Title: Tainted Commons, Public Health: The Politico–Moral Significance of Cholera in Vietnam
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In October 2007, a series of cholera epidemics broke out in Hanoi, interrupting a moment of economic triumphalism in post-transition Vietnam. In seeking the source of a refractory disease associated with poverty and underdevelopment, officials, media, and citizens not only identified scapegoats and proposed solutions, they also endorsed particular visions of moral conduct, social order, and public health. Controversy over cholera, a potent politico–moral symbol, expressed an imaginary of “tainted commons” (i.e., an emergent space of civil society and small-scale entrepreneurship from which the state has partially withdrawn, while still exercising some measure of scrutiny and control). The ambiguities of this situation permitted the state to assume moral postures, evade responsibility, and deflect criticism to convenient targets. Prevalent outbreak narratives thus played on anxieties regarding specifically classed and gendered social groups, whose behavior was imagined to contravene ideals of public health and order. [infectious disease, public health, Vietnam, outbreak narratives, gender]

2007 was an eventful year for Vietnam, beginning in January with the country’s accession to the World Trade Organization: a coveted benchmark in the pursuit of integration with global markets. The rise of a middle class continued, with novel cultural products including the premiere of the TV series “Vietnam Idol.” By September, with the nation’s foreign direct investment, economic growth, and tourism at record rates, the Ministry of Sports, Culture, and Tourism placed an advertising spot for Vietnam on CNN, portraying the country as “an attractive destination with diversified and abundant cultural aspects and tourism products” (footprintsvietnam.com 2007).

In October, there was a break in the good news. It began rather innocuously when an elderly male rice farmer arrived at a Hanoi hospital with acute diarrhea and vomiting. The case was confirmed as cholera, an enteric infection spread by food and water. Because cholera is a reportable disease whose occurrence must be communicated to global health authorities, the hospital notified the Ministry of Health, and an epidemiological investigation team was dispatched to the man’s home village (Krickeberg et al. 2011:22). A few days later, three unrelated cases of cholera appeared. By early November, though over 100 cases of cholera had been lab confirmed, the state had still not declared an epidemic (BBC Vietnamese 2007). By mid-November, disease had spread across 14 provinces and caused at least 1,880 cases of what the Ministry of Health termed “acute diarrhea” (tiêu chảy cấp)—of which 240 cases were confirmed as cholera (WHO 2008). A second wave of infections occurred in 2008, followed by another large outbreak in 2009 and a smaller one in 2010. Between October 2007 and July 2009, some 8,000 cases of clinical, or symptomatic, cholera, were reported (Trần Nhur Dương et al. 2009).
Not only was this wave of mass infection dissonant with the triumphalist ambience of economic expansionism, it was also epidemiologically mysterious. Cholera is not endemic in North Vietnam, and has been reported only rarely since 1976 (Dalsgaard et al. 1999:69). Further, outbreaks are generally spatially concentrated, limited to rural areas, and traced to a single place or event, such as a shared ceremonial meal. In 2007, cholera was scattered across Hanoi with no obvious point source; uncharacteristically, infection appeared to be spreading from the city into surrounding provinces. From a public health assessment of Vietnam based on macroeconomics, the outbreaks were even more surprising, given that cholera is associated with poverty and social upheaval: war, natural disasters, and mass population movements. In 2005, an Asian Development Bank report had stated that Vietnam’s Red River Delta enjoys the “epidemiological profile of a middle-income country” (Bloom et al. 2005:1).

These events appeared all the more startling given their contrast to Vietnam’s prior successful experiences of disease control. Vietnam eradicated cholera at midcentury; more recently, the country was lauded for controlling SARS and avian influenza. In contrast, both Vietnamese and foreign health experts critiqued the state’s approach to the cholera outbreaks, pointing to irregularities in epidemiological reporting, failure to put forward reliable accounts of the cause of contagion, and implementation of less effective disease prevention measures.

In spring 2008, Prime Minister Nguyễn Tấn Dũng issued a statement to ministers and provincial chiefs to the effect that cholera affected not only “our people’s health but also socioeconomic development, tourism and social security” (Channel News Asia 2008). Dũng’s strongly worded assessment was uncharacteristic of the government’s response to the outbreaks, which was otherwise marked by denial, indirection, and semantic vagueness, and featured improbable assessments of risk factors, victim-blaming, and the persistent designation of cholera as acute diarrhea.

As a U.S. diplomatic cable noted, this terminology drew criticism in the media and “raised questions as to whether (…) Vietnamese citizens [will] change their risky behaviors” (Michalak 2008:2). For example, in November 2007, shortly after the beginning of the outbreak, the news website Saigon Tiếp Thị Online published an article titled “Tell the People It’s Cholera.” Its author noted that Vietnamese law required the announcement of a cholera outbreak following the confirmation of a single case of cholera (Nam Nguyên 2007).

