*Modern American History* (2019), **2**, 299–320
doi:10.1017/mah.2019.33

CAMBRIDGE
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ARTICLE

# "The Paradise of the Latrine": American Toilet-Building and the Continuities of Colonial and Postcolonial Development

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*The Sanitary Hamlet Program, a rural health project intended to serve counterinsurgency goals in wartime Vietnam, focused on ending open-air defecation and instructing Vietnamese in the correct use of latrines. This program belongs within a larger arc of American nation-building* cum *toilet-building at home and abroad in the twentieth century; American toilet-building shared common features and served common functions from the age of formal empire through the postcolonial era. Looking beyond the rhetoric of modernization to on-the-ground practices reveals how American approaches to international development after 1945 continued to be shaped by racialized perceptions of foreign peoples. But the project was not simply the product of an American neo-colonial impulse. It was also an expression of South Vietnamese leaders' postcolonial worldview—one that similarly targeted unsanitary peasants for hygienic reform.*

At the August 1961 launch of the Alliance for Progress (AFP), the United States' modernization program for Latin America, Che Guevara delivered a scathing attack on American imperialism. Addressing the assembled Latin American dignitaries, Guevara condemned the AFP as nothing but a U.S. scheme to undermine Cuba's revolutionary role in Latin America and to perpetuate Latin American dependence on the United States. In denouncing the AFP, Guevara chose to critique what he perceived as a uniquely American approach to international development. The United States, he suggested, promised only "the paradise of the latrine." It seemed the United States was "thinking of making the latrine the fundamental thing" to improve the social conditions of the poor. Indeed, national economic planning amounted to nothing more than the planning of toilets. Only once the United States had taught the poor how to be clean could they enjoy the benefits of production. "It is a bit like … I do not know," mused Guevara, "but I would almost classify it as a colonial mentality."[1]

Che Guevara was not alone among the famous anti-colonialists of the twentieth century in identifying the links between sanitation and colonial rule. For Frantz Fanon, the colonial state's use of medical science formed part of a larger system of oppression, because a visit from the doctor was usually accompanied by a visit from the army. "The statistics on sanitary improvements," Fanon noted, "are not interpreted by the native as progress in the fight against illness … but as fresh proof of the extension of the occupier's hold on the country." The "native" recognized the value of some of these colonial interventions, but "this good faith is immediately taken advantage of by the occupier and transformed into justification for the occupation." Fanon argued that a

I would like to thank Tanya Harmer for directing my attention to Che Guevara's interest in latrines, Stuart Schrader, members of the NYU U.S. in the World writing workshop, and the anonymous reviewers at *Modern American History*.

[1]Che Guevara, "Economics Cannot Be Separated from Politics," Speech at Punta del Este, Aug. 8, 1961, https://www.marxists.org/archive/guevara/1961/08/08.htm (accessed Aug. 31, 2019).

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https://doi.org/10.1017/mah.2019.33 Published online by Cambridge University Press

radical transformation took place in the areas liberated from France by the Front de Libération National in Algeria. Here, "the problems of hygiene and of prevention of disease were approached in a remarkably creative atmosphere. The latrines recommended by the colonial administration had not been accepted in the *mechtas* but they were now installed in great numbers. Ideas on the transmission of intestinal parasites were immediately assimilated by the people."[2]

Were Guevara and Fanon correct? Did sanitation merely amount to a form of colonial or neocolonial social control? Was Guevara right to suggest that this was a particularly American phenomenon? While Fanon correctly noted that many postcolonial states appropriated these colonial projects upon independence, was it true that these reforms were then embraced by their citizens? Ruth Rogaski has noted that historians of modern biomedicine and public health "have faced two analytical paths: either it brings the desirable benefits of health and modernity … or it is a mode of social control, a coercive force, which, in creating modernity, limits the range of possible expressions of humanity." There is no reason, Rogaski suggests, why it cannot be both.[3] Health education and improved sanitation remain unquestionably positive development goals, but they can also become modes of social control and regulation. Public health systems give states enormous power to intervene in and regulate their citizens' private lives. While many development projects enter the workplace, public health projects enter the home, and, in many postcolonial settings, public health systems allowed new states to build new citizens. In the name of extending health care into the countryside in ways that colonial states had never attempted, governments could create the kind of modern citizens they wanted by determining the way people should cook, eat, clean, dispose of waste, defecate, and reproduce. Such projects were as much about staking the state's claim on the population and establishing the writ, sovereignty, and legitimacy of the postcolonial state in rural areas, as they were about giving citizens a better standard of life. Thus, it is no surprise that in the years after independence, peasant populations sometimes accepted and sometimes resisted the postcolonial state's health interventions.[4]

The Sanitary Hamlet Program in Vietnam, a joint South Vietnamese–U.S. effort, set out to improve rural health and serve the goals of counterinsurgency during the final years of the Vietnam War. The project focused on health education, clean water, and especially latrine construction. The program identified shortcomings in existing Vietnamese defecatory practices and targeted the peasantry—particularly women and refugees—for sanitary reform. The United States and South Vietnamese governments built thousands of toilets in the countryside and sought to educate ordinary Vietnamese in their use. The goal was to forge a new sanitary citizenship that might transform rural life and secure rural dwellers' commitment to the state. Situating this project within a much larger sweep of American engagement in toilet-building at home and abroad highlights the continuities in American approaches to international development from the age of formal empire to the postcolonial era. These continuities appeared not only in rhetoric but also in on-the-ground practices and reveal the blurred lines between domestic and foreign development strategies.

Historians of international development and the history of medicine have identified two major themes in Cold War–era global public health: disease eradication and population

[2]Frantz Fanon, *A Dying Colonialism* (New York, 1965), 122–43.

[3]Ruth Rogaski, "Vampires in Plagueland: The Multiple Meanings of *Weisheng* in Manchuria," in *Health and Hygiene in Chinese East Asia: Policies and Publics in the Long Twentieth Century*, eds. Angela Ki Che Leung and Charlotte Furth (Durham, NC, 2010), 156.

[4]Sunil Amrith, *Decolonizing International Health: India and Southeast Asia, 1930–1965* (Basingstoke, UK, 2006); Liping Bu and Ka-che Yip, eds., *Public Health and National Reconstruction in Post-War Asia: International Influences, Local Transformations* (New York, 2015); John DiMoia, *Reconstructing Bodies: Biomedicine, Health, and Nation-Building in South Korea since 1945* (Stanford, CA, 2013).

https://doi.org/10.1017/mah.2019.33 Published online by Cambridge University Press

planning. Disease eradication programs originated in localized projects in the interwar years but took on a global dimension after 1945. The World Health Organization's preference for top-down technical interventions and emphasis on worker productivity, combined with post-colonial leaders' desires to overcome the failures of colonial medicine, led to global efforts to eradicate malaria, smallpox, and other diseases. Deploying technological rather than disciplinary solutions allowed the WHO to intervene on a large scale without tackling thorny and locally specific cultural or social issues. The results of these efforts were mixed. By 1980, the WHO could declare that smallpox had been eliminated, but the organization had long since abandoned its efforts to eradicate malaria. In any case, technocratic fears in the 1960s and 1970s that improvements in public health in the Third World were priming a "population bomb" shifted the focus of global public health to increasingly coercive population growth control programs.[5]

In examining these two technocentric global health regimes, historians have largely overlooked the politics of sanitation. Alongside disease eradication and population control, American toilet-building as nation-building dated back to the colonial era and continued into the Cold War. But whereas a small number of historians of U.S. colonialism and the Progressive Era have examined the centrality of latrine construction to public health projects in U.S. colonies and at home, historians of U.S. foreign relations have overlooked the continuation of this disciplinary health regime in the postcolonial Global South after 1945.[6] The failure to elaborate on a development approach with both colonial and domestic roots seems a surprising oversight, given the work of historians who identify the roots of the United States's Cold War development projects in the colonial era, as well as scholarship that reveals the overlapping personnel, discourse, and practices of U.S. domestic and overseas development projects in the era of the Great Society.[7] Andrew Rotter has called for historians of U.S. foreign relations to pay closer attention to the ways in which the senses shaped American encounters abroad, and few areas present as promising an area of investigation in this regard as sanitation. Susan Carruthers has taken up this call, highlighting how American soldiers in occupied Europe and East Asia during and after World War II created social and racial hierarchies by recording their disgust at the sanitary habits of people and the conditions of their toilets.[8] Yet no work places U.S. sanitation schemes in a wider chronological and global frame; underscores how sensory perceptions and responses shaped biopolitical reforms on the ground; or

[5]Amrith, *Decolonizing International Health*; Alison Bashford, *Global Population: History, Geopolitics, and Life on Earth* (New York, 2014); Matthew Connelly, *Fatal Misconception: The Struggle to Control World Population* (Cambridge, MA, 2008); Erez Manela, "A Pox on Your Narrative: Writing Disease Control into Cold War History," *Diplomatic History* 34, no. 2 (Apr. 2010): 299–323; Randall M. Packard, "Malaria Dreams: Postwar Visions of Health and Development in the Third World," *Medical Anthropology* 17, no. 3 (1997): 279–96.

[6]In his work on biopolitics in the U.S.-occupied Philippines, Warwick Anderson suggests that aspects of the post-war international health services lie in U.S. colonial projects, though exploring those links lies beyond the purview of his book. This article investigates Anderson's suggestion. Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines* (Durham, NC, 2006), 183–4.

[7]On the colonial-era roots of international development see Michael Adas, *Dominance by Design: Technological Imperatives and America's Civilizing Mission* (Cambridge, MA, 2006); Amanda Kay McVety, *Enlightened Aid: U.S. Development as Foreign Policy in Ethiopia* (New York, 2012); David Ekbladh, *The Great American Mission: Modernization and the Construction of an American World Order* (Princeton, NJ, 2011). On the "Global Great Society," see Stuart Schrader, "To Secure the Global Great Society: Participation in Pacification," *Humanity* 7, no. 2 (Summer 2016): 225–53; Sheyda Jahanbani, "'Across the Ocean, Across the Tracks': Imagining Global Poverty in Cold War America," *Journal of American Studies* 48, no. 4 (Nov. 2014): 937–74; Daniel Immerwahr, *Thinking Small: The United States and the Lure of Community Development* (Cambridge, MA, 2015).

[8]Andrew J. Rotter, "Empire of the Senses: How Seeing, Hearing, Smelling, Tasting, and Touching Shaped Imperial Encounters," *Diplomatic History* 35, no. 1 (Jan. 2011): 3–19; Susan L. Carruthers, "Latrines as the Measure of Men: American Soldiers and the Politics of Disgust in Occupied Europe and Asia," *Diplomatic History* 42, no. 1 (Jan. 2018): 109–37.

