system became fully operational, joint utilization was applied to 26 provinces, 187 districts and provided 1,300 new beds and almost 4,000 new military medical and paramedical personnel to care for civilian and military patients.

The Tet offensive in the spring of 1968 marked a highpoint not only of military disruption in South Viet Nam, but also the crisis in medical care and relief of war victims. A high level of assistance continued in 1969 to accommodate the abnormal clinical workload brought on by war injured civilians. Available statistics showed that during the months of the most intense fighting civilian war casualties ran about 12% of all patients admitted monthly to MDH hospitals. This workload taxed already overburdened staff and facilities. Reflecting the ebbing of military action, civilian war casualties during the last quarter of 1969 dropped to a monthly average of 4,000 compared to 6,700 a month during 1968.

In 1969, with the implementation of the joint utilization program, and with reduced level of military activity, personnel and funding levels in public health assistance began to decline. A total of 40 U.S. and Free World medical teams were operating in 43 provinces and the Saigon Prefecture as of June 1969 compared to 43 such teams on year earlier. The U.S. Mission was satisfied that the Vietnamese capability to handle casualty care and to manage the delivery of health services had increased sufficiently to justify this reduction and to continue plans to further phase down medical care assistance. These teams or elements of them had also increased their district health coverage from 75 districts to 97 districts during the same one year period with visits to at least one dozen more two times per week. In addition advisory assistance continued to be provided under the Volunteer Physicians Program with about 150 U.S. physicians serving two month tours between the summer of 1968 and the summer of 1969. These physicians were able to provide specialized skills, e.g., in orthopedics, ophthalmology and public health and give senior leadership to

leadership to MILPHAP teams which were usually composed of young medical officers.

Thus 1969 was a year in which urgent civilian medical care requirements were brought under satisfactory control and gains could be made in upgrading the quality of services. The USAID program began to look more toward renewing its emphasis on advisory assistance and upgrading overall public health services and facilities than on provision of operational personnel to fill the staffing gap in the area of medical treatment. Although the FY 1969 funding level was over \$20 million, personnel levels by the summer of 1969 had fallen to about 150 direct hire, some 30 PASA, 140 U.S. contractor personnel, and around 240 TCNs, most on contract. More traditional project areas began to reemerge. Under the fledgling Public Health Services Project aimed at developing national disease control programs, AID, other donor nations and the Vietnamese government provided vaccines for more than 20,000,000 immunizations during 1969, and the MOH approached its objective of providing district health centers with refrigeration for vaccine storage. Forty-one new garbage trucks were made available to serve the large urban centers. 60 new baby clinics opened in 1969, and three family planning research clinics were added.

The National Institute of Public Health inaugurated its training program in December 1969 with principal advisory and material support from the World Health Organization. Australian and Canadian advisors supported preparation of a site plan and design for a permanent facility.

Meanwhile, the Malaria Control Project sprayed over a half million houses in high incidence areas during 1969 while in Health Logistics, increased MOH staffing eliminated the requirement for a contract to provide TCNs as warehousemen, and construction of 14 warehouses was completed. The Medical and Dental Education Project continued to make meaningful progress. 160 physicians and 23 dentists were graduated from the University of Saigon in 1969. The initial

phase of the architectural and engineering study of the teaching hospital for the Medical Sciences Center has begun, with the GVN funding the local currency portion of the costs. Assistance of counterpart U.S. medical school departments is being provided to four basic science and 11 clinical science departments of the Faculty of Medicine. Six medical faculty members resumed school appointments after having completed long term medical training in the U.S. medical schools, while 21 continued their work in graduate courses. Eleven key members of the faculty of dentistry completed a short study tour of selected U.S. dental schools and related institutions.

1970-1975: Consolidation of gains and a sharply reduced program

The decade of the 1970s began with USAID still funding a public health assistance program of about \$20 million a year. Over half of this funding fell under the Health Logistics Support Project (excluding DOD funding), primarily for purchase of medical supplies and equipment and vehicle and warehousing support. This level of funding made public health easily the largest program of the USAID Mission to Vietnam during the transitional years when the program emphasis returned to longer range development goals. The FY 1971 public health program, for example, consisted of the following nine projects with Population and Family Planning being new that year:

- Public Health Services
- Medical and Dental Education
- Malaria Control
- Medical Care (Provincial Health Assistance)
- Health Logistics Support
- National Rehabilitation Institute
- Public Health Technical Support
- National Center for Plastic Surgery
- Population and Family Planning

The funding level that year amounted to \$19.5 million of which \$11.5 million went for health logistics, mostly medical supplies.

