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

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Abstract: This article examines the Sanitary Hamlet Program, a rural health project to serve counterinsurgency goals in wartime Vietnam. The program focused on ending open-air defecation and instructing Vietnamese in the correct use of latrines. It situates this story within a larger arc of American nation-building cum toilet-building at home and abroad in the 20th Century. In doing so, the article reveals that American toilet-building shared common features and served common functions from the age of formal empire to the postcolonial era. Looking beyond the rhetoric of modernization to on-the-ground practices reveals the ways in which 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 which 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 launched 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 to be 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 latrines. 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 was part of a larger system of oppression, because the visit of the doctor was usually accompanied by the visit of 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 this situation was radically transformed in the areas liberated 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 amount to a form of colonial or neocolonial social control or was it a benevolent humanitarian intervention? Was Guevara right to suggest that this was a particularly American phenomenon in the middle of the 20th century? Fanon was correct to note that many postcolonial states appropriated these colonial projects upon

The author would like to thank Tanya Harmer for directing his attention to Che Guevara's interest in latrines, Stuart Schrader, members of the NYU Gallatin School's US in the World reading group, and the anonymous reviewers at Modern American History.

1 Che Guevara, "Economics Cannot be Separated from Politics," Speech at Punta del Este, August 8, 1961, accessed June 13, 2018, https://www.marxists.org/archive/guevara/1961/08/08.htm.

2 Frantz Fanon, A Dying Colonialism (New York: Grove Press, 1965), 122-143.

independence, but 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 are unquestionably positive development goals but they can also manifest as 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 that 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.

This paper examines the Sanitary Hamlet Program in Vietnam, a joint South Vietnamese-U.S. effort 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, in particular, latrine construction. However, I argue that this project must be situated within a much

[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: Duke University Press, 2010), 156.

larger sweep of American engagement in toilet-building at home and abroad from the 1900s to the 1970s. In doing so, I highlight the continuities in American approaches to international development from the age of formal empire to the postcolonial era, not only in rhetoric but also in on-the-ground practices, as well as the blurred lines between domestic and foreign development strategies.

An exploration of American toilet building projects in the 20th century reveals four common themes. These projects occurred in often starkly different geographical and temporal settings and political, economic, or social contexts. Technologies changed, as did American ideas that vulnerability and resistance to disease were racially determined. And yet these themes hold steady. Firstly, reformers 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 were in need of modernization. In both colonial and postcolonial settings, hygiene became a symbol of difference between the new modernizing elites, in whom the United States often found willing collaborators, and their "backward" citizens. A second feature was the notion that hygienic behavior would produce politically docile and economically productive populations. During the United States' colonial wars and postcolonial counter-insurgencies, health education and sanitation served as a disciplinary force, a tool for pacifying civilians and mobilizing resources. By attacking the diseases which led to losses in productivity, sanitation projects at home and abroad would raise the targets of reform out of economic backwardness to produce efficient and virtuous citizens. Thirdly, from exhibits of sanitary houses in the Philippines to school toilets as beacons of hygiene in the US South, sanitation was frequently

propagated through models to be replicated by the targets of reform. Such models represented a snapshot of the sanitary future and allowed reformers to produce the future on a manageable scale. However, these models were often all that remained at the end of such interventions, and sometimes in less than tip-top shape. Finally, health education and sanitation seemed to allow for the creation of eventually healthy, self-governing citizens. Once the targets of reform had been taught, the state or non-state actor providing health education or sanitary facilities could 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. This article demonstrates how these themes featured in American toilet-building ventures at home and abroad during the 20th century, before examining how they played out in wartime Vietnam.

The Sanitary Hamlet Program reveals the continued linkages Americans drew between sanitation and pacification across the colonial and postcolonial eras. But the program also reveals how some postcolonial leaders perpetuated the discourse of the unsanitary subject after independence and, as Fanon noted, continued to implement projects which 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, was 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 development visions. In the Sanitary Hamlet Program, the United States' sanitizing mission coalesced with the modernizing vision of postcolonial RVN elites. These elites embraced some of the assumptions of the colonial state, but the program was also the product of RVN leaders' particularist views of rural modernity.

(Com)Modes of Intervention: Colonialism, Philanthropy, and Latrine Construction

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 planning. Disease eradication programs had their origins 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 postcolonial 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 largescale, 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.[4]

[4] Sunil Amrith, Decolonizing International Health: India and Southeast Asia, 1930-1965 (Basingstoke: Palgrave MacMillan, 2006), 12-17; Alison Bashford, Global Population: History, Geopolitics, and Life on Earth (New York: Columbia University Press, 2014); Matthew Connelly, Fatal Misconception: the Struggle to Control World Population, (Cambridge: Harvard University Press, 2008); Erez Manela, "A Pox on Your Narrative: Writing Disease Control into Cold War History," Diplomatic History 34, no. 2 (2010): 299-323; Randall M. Packard, "Malaria Dreams: Postwar Visions of Health and Development in the Third World," Medical Anthropology 17, no. 3 (1997): 279-296.