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identifies the salience of latrine construction as a tool of empire, governance, and biopolitical reform.[9]

Across the twentieth century, Americans built toilets in starkly different places and in widely varying political, economic, and social contexts. Technologies changed, as did American ideas that vulnerability and resistance to disease were racially determined. But several themes held steady. Reformers always employed hygiene as a marker of difference between themselves and the targets of reform. In the colonial context, the unsanitary habits of the "natives" served to establish hierarchies of race and legitimize colonial rule. In the domestic context, poor sanitation provided the basis for casting the U.S. South and southerners as problematic and diseased. Both populations required modernization. In colonial and postcolonial settings, hygiene became a symbol of difference between new modernizing elites, in whom the United States often found willing collaborators, and their "backward" citizens.

Americans also persisted in the notion that hygienic behavior would produce politically docile and economically productive populations. During the United States's colonial wars and postcolonial counterinsurgencies, health education and sanitation served as a disciplinary force—a tool for pacifying civilians and mobilizing resources. Planners hoped that by attacking the diseases that led to losses in productivity, sanitation projects would raise the targets of reform out of economic backwardness to produce efficient and virtuous citizens. Additionally, from exhibits of sanitary houses in the Philippines to school toilets as beacons of hygiene in the U.S. South, reformers intended that the targets of reform replicate certain structural models. Such models represented a snapshot of the sanitary future on a manageable scale. These models were often all that remained at the end of such interventions, and in less than tip-top shape.

Finally, health education and sanitation appeared to promise the creation of eventually vigorous and self-governing citizens. The state or non-state actor providing the education or facilities might then retreat from its responsibilities. Reformers hoped, or at least claimed, that limited interventions would have profound consequences, laying the ground for long-term, sustainable behavior and infrastructures. And yet these limited interventions, combined with the degradation of models over time and resistance from the targets of reform, gave these projects a decidedly performative sheen. Reformers generally concluded with disappointment that the targets of reform could not overcome their hygienic backwardness.

The Sanitary Hamlet Program reveals the continued linkages Americans drew between sanitation and pacification across the colonial and postcolonial eras. American approaches to sanitation in Vietnam suggest that international development at the height of the Cold War remained grounded in a civilizational discourse and tutelary strategy reminiscent of late colonial development. American judgments about Vietnamese hygienic behavior expose the continued racialization of foreign peoples based on perceived cultural deficiencies. To combat these inadequacies, American development officials debated the relative utility of different types of toilets in the Vietnamese countryside and the most appropriate ways for Vietnamese to dispose of human waste. They viewed sanitation as one tool with which to transform and modernize South Vietnam's rural communities and political identities, believing that intervention in the most intimate spheres of Vietnamese rural life, including everyday practices such as defecation, could help determine the outcome of the war.

The program also demonstrates how postcolonial leaders perpetuated the discourse of the unsanitary subject after independence and, as Fanon noted, continued to implement projects

[9]I am drawing on Michel Foucault's concept of biopolitics as a mode of governance with the management of life as its fundamental objective, including the power to foster certain kinds of life and to allow other kinds of life to die. Foucault notes that such power is diffused through multiple nodes and functions to encourage populations to self-regulate in the field of public health. See Paul Rabinow and Nikolas S. Rose, *The Essential Foucault: Selections from Essential Works of Foucault, 1954–1984* (New York, 2003).

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that reflected their colonial predecessors' assumptions about hygiene and social control. This might appear unsurprising in the case of the Republic of Vietnam (RVN), sometimes dismissed as an instrument of U.S. power. Undoubtedly the RVN, though free from formal imperial control, remained under pervasive American influence. But U.S. policy makers could not choreograph South Vietnamese politics according to their wishes. Nation-building projects were the outcome of U.S. and RVN policy makers' sometimes conflicting, sometimes converging, and sometimes compromising developmental visions. In the Sanitary Hamlet Program, the United States's sanitizing mission coalesced with the modernizing vision of RVN elites. These elites embraced some of the assumptions of the colonial state, including a faith in western biomedicine, but the program was also the product of their views of rural modernity, in particular an essentialist understanding of the Vietnamese village.

## (Com)Modes of Intervention

Although colonial medicine initially focused on protecting white enclaves, the development of the germ theory of disease in the late nineteenth century convinced colonial health officials, albeit slowly and unevenly, that colonizers would remain vulnerable unless medical interventions also targeted potentially diseased "natives."[10] The shift away from theories of miasma and purely environmental explanations of disease to a focus instead on germs facilitated the rise of modern public health, requiring emphases on health education and the targeting of microbes and vectors of disease. During the early twentieth century, the more self-consciously "progressive" colonial powers such as the United States and Japan therefore instituted hygienic reform campaigns in their colonies. Seeing the apparent filth of the colonized as a racial deficiency, divorced from social or economic context, colonial officials began instructing subjects about good hygienic habits, including the use of sanitary latrines. Protecting the health of local labor would allow colonial powers to better exploit the resources of empire, but officials also used the image of the unsanitary "native" to justify the continuation of colonial rule. If these people could not govern their own personal hygiene, colonial authorities and intellectuals reasoned, they very well could not govern their own nations. In contrast with earlier visions of imperial medicine, colonial officials now saw these subjects as capable of change. But only through a process of reform could they become ready for independence. Applying this logic, colonial powers could defer independence indefinitely.[11]

In the occupied Philippines, in a bid to protect the white population and to pacify colonial subjects, U.S. officers extended the logic of military sanitation to the population at large, conducting street cleaning and vaccination campaigns and deploying teams of inspectors to enforce sanitary regulations. As Warwick Anderson notes, Americans became obsessed with the presumed "promiscuous defecation" of Filipinos and demanded that they embrace sanitary reform. Americans aspired to construct toilets throughout the archipelago, but they began by installing permanent sanitary exhibits in many towns. Colonial officials even introduced "privy day," during which Filipinos were expected to build or repair their toilets.[12] The United States was not unique among the colonial powers in this regard. In colonized Korea, Japanese popular writings about Korean hygienic habits established difference between colonizers and the colonized,

[10]David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley, CA, 1993); Mariola Espinosa, "A Fever for Empire: U.S. Disease Eradication in Cuba as Colonial Public Health," in *Colonial Crucible: Empire in the Making of the Modern American State*, eds. Alfred McCoy and Francisco A. Scarano (Madison, WI, 2009), 288–96; Warwick Anderson, "Excremental Colonialism: Public Health and the Poetics of Pollution," *Critical Inquiry* 21, no. 3 (Spring 1995): 640–69, here 645–6.

[11]Anderson, *Colonial Pathologies*; Bonnie McElhinny, "'Kissing a Baby Is Not at All Good for Him': Infant Mortality, Medicine, and Colonial Modernity in the U.S.-Occupied Philippines," *American Anthropologist* 107, no. 2 (June 2005): 183–94; Amrith, *Decolonizing International Health*, 9–11; Arnold, *Colonizing the Body*, 13, 61.

[12]Anderson, *Colonial Pathologies*, 45–129.

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while military-trained "hygiene police" launched aggressive public health campaigns, including home inspections. Failing to reform Korean behavior within their private dwellings, Japanese colonial officials built a network of public toilets in Seoul. But Korean treatment of these public facilities failed to live up to Japanese expectations.[13] Such reforms may have been intrusive, but they were nonetheless extremely limited in scope. Colonial powers could be more easily condemned for neglecting the health of their colonial subjects than for imposing biomedical interventions.[14]

Such programs in the colonial periphery often shaped projects targeting the urban or rural poor in the metropole. The presence of tropical diseases in the U.S. South, for example, made it easier for U.S. reformers to conceptualize the South, along with the colonies, as a problem area, distinct from the rest of the country.[15] Reformers in the South were able to draw on the work of army surgeon Bailey K. Ashford, who had uncovered the link between hookworm disease and anemia during the military occupation of Puerto Rico in the wake of the Spanish-American War. After examining ill peasants' feces, Ashford concluded that anemia was not the product of a poor diet, but instead caused by conditions on the island's coffee plantations in which the hookworm parasite thrived. Lacking toilets, workers practiced open defecation and could ill afford shoes. The hookworm parasite travelled through the soft skin between the toes of barefoot people who encountered the "polluted" soil. Although many peasants embraced the subsequent eradication program, an emphasis on medical treatment rather than sanitary improvements led to high reinfection rates.[16]

Domestic programs similarly served to reinforce hierarchies of race and citizenship. Drawing on Ashford's work, zoologist Charles Wardell Stiles set out to investigate hookworm disease in the American South. Although the disease affected as much as 40 percent of the southern population across all social groups, the prevalence of the disease among poor whites, many of whom practiced open defecation, preoccupied Stiles the most. The pale and bony appearance of sufferers seemed to confirm eugenicists' suspicions of white racial degeneration, but reformers like Stiles believed eradication would secure poor whites' racial fitness, transforming them into productive workers who could attract northern investment. For these reasons, the idea that poor whites shared a common "germ of laziness" with colonized peasants did not last long, because it threatened the racial hierarchies upon which colonialism and Jim Crow rested.[17]

Stiles found a sponsor in the Rockefeller Foundation's Sanitary Commission on the Eradication of Hookworm Disease (RSC), launched in 1909. The RSC posed the problem as one of individual responsibility, rather than social inequities, and aimed to end soil pollution through hygiene education and the construction and proper use of sanitary latrines. Schoolhouses, deemed centers of infection, became "models of modern hygiene" for the surrounding community through the construction of sanitary privies and health education. Reformers faced resistance to sanitary engineering from some local communities and health professionals, but the program significantly reduced infection rates and led to corresponding increases in school attendance, literacy, and income. Stories of recovery invariably pointed to

[13]Todd A. Henry, "Sanitizing Empire: Japanese Articulations of Korean Otherness and the Construction of Early Colonial Seoul, 1905–1919," *Journal of Asian Studies* 64, no. 3 (Aug. 2005): 639–75.

[14]Amrith, *Decolonizing International Health*, 22.

[15]Natalie J. Ring, *The Problem South: Region, Empire, and the New Liberal State, 1880–1930* (Athens, GA, 2012), 3–10.

[16]Jose Amador, *Medicine and Nation Building in the Americas, 1890–1940* (Nashville, TN, 2015), 68–94; Nicole Elise Trujillo-Pagan, "Worms as a Hook for Colonising Puerto Rico," *Social History of Medicine* 26, no. 4 (Nov. 2013): 611–32.

[17]Matthew Wray, *Not Quite White: White Trash and the Boundaries of Whiteness* (Durham, NC, 2006), 98–104; Amador, *Medicine and Nation Building*, 91.

