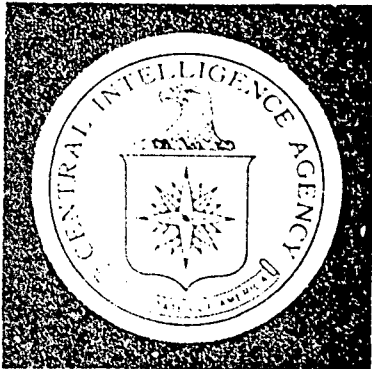


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MEDICAL CARE AND ASSOCIATED PROBLEMS OF THE VIET CONG—A STATUS REPORT

[REDACTED]
Life Sciences Division
OSI/CIA

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SUMMARY AND CONCLUSIONS

Medical support for the Viet Cong combat units has been carried out in the face of almost unbelievable difficulties. In spite of good planning and a well organized system for combat medical services, the Viet Cong is plagued by a lack of sufficiently trained physicians at the various health stations, inadequate transport methods for evacuation of the wounded, inadequate supply of medicines at all stations, and fatalities resulting from infectious diseases endemic to Vietnam. Although the Viet Cong are efficient in evacuating the wounded from the battlefield to the first echelon of medical aid, their greatest deficiency

lies in the slowness of evacuation to areas capable of providing definitive care as evidenced by the killed to wounded ratio of 1:1.2 to 1:1.5 from battle casualties.

As an integral part of operational planning, the Viet Cong make preparations for placing medical facilities in pre-located areas in support of combat missions. Nevertheless, only 50 percent of the wounded can be expected to receive the necessary medical treatment within 24 hours after injury and estimates suggest that between 25 and 42 percent of the wounded have died, most of them enroute to medical facilities.

DISCUSSION

Combat Medical Preparations

It is the responsibility of all Viet Cong unit commanders and their chief medical cadres, prior to launching a combat operation, to organize and prepare facilities to insure the timely evacuation of the sick and wounded. The Viet Cong emphasize this phase of medical service

to provide assurance that the wounded will be treated and to restore the wounded to combat status as soon as possible. In addition, rapid evacuation would deny precise casualty figures to the enemy and deny to the enemy intelligence from wounded Viet Cong. Casualties are removed from the field as quickly as possible by troops or by civilian laborers recruited for that purpose.

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The Viet Cong make elaborate preparations for medical support during combat operations. These can be effected rapidly when an operation involves single small unit actions or a series of them. In major operations, successful medical support is vulnerable due to larger numbers of wounded, enemy interdiction of escape routes, and enemy discovery of fixed medical facilities.

Pre-combat medical preparations are carried out systematically as follows:

(1) Review of the situation and mission using information procured from Chief, Rear Services Echelon;

(2) fix the missions of unit medical sections involved, and prepare to improvise to meet new contingencies;

(3) review TO&E and the status of medical support to be certain that sufficient cadre is available to support the mission. (Supplies usually come from province or district clandestine depots);

(4) the Battalion or Regimental surgeon conducts terrain reconnaissance, selects evacuation routes, and places medical stations in concealed areas;

(5) the surgeon then forwards a Medical Resolution to Chief, Rear Services, that includes a medical preparedness statement, deployment of medical stations, and casualty estimates;

(6) all echelons of the medical service involved in the mission are coordinated and the shortcomings of previous battles are reviewed;

(7) a critique of medical effectiveness follows each operation.

Evacuation and Treatment

The Viet Cong medical chain of command has six levels ranging from platoon (company) aid station to zone hospital. Management of the wounded is effected systematically. The wounded are evacuated by any available means to one of the concealed platoon aid stations where bleeding is controlled, bandages are applied, and bones are splinted. Casualties are then transported by stretcher or other devices to the battalion aid station which contains a first aid cell whose Table of Organization and Equipment (TO&E) calls for three persons including at least one physician. This station is usually located 400 to 2500 meters to the rear of the combat area. Minor wounds are treated in the aid station, and some surgery is performed. The more seriously wounded are then evacuated to the regimental mobile surgical unit where light wounds and shock are treated, and where routine surgery is performed. Post-operative care is given here, with a maximum in-patient time of 15 days. Recuperating patients are carried over jungle trails to a series of Regional or District hospitals of about 10 or more beds each. The regional hospital is primarily a dispensary which handles not only wounded but also the sick—both military and local civilian. In this sense the regional hospital performs a civil affairs functions. The Regional hospitals are in wooden huts hidden in the forest.

The most severely wounded often bypass the regional level and are taken to

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the provincial military hospital with approximately 50 or 60 beds which is located usually in a remote area and well concealed. Here, general medical and surgical facilities exist in underground rooms and blood transfusion can be made. Apparently no whole blood transfusions are available below provincial level due to a lack of power and refrigeration facilities. Long periods of recuperation are handled here, and general medical aid is often given local civilians. The largest hospitals are at the zone level, containing about 100 beds or more, and are equipped for general medical and surgical service as are the provincial hospitals. The only difference appears to be size. Zone hospitals are also hidden in the jungle and contain underground facilities.

The organization works well as long as combat operations go as planned and units are not cut off from the chain of medical facilities. Even when all goes as planned, however, a major weakness exists in the time required for wounded to be "hand carried" to the various levels of medical facilities. According to available information, only about 50 percent of the Viet Cong wounded can receive the necessary medical treatment within 24 hours of being hit.