In examining these two technocentric global health regimes, historians have overlooked a third theme. Like 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 entirely neglected the continuation of this disciplinary health regime in the postcolonial Global South after 1945.[5] 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' Cold War development projects in the colonial era, as well as scholarship which reveals the overlapping personnel, discourse, and practices of U.S. domestic and overseas development projects in the era of Lyndon Johnson's Great Society.[6] 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 Two created social and racial hierarchies by recording their disgust at the sanitary

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5 In his masterful 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: Duke University Press, 2006), 183-184.

6 On the colonial era roots of international development see Michael Adas, Dominance by Design: Technological *Imperatives and America's Civilizing Mission* (Cambridge: Harvard University Press, 2006); Amanda Kay McVety, Enlightened Aid: U.S. Development as Foreign Policy in Ethiopia (New York: Oxford University Press, 2012) David Ekbladh, The Great American Mission: Modernization the Construction of an American World Order (Princeton: Princeton University Press, 2011); on the "Global Great Society" see Stuart Schrader, "To Secure the Global Great Society: Participation in Pacification," Humanity 7, no. 2 (2016): 225-253; Sheyda Jahanbani, "'Across the Ocean, Across the Tracks': Imagining Global Poverty in Cold War America," Journal of American Studies 48, no. 4 (2014): 937-974; Daniel Immerwahr, Thinking Small: The United States and the Lure of Community Development (Cambridge: Harvard University Press, 2015).

habits of people and the conditions of their toilets.[7] 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 identifies the salience of latrine construction in U.S. international history in the 20th century. By doing so, this article highlights the striking continuities in the logic of one American approach to international development over the course of the 20th Century: the role of the toilet as a tool of empire, governance, and biopolitical reform.[8]

Although colonial medicine initially focused on protecting white enclaves, the development of the germ theory of disease in the late 19th century convinced colonial health officials, albeit slowly and unevenly, that colonizers would remain vulnerable unless medical interventions also targeted potentially diseased "natives."[9] 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 an emphasis on health education, as well as the targeting of microbes and vectors of disease. From the early 20th 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

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7 Andrew J. Rotter, "Empire of the Senses: How Seeing, Hearing, Smelling, Tasting, and Touching Shaped Imperial Encounters," Diplomatic History 35, no. 1 (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 (2018): 109-137.

8 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: New Press, 2003).

9 David Arnold, Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India (Berkeley: University of California Press, 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: University of Wisconsin Press, 2009), 288-296; Warwick Anderson, "Excremental Colonialism: Public Health and the Poetics of Pollution," Critical Inquiry 21, No. 3 (1995): 645-646.

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 personal hygiene, colonial authorities and intellectuals reasoned, they very well could not govern themselves. 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.[10]

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 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.[11] 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, while military-trained "hygiene police" launched aggressive public health campaigns, including home inspections. Failing to reform Korean behavior within their private dwellings, Japanese colonial

[10] Anderson, Colonial Pathologies, passim; 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 (2005): 183-194; Amrith, Decolonizing International Health, 9-11; Arnold, Colonizing the Body, 13, 61.
[11] Anderson, Colonial Pathologies, 45-129.

officials built a network of public toilets in Seoul. But Korean treatment of these public facilities failed to live up to Japanese expectations.[12] 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.[13]

These 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 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.[14] Reformers in the U.S. 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 due to the 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 any barefoot people who encountered the "polluted" soil. Although the subsequent eradication program was embraced by many peasants, the emphasis on medical treatment over sanitary improvements led to high reinfection rates.[15]

As was the case in the colonies, domestic programs served to reinforce hierarchies of race and citizenship. Drawing on Ashford's work, zoologist Charles Wardell Stiles set out to

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[12] 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 (2005): 635-675.
[13] Amrith, Decolonizing International Health, 22.
[14] Natalie J. Ring, The Problem South: Region, Empire, and the New Liberal State, 1880-1930 (Athens: University of Georgia Press, 2012), 3-10.
[15] Jose Amador, Medicine and Nation Building in the Americas, 1890-1940 (Nashville: Vanderbilt University Press, 2015), 68-94; Nicole Elise Trujillo-Pagan, "Worms as a Hook for Colonising Puerto Rico," Social History of Medicine 26, no. 4 (2013): 611-632.

investigate hookworm disease in the U.S. south. Although the disease affected as much as 40% of the southern population across all social groups, Stiles was preoccupied with the prevalence of the disease among poor whites, many of whom practiced open defecation. 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 whiteness, transforming them into productive workers and attracting 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.[16]

Stiles found a sponsor in the Rockefeller Foundation's Sanitary Commission on the Eradication of Hookworm (RSC) which was 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 a corresponding increase in school attendance, literacy, and income. Stories of recovery invariably pointed to increased earnings and improved living standards that resulted.[17] Narratives of productivity and

[16] Matthew Wray, Not Quite White: White Trash and the Boundaries of Whiteness (Durham: Duke University Press, 2006), 98-104; Amador, Medicine and Nation Building, 91.