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increased earnings and improved living standards.[18] Narratives of productivity and efficiency also animated the Rockefeller Foundation's International Health Division (IHD), which by the mid-1920s was active throughout Latin America and the British empire. The IHD focused primarily on areas of economic production, dedicating substantial energy to persuading plantation owners to invest in latrines. By the late 1920s, however, the division increasingly shifted its focus away from sanitation toward laboratory research on the etiology of yellow fever and malaria, paving the way for the technologically driven campaigns of the postwar years.[19]

After 1945 Americans continued to form judgments about peoples' fitness for self-rule based on their adherence to sanitary norms. In occupied Korea, Americans were unimpressed by forty years of Japanese reforms. Public defecation, the absence of sanitary facilities, and continued use of night soil convinced many Americans that Koreans were not ready for independence.[20] And Americans continued to build toilets to address these shortcomings. The Institute for Inter-American Affairs (IIAA), a U.S. government agency established as a bulwark against Nazi influence in Latin America but acquiring an anti-Communist rationale after the war, carried out sanitation and disease eradication programs targeting U.S. military bases and workers in raw material–producing areas. By 1953, the institute estimated it had assisted in the construction of almost 40,000 outdoor toilets in rural areas of Latin America.[21] It is hardly a surprise that Che Guevara identified this phenomenon as the central plank of U.S.-sponsored development in the western hemisphere.

Toilets were also a common product of postwar community development projects. Theoretically, this approach empowered local communities to select their own development schemes by consensus and then carry out the projects with the assistance of government workers, using their own labor and funds.[22] But a gap often existed between theory and practice. In model villages in the heartland of the communist insurgency in northeast Thailand, for example, Thai Community Development workers built "shiny new toilets" along main roads without consulting the villagers about their preferences. The toilets provided physical evidence of progress for visiting dignitaries from Bangkok but went entirely unused because they were too far from villagers' homes.[23] Further evidence from Thailand indicated that the message of health education may have been getting through, but it appears that, for at least some peasants, toilets remained a manifestly American product. Resistance to sanitary engineering also developed for practical reasons. Sometimes, a verdant rice paddy simply offered more aesthetically pleasing surroundings. As one Thai farmer told an American doctor:

[18]John Ettling, *The Germ of Laziness: Rockefeller Philanthropy and Public Health in the New South* (Cambridge, MA, 1981), 22–5; Ring, *The Problem South*, 61–76; William A Link, "Privies, Progressivism, and Public Schools: Health Reform and Public Education in the Rural South, 1909–1920," *Journal of Southern History* 54, no. 2 (Nov. 1988): 623–42, here 630–1; John Farley, *To Cast Out Disease: A History of the International Health Division of the Rockefeller Foundation, 1913–1951* (Oxford, UK, 2004), 27–43; Hoyt Bleakley, "Disease and Development: Evidence from Hookworm Eradication in the American South," *The Quarterly Journal of Economics* 122, no. 1 (Feb. 2007): 73–117.

[19]Soma Hewa, *Colonialism, Tropical Disease, and Imperial Medicine: Rockefeller Philanthropy in Sri Lanka* (Lanham, MD, 1995), 40–85; John Farley, "The International Health Division of the Rockefeller Foundation: The Russell Years, 1920–1934," in *International Health Organisations and Movements, 1918–1939*, ed. Paul Weindling (Cambridge, MA, 1995), 203–21, here 218.

[20]Carruthers, "Latrines as the Measure of Men," 18–9.

[21]Wilton L. Halverson, "Health South of the Border," Institute of Inter-American Affairs: Building a Better Hemisphere Series, no. 17, Jan. 1953, document ID: PN-AEC-017, USAID Development Experience Clearinghouse (USAID-DEC); Andre Luiz Vieira de Campos, "The Institute of Inter-American Affairs and its Health Policies in Brazil during World War Two," *Presidential Studies Quarterly* 28, no. 3 (Summer 1998): 523–34; Claude C. Erb, "Prelude to Point IV: The Institute for Inter-American Affairs," *Diplomatic History* 9, no. 3 (July 1985): 249–69.

[22]Immerwahr, *Thinking Small*.

[23]James Jouppi, *War of Hearts and Minds: An American Memoir* (Bloomington, IN, 2011), 124–5.

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> You Americans are strange. Before you came here, if I felt like relieving myself, I found a quiet spot in the open with gentle breezes and often a pleasant vista. Then you came along and convinced me that this material that comes from me is one of the most dangerous things with which people can have contact…. Then the next thing you told me was that I should dig a hole, and not only I, but many other people should concentrate this dangerous material in that hole. So now I have even closer contact with not only my own but everyone else's, and in a dark, smelly place with no view at that.[24]

Although occurring in dramatically differing contexts, American toilet-building performed some similar functions at home and abroad from the early twentieth century to the height of the Cold War. The absence of sanitary facilities among certain populations allowed American reformers to establish or reinforce hierarchies of race and citizenship. The solution, toilet-building, was supposed to serve military, political, and economic goals, pacifying the targets of reform and mobilizing resources. Sanitary models served as exemplars for replication by surrounding communities. Reformers hoped that such models would encourage the targets of reform to govern themselves in the field of public health, though they were frequently disappointed by their subjects' inability to overcome their unsanitary habits. The American War in Vietnam might seem to offer the least likely setting for such a project of biopolitical reform. And yet, during its final years, American development officials and their South Vietnamese allies attempted ambitious programs that followed the same logic that had inspired efforts from turn-of-the-century colonial Philippines to Cold War Latin America.

## The Sanitary Hamlet Program in South Vietnam

American observers of interwar French Indochina placed the Vietnamese in a racialized cultural hierarchy, viewing them as "primitive," "lazy," "unclean," and innately incapable of self-governance. At the same time, they viewed French colonialism as an economic, administrative, and moral failure. In the area of rural public health, French colonial authorities had made limited inroads. Large scale vaccination campaigns during the interwar years, primarily for the purposes of protecting the white population and mobilizing colonized labor, significantly reduced instances of smallpox and cholera, but rural public health services were non-existent and most Vietnamese never encountered western medicine. Americans asserted that as superior colonizers, their civilizing mission in the Philippines was uniquely effective, and that the United States could do a better job than the French in guiding Vietnam out of its backwardness. Despite their dismissal of French colonialism, Americans relied on French Orientalist writings for their information about Indochina, generating a shared Euro-American colonial discourse.[25]

The assumption that the Vietnamese required continued American tutelage implicitly informed American nation-building strategies in South Vietnam after partition in 1954. Through massive military and civilian presence in the country, and huge infusions of economic and military aid, the United States exercised extensive influence, supporting certain political and military personalities, backing coups, and pressuring, cajoling, or advising South Vietnamese leaders to implement their preferred policies. American social scientists and development experts helped uphold American power over the RVN by producing a vast body of knowledge on South Vietnam's problems of insurgency and "underdevelopment," advocating solutions, sidelining alternatives, and paving the way for nation-building interventions. Undoubtedly, the American presence undercut RVN sovereignty, but scholars have revealed

[24]Kees van Dijk, "Soap Is the Onset of Civilization," in *Cleanliness and Culture: Indonesian Histories*, eds. Kees van Dijk and Jean Gelman Taylor (Leiden, 2011), 1–40, here 4.

[25]Mark Philip Bradley, *Imagining Vietnam and America: The Making of Postcolonial Vietnam, 1919–1950* (Chapel Hill, NC, 2000), 46–7; Pierre Brocheux and Daniel Hemery, *Indochina: An Ambiguous Colonization, 1858–1954* (Berkeley, CA, 2009), 204–5, 255–8.

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how the United States nevertheless struggled to dictate South Vietnamese politics, and the extent to which nation-building emerged out of contested and conflicting U.S. and South Vietnamese visions and agendas. Not only were U.S. officials highly sensitive to accusations of neocolonialism, moving them to tread carefully on RVN sovereignty, but also, unsurprisingly, South Vietnamese political and social dynamics predated U.S. intervention and shaped the origins, course, and outcome of the war.[26] RVN elites chafed at their dependency on the United States and viewed development as a means of escaping this condition. For these reasons, RVN and U.S. officials did not march in lockstep with one another. In the realm of sanitation, however, they shared a discourse of modernization, civilization, and social control, in part because RVN leaders accepted some of the premises about hygiene upon which colonial domination had rested. But they blended these universalizing ideas with a particular understanding of Vietnamese history, culture, and needs.

Despite the emphasis on nation-building during the early years of the American War, by the late 1960s the United States and its RVN allies had made little progress in building a public health infrastructure in the countryside. U.S. health assistance to Vietnam began with nursing education programs during the First Indochina War, followed by technical assistance, overseas training programs, and the provision of medical equipment. The World Health Organization also ran a malaria eradication program alongside the South Vietnamese government. Although the United States posted American doctors to provincial hospitals and supported training programs, civilian health services remained critically understaffed and under-resourced. The vast majority of doctors served in the armed forces, while the rest mostly practiced in towns and cities. Rural health stations, staffed by part-time government workers equipped with a medical chest and training manual, became ready targets for insurgent attacks, and rural populations continued to rely primarily on practitioners of indigenous medicine.

As the conflict escalated in the early 1960s, the United States increasingly used health care to serve counterinsurgency goals. Often conducted during "cordon and search" operations, the Medical Civic Action Program (MEDCAP) and Dental Civic Action Program (DENTCAP) provided outpatient care in rural areas while simultaneously training South Vietnamese medical technicians.[27] Troops would surround a village and question military-aged residents while U.S. and Vietnamese medics immunized villagers against common diseases, treated basic medical problems, extracted teeth, and handed out soap and leaflets on hygiene. Military bands and magicians performed as the crowd looked on, sometimes with enthusiasm and sometimes with dismay. One report complained that MEDCAP might have some advantage in convincing locals that "Western magic is more powerful than local magic," but it "represents an inexcusable prostitution of medical facilities."[28] Despite American claims that the program would deliver better health care, the true aim was "psychological rather than medical," focused on winning the loyalty of the rural population by establishing a benevolent government presence in the countryside.[29]

Such piecemeal efforts did not address the poor sanitation responsible for many common illnesses in Vietnam. The Walter Reed Army Institute of Research reported that hookworm disease

[26]Philip E. Catton, *Diem's Final Failure: Prelude to America's War in Vietnam* (Lawrence, KS, 2002); Edward G. Miller, *Misalliance: Ngo Dinh Diem, the United States, and the Fate of South Vietnam* (Cambridge, MA, 2013).

[27]Robert J. Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War* (Lubbock, TX, 2004), 53–61.