Evacuation of the Dead

Evacuation of dead Viet Cong is a priority assignment quite independent of the evacuation and care of the wounded. In fact, it is given even higher priority than wounded as a counterintelligence measure. If the slain man's comrades cannot evacuate his body, a combat team

may be made up and sent to do so for security purposes—the possibility of further losses notwithstanding. Burying of the dead is planned in advance of combat operations and is part of the medical pre-operational planning phase. Burying operations are carried out by a Rear Services Medical Station.

Wounds and Diseases

Although some data on Viet Cong/North Vietnamese Army wounds and diseases are available from captured enemy documents, these documents ordinarily refer only to small, individual units, and conclusions drawn from them necessarily must remain somewhat tenuous. The overall ratio of killed in action (KIA)* to wounded in action (WIA) has been estimated at between 1:1.2 to 1:1.5; these reflect the rigors of evacuation by foot and the variable quality of medical care under clandestine conditions. A figure of 3 percent has been mentioned for death during hospitalization. This may be a reflection of the fact that many die—estimated range from 25 to 42 percent—enroute to hospitals. The average hospitalization time for wounded is given as 24 days. Of the 24-day survivors, perhaps as many as 60 percent return to duty in some capacity. Another captured document delineates types of wounds as 28 percent from ball ammunition, 69 percent from shell and grenade fragments, and the remain-

* The KIA figure given here appears to include those troops killed outright and those deceased while in transport to medical facilities. Other VC unit medical reports have separated KIA from "deceased during transport."

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ing 3 percent are unspecified. Severity of wounds according to one Viet Cong breakdown was: 14 percent serious (head, spine, chest, abdomen); 30 percent slight (ambulant). These figures apparently are given for wounds at the time of their occurrence and do not reflect loss of life or worsening of the condition due to delays in evacuation.

Data on diseases among the Viet Cong are not as well developed as for wounds. Malaria appears to be the most prevalent. In highland areas, and in Laos and Cambodia, the average infestation rate is estimated at 32 to 50 percent among Viet Cong with the peak season between April and June, although the incidence occasionally reaches 100 percent in some NVA and Viet Cong units. Falciparum is highest in incidence (20 falciparum to 1 of the other forms) and US casualties from falciparum malaria becomes heavy whenever Viet Cong held areas are taken and occupied. Treatment of falciparum malaria by US medical units is with quinine plus pyrimethamine (amidopyrimidine). Viet Cong treatment up until about August 1967 was by quinine and synthetic antimalarials other than pyrimethamine. Pyrimethamine is now used but amounts are inadequate due to resupply difficulties.

Gastrointestinal diseases is the second most important infectious disease in Vietnam and may infect some 30 percent of the Viet Cong. The primary epidemiological factor here is inadequate sanitation. Respiratory and nutritional diseases are next in incidence but do not represent a major factor in disability.

Plague is always a problem in this area, but few cases are known to have been reported by the Viet Cong.

Although only sporadic figures are available for disease casualties among the Viet Cong, it appears that diseases may be the major cause of morbidity and mortality among both Viet Cong and North Vietnamese Army forces in South Vietnam. The primary reason is that in the South, Viet Cong control over public health conditions is inadequate even though well organized. The conditions have worsened as US combat operations have been stepped up. The necessity of continually moving medical facilities to back up tactical maneuver and the resulting difficulty of logistical support, makes prophylaxis and sanitation increasingly difficult to achieve. The ratio of disease casualties to wound casualties will be clearly adjusted in favor of wounds should NVA and Viet Cong units commence operations on a divisional scale. In such a case medical facilities of both units will be greatly overtaxed since battle wounds generally require longer periods of convalescence.

Supplies and Training

All drugs used by the Viet Cong must be brought into South Vietnam through existing infiltration routes, open purchase in Saigon, captured from US forces, or procured through neutral countries. Most of the medical supplies entering Viet Cong areas via infiltration routes originate in the USSR (2.5 percent); Communist China (2.5 percent), and the Communist bloc countries (3.0 percent) —

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approximate percentages based on captured medical supplies and POW interrogations. These supplies are transported either directly to Hanoi and infiltrated down the Ho Chi Minh Trail to the south, or through Laos and Cambodia to the Viet Cong.

Fixed medical installations have been established throughout Viet Cong operational areas. These installations serve combat casualties and also perform a perfunctory civil affairs function among the South Vietnamese peasantry. Medical training units, semi-permanent paramedical schools, in which Viet Cong medics can be trained have been established—even in areas occupied by US military forces.

Viet Cong medical support bases also exist in Cambodia and in Laos. Recent reports indicate that there are 98 clandestine medical facilities under control of the Pathet Lao ranging in size from 10 to over 100 beds. Approximately 1000 personnel of which less than 5 percent are doctors staff the facilities. The facilities provide medical care to the Pathet Lao military, and civilian personnel in operational areas not secured by the Pathet Lao and presumably also to elements of the Viet Cong. Certain Viet Cong VIPs are reported to have been treated at the French built Calmette Hospital in Phnom Penh after evacuation from combat areas in aircraft owned by French plantations in South Vietnam.

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