[17] John Ettling, The Germ of Laziness: Rockefeller Philanthropy and Public Health in the New South (Cambridge: Harvard University Press, 1981), 22-25; 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 (1988): 630-631; John Farley, To Cast Out Disease: A History of the International Health Division of the Rockefeller Foundation (1913-1951) (Oxford: Oxford University Press, 2004), 27-43; Hoyt Bleakley, "Disease and Development: Evidence from Hookworm Eradication in the American South", The Quarterly Journal of Economics 122, no. 1 (2007): 73-117.

efficiency were also evident in the Rockefeller Foundation's International Health Division (IHD), which by 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. From the late 1920s, however, the division increasingly shifted its focus away from sanitation to laboratory research into the etiology of yellow fever and malaria, paving the way for the technologically driven campaigns of the postwar years.[18]

One might get the impression from the historiography of Cold War development that American nation-building and pacification cum toilet-building ended with the era of decolonization but it appears that historians have simply overlooked the continuities in discourses and strategies of sanitation after 1945. Americans continued to make judgements about peoples' fitness for self-rule based on their adherence to American sanitary norms. In occupied Korea, Americans were evidently unimpressed by forty years of Japanese reforms. The absence of sanitary facilities, public defecation, and continued use of night soil, convinced many Americans that Koreans were not ready for independence.[19] And Americans continued to build toilets to address these shortcomings. The Institute for Inter-American Affairs (IIAA), a U.S. government agency established as 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 forty thousand outdoor toilets

[18] Soma Hewa, Colonialism, Tropical Disease, and Imperial Medicine: Rockefeller Philanthropy in Sri Lanka (Lanham: University Press of America, 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: Cambridge University Press, 1995), 218.
[19] Carruthers, "Latrines as the Measure of Men," 18-19.

in rural areas of Latin America.[20] 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 post-war community development projects. Theoretically, this approach empowered local communities to select their own development schemes by consensus and the community would then carry out the projects with the assistance of government workers, using their own labor and funds.[21] There was, however, often a gap between theory and practice. In model villages in the heartland of the communist insurgency in northeast Thailand, for example, Thai Community Development workers would build "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.[22] 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 were a manifestly American product and there were practical reasons for resistance to sanitary engineering. Sometimes, a verdant rice paddy simply offered more aesthetically pleasing surroundings. As one Thai farmer told an American doctor:

> 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

[20] Wilton L. Halverson, "Health South of the Border," Institute of Inter-American Affairs: Building a Better Hemisphere Series, No. 17, January 1953, USAID Development Experience Clearinghouse (USAID-DEC), Document ID: PN-AEC-017; 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 (1998): 523-534; Claude C. Erb, "Prelude to Point IV: The Institute for Inter-American Affairs," Diplomatic History 9, no. 3 (1985): 249-269.
[21] Immerwahr, Thinking Small, passim.
[22] James Jouppi, War of Hearts and Minds: An American Memoir (Bloomington: iUniverse, 2011), 124-125.

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.[23]

Although occurring in dramatically differing contexts, American toilet-building performed some similar functions at home and abroad during these decades. 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 eventually 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 the latter years of the war, American development officials and their South Vietnamese allies attempted ambitious programs which adhered to a similar logic as those stretching from the colonial Philippines to Cold War Latin America.

Nation-Building or Toilet-Building?: The Sanitary Hamlet Program in South Vietnam

American observers of interwar French Indochina, Mark Bradley has revealed, placed Vietnamese in a racialized cultural hierarchy, viewing them as "primitive," "lazy," "unclean,"

[23] Kees van Dijk, "Soap is the Onset of Civilization," in Cleanliness and Culture: Indonesian Histories, eds. Kees van Dijk and Jean Gelman Taylor (Leiden: KITLV Press, 2011), 4.

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. Largescale 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 they were superior colonizers, that 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 for their information about Indochina on French Orientalist writings, generating a shared Euro-American colonial discourse.[24]

These assumptions and perceptions formed in the interwar years continued to inform American policies toward Vietnam during World War Two and beyond. Implicit in American nation-building strategies in South Vietnam after partition in 1954, was the assumption that Vietnamese required continued American tutelage. Through its massive military and civilian presence in the country and its huge infusions of economic and military aid which kept the country afloat, the United States exercised extensive influence on South Vietnam's politics and society. U.S. officials supported certain political and military personalities, backed coups, and pressured, cajoled or advised South Vietnamese leaders to implement their preferred policies. American social scientists and development experts helped uphold American power over the RVN, producing a vast body of knowledge on South Vietnam's problems of insurgency and

[24] Mark Philip Bradley, Imagining Vietnam and America: The Making of Postcolonial Vietnam, 1919-1950 (Chapel Hill: University of North Carolina Press, 2000), 46-47; Pierre Brocheux and Daniel Hemery, Indochina: An Ambiguous Colonization, 1858-1954 (Berkeley: University of California Press, 2009), 204-205; 255-258.