[28]"Summary of Certain Observations and Conclusions, Visit of Dr. David McK. Rioch, Director, Division of Neuropsychiatry Walter Reed Army Institute of Research," Mar. 21–Apr. 9, 1964, reel 1, box 1, History Backup Files (II), Papers of William C. Westmoreland, part I, History, Statements, and Clippings File, Roosevelt Institute for American Studies, Middelburg, Netherlands.

[29]"Memo (MACV-IVC-4) - Medical Civic Action Program (MEDCAP) - re: summary of program," Oct. 11, 1967, item no.: 9860104003, folder 04, box 01, John Proe Collection, Texas Tech University-Vietnam Virtual Archive (hereafter TTU-VVA).

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was "almost universal," and dysentery and acute enteric diseases were very common, "reflecting the sanitary conditions and hygienic habits of the population." "Excreta disposal facilities" were inadequate, and most sewage was discharged into rivers.[30] These problems had become even worse in refugee camps where after-care and sanitation were almost non-existent. In many camps, refugees received little or no food, had no access to water, and had inadequate shelter. Where there were toilets, one American observer noted, "people won't use them anyway."[31]

For the American soldier serving in Vietnam, filth was everywhere, and powerful smells were often the first thing GIs noted upon their arrival. Many were struck by the pungent smell of *nuoc mam*, the ubiquitous Vietnamese fish sauce. "The whole country smelled like that," reported Marine Private Bill Hancock. "When you first got over there it was really pungent and really was, kind of an offensive odor to us."[32] Others recoiled at Vietnamese sanitary behavior, and soldiers' comments reveal how Americans continued to place Vietnamese in a racialized hierarchy based on sanitary practices. The people "live like pigs," remarked one soldier. "It's like they're pigmies or Africans or something," exclaimed another soldier. "They're very ignorant. They shit and wipe their ass with their finger. They smell. The villages stink. Stink!"[33] The sight of Vietnamese squatting in fields was particularly disturbing to young U.S. troops. Sven Eriksson, the pseudonymous antihero of Daniel Lang's *New Yorker* feature-turned-movie *Casualties of War*, went so far as to say that the perceived filth of the villagers devalued the American cause in Vietnam: "All that many of us could think … was that we were fools to be ready to die for a people who defecated in public."[34] Some soldiers even feared the deadly potential of Vietnamese excrement. According to some GIs, North Vietnamese and Viet Cong troops employed "shit bombs," produced using ammonia from broken down human waste.[35]

Ironically, the foulest-smelling sites in Vietnam were often American bases and camps. In rudimentary outhouses, soldiers would sit over a hole and defecate into a modified fifty-five-gallon drum below. Soldiers on latrine duty routinely removed the drums and, while stirring the contents, burned the American excrement with aviation fuel or diesel. So appalling was the stench that other "free world" soldiers such as New Zealanders, who employed different means of waste disposal, commented upon the "horrendous practice." The implication, that defecation practices were shaped by context, was evidently lost on American soldiers as they made judgments about Vietnamese. Instead, some units would pool money and outsource the task to a Vietnamese "shit burner," at least one of whom was witnessed conducting the job with a plastic bag over his head to mask the stench.[36]

[30]"Health Data Publications, no. 5 (Revised), January 1966 - The Republic of Viet-Nam (South Viet-Nam) - Department of Health Data, Division of Preventive Medicine," Jan. 1966, item no.: 16090119001, folder 19, box 01, Robert M. Hall Collection, TTU-VVA.

[31]U.S. Congress, Senate, Committee on the Judiciary, Subcommittee to Investigate Problems Connected with Refugees and Escapees, *Civilian Casualty, Social Welfare, and Refugee Proble* [sic], 91 Cong. 1st sess., June 24–25, 1969, item no.: 2391022003, folder 22, box 10, Douglas Pike Collection: Unit 11- Monographs, TTU-VVA, 46; General Accounting Office, *Refugee and Civilian War Casualty Problems in Vietnam- Prepared for Subcommittee to Investigate Problems Connected with Refugees and Escapees of the Committee on the Judiciary United States Senate*, Dec. 14, 1970, item no.: 2223108011, folder 08, box 31, Douglas Pike Collection: Unit 03 - Refugees and Civilian Casualties, TTU-VVA.

[32]"Interview with William Hancock," June 30, 2003, item no.: OH0311, William Hancock Collection, TTU-VVA.

[33]George C. Herring, "'Peoples Quite Apart': Americans, South Vietnamese, and the War in Vietnam," *Diplomatic History* 14, no. 1 (Winter 1990): 1–23, here 12; Christian G. Appy, *Working Class War: American Combat Soldiers and Vietnam* (Chapel Hill, NC, 1993), 129–30.

[34]Daniel Lang, "Casualties of War, an Atrocity in Vietnam," *New Yorker*, Oct. 18, 1969.

[35]Mark Baker, *NAM: The Vietnam War in the Words of the Men and the Women Who Fought There* (London, 1983), 142–3.

[36]"Interview with Kevin Bovill," May 5, 2000, item no.: OH0091, Kevin Bovill Collection, TTU-VVA; "Narrative-DASPO/MACV ArmyAPhoto Teams Meets Odd Events and Execration Jobs," item no.: 10400115003, folder 15, box 01, William Foulke Collection, TTU-VVA.

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Not only the "grunts" believed the Vietnamese filthy. Development professionals, whose job was to assist the U.S. war effort by implementing social and economic improvements, also condemned Vietnamese practices. Larry Flanagan, an officer with the U.S. Agency for International Development (USAID), said, "They have no idea of why a clean market is any better than a dirty market; it's just a market and leaving trash around has been a way of life for who knows how long." For Flanagan, filth was a Vietnamese tradition.[37] GIs found it galling that their South Vietnamese counterparts dismissed American attempts to make improvements in the countryside. One GI recounted how he witnessed a group of South Vietnamese soldiers laughing at American efforts to teach a group of villagers better sanitary practices. These Vietnamese were "so stupid that they [didn't] understand that a great people want[ed] to help a weak people," noted the soldier. "Somebody had to show poor people better ways of livin', like sewer disposal and sanitation and things like that."[38]

Paradoxically, it was only during the period of "Vietnamization" that the South Vietnamese government and its U.S. sponsors attempted to establish a sustainable public health system in the countryside as part of their counterinsurgency strategy. Following the 1968 Tet Offensive, the Johnson and Nixon administrations began winding down the U.S. commitment to Indochina and shifted the burden of fighting to the South Vietnamese military. But the South Vietnamese state's financial and manpower resources were thinly stretched. As the RVN prepared for general mobilization in response to the Tet Offensive, the Ministry of Health (MOH) expressed concern that more medical personnel would be drafted, leading to paralysis in some areas of civilian health. The military, the MOH noted, had nearly its full complement of physicians, pharmacists, and dentists, while the civilian branch had less than 40 percent of its required staff.[39] The military's drain on national resources was such that by 1970 the MOH's operations accounted for just 2.9 percent of the national budget. Minister of Health Tran Minh Tung noted that in most countries this figure was 6 to 12 percent. To compensate for the shortfall, the ministry sought assistance from "free world" countries other than the United States, and in 1970 raised $21 million, more than its projected budget for 1971. Donor countries, however, proved most willing to assist with hospital construction and training programs, leaving little left over for rural health projects.[40]

These shortages affected all areas of nation-building and development, necessitating a counterinsurgency strategy based on local self-sufficiency—an approach that was also in keeping with RVN leaders' understanding of the social, economic, and political function of Vietnam's villages. RVN elites hoped to transform South Vietnam's rural communities into versions of the closed, corporate villages they believed had existed in northern Vietnam's Red River Delta in the precolonial era. They viewed these villages as the essence of Vietnam's pastoral culture and imagined them to have been cooperative, economically self-sufficient, autonomous, and fundamentally democratic, because "power [was] held by the people" and the village notables served the people's interests. Quite possibly a product of Orientalist colonial writings on Southeast Asia, many anticolonial nationalists embraced this understanding. As the Vietnamese migrated south in the seventeenth and eighteenth centuries,

[37]"U.S. Aid Interview #6 with Larry Flanagan, Provincial Representative with Agency for International Development, Region II, Darlac," May 31, 1966, item no.: 0880223001, folder 23, box 02, Larry Flanagan Collection, TTU-VVA.

[38]Loren Baritz, *Backfire: A History of How American Culture Led Us into Vietnam and Made Us Fight the Way We Did* (Baltimore, MD, 1998), 4.

[39]"Ministry of Health's Viewpoint Concerning the General Mobilization Order," Apr. 18, 1968, box 2, Health and Sanitation FY '68, USAID Mission to Vietnam/Public Health Division, Subject Files of the Assistant Director, 1966–1970, RG286, National Archives, College Park, MD [hereafter NARA-II].

[40]"V/v Tong Ket Tinh Hinh Ngoai Vien ve Y Te trong nam 1970" ["Summary of Foreign Aid Situation for Health in 1970"], Dec. 11, 1970, folder 27150, Phu Thu Tuong [Office of the Prime Minister], Trung Tam Luu Tru Quoc Gia II [National Archives Center II, Ho Chi Minh City, hereafter TTLTQGII].

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they had established more scattered settlements and, RVN elites believed, the close-knitted nature of village life had been lost. The villages' essential character had been further undermined by French colonialism and Viet Cong subversion, which had destabilized the spirit of collective responsibility and organizational structures that might have been mobilized against the insurgency.[41] The history of RVN counterinsurgency and development efforts reveals repeated attempts to reconstitute South Vietnam's rural settlements as self-defending, self-governing, and self-developing units.

The restoration of this order appeared more feasible because of the new dynamics of the war in the countryside after 1968. Following the massive and costly North Vietnamese and National Liberation Front (NLF) offensives of 1968, U.S. and South Vietnamese forces launched a counter-offensive that attempted to fill the resulting power vacuum. They spread out into the countryside, establishing a thin network of village security posts manned by local paramilitary forces, often with violent and devastating consequences for the local population.[42] Beyond these security posts, the outlying hamlets in many villages became sites of contested rule, remained enemy-controlled, or were wiped off the map altogether. As with all counterinsurgency operations, this campaign witnessed not only the selective destruction of communities and physical spaces, but also an effort to reconstruct a new political, socioeconomic, and spatial order thereafter. Within these government-controlled spaces, the RVN re-introduced village council elections and launched the Village Self-Development Program (VSDP), a scheme that granted villages funds to carry out popularly selected community development projects. The VSDP aimed to "restore the vitality and the authority of the villages through the democratic activities of the rural people."[43] Amidst ongoing negotiations in Paris and the prospect of a ceasefire-in-place and competitive elections with the NLF, the objectives of these efforts were to stake a government claim on the countryside, restore communal solidarity, and draw villagers into a relationship with the state.