Finally, a number of Vietnamese scientists were also dismayed by the approach to cholera control. One scientist I interviewed noted that the urban water supply was excluded from official discussion of risk factors—an omission she believed to be politically motivated, given the deeply negative public relations implications of acknowledging a waterborne epidemic. However, as the prime minister’s remark suggested, the state appreciated cholera’s significance as a political issue as well as a technical one, and as a potential threat to domestic affairs as well as to Vietnam’s image overseas. Although cases of probable cholera continued to accumulate through 2010, competing “outbreak narratives” (Wald 2007) advanced by diverse actors suggested how health risks were imagined and attributed in the absence of a unifying account.

It is easy to understand why the Vietnamese state sought to avoid understanding the health problem in the ways cholera is characteristically understood, as this would entail significant embarrassment and expense. It is less obvious why they misunderstood it in precisely the ways they did. This article will show how other sorts of anxieties concerning the state’s responsibility for—and control over—the rapidly developing public sphere, market economy, and civil society led them to seek the causes of the outbreak in what they perceived as a “tainted commons.”
Study Design and Methods

Attempts to identify the source of cholera, nominate scapegoats, and propose solutions also advance models of society: as medical anthropologist Shirley Lindenbaum has noted, outbreaks of infectious disease represent an opportunity to examine the “relationships among cultural assumptions, institutional forms, and states of mind” (2001:363). Following medical historian Charles Rosenberg’s observation that cholera can be appropriated as “a way of gaining access to particular configurations of demographic and economic circumstances, ideas, and institutional relationships” (1992:118), I use these episodes in Hanoi as a point of departure for analyzing social as well as public health concerns in Vietnamese society. I draw on ethnographic interviews with public health officials, scientists, and Hanoians in their homes; I also provide a critical reading of mainstream media and weblog coverage of the cholera episodes.

However, I do not rest on a solely discursive analysis. Several significant inputs were omitted from most accounts of cholera’s potential causation, and I seek to reinstate the role of urban infrastructure, a little acknowledged macro-structural risk factor. Though there is, to my mind, no final verdict on the true cause of cholera, Hanoi’s water supply and urban sanitation system—although representing potentially significant underlying factors—were widely overlooked. Drawing on the accounts of skeptical scientists, I discuss the possibility that Hanoi’s cholera outbreaks revealed more systemic and serious shortcomings than official and prevailing accounts suggested. The connection between disinvestment in public infrastructure and a lapse in public health outcomes refocuses the issue away from what the state perceived and portrayed as a tainted commons, calling into question the role of this construct in state discourse and the national imaginary.

Outbreak Narratives

As cases of cholera spread through the capital and beyond, Vietnamese health officials and state media formulated outbreak narratives—paradigmatic stories of disease emergence that recount not only the progress of contagion but also themes such as culpability, risk, and the role of science and the state (Wald 2007). During the outbreaks, public health messages saturated urban neighborhoods, with advisories read over loudspeakers and disseminated in flyers. Daily newspapers ran reports about the cholera, drawing content from Ministry of Health press releases. Official and lay outbreak narratives sought to account for cholera’s source and transmission; suspects included cross-border dog trafficking, food from market stalls, discharge of waste on railroad lines, polluted surface water and drainage ditches, and vegetables grown atop fields of sewage. Interventions included inspecting and closing food outlets and dosing urban lakes and household water tanks with chlorine. Oral vaccine was distributed in heavily affected neighborhoods (VietnamNetBridge 2008).

Ultimately, food became the focus of the state’s outbreak narrative. By spring 2008, the Ministry of Health had named numerous food products, including blood pudding, pork intestine, raw vegetables, fermented pork roll (nem chua), ice, fruit, dog meat (thịt chó), and shrimp paste (mắm tôm) as risky. These products and the circumstances of their sale and consumption were described in accounts that conflated contamination with stigmatized social groups and behaviors. Advisories encouraged residents to avoid the foods in question, and Ministry of Health officials and media vilified the informal sector: Journalists writing about the cholera epidemics accused vendors of “covering their customers’ eyes” (bao khuất mắt trông coi) and “concealing cholera”
(coi thường bệnh tả). As during Venezuela’s cholera outbreaks of the early 1990s, middle-class individuals were imagined to be at risk to the extent that they patronized itinerant food vendors (Briggs and Mantini-Briggs 2004:37).