"underdevelopment," attaching solutions, sidelining alternatives, and paving the way for nation-building interventions. Undoubtedly, the American presence undercut RVN sovereignty, but scholars have revealed the extent to which the United States struggled to dictate South Vietnamese politics and to which nation-building was the outcome 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, perhaps unsurprisingly, South Vietnam also had its own political and social dynamics which predated U.S. intervention and which shaped the origins, course and outcome of the war.[25] 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 toward 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

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

supported training programs, civilian health services remained critically understaffed and under-resourced. The vast majority of doctors served in the armed forces, while remaining civilian doctors 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 population continued to rely primarily on practitioners of indigenous medicine.

As the conflict escalated in the early 1960s, the U.S. 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.[26] 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 MEDCAPs 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".[27] American claims that the program would deliver better health care aside, the true aim was "psychological rather than medical," focused on winning the

[26] Robert J. Wilensky, Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War (Lubbock, TX: Texas Tech University Press, 2004), 53-61.
[27] "Summary of Certain Observations and Conclusions, Visit of Dr. David McK. Rioch, Director, Division of Neuropsychiatry Walter Reed Army Institute of Research," March 21-April 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.

loyalty of the rural population by establishing a benevolent government presence in the countryside.[28]

Such piecemeal efforts did not address the poor sanitation which was responsible for many common illnesses in Vietnam. The Walter Reed Army Institute of Research reported that hookworm disease 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.[29] These problems were even worse in refugee camps. After-care and sanitation were almost non-existent. In many camps, refugees received little or no food, had no access to water, and inadequate shelter. Where there were toilets, one American observer noted, "people won't use them anyway."[30]

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."[31] For others, it was Vietnamese sanitary behavior at which they recoiled, and soldiers' comments reveal the extent to which Americans continued to

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[28] "Memo (MACV-IVC-4) - Medical Civic Action Program (MEDCAP) - re: summary of program," October 11, 1967, Folder 04, Box 01, John Proe Collection, Texas Tech University-Vietnam Virtual Archive (hereafter TTU-VVA), Item No.: 9860104003.

[29] "Health Data Publications, No. 5 (Revised), January 1966 - The Republic of Viet-Nam (South Viet-Nam) - Department of Health Data, Division of Preventive Medicine," January 1966, Folder 19, Box 01, Robert M. Hall Collection, TTU-VVA, Item No.: 16090119001.

[30] "Hearings Before the Subcommittee to Investigate Problems Connected with Refugees and Escapees of the Committee on the Judiciary, United States Senate, Ninety-First Congress, First Session on: Civilian Casualty, Social Welfare, and Refuge Proble [sic]," Folder 22, Box 10, Douglas Pike Collection: Unit 11- Monographs, TTU-VVA, Item No.: 2391022003; "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 by the General Accounting Office," December 14, 1970, Folder 08, Box 31, Douglas Pike Collection: Unit 03 - Refugees and Civilian Casualties, TTU-VVA, Item No.: 2223108011.

[31] "Interview with William Hancock," June 30, 2003, William Hancock Collection, TTU-VVA, Item No.: OH0311

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!"[32] 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".[33] 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.[34]

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 would routinely remove the drums and, while stirring the contents, burn this American shit 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 judgements about Vietnamese. Instead, some units would pool money and outsource the task to a

[32] George C. Herring, "'Peoples Quite Apart': Americans, South Vietnamese, and the War in Vietnam," Diplomatic History 14, no. 1 (1990): 12; Christian G. Appy, Working Class War: American Combat Soldiers in Vietnam (Chapel Hill: University of North Carolina Press), 129-130.
[33] Daniel Lang, "Casualties of War," New Yorker, 18 October 1969.
[34] Mark Baker, NAM: The Vietnam War in the Words of the Men and The Women Who Fought There (London: Abacus, 1983), 142-143.

Vietnamese "shit burner," at least one of which was witnessed conducting the job with a plastic bag over his head to mask the stench.[35]

It was not only the "grunts" who believed that Vietnamese were 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.[36] 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 ARVN 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."[37]

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 later Nixon administration began winding down the U.S. commitment to Indochina and shifted the burden of fighting to the South Vietnamese military.

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[35] "Interview with Kevin Bovill," May 5, 2000, Kevin Bovill Collection, TTU-VVA, Item No.: OH0091; "Narrative- DASPO/MACV ArmyAPhoto Teams Meets Odd Events and Execration Jobs," Folder 15, Box 01, William Foulke Collection, TTU-VVA, Item No.: 10400115003.

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

[37] Loren Baritz, Backfire: A History of How American Culture Led Us into Vietnam, (Baltimore: Johns Hopkins University Press, 1998), 4.