The following fiscal year, with the same program of projects, the USAID

public health budget fell to less than \$12.5 million with Health Logistics still accounting for about half. Health sector assistance was now dropping rapidly due both to more peaceful military conditions and to considerable success in health sector development activities begun much earlier. During the early 1970s, the Vietnamese government's capacity to meet its own health service needs continued to expand. For example, over 200 doctors and 200 nurses and other medical personnel were then being graduated annually. All plans for the health sector anticipated a continuing decline in the level of U.S. assistance. The program that remained was largely an extensive program of medical and dental education, performed under contract by the American Medical Association and the American Dental Association and the continued provision of substantial amounts of medical supplies and equipment for all public hospitals and clinics. Plans were under way to phase these activities out by about FY 1975 and the phase down of most of the other activities in the program was already making rapid progress. Direct hire personnel in USAID's Public Health Division in 1972 numbered about 70 with some four PASAs and another 70 contract personnel. There were in addition still about 120 TCN contract personnel associated with Health Logistics and Public Health Services (disease control programs).

Progress during these years prior to the Communist takeover of South Vietnam was encouraging to most of those associated with health sector development. Civilian war casualty hospital admissions declined by over half from an average of over 7,000 per month in 1968 to 3,350 per month in 1971. By the end of 1972 Vietnamese medical facilities handled 97% of all civilian war casualties despite increasing numbers of hospital admissions for all other causes. By this time under the Joint Utilization Program over 2,000 military medical

personnel were assigned to MOH hospitals caring for civilian war casualties and U.S. and FWA medical teams had been reduced to 22. Voluntary physicians sponsored by the AMA had been reduced from 24 in January 1971 to 15 one year later.

Concurrent with the diminishing requirement for operating medical personnel came the return of longer range programs aimed at establishing self-sustaining development for the MOH in areas which had been bolstered by external assistance. For example, under the medical care project, a hospital administration training program had been launched by the end of 1972, and the National Laboratory System was proceeding rapidly toward its planned FY 1973 completion, with 45 Class A, 15 Class B and 3 Class C laboratories established, 366 trained assistant technicians in the system, and 226 others in training. The U.S. Public Health Service PASA team under the Public Health Service Project was rapidly working itself out of a job by 1972. The previous year, significant reductions were achieved in the incidence of two of the most serious endemic diseases in South Vietnam. Incidence of plague fell 14%, while cholera was reduced 86% to only 239 cases. Sanitation services had been established in 31 provinces during 1972 with the remaining provinces to have systems in operation by June of FY 1973.

During the peak war years, USAID had undertaken a project aimed at assisting the GVN to develop the capability to rehabilitate seriously handicapped persons, both medically and emotionally. Under a contract with the World Rehabilitation Fund, Inc. the National Rehabilitation Institute was established in 19___. One of the principal targets of this project was to achieve the capacity to provide or repair 11,500 prosthetic/orthotic devices annually. By calendar year 1971, a total of over 10,500 of these devices for the physically handicapped had been fitted or repaired at locations in Saigon, Can Tho, Danang and Qui Nhon.

At the same time substantial progress was being made in the in-country production of prosthetic and orthotic devices. The Institute produced over 7,100 devices in 1971, while repairing over 3,400. Much of the hardware and material needed for the production of these devices was by this time being manufactured in country, and self sufficiency in production would be realized before the project terminated in FY 1973. Training in all aspects of this program was an ongoing process.

Finally, the appearance of a Population and Family Planning Project in the early 1970s was further symptomatic of the growing preoccupation with long range development and planning. USAID had provided limited advisory and commodity assistance for family planning since 1969 through the Maternal and Child Health System of the Ministry of Health. This assistance had been funded under the Public Health Services Project. The separate population project was established in 1971 in anticipation of legislative action to remove legal inhibitions to family planning in Viet Nam, which were a legacy of the former French colonial administration. Unfortunately this new project and the government's family planning program achieved only limited success in large part because the political will did not prove to be present to support fundamental change, and the expected legislative action never materialized during the life of the project which was still ongoing at the time of the Communist takeover. Some progress was achieved considering the point at which the program was begun. From virtually none, the number of family planning clinics in 1974 had reached 138. These clinics were located in all 44 province capitals, 75 of the 257 district health facilities and the hospitals of 11 large cities. In addition, official recognition of the importance of family planning did appear to be growing with the passage of time. An interministerial National

Population Council was created in April of 1973 with the Prime Minister as chairman. The objective of this council was to develop a national policy on population and coordinate the activities of the various public and private agencies who would be working in the field. Under the pressure of continuing hostilities, organization of the working groups under this council was much delayed, and a national population plan was never developed.