RVN leaders, however, did not subscribe to an entirely idealized vision of the villages. As Minister for Rural Development Nguyen Duc Thang noted, rural pacification would preserve the villages' "fine customs," while eliminating "depraved" ones.[44] Elections and community development projects would restore village autonomy, but some aspects of rural life required modernization. The Ministry of Health assisted with these larger goals of popular mobilization, self-sufficiency, and the modernization of rural behavior. Guided by the government's pacification slogan—"the people act, the cadres mobilize, and the government supports"—these rural health projects would nevertheless eliminate "backward" customs. The RVN Ministry of Health noted that rural people would not overcome their "unsanitary habits" until "their ancient traditions and obscur [sic] superstitions" had been "cleared away from their minds."[45] The RVN not only wished to eradicate peasant superstitions about the causes of illness but, unlike medical authorities in North Vietnam, the state also sidelined indigenous

[41]Nguyen Dang Thuc, *Democracy in Traditional Vietnamese Society* (Saigon, 1961), 5; Jason A. Picard, "'Fertile Lands Await': The Promise and Pitfalls of Directed Resettlement, 1954–1958," *Journal of Vietnamese Studies* 11, nos. 3–4 (Summer–Fall 2016): 58–102; Geoffrey Stewart, "Hearts, Minds and Cong Dan Vu: The Special Commissariat for Civic Action and Nation-Building in Ngo Dinh Diem's Vietnam, 1955–1957," *Journal of Vietnamese Studies* 6, no. 3 (Fall 2011): 44–100, here 62–5.

[42]David Elliott, *The Vietnamese War: Revolution and Social Change in the Mekong Delta, 1930–1975*, vol. 2 (Armonk, NY, 2000), 1145–56.

[43]"Chuong Trinh Tu Tuc Phat Trien Xa" [Village Self-Development Program], Feb. 24, 1969, folder 109, Phu Tong Thong De Nhi Cong Hoa [Office of the President of the Second Republic, hereafter PTTDNCH], TTLTQGII.

[44]Nguyen Duc Thang, *Duong Loi Xay Dung Nong Thon cua Chinh Phu trong nam 1967* [*The Government's Rural Development Policy in 1967*] (Saigon, 1966), 21–2.

[45]"Chuong Trinh Hoat Dong 4 nam (1972–1975) cua Bo Y Te" ["Ministry of Health's Four-Year Program of Activities (1972–1975)"], Folder 3754, PTTDNCH-TTLTQGII; "Guidebook for Setting Up Sanitary Hamlet," Dec. 17, 1970, file 1606-07A Sanitation- 1971 (Part 1 of 2), box 43, MACV, HQ CORDS, MR4/Public Health Div, General Records, 1966- 1972, RG472, NARA-II.

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Vietnamese medical practices from its nation-building agenda. After all, as Van Van Cua, an army medical doctor and instructor at the National Institute of Public Health noted, sanitation emanated from a Euro-American core, beginning with the work of Edwin Chadwick in England and Lemuel Shattuck in the United States.[46] Encouraging rural Vietnamese to defecate in the correct place, embrace germ theory, and dispose of their rubbish in an acceptable fashion thus became part of the mission to force them from tradition to modernity. In this sense, elite South Vietnamese attitudes about the peasantry's hygienic habits mirrored the late colonial discourse of the unsanitary Other.

Yet even as American and South Vietnamese officials attempted to transform hygienic habits in the countryside, they debated the relative merits of existing rural practices. One of the most hotly disputed issues, never resolved, was the use of fishpond latrines. A common feature of the rural landscape, these rudimentary and rickety structures consisted of a wooden platform with a hole jutting out over a pond into which residents would defecate. The fish from the pond were harvested and consumed by the hamlet residents or sold at local markets. Although fishpond latrines were outlawed in a 1956 decree, construction continued unabated. American and South Vietnamese officials by no means concurred on the ban. In some instances, American agencies actively promoted the practice. In 1966, USAID published guidance for setting up fishpond latrines in hamlet schools in the Mekong Delta. The authors noted that "the fishpond latrine has fallen into disrepute because educated Vietnamese consider it to be primitive" and insisted the fish would spread disease. But in the case of rural schools, other forms of toilet had failed to produce the desired results, and fishpond latrines seemed the most practical solution. Over the next several years, USAID officials and South Vietnamese development cadres helped villagers construct many such structures in the delta.[47]

Subsequent investigations by American and RVN officials, however, voiced concern about the health implications of fishpond latrines. Most ponds were connected to nearby rivers and canals, with no control over the sewage flow, potentially contaminating local water supplies. In some instances, when residents harvested the fish, they emptied the pond into a nearby field or stream. The assumption, held by some advocates of the practice, that villagers first "cleaned" the fish by transferring them to another pond for some period of time before they were consumed, proved untrue in more than half the cases observed by one American investigator. Some development officials debated the wisdom of eating fish raised under such conditions, especially as consumers purchasing the fish at local markets may have been unaware of its provenance. These debates also produced a cleavage within the RVN bureaucracy as to whether the ponds could be harnessed toward the government's vision of rural modernity. Ministry of Health officials condemned fishpond latrines as unsanitary, but Ministry of Agriculture planners saw these latrines' potential contribution to increasing protein production in the countryside. Despite these disagreements, the destruction of fishpond latrines would become one of the goals of the Sanitary Hamlet Program.[48]

[46]Van Van Cua, "Vai Tro Y Te, Ve Sinh Cong Cong trong Khuon Kho Phat Trien Quoc Gia" ["The Role of Health, Public Health within the Framework of National Development"], *Phat Trien Xa Hoi trong Khuon Kho Phat Trien Quoc Gia, 19.4.1971–24.4.1971: Tai Lieu Hoi Thao* (Saigon, 1971), 164–5. On Vietnamese medicine, see Laurence Monnais, C. Michele Thomson, and Ayo Wahlberg, eds., *Southern Medicine for Southern People: Vietnamese Medicine in the Making* (Newcastle Upon Tyne, UK, 2012); Mitchitake Aso, "Patriotic Hygiene: Tracing New Places of Knowledge Production about Malaria in Vietnam, 1919–1975," *Journal of Southeast Asia Studies* 44, no. 3 (2013): 423–43.

[47]"Fish Pond Latrines," Apr. 22, 1971, box 43, Sanitation 1971 (Part 1 of 2), MACV, HQ CORDS, MR4/ Public Health Div, General Records, 1966- 1972, RG472, NARA-II; "Fish Pond Latrines for Delta Hamlet Schools- Region IV- Can Tho," Dec. 1, 1966, box 44, Fish Pond Latrines- 1970, MACV, HQ CORDS, MR4/ Public Health Div, General Records, 1966- 1972, RG472, NARA-II.

[48]Joseph E. Higuera, "Fish Pond Latrines," Jan. 11, 1971, box 43, Sanitation- 1971 (Part 2 of 2), MACV, HQ CORDS, MR4/ Public Health Div, General Records, 1966–1972, RG472, NARA-II.

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Fishpond latrines aside, no general agreement about which type of sanitary toilet was most suitable to rural Vietnam existed. As the U.S. and South Vietnamese prepared to launch the Sanitary Hamlet Program, Wilson Adams, the Regional Sanitarian for I Corps, offered some cautionary advice. Experience revealed that rural Vietnamese did not like sheltered pit latrines because they were "odorous and invite fly breeding." Villagers proved more receptive to pour-flush, water-sealed latrines, which could be easily constructed but proved more problematic to maintain. These sheltered, squat latrines featured an S-shaped or "gooseneck" bend in the pipe leading down to the pit, ensuring a small quantity of water always remained in the pipe and acted as a barrier to flies and odors. Unlike pit latrines, the user could not see down into the pit below. However, someone had to frequently replenish the water receptacle, while failure to adequately flush the toilet quickly resulted in "deterioration of conditions to something far worse than the most poorly maintained pit latrine, and a situation which renders impossible the flushing by a conscientious user." Regardless of which latrine was built, Adams noted, rural Vietnamese did not like communal toilets. Family latrines tended to be much better maintained, but this was expensive and, in highly congested areas, including in refugee camps and many rural hamlets, not feasible. Any plan to provide community latrines would require strong leadership by the hamlet chief.[49]

Despite these uncertainties, U.S. and South Vietnamese planners agreed on the broader goal of sanitizing and beautifying South Vietnam's rural hamlets. With this in mind, the RVN launched the National Sanitary Hamlet Program with two pilot hamlets in 1965 and expanded the program into a nationwide campaign in 1969. The program aimed to put an end to open defecation and to instruct villagers in the proper construction and use of toilets, disposal of waste, and establishment of a clean water supply. USAID officials happily reported that this "increased, and real, interest in public health concepts" constituted "the most significant and exciting change" in years.[50] By encouraging villagers to sanitize their communities in a collaborative effort with one another and with the state, the RVN government and its U.S. advisers hoped to forge an anti-Communist identity in the villages and to provide the peasantry with the means to manage its own health care needs. The government chose model hamlets in select areas based on security, the likelihood of local cooperation, and sanitary needs. Residents in other hamlets could elect to voluntarily replicate these efforts and turn their communities into sanitary ones with funds from the VSDP combined with their own money and labor.

Each of the RVN's forty-four provincial health services sent ten employees, including sanitarians and health educators, to attend a four-day course at the National Training Center in Vung Tau. Here, attendees spent mornings studying the purpose and theory of the Sanitary Hamlet Program, including lessons in how to construct latrines. In the afternoons, trainees visited a local hamlet for practical implementation of these ideas. On the first day, trainees were encouraged to visit hamlet families and earn their goodwill. On the second afternoon, trainees jumped straight to the point, informing the families of diseases caused by feces and suggesting that they join the trainees in the construction of a latrine.[51]

[49]"Cam Toai Tay Hamlet Sanitation Survey- Findings and Recommendations," Jan. 21, 1969, box 2, Medical Assistance Training Program Files- Memos/Meetings/Training Aids/Reports, 1969, MACV, Office of Civil Operations and Rural Development Support, MR1 Public Health Division, RG472, NARA-II.

[50]"Preliminary Plan, Rural Health Development, 1966," (undated), box 1, HLS General FY '66, USAID Mission to Vietnam/Public Health Division, Subject Files of the Assistant Director, 1966–1970, RG286, NARA-II; "Public Health Branch," Feb. 1972, box 62, Health Education/Malaria Eradication, CORDS Historical Working Group Files, 1967–1973, RG472, NARA-II.