With "Vietnamization", 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% of its required staff.[38] The military's drain on national resources was such that by 1970 the MOH's operations accounted for just 2.9% of the national budget. Minister of Health Tran Minh Tung noted that in most countries this figure was 6-12%. To compensate for the shortfall, the ministry sought assistance from "free world" countries other than the United States and in 1970 raised US$21m, more than its projected budget for 1971. However, these countries were mostly willing to assist with hospital construction and training programs and there was little left for rural health projects.[39]

These shortages affected all areas of nation-building and development, necessitating a counterinsurgency strategy based on local self-sufficiency. But the requirement of self-sufficiency 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 which 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, and autonomous. They were fundamentally democratic because

[38] "Ministry of Health's Viewpoint Concerning the General Mobilization Order", April 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 (NARA-II), College Park, MD.
[39] "V/v tong ket tinh hinh ngoai vien ve y te trong nam 1970" [Summary of Foreign Aid Situation for Health in 1970], 11 December 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].

"power [was] held by the people" and the village notables served the people's interests. This image was a product of Orientalist colonial writings on Southeast Asia, but it was one many anticolonial nationalists embraced. As the Vietnamese migrated south in the 17th and 18th century, they 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, destabilizing the spirit of collective responsibility and organizational structures with which might be mobilized against the insurgency.[40] 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 was not only desirable, but appeared more feasible due to 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 which 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 and around which the local population was violently compelled to move.[41] In many villages, the government now controlled only some of the village's several hamlets, while the rest remained contested, enemy-controlled, or were wiped off the map altogether. As with all counter-insurgency operations, this campaign witnessed not only the selective destruction of communities and physical spaces, but also an effort to reconstruct a new

[40] Nguyen Dang Thuc, Democracy in Traditional Vietnamese Society, (Saigon: Department of National Education, 1961), 5; Jason A. Picard, '"Fertile Lands Await": The Promise and Pitfalls of Directed Resettlement, 1954-1958', Journal of Vietnamese Studies 11 (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 (2011), 62-65.

[41] David Elliott, The Vietnamese War: Revolution and Social Change in the Mekong Delta, 1930-1975, vol. 2 (Armonk, NY: M.E. Sharpe, 2000), 1145-1156.

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, a scheme which granted VN$1,000,000 (approx. $8,500) to villages to carry out popularly selected community development projects. The VSD aimed to "restore the vitality and the authority of the villages through the democratic activities of the rural people."[42] Amidst ongoing negotiations in Paris and the prospect of a ceasefire-in-place and competitive elections with the NLF, the objective of these efforts was to stake a government claim on the countryside, restore communal solidarity, and to draw villagers into a relationship with the state.

RVN leaders did not have a wholly idealized vision of the villages, however. As Minister for Rural Development Nguyen Duc Thang noted, rural pacification would preserve the villages' "fine customs," while eliminating "depraved" ones.[43] Elections and community development projects would restore village autonomy, but aspects of rural life required modernization. The Ministry of Health was enlisted in this larger goal of popular mobilization, self-sufficiency, and the modernization of rural behavior. The rural health program was guided by the government's pacification slogan: "the people act, the cadres mobilize, and the government supports," but these projects would also 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" about the causes of disease had been "cleared away from their minds."[44] While authorities in North Vietnam enlisted indigenous medical practices in their war of

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[42] 'Chuong Trinh Tu Tuc Phat Trien Xa' [Village Self-Development Program], February 24, 1969, Folder 109, Phu Tong Thong De Nhi Cong Hoa [Office of the President of the Second Republic, hereafter PTTDNCH], TTLTQGII.
[43] Nguyen Duc Thang, "Duong Loi Xay Dung Nong Thon cua Chinh Phu trong nam 1967" [The government's rural development policy in 1967], (Saigon: Tong Bo Xay Dung Nong Thon va Tong Bo Thong Tin Chieu Hoi, 1966), 21-22.
[44] "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", December 17, 1970, Box 43, File 1606-07A Sanitation- 1971 (Part 1 of 2), MACV, HQ CORDS, MR4/Public Health Div, General Records, 1966- 1972, RG472, NARA-II.

resistance against France and the United States and in domestic nation-building, RVN authorities sidelined such practices in favor of western biomedicine. 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.[45] 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 the peasantry's hygienic habits mirrored the late colonial discourse of the unsanitary Other.

Even as American and South Vietnamese officials attempted to transform hygienic habits in the countryside, however, they debated the relative merits of existing rural practices. One of the most hotly disputed issues, and one that was never resolved, was the use of fish pond 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, and into which residents would defecate. The fish from the pond were harvested and consumed by the hamlet residents or sold at local markets. Although fish pond 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 fish pond latrines in hamlet schools in the Mekong Delta. The authors noted that "the fish pond latrine has fallen into disrepute because educated Vietnamese consider

[45] 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: Bo Xa Hoi, Truong Cong Tac Xa Hoi, 1971), pp. 164-165. On Vietnamese medicine see Laurence Monnais et al eds., Southern Medicine for Southern People: Vietnamese Medicine in the Making (Newcastle Upon Tyne: Cambridge Scholars, 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): 423-443.

it to be primitive" and insist the fish will spread disease. But in the case of rural schools, other forms of toilet had failed to produce the desired results and fish pond 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.[46]

Subsequent investigations by American and RVN officials, however, voiced concern about the health implications of fish pond 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 fish pond 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 fish pond latrines would become one of the goals of the Sanitary Hamlet Program.[47]

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[46] "Fish Pond Latrines," April 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," December 1, 1966, Box 44, Fish Pond Latrines- 1970, MACV, HQ CORDS, MR4/ Public Health Div, General Records, 1966- 1972, RG472, NARA-II.