The three years leading up to the collapse of the program of U.S. aid and the fall of the Thieu government in South Viet Nam saw an extremely reduced level of public health assistance although at this same time planning began on two major new projects which would have reversed the downward trend in public health assistance funding by FY 1976. In FY 1973 the public health funding level was \$9.7 million covering essentially those projects listed above, and in FY 1974 the level was down to \$7.3 million. By FY 1975 the Medical Care Project had terminated as had Malaria Control and the National Rehabilitation Institute Project and Medical and Dental Education was in its next to final year. FY 1975, of which three quarters had passed at the point of program collapse, would have seen an estimated \$4.5 million funding level in public health assistance. However, the new projects, Community and Preventive Medicine and Rehabilitation of the Disabled, were looking toward a combined annual funding level of \$6 to \$7 million beginning in FY 1976. These projects never got past the planning stage.

As calendar year 1974 commenced, the USAID Public Health Division employed 11 direct hire staff and no personnel on loan from other government agencies. In addition there were about 26 people on contract, primarily under the Medical and Dental Education project. One year later, on the eve of the collapse of the Thieu government and the evacuation of U.S. personnel, there were six people in the Public Health Division with some 17 contract personnel remaining

in Medical and Dental Education.

At this point with Medical and Dental Education and Health Logistics Support scheduled for termination in FY 1976, virtually the only program of significance left in public health assistance involved the two new projects still on the drawing boards. It should be noted here that public health was not the only program sustaining severe cutbacks in funding levels during these years. As reported elsewhere in this history of AID programs in Viet Nam, Congressional willingness to support levels of assistance comparable to those of the peak war years had all but dried up. The much reduced public health program of the mid-1970s was an important reflection of the austerity actively being imposed on the overall Viet Nam program by Congress and the resultant struggle within the U.S. Mission to set priorities under conditions of diminishing resources. Under these circumstances public health was not being accorded the priority of more pressing aspects of humanitarian assistance involving relief and resettlement of refugees and child care.

In another and equally important sense the reduced level of funding in public health assistance reflected the considerable success which the program had achieved in the past toward building self sufficient health institutions in South Viet Nam. The Health Logistics Support Project which had grown out of the crushing need to swiftly supply medicine and supplies to war time hospitals in the late 1960s, had sought to institutionalize a system to provide for the immediate commodity and maintenance requirements of the health sector—and do this ultimately without foreign assistance—had largely succeeded in this objective by 1975. In addition, the development of a modern and self regenerating Vietnamese dental education system had been accomplished by this time and the goals of the medical education program were right on schedule.

The medical faculty had reached over 75% of its projected full time strength of 250 and by the end of the program was meeting and exceeding the project target of graduating 200 internationally qualified physicians annually.

At the end of the program USAID was looking toward a new phase in assistance to the health sector in South Viet Nam. As it was being developed by USAID, WHO and MOH experts, the Community and Preventive Medicine project would have sought to focus on preventive health and sanitation primarily at district at lower level throughout rural South Viet Nam. With basic health institutions firmly in place, the project was to concentrate on reducing hospital admissions and expanding health services to reach rural and urban underprivileged populations at a preventive rather than curative stage. In concert with this proposed project a new effort at rehabilitation of the disabled was to be developed in recognition of the continuing problem of reabsorbing handicapped war victims into productive society. The project as proposed was aimed at providing quality treatment and rehabilitative services to amputees, the blind, deaf, and paralyzed throughout the country. Whereas previous assistance (under the National Rehabilitation Institute project) had introduced a physical therapy and rehabilitation program which included the local manufacture, fitting and repair of prosthetic/orthotic devices for the handicapped. This project was intended to expand the program to provide physical as well as social and vocational rehabilitation to disabled war victims. The project would have meant a vast expansion of various rehabilitation institutions in South Viet Nam.

Thus the Communist takeover of April 1975 caught the USAID public health program in a transitional stage. Although much more remained to be done very much had been accomplished. It is clear that the quality of health services and the institutions created during the long American era in South Viet Nam

will in some measure make the quality of life for the average Vietnamese under a Communist regime better than it would have been otherwise. The United States left behind a Viet Nam of substantial resources both human and otherwise. The health sector is no exception.