[51]"Attendance at the Training Course Under the Program for the Creation of Sanitation Hamlets, and at the Vung Tau National Cadre Training Centre," Nov. 6, 1970, Box 31, Sanitation -1970, MACV, HQ CORDS, MR4/Public Health Div, RG 472, NARA-II; "Bang Tom Tat Bien Ban Phien Hop Hoi 10g30 ngay 18-12-70 tai Van Phong Ong Dong Ly Thao Luan Tiep ve Viec Huan Luyen Can Bo Lap Ap Ve Sinh tai Trung Tam Huan Luyen Can Bo Quoc Gia Vung Tau" ["Summary of Proceedings of Meeting at 10.30 on 18.12.70 in the Office

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Having returned to their provinces, these health officials selected hamlets to serve as models and then visited those sites to establish a local Health Protection Committee composed of hamlet leaders. With the assistance of the committee, the health officials would conduct a house-to-house survey to map the sanitary conditions of the hamlet, during which residents would be exhorted to participate in the project. Health services would then attempt to mobilize the people through slogans, loudspeaker broadcasts, and movies, and local teachers would lead hamlet school children in renditions of the sanitary hamlet song. Once the project launched, the health workers would lead the community in the construction of a water-sealed latrine for each home, sanitary wells, garbage pits, and washable concrete marketplaces. Open-air latrines would be destroyed, and residents would conduct a general cleaning of public areas. The people would be immunized against common illnesses such as cholera and plague.[52]

Long Qui hamlet in Tay Ninh province became one of the earliest sanitary hamlets. Government cadres explained the need for better sanitation to the villagers and then solicited contributions of labor and money. With the assistance of a platoon of U.S. civic action troops, they directed the villagers in the drainage of the area to prevent malaria, the construction of 262 water-sealed latrines and wells with cement walls, and instruction in "a concentrated cleaning effort in homes, kitchens, pigsties, etc." Upon completion, U.S. observers reported, "many health hazards had been removed." The program promised not simply medical benefits. It had also "led to [a] more attractive hamlet and a sense of community spirit."[53] Improvements would make residents healthier, but also, by making the villages more aesthetically pleasing, the sanitary hamlets appealed to the sensibilities of U.S. advisers and urbane Vietnamese officials. The mass mobilization of villagers for the public good forged stronger community links. Hygiene would therefore serve the goals of counterinsurgency.

South Vietnam's refugee population became one of the principal targets of the program. These refugees had been driven into camps by an often-deliberate U.S. and South Vietnamese military strategy. In a 1968 memo, U.S. military commander William Westmoreland noted that eliminating revolutionary forces from the villages was "very time consuming," but removing the people upon whom those guerillas relied "can be carried out relatively quickly." As a result, at least one-third of the South Vietnamese population registered as refugees at one time or another between 1965 and 1972.[54] During the early years of the U.S. intervention, there seemed to be no contradiction between population displacement and health care in the minds of U.S. and South Vietnamese military planners and policy makers. As a captive, dependent population, and despite the general lack of sanitation in the camps, refugees presented an ideal target for disease eradication. Mobile health teams visited the camps and administered vaccinations, rising from 4.1 million nationwide inoculations in 1964 to 27.8 million in 1968.[55] However, as Warwick Anderson notes, immunization programs do not give states the same regulatory power over citizens' bodies as do campaigns of hygienic reform. A state can immunize its people, but they would not become modern, disciplined citizens until

of the Director of the Cabinet to Discuss Cadre Training to Establish Sanitary Hamlets at the Vung Tau National Training Center"], Dec. 23, 1970, folder 2089, Bo Y Te [Ministry of Health], TTLTQGII.

[52]"Guide Book for Setting Up Sanitary Hamlet," Dec. 17, 1970, box 43, Sanitation-1971 (Part 1 of 2), MACV, HQ CORDS, MR4/Public Health Div, RG 472, NARA-II.

[53]"UN [sic] Bulletin: Self-Reliance," July 1, 1971, item no.: 2131806129, folder 06, box 18, Douglas Pike Collection: Unit 02 - Military Operations, TTU-VVA; "Recommendation for the Award of the Meritorious Unit Commendation," May 18, 1971, 2nd Civil Affairs Company (1 of 2), 1971 Meritorious Unit Commendations, Vietnam Service Awards, RG472, http://www.fold3.com/image/#269639814 (accessed Aug. 31, 2019).

[54]Gregory A. Daddis, *Westmoreland's War: Reassessing American Strategy in Vietnam* (Oxford, UK, 2014), 107–8; Thomas C. Thayer, *War Without Fronts: The American Experience in Vietnam* (Boulder, CO, 1985), 221.

[55]E. A. Vastyan, "Civilian War Casualties and Medical Care in South Vietnam," *Annals of Internal Medicine* 74, no. 4 (1971): 611–24.

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they began to follow modern hygiene and sanitation practices.[56] The RVN Ministry of Health noted that immunization efforts were "less important" than environmental sanitation and health education for the very reason that immunization did not require "the support of the population." Popular acceptance of environmental sanitation and health education, unlike immunization, provided a yardstick by which government officials could measure rural political identities and acceptance of the government more generally.[57]

With relatively improved security in the countryside after 1968, the RVN encouraged and incentivized urban-dwelling peasants and refugees to return to rural areas. As USAID director John Hannah observed, these refugees needed to be integrated into a national political community. The goal of the Return-to-Village (RTV) program, Hannah said, was therefore "to move these war victims out of the status of refugees and back into the status of normal citizenship."[58] The director of the U.S. mission's Refugee Directorate, William Hitchcock, claimed that by combining the RTV program with community development, the program would transform refugees into "viable and willing members of an essentially participant society."[59] In 1971, the RVN decided to establish sanitary hamlets at all RTV and resettlement sites. It combined refugee resettlement with the Sanitary Hamlet Program to shape a new rural citizenry. By encouraging de-urbanization, community development, and hygienic reform, government planners expressed a vision of rural modernity that tied hygiene and sanitation to political stability.

Mobile health teams visited the refugee groups targeted for resettlement, screening them for TB, dysentery, parasites, and skin conditions, treating suspected cases and immunizing others. When the teams detected malaria, they carried out "a radical one-day treatment" of the entire group, and, in instances of infestation, the teams conducted thorough delousing. The target group was then subjected to two weeks of intensive health education with health workers employing loudspeakers, leaflets, films, and demonstrations. Finally, within the new communities, under the supervision of government cadres and American advisers, the resettled refugees constructed sanitary facilities. Rural health teams then made periodic follow-up visits to conduct health education "on a lower level of intensity."[60] Such education sought to transform a rural culture in the shortest possible time, allowing the state to retreat from health care responsibilities. As the RVN's 1972–1975 Four Year Economic Plan stated, health education would produce "a self-reliant public health system."[61] Once educated, a self-regulating citizenry would have minimal health care needs and would place less of a burden on precious state resources. Instead, they would become productive members of the community, dedicated to the anti-Communist cause. The now resettled refugees, one assumes, must have wondered why, if sanitation was so important, the camps and reception centers had been so filthy.

The Sanitary Hamlet Program also reflected and reinforced international development's gendered and Eurocentric assumptions about male productivity and female reproduction, as well as those about women's role in homemaking and hygiene. The theoretical development literature of the 1950s and 1960s rarely discussed women's role in economic development, but projects like the Sanitary Hamlet Program did target their role in the home.[62] These gendered assumptions

[56]Warwick Anderson, "Immunization and Hygiene in the Colonial Philippines," *Journal of the History of Medicine and Allied Sciences* 62, no. 1 (Jan. 2007): 1–20.

[57]"Guidebook for Setting Up Sanitary Hamlet."

[58]U.S. Congress, Senate, Committee on the Judiciary, Subcommittee to Investigate Problems Connected with Refugees and Escapees, *Civilian Casualty, Social Welfare, and Refugee Proble* [sic], 91 Cong. 1st sess., June 24–25, 1969, item no.: 2391022003, folder 22, box 10, Douglas Pike Collection: Unit 11- Monographs, TTU-VVA, 10.

[59]Louis A. Wiesner, *Victims and Survivors: Displaced Persons and Other War Victims in Viet-Nam, 1954–1975* (Westport, CT, 1988), 212.

[60]"GVN Refugee Resettlement Plan," Aug. 1971, item no: 2321607004, folder 07, box 16, Douglas Pike Collection: Unit 06 - Democratic Republic of Vietnam, TTU-VVA.

[61]*Four Year National Economic Development Plan, 1972–1975* (Saigon, 1972), 226.

[62]Jane L. Parpart, "Who Is the 'Other'?: A Postmodern Feminist Critique of Women and Development Theory and Practice," *Development and Change* 24, no. 3 (July 1993): 439–64.

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seemed particularly misplaced in wartime Vietnam. While Vietnamese women had always been involved in agricultural labor, by the early 1970s the war had drained male labor off the land, and women were increasingly responsible for farm work. Government surveys of several villages in Ben Tre province in 1971 revealed that women comprised between 60 and 77 percent of agricultural workers between the ages of sixteen and sixty.[63] Despite this, or perhaps because of the demands agriculture placed on female labor at the expense of homemaking, many development projects attempted to foster female domesticity and assigned women a role in rescuing their families from what development workers perceived as ill health, squalor, and offensive surroundings.

The Sanitary Hamlet Program emerged as the most sustained effort in a line of projects targeting women's role in hygienic reform. Beginning in the 1950s, female home economics agents with the RVN's National Agricultural Extension Service met with village women in their homes to discuss personal hygiene, sanitation, childcare, and nutrition. They also offered tips in how to create "well-arranged, convenient, well-ventilated, and attractive homes." Girls were drafted into 4-T Clubs, Vietnam's equivalent of the 4-H rural youth clubs founded in the United States in the early twentieth century and exported to dozens of countries in the early Cold War.[64] As Gabriel Rosenberg has argued, the 4-H clubs reinforced a gendered division of rural labor in which boys focused on revenue production and girls focused on household management and beautification. In Vietnam, while a small number of girls joined boys working on crop improvement and livestock projects, home economics agents led all-female 4-T home improvement clubs, focusing entirely on nutrition, food preparation, and sewing.[65]

The new sanitary hamlets also served as a target of intervention for the Community Health and Population Studies (CHAPS) program, conceived by USAID as a means of surreptitiously spreading information about family planning at the village level. A French-colonial-era law prohibiting contraception remained on the statute books in South Vietnam, and while MOH officials and civil society groups lobbied resistant legislators to overturn the law, the government implemented a limited family planning program. The CHAPS program trained workers to live with peasant families and stimulate competition in household improvement within villages. Many of the urban-dwelling workers "had never imagined the complete disorder and lack of even rudimentary sanitary facilities that prevail in the peasant home." Indicating the importance of aesthetics and sense of propriety to American and urban Vietnamese biopolitical reforms, workers also encouraged families to put up curtains separating sanitary facilities from the rest of the home, which would hopefully in time be succeeded by a separate, tiled room. These changes could only be implemented within the economic means of each family, providing an opportunity for CHAPS workers to inform villagers that fewer children would mean more money to invest in the family's health. In time CHAPS workers were phased out and replaced by local leaders, including village midwives deemed to have readiest access to the home. The program was also scaled up from the home to the marketplace, schools, and local government buildings. One village leader noted that the program had instilled so much civic pride in his village that local farmers had stopped spitting on the floor of the town hall. As the Sanitary Hamlet Program expanded, sanitarians and health educators working on the project also received CHAPS training in family planning promotion techniques.[66]

[63]David W. P. Elliott, *The Vietnamese War: Revolution and Social Change in the Mekong Delta, 1930–1975* (New York, 2003), 372–4.