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

Fish pond latrines aside, there remained an open question as to which type of sanitary toilet was most suitable to rural Vietnam. 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 were more receptive to pour-flush, water-sealed latrines which could be easily constructed but maintenance proved more problematic. 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 barrier to flies and odors. These latrines were also more aesthetically pleasing because, 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 refugee camps and many rural hamlets, not feasible. Any plan to provide community latrines would require strong leadership by the hamlet chief.[48]

Despite these uncertainties, U.S. and South Vietnamese planners could agree on the broader goal of sanitizing and beautifying South Vietnam's rural hamlets. With this goal 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

[48] "Cam Toai Tay Hamlet Sanitation Survey- Findings and Recommendations," January 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.

open defecation and to instruct villagers in the proper construction and use of toilets, as well as the disposal of waste and the establishment of a clean water supply. USAID officials were pleased to report this "increased, and real, interest in public health concepts" constituted "the most significant and exciting change" in years.[49] 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 Village Self-Development program combined with their own money and labor.

Each of the RVN's forty-four provincial health services were called upon to send 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.[50]

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[49] "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", February 1972, Box 62, Health Education/Malaria Eradication, CORDS Historical Working Group Files, 1967-1973, RG472, NARA-II.

[50] "Bang Tom That 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 of the Director of the Cabinet to Discuss Cadre Training to Establish Sanitary Hamlets at the Vung Tau National Training Center], December 23, 1970, Folder 2089, Bo Y Te [Ministry of Health], TTLTQG.

Having returned to their provinces, these health officials selected hamlets to serve as models and then visited the site 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 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 market places. Open-air latrines were destroyed and residents conducted a general cleaning of public areas. The people would be immunized against common illnesses such as cholera and plague.[51]

Long Qui hamlet in Tay Ninh province, was 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 then instructed the villagers in "a concentrated cleaning effort in homes, kitchens, pigsties, etc". Upon completion, U.S. observers reported, "many health hazards had been removed." The program was not simply about medical benefits, however. Aside from these, the project had also "led to more attractive hamlet and a sense of community spirit."[52] Improvements would make residents healthier but also, by making

[51] "Guide Book for Setting Up Sanitary Hamlet," December 17, 1970, Box 43, Sanitation-1971 (Part 1 of 2), MACV, HQ CORDS, MR4/Public Health Div, RG 472, NARA.
[52] "UN [sic] Bulletin: Self-Reliance," July 1, 1971, Folder 06, Box 18, Douglas Pike Collection: Unit 02 - Military Operations, TTU-VVA, Item No.: 2131806129; "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, accessed June 10, 2018, http://www.fold3.com/image/#269639814.

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.

In some cases, government health cadres were pleased to report 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 rubbish 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 only meet with the people 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 single-handedly 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.[53]

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 removing the revolutionary forces from the villages was "very time consuming" but removing the people, upon whom the guerillas relied, "can be carried out relatively quickly." As the result of such policies, at least one third of the South Vietnamese population registered as refugees at

[53] "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.

one time or another between 1965 and 1972.[54] During the early years of the U.S. intervention, there seemed in the mind of the U.S. and South Vietnamese military planner and policymaker no contradiction between population displacement and health care. 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 vaccinations 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 campaigns of hygienic reform. A state can immunize its people but they would not become modern, disciplined citizens until 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 the relatively improved security in the countryside after 1968, the government encouraged and incentivized urban-dwelling peasants and refugees to return to rural areas. As USAID director John Hannah implied, these refugees were not part of a national political community. The goal of the 'Return-to-Village' (RTV) program, Hannah said, was "to move

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[54] Gregory A. Daddis, *Westmoreland's War: Reassessing American Strategy in Vietnam* (Oxford: Oxford University Press, 2014), 107-108; Thomas C. Thayer, War Without Fronts: the American Experience in Vietnam (Boulder: Westview, 1985), 221.
[55] E.A. Vastyan, "Civilian War Casualties and Medical Care in South Vietnam," Annals of Internal Medicine 74, no. 4 (1971): 611 –624.
[56] Warwick Anderson, "Immunization and Hygiene in the Colonial Philippines," Journal of the History of Medicine and Allied Sciences 62, no. 1 (2007): 1–20.
[57] "Guidebook for Setting Up Sanitary Hamlet."

these war victims out of the status of refugees and back into the status of normal citizenship."[58] By combining the RTV program with community development, the Director of the U.S. mission's Refugee Directorate William Hitchcock claimed, the program would transform refugees into "viable and willing members of an essentially participant society."[59] The rehabilitation of the refugee and war victim population, it seems, not only included efforts to bring them back into the community of productive workers and loyal government supporters, but also included more sanitary habits to regulate behavior in new communities. In 1971, the government decided to establish sanitary hamlets at all RTV and resettlement sites. The RVN 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 were expressing a vision of rural modernity which 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 week's 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 new sanitary facilities. Following the establishment of the new, sanitized

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[58] "Testimony of John Hannah (Administrator, Agency for International Development)," Hearings Before the Subcommittee to Investigate Problems Connected with Refugees and Escapees of the Committee on the Judiciary, Senate, 91st Cong. 1 (Washington: Government Printing Office, 1969), 10.
[59] Louis Wiesner, Victims and Survivors: Displaced Persons and Other War Victims in Viet-Nam, 1954-1975 (Westport, CT: Greenwood Press, 1988), 212.

settlements, rural health teams made periodic visits to conduct health education "on a lower level of intensity" than during the initial two week-long saturation.[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, would be productive members of the community, and would therefore place less of a burden on precious state resources.

Subjecting refugees to the sanitary hamlet program, the government and its U.S. advisors targeted displaced people, often living in unsanitary, overcrowded camps, immunized them and educated them about preventing illness, before sending them back to clean villages. The idea was that the refugees would return to their villages healthier, more productive, and more dedicated to the anti-Communist cause. Camps therefore served as training grounds for a new form of citizenship. The refugees, one assumes, must have wondered why, if sanitation was so important, were the camps and reception centers so filthy. Even in the case of the non-refugee population the program was, for a government that had previously done little in the medical sphere to reach them, an ambitious intervention in the lives of the people, with the state reaching right inside peasant's homes.

In this sense, the Sanitary Hamlet Program also reflected and reinforced international development's gendered and Eurocentric assumptions about male productivity and female reproduction, but also 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

[60] "GVN Refugee Resettlement Plan," August 1971, Folder 07, Box 16, Douglas Pike Collection: Unit 06 - Democratic Republic of Vietnam, TTU-VVA, Item No: 2321607004.
[61] Four Year National Economic Development Plan, 1972- 1975 (Saigon: Directorate General of Planning, 1972), 226.

projects like the Sanitary Hamlet Program did target their role in the home.[62] These gendered assumptions 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 between 60-77% of agricultural workers between the ages of sixteen and sixty were women.[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 was 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 that began in the United States in the early 20th Century and were exported to dozens of countries in the early Cold War.[64] As Gabriel Rosenburg 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

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[62] Jane L. Parpart, "Who is the 'Other'?: A Postmodern Feminist Critique of Women and Development Theory and Practice," Development and Change 24 (1993): 439-464.
[63] David W.P. Elliott, The Vietnamese Revolution: War and Social Change in the Mekong Delta, 1930-1975 (Concise edition) (New York: Routledge, 2003), 372-374.
[64] "Completion of Tour Report: Alice E. Smith, Home Economics Advisor, Agricultural Extension, ADDP/USAID/Vietnam," March 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.

improvement and livestock projects, home economics agents led all-female 4-T home improvement clubs, focusing entirely 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 adopted a permissive attitude to the issue. 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 a curtain 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. The workers were soon phased out and replaced by local leaders, including village midwives who were 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 sufficient civic pride in his village that local farmers had stopped spitting on the floor of the town hall. As the Sanitary Hamlet Program took

[65] Gabriel N. Rosenberg, The 4-H Harvest: Sexuality and the State in Rural America (Philadelphia: University of Pennsylvania Press, 2016); "4-T Programs in Vietnam, 1955-1970," March 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.

off, sanitarians and health educators working on the project also received CHAPS training in family planning promotion techniques.[66]

Like so many counterinsurgency schemes in Vietnam, the gap between design and practice was one of the primary shortcoming of the sanitary hamlets. In 1971, the MOH ordered each provincial health service to select three model hamlets which would act as beacons of hygiene for surrounding hamlets to replicate through the Village Self-Development program. Each province received VN$100,000 (US$850) for each of the three hamlets. Cadres would then mobilize the local population in the construction of sanitary facilities, which MOH officials estimated would take 30-45 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 government 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 twice washed out before a permanent structure was built, and a slow-sand filter to treat raw water into potable water. The latter was 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

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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.