[64]"Completion of Tour Report: Alice E. Smith, Home Economics Advisor, Agricultural Extension, ADDP/USAID/Vietnam," Mar. 19, 1970, box 12, End of Tour Report –ADM (1-3)- 1970, MACV, HQ CORDS, MR4/New File Dev Div, Agr Br, RG472, NARA-II.

[65]Gabriel N. Rosenberg, *The 4-H Harvest: Sexuality and the State in Rural America* (Philadelphia, 2016); "4-T Programs in Vietnam, 1955–1970," Mar. 21, 1970, box 6, End of Tour Report - ADM (1-3)-1970, MACV, HQ CORDS, MR4/New File Dev Div, Agr Br, RG472, NARA-II.

[66]"Community Health and Population Studies Workers," July 1, 1970, box 14, Pacification Plan 1970, MACV, HQ CORDS, MR4/New File Dev Div, Agr Br, RG472, NARA-II.

https://doi.org/10.1017/mah.2019.33 Published online by Cambridge University Press

Like so many counterinsurgency schemes in Vietnam, the gap between design and practice proved one of the primary shortcomings of the sanitary hamlets. In 1971, the MOH ordered each provincial health service to select three model hamlets that would act as beacons of hygiene for surrounding hamlets to replicate through the VSDP. Each province received a small grant for each of the three hamlets. Cadres would then mobilize the local population to contribute additional money and labor for the construction of sanitary facilities, which MOH officials estimated would take 45 days.[67] In practice, the government and U.S. advisers poured resources into some model hamlets that others could not hope to receive, while construction projects often took several months to complete.

The hamlet of Ong Huong near Bien Hoa provides an illustrative example. The RVN chose Ong Huong as a model because of its size, population of over 2,000 people, and proximity to water sources. The project began with U.S. advisers providing transport for 100 students to assist Ong Huong's residents "in a beautification effort." These advisers then helped residents construct 100 garbage pits, 20 animal pens, and 113 water-sealed latrines at a total of 1,500 man hours. They built a dam, which washed out twice before a permanent structure could be completed, and a slow-sand filter to treat raw water into potable water. The latter proved a "major undertaking," which required well over 2,000 man hours and the assistance of the local Popular Forces platoon. Local carpenters and laborers, with U.S. engineers overseeing the task, took five months to build a water tower with a 5,000-gallon tank mounted on top. The water was treated with calcium hypochlorite and the villagers installed two diesel pumps. The U.S. unit responsible for aiding the project reported that water-borne communicable diseases would be eliminated from the hamlet and that the potable water supply "has encouraged the local populace to continue good sanitation habits."[68]

For the Ministry of Health, health education had the power for the wholesale transformation of rural society. The Sanitary Hamlet program was not just a model for better health in the countryside, but the first step toward rural modernization in all areas. MOH planners noted that the program provided a model for other government ministries in the same way that the sanitary hamlets provided a model for unsanitary hamlets. As the model hamlets proliferated, all hamlets would become sanitized. The next step would be an Agricultural Hamlet in which farming methods would be modernized, followed by Education Hamlets aimed at "expanding culture."[69]

Ong Huong served as one of these showcases; public health officials visited the hamlet to see the latrines, wells, and slow sand filter.[70] Officials hoped that residents of surrounding hamlets would be so inspired that they would vote to implement projects to sanitize their own hamlets through the Village Self-Development fund. But the cost of the Ong Huong project totaled VN $350,000, plus the donation of surplus American supplies and well over 3,500 man hours. U.S. engineers estimated that a slow sand filter could cost up to VN$1,115,000 including materials and labor.[71] Surrounding hamlets, inspired by beautified Ong Huong, would therefore be hard pressed to match this effort. Under the VSDP, the government contributed VN$1,000,000 to

[67]"V/v Cap Kinh Phi de Xu Dung vao Viec Thiet Lap cac Ap Ve Sinh" [Finance for use in the establishment of Sanitary Hamlets'] Feb. 13, 1971, folder 2098, Bo Y Te, TTLTQGII; "GVN Refugee Resettlement Plan"; "Ty Y Te Kontum- Ke Hoach Lap Ap Ve Sinh, 1971" ["Kontum Health Service- Plan to set up Sanitary Hamlets, 1971"], Feb. 5, 1971, folder 2098, Bo Y Te, TTLTQGII.

[68]"MACV/CORDS Advisory Team 98 Accomplishments," May 13, 1972, Civil Operations and Rural Development Support, Military Region 3 And Its Assigned Units, 1970–1972, Meritorious Unit Commendations, Vietnam Service Awards, RG472, http://www.fold3.com/image/#268892424 (accessed Aug. 31. 2019).

[69]"Guidebook for Setting Up Sanitary Hamlet."

[70]"Report for Week Ending November 7–13, 1971," Nov. 16, 1971, folder 1601-03 PH General 1971, box 36, MACV, HQ CORDS, MR4/Public Health Div, General Records 1966–1972, RG472, NARA-II.

[71]"Engineer Cost Estimate – Slow Sand Filter Water System," Apr. 30, 1971, file 1606-07A Sanitation- 1971 (Part 1 of 2), box 43, MACV, HQ CORDS, MR4/ Public Health Div, General Records, 1966- 1972, RG472, NARA-II.

https://doi.org/10.1017/mah.2019.33 Published online by Cambridge University Press

every village that held elections, but these funds, in principle, had to be shared among several hamlets.

Throughout the war, Americans and their South Vietnamese counterparts developed a series of surveys to measure the impact of pacification programs on the political identities of the population. As one CIA report stated, "this is almost impossible."[72] When it came to the sanitary hamlets, however, U.S. personnel discovered a way to measure the more quantifiable benefits of the program. The primary indicator of whether sanitation had improved in the newly upgraded hamlets was the level of intestinal parasites in the local population before and after sanitary improvements had been made. Americans were assisted in this task by members of the Korean Preventive Medicine (KOPREM) team, for whom the war in Vietnam provided a useful training ground for South Korea's own battle against parasites.[73] In Military Region III, KOPREM members, as well as the Parasitology Department of the U.S. 9th Medical Laboratory, provided diagnostic services for parasitic diseases, collecting water and fecal samples and taking them back to the lab where they determined the levels of parasitic infection in the newly sanitized villagers.[74] Rather than being a program that "reaches into the very heart of the hamlets" as one senior U.S. adviser claimed, it was in fact a program that reached into the bowels of the hamlet.[75] Almost sixty years earlier, during a cholera outbreak in the Philippines, American scientist E. L. Munson had conceded that American feces collection amounted to "an invasion of the accepted rights of the home and of the individual on a scale perhaps unprecedented for any community."[76] If modern sanitation meant the rather humiliating process of foreigners coming into your home and inspecting the contents of your new toilet, one can imagine that at least some peasants felt ambivalent about the program. Some newly sanitized villagers simply expressed amusement: "Every three days or so," one said, "there is a group of Americans who come to see the toilets."[77]

The Sanitary Hamlet Program aimed to abolish existing hygienic practices and force the peasantry to modernize. As a corollary, the villagers, seeing visible improvements in their standard of living, could be more easily co-opted into the government's support base. In some cases, government health cadres reported that villagers embraced the program. In the summer of 1971, government cadres brought the program to Tan Thanh 3, a hamlet of 900 farm people in An Xuyen province. Families in the hamlet had no sanitary or garbage disposal facilities or potable water and relieved themselves in the rivers and fields. In spite of the challenges of establishing a sanitary hamlet here, government cadres praised the cooperation of the people. Heavy rains slowed progress, and the agricultural calendar meant that government cadres could meet with the people only after they had finished work. Nonetheless, within three months, villagers had constructed 107 toilets and 132 garbage pits under the guidance of the hamlet health committee. One poor farmer, Mr. Lam, even singlehandedly constructed a goose-neck toilet entirely from cement. Cadres noted the "technical shortcomings" of the finished product but identified Mr. Lam's enthusiasm for the program as evidence of local support.[78]

[72]"The Pacification Effort in Vietnam," Jan. 18, 1969, frame 0547, reel 7, CIA Research Reports: Viet Nam and Southeast Asia, 1946–1976, RIAS.

[73]Mark Harrison and Sung Vin Yim, "War on Two Fronts: The Fight Against Parasites in Korea and Vietnam," *Medical History* 61, no. 3 (July 2017): 401–23.

[74]"Activity: Public Health, Reporting Period from 21 March to April 21, 1970," box 5, M/R Nursing Folder 1, MACV, HQ CORDS/Military Region 3, Public Health Division, RG472, NARA-II; "Tasks Performed," Aug. 19, 1971, 9th Medical Laboratory, 1970–1971, Meritorious Unit Commendations, Vietnam Service Awards, RG472, NARA-II, http://www.fold3.com/image/#269629473 (accessed Aug. 31, 2019).

[75]"End of Tour Report – DEPCORDS II CTZ – Mr. James Megellas," May 19, 1970, box 22, End of Tour/J. Megellas, CORDS Historical Working Group Files, 1967–1973, RG472, NARA-II.

[76]Anderson, "Excremental Colonialism," 646.

[77]Gloria Emerson, "Vietnam Hamlet a Sanitary Model," *New York Times*, Oct. 12, 1970, 14.