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'] February 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], February 5, 1971, Folder 2098, Bo Y Te, TTLTQGII.

the task, took 5 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 hamlet served as one of these showcases; public health officials visited the hamlet to see the latrines, wells, and slow sand filter.[70] The idea was 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 total cost of the Ong Huong project was 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

[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, accessed 10 June 2018, http://www.fold3.com/image/#268892424.
[69] "Guidebook for Setting Up Sanitary Hamlet".
[70] "Report for Week Ending November 7- 13, 1971," November 16, 1971, Box 36, Folder 1601-03 PH General 1971, MACV, HQ CORDS, MR4/Public Health Div, General Records 1966-1972, RG472, NARA-II.

including material and labor.[71] Surrounding hamlets, inspired by beautified Ong Huong, would therefore be hard pressed to match this effort. Under the VSD program the government contributed VN$1,000,000 to every village which 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 to measure 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. Having not long ago been subject to othering, in Vietnam the KOPREM members encountered some "unbelievably strange customs" among rural Vietnamese.[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

[71] "Engineer Cost Estimate – Slow Sand Filter Water System," April 30, 1971, Box 43, File 1606-07A Sanitation-1971 (Part 1 of 2), MACV, HQ CORDS, MR4/ Public Health Div, General Records, 1966- 1972, RG472, NARA-II.
[72] "The Pacification Effort in Vietnam," January 18, 1969, Reel 7, frame 0547, 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 (2017): 419.
[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," August 19, 1971, 9th Medical Laboratory, 1970-1971, Meritorious Unit Commendations, Vietnam Service Awards, RG472, NARA-II, accessed 2 June 2018, http://www.fold3.com/image/#269629473.

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 60 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 were not terribly enthused 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. 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.[78] 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 which were supposed to voluntarily adopt MOH guidelines. Even where the government

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[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, October 12, 1970.
[78] "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 va 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], March 10, 1971, Folder 2098, Bo Y Te, TTLTQGII.

was able to establish sanitary hamlets, there were practical reasons as to why the villagers did not always meet 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".[79] As a result of the population relocation which 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."[80]

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 was holding 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 there were problems. The government expected these villagers to maintain certain levels of hygiene and sanitation but rather than

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

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 there was an overemphasis on the physical infrastructure of the hamlets to the detriment of continuous health education, evidence perhaps that the aesthetics of the project were more important than disease prevention.[81] 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.[82] There was some skepticism among foreign advisers as to whether the RVN 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.[83] American officials were somewhat more optimistic, though believed there was a need for continued tutelage. In Congressional testimony in April 1972 Robert Nooter of USAID said 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 was at least indicative of the GVN's attempt to focus on long-range planning.[84] 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",

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[81] "Public Health Activities: 1 December through 31 December 1971," December 30, 1971, Box 33, Community Health Specialist-1971, MACV, HQ CORDS, MR4/ Public Health Div, General Records, 1966- 1972, RG472, NARA-II.
[82] John Kennedy, "Public Health Services", December 6, 1973, USAID-DEC, Document ID: PD-AAF-587-D1; "Chuong trinh hoat dong 4 nam (1972-1975) cua Bo Y Te,".
[83] Harrison and Sung, "War on Two Fronts," 420-421.
[84] "Testimony of Robert H. Nooter", Foreign Assistance and Related Agencies Appropriations for 1973: Hearings Before a Subcommittee of the Committee on Appropriations (Part 2), House of Representations, 92nd Cong. 2, (Washington: Government Printing Office, 1972), 404.

noted one senior adviser.[85] 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."[86] By 1975, the total number of sanitary hamlets had risen to 275, many of which had more than 1,000 residents. However, in the final analysis, USAID ruled the sanitary hamlets a "crash program" which 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".[87]

Conclusion

Despite the deliberate hyperbole of his 1961 speech, Che Guevara had a valid critique of American developmentalism in the 20th Century. Toilet-building was 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

[85] "End of Tour Report – DEPCORDS II CTZ – Mr. James Megellas."
[86] "Review of 1st Half 1971 CD&LD Plan," November 24, 1971, Box 44, PHAP 1971 CD&LD Plan, MACV, HQ CORDS, MR4/ Public Health Div, General Records, 1966- 1972, RG472, NARA-II.
[87] Isaiah A. Jackson Jnr., "Health Advisory Services (formerly Public Health Services)," October 31, 1975, USAID-DEC, Document ID: PD-AAF-587-F1;

must conclude that these efforts were largely performative. The unsanitary Other was 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 were never quite capable of meeting 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 in the Third World, and the moral power of the black freedom movement at home, produced a postwar racial liberalism that would no longer deny Third World people's capacity for self-government and would temper explicitly racist statements, development projects informed by this racial liberalism still adopted an assimilationist and paternalist attitude to foreign peoples. We perhaps see this more clearly if we look beyond the rhetoric of modernization to on-the-ground practices such as toilet-building. 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 exceptionalizing difference and creating hierarchies among populations. Open defecation remained a barrier to the attainment of American standards of civilization. These racialized perceptions produced a tension. On the one hand, Americans expressed disgust at the assumed inability or refusal of the Other to defecate appropriately. On the other hand, was compulsion 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 backward 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 the case of South Vietnam, political 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 compel us to reconceptualize the RVN, not simply as an appendage of the United States but a product of Vietnamese history and actor of significance in 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 separate toilets to 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 lead to measurable health improvements.[88]

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[88] Joe Friesen, "Nato's Potty Rules Shut Out Afghans," The Globe and the Mail, March 26, 2007; "Latrine Sanitation Options Manual: Afghan Sustainable Water Supply and Sanitation," May 5, 2010, USAID-DEC, Document ID: PA-00N-3BF.