[78]"Ban Tuong Trinh ve Ket Qua Cong Tac Lap Ap Ve Sinh tai Tan-Thanh 3 cua Ty Y Te An Xuyen," undated, box 43, Sanitation-1971 (Part 1 of 2), MACV, HQ CORDS, MR4/Public Health Div, RG 472, NARA-II.

https://doi.org/10.1017/mah.2019.33 Published online by Cambridge University Press

But the evidence suggests it was not so easy to transform a rural culture, and peasants did not always respond as the government hoped. In Buu Son district in the central coastal province of Ninh Thuan, the provincial health services had to abandon attempts to establish a sanitary hamlet at Dac Nhon because the people had failed to respond satisfactorily to the cadres' exhortations to sanitize themselves.[79] If the residents of one of the three hamlets that the provincial services had identified as a potential model site did not embrace the program, it did not bode well for those hamlets that were supposed to voluntarily adopt MOH guidelines. Even where the government could establish sanitary hamlets, villagers often had practical reasons for not always meeting the government's expectations. The toilets, mused a resident of one of the newly sanitized model hamlets, were "good at night but in the day time" when people were working they "still prefer the rice fields or the river banks."[80] As a result of the population relocation that had made the construction of the sanitary hamlets possible, many peasants now lived kilometers from their fields; they were therefore unlikely to venture home to relieve themselves. Further evidence indicated that villagers may have accepted the sanitary upgrade, but the true focus of their concerns lay elsewhere. The village councils in three adjoining villages in Chau Doc province used the occasion of a sanitary hamlet dedication ceremony to pass a petition to a U.S. public health worker. Addressed to the RVN President, Prime Minister, and the National Assembly, the petition made no mention of the recent sanitary improvements. Instead, the councils requested that the government dredge the local Vinh An Ha canal. Such an action would improve livelihoods of 30,000 people by boosting agricultural production and transportation. These village leaders also appeared to turn the language of sanitation against the government, noting that the shallow and dry canal meant the people's "eating and drinking [are] unsanitary."[81]

The model sanitary hamlets cost significantly more than the government was capable of contributing elsewhere. With the expectation that neighboring hamlets would replicate these construction efforts, the MOH held those peasants to standards of hygiene with which they were previously unfamiliar and that their economic status did not allow them to achieve and maintain. Even within the model sanitary hamlets, serious problems emerged. The government expected these villagers to maintain certain levels of hygiene and sanitation, but rather than encouraging self-sufficiency, the government had built complex sanitation works, such as slow sand filters, which the villagers could not maintain without government assistance. Some U.S. advisers complained that RVN officials had overemphasized the physical infrastructure of the hamlets to the detriment of continuous health education, evidence perhaps that the aesthetics of the project had actually outweighed disease prevention.[82] But it was also the case that manpower and resources for maintenance and health education remained critically deficient.

By the end of 1971, there were 141 sanitary hamlets throughout the country, and the MOH planned one hamlet and one fully sanitized village in each of the country's 257 districts by the end of 1973.[83] Foreign advisers expressed some skepticism and wondered whether the RVN

[79]"Ty Truong Ty Y Te Tinh Ninh Thuan kinh goi Ong Giam Doc Nha Nhan Vien va Tai Chanh Bo Y Te, v/v Xin Uy Ngan Lap Ap Ve Sinh nam 1971" ["Province Health Services Chief, Ninh Thuan to Director of Personnel and Finance Directorate, Ministry of Health, Request for funds for establishing Sanitary Hamlets in 1971"], Mar. 10, 1971, folder 2098, Bo Y Te, TTLTQGII.

[80]Emerson, "Vietnam Hamlet a Sanitary Model."

[81]"Petition from the Inhabitants in 3 Villages, Long Phu, Phu Vinh (Tan Chau) and Chau Phong of Chau Doc Province, for the Redredging of Vinh An Ha Canal," May 14, 1971, box 44, Sanitation 1971 (Part 1 of 2), MACV, HQ CORDS, MR4/Public Health Div, RG472, NARA-II.

[82]"Public Health Activities: 1 December through 31 December 1971," Dec. 30, 1971, box 33, Community Health Specialist-1971, MACV, HQ CORDS, MR4/ Public Health Div, General Records, 1966–1972, RG472, NARA-II.

[83]John Kennedy, "Public Health Services," Dec. 6, 1973, document ID: PD-AAF-587-D1, *USAID-DEC*; "Chuong Trinh Hoat Dong 4 nam (1972–1975) cua Bo Y Te."

https://doi.org/10.1017/mah.2019.33 Published online by Cambridge University Press

could sustain the effort. For KOPREM leaders, who had wrapped up their mission in 1970, Vietnam had revealed the limits of health education in rural Asia, and, in part due to this experience, medical treatment became the South Korean state's preferred method for dealing with parasitic infection at home.[84] American officials remained somewhat more optimistic, though they also anticipated the need for continued tutelage. In Congressional testimony in April 1972, Robert Nooter of USAID said that preventive health care was "new to [the South Vietnamese]. I hesitate to say they are ready to take over that whole field," but the Sanitary Hamlet Program at least illustrated the RVN's attempt to focus on long-range planning.[85] On the ground, American officials expressed similar sentiments. "It would be unrealistic to assume that the Vietnamese are prepared … to take over and effectively operate their own programs in this field," noted one senior adviser.[86] It seemed to John Ely, the director of U.S. public health efforts in Military Region IV, that educated Vietnamese understood the need for potable water, but "the chances of motivating the hamlet peasant to treat his drinking water are very slim." It would be better to concentrate on educating first graders in the hope that the next generation would have "sufficient knowledge." The Vietnamese would "need continuing advice … for many years to come."[87] By 1975, the total number of sanitary hamlets had risen to 275, many of which had more than 1,000 residents. However, in their final analysis, USAID ruled the sanitary hamlets a "crash program" that served no long-term value. The peasantry was apparently interested and keen to dedicate time to completing projects, but, given the dearth of sanitary agents and health education officers, "the people soon reverted to their old habits."[88]

## Conclusion

Despite the deliberate hyperbole of his 1961 speech, Che Guevara had voiced a valid critique of American developmentalism in the twentieth century. Toilet-building indeed formed a significant feature of U.S. plans for the modernization of "backward" parts of the world. Across time and space, American toilet-building projects followed a similar logic, performed similar functions, and shared certain discursive continuities. The absence of adequate sanitary facilities singled out populations for sanitary reform, and such interventions would, it was anticipated, create new political identities. Reformers therefore presented unsanitary populations with paradigmatic examples of sanitary infrastructure and behavior in the hope that this would produce a ripple effect. Nonetheless, one must nevertheless conclude that these efforts were largely performative. The unsanitary Others were presented with the bounties of modernity, but the onus was on them to uphold reformers' standards. It should have come as little surprise, then, that the targets of reform never quite met reformers' expectations.

These projects suggest that U.S. approaches to international development after 1945 might not be so neatly split off from the late colonial, civilizing mission. Although the horror of the Holocaust, the imperatives of Cold War competition with the Soviet Union, especially for hearts and minds in the Global South, and the moral power of the black freedom movement at home together produced a postwar racial liberalism that would no longer deny formerly colonized people's capacity for self-government and would temper explicitly racist statements,

[84]Harrison and Sung, "War on Two Fronts," 420–1.

[85]U.S. Congress, House of Representatives, Committee on Appropriations, "Testimony of Robert H. Nooter," *Foreign Assistance and Related Agencies Appropriations for 1973: Hearings Before a Subcommittee of the Committee on Appropriations (Part 2)*, 92 Cong. 2nd sess., (Washington, DC, 1972), 404.

[86]"End of Tour Report – DEPCORDS II CTZ – Mr. James Megellas," May 19, 1970, box 22, End of Tour/J. Megellas, CORDS Historical Working Group Files, 1967–1973, RG472, NARA-II.

[87]"Review of 1st Half 1971 CD&LD Plan," Nov. 24, 1971, box 44, PHAP 1971 CD&LD Plan, MACV, HQ CORDS, MR4/ Public Health Div, General Records, 1966- 1972, RG472, NARA-II.

[88]Isaiah A. Jackson Jnr., "Health Advisory Services (formerly Public Health Services)," Oct. 31, 1975, document ID: PD-AAF-587-F1, *USAID-DEC*.

https://doi.org/10.1017/mah.2019.33 Published online by Cambridge University Press

development projects informed by this racial liberalism still adopted an assimilationist and paternalist attitude to foreign peoples. While the postwar discourse of international development may not have drawn on the biological determinism of earlier eras and was noticeably less bigoted, practical approaches to development on the ground still placed people in a racialized hierarchy based on what were imagined to be culturally determined behaviors. From the colonial Philippines to postcolonial Vietnam, sanitary behavior served as one way of creating hierarchies among populations. Open defecation remained a barrier to the attainment of American standards of civilization. These racialized perceptions also produced a persistent tension. On one hand, Americans expressed disgust at the assumed inability or refusal of the Other to defecate appropriately. On the other hand, they felt compelled to transform the sanitary habits of the Other, often in the service of larger pacification goals and despite the uncertainties about the likelihood of success.

The United States found willing partners in the colonial and postcolonial elite, who viewed the modernization of their populations as essential to independence and economic development. Hygiene was one of the most obvious ways in which the postcolonial elite could distinguish itself from the masses, deliver the fruits of modernity, and legitimize its rule. In South Vietnam, local political and social dynamics shaped the formulation and execution of development projects as much as American power. South Vietnam's leaders had a vision of rural society based on their reading of the precolonial village, but elite discourse on sanitary behavior in the countryside echoed colonial attitudes to the peasantry, and RVN rural health programs reflected colonial premises about the relationship between hygiene, discipline, and political stability. These findings present a challenge to any presentation of the RVN as an appendage of the United States or a conduit for American power. Historians of the war should understand the RVN as a product of Vietnamese history and as an actor of significance in determining the course and outcome of the war.

It is perhaps too soon to draw a line under such activities. In 2007, reports emerged that Afghan nationals working on NATO's Kandahar Air Base were required to use toilets separate from those used by NATO forces. U.S. officer Lt. Col. Jack Blevins explained, "It's not based on a racial thing; it's just how they use toilets. They're not used to toilets. They use squats, or holes in the ground…. When they use our port-a-potties, they stand on the seats and it causes quite a mess." Meanwhile, in Afghanistan's rural provinces, USAID and other donor agencies, alongside the Afghan Ministry of Rural Rehabilitation and Development, launched ambitious plans for "community-led total sanitation." Projects aimed to change local sanitation habits, including encouraging community members to "pressure one another to maintain safe habits." In an indication that U.S. aid agencies continued to face the same challenges that had beset earlier efforts, project designers noted that practitioners should not measure success simply in terms of toilets built. Rather, the focus should be on "the use and maintenance of latrines," which led to measurable health improvements.[89]

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[89]Joe Friesen, "NATO's Potty Rules Shut Out Afghans," *The Globe and the Mail*, Mar. 26, 2007, https://www.theglobeandmail.com/news/world/natos-potty-rules-shut-out-afghans/article17994076/ (accessed Aug. 31, 2019); "Latrine Sanitation Options Manual: Afghan Sustainable Water Supply and Sanitation," May 5, 2010, document ID: PA-00N-3BF, *USAID-DEC*.

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