By 2008, the most frequently repeated account of the cholera posited that dog meat and shrimp paste, often consumed together, were the leading causes. This information was published in major national newspapers, including Thanh Niên, Tuổi Trẻ, and Sài Gòn Giải Phóng as well as by the English-language VietnamNet and Việt Nam News, the U.S. financial news website Bloomberg.com, and the UN publication IRIN News. After the most acute outbreaks had passed, scientific publications on the link between cholera and dog meat consumption also appeared in the Vietnamese public health journal Preventive Medicine (Trần Như Dương et al. 2010), The Open Infectious Disease Journal (Tuan Cuong Ngo et al. 2011), and PLoS Neglected Tropical Diseases (Dang Đức Anh et al. 2011). The dog meat and shrimp paste theory, which was repeated by scientists and policymakers as well as laypeople, appeared questionable from a bacteriological perspective: Dog meat is served thoroughly cooked, and shrimp paste is 15–30% salt. Further, the two foods are frequently eaten with fresh herbs, which are liable to have been grown in fields fertilized with human waste or washed in contaminated water. Nonetheless, Vietnam’s WHO representative stated that “Eating dog meat or other food from outlets that serve it is linked to a 20-fold increase in the risk of developing the severe acute watery diarrhea commonly caused by the cholera bacterium” (Bennett and Nguyen 2008:1). In 2010, while I was conducting interviews in Hanoi, these foods were still suspected. The question “Do you know what caused the cholera at the end of 2007?” often prompted my respondents, poor and near-poor Hanoians, to name dog meat and shrimp paste and to express misgivings about street food:

Martha Lincoln How do you and your family prevent cholera?

Respondent We prevent it like they [advisories] require us to, not eating shrimp paste or blood pudding or pork intestine, not eating raw things. We keep away from those foods and don’t eat improperly. Before, the family still ate noodles with shrimp paste and dog meat, but from the time they propagandized, the family doesn’t eat it any more.

—Trần Văn Nghĩa, male, 73, Hoàn Kiếm district, Hàng Gai ward, August 24, 2010.

Some versions of this narrative highlighted the risk posed from deviation from class and gender norms. In the following section, I describe how these accounts imagined public health risks.

Food from “Outside”

Since Vietnam’s mid-1980s market liberalization reforms sanctioning private ownership and enterprise, food is prepared and sold by unlicensed small traders on virtually every square foot of city sidewalks and streets. These scenes are sometimes celebrated as a picturesque aspect of the city’s traditional culture; vendors are often interpreted as evidence of Vietnam’s entrepreneurial energy. During the cholera epidemics, however, official advisories as well as media reports portrayed Hanoi’s informal food sector as a sinister institution. News articles implied that the cholera outbreaks could be attributed principally to the public’s insistence on eating street food.
One story asserted that “subjective (chủ quan) habits and psychology have kept many people from losing their taste for eating along the side of the road” (VnMedia 2009:1).

Narratives of uncanny commodities as well as undisciplined consumption came to my attention often during fieldwork. News articles reported chemical contamination or adulteration of food products and warned about the dangers of products of “unclear origin” (không rõ nguồn gốc), a term applied both to domestic goods and to Chinese imports. Stories circulated regarding attractive products that were not what they seemed: Dried squid was bleached white, or made out of rubber; outsize apples had been grown with chemical fertilizer in China; prepared street food was fried in carcinogenic grease. The sheer number of these stories indexed the inadequacy of the state’s regulatory apparatus in the market reform era and the risks borne by increasingly unregulated markets, which were perceived as too open to the pollution, corruption, and temptations of civil society and the profit motive.

In the specific case of cholera, however, the likelihood that street food vendors could be responsible for thousands of cases of cholera in numerous provinces is dubious at best. Nonetheless, interviews with laypeople regarding cholera elicited numerous statements indicating distrust of goods produced and sold in public. In over 100 conversations, when I asked city residents “Is street food as safe as food prepared at home?” men and women often replied rhetorically “How could it be as safe?” then proceeded to explain how foods exposed to the environment—whose attributes included heat, wind, insects, and the polluting atmosphere—were especially dangerous. These explanations, while referencing contagionist models of food-borne illness, only rarely included a discussion of bacteria (vì khuẩn) or viruses (vì rút).

The tendency of both officials and the public to associate cholera with the informal sector may have gained additional traction, I speculate, because it tapped into non-biomedical models of disease causation that are widely held in Vietnam. Vietnamese people commonly cite changing weather and the atmosphere as factors in illness episodes. Therefore, official explanations of cholera that drew on humoral models of cholera causality—citing weather and certain types of foods—were conceivably accepted because they corresponded to preexisting explanatory models.

Interview respondents’ remarks also suggested a tendency to perceive salespeople in the informal sector as unscrupulous and profit-motivated agents in a deregulated public sphere. For example, 33-year-old Mrs. Thanh suggested that vendors wash raw vegetables in a haphazard way (ào ào); Mrs. Oanh, quoted below, suggested that vendors went out of their way to be deceptive:

\[\text{ML} \quad \text{Do you ever eat street food?}\]

\[\text{Cô Oanh} \quad \text{Never, I feel that the people (người ta, here meaning vendors) pull the wool over your eyes. I’m afraid that it is stale, or dirty, so I don’t dare to buy it, I just buy fresh things to bring home.}\]

—Trần Kim Oanh, female, 51 years old, Hoàng Mai district, Đại Kim ward, March 1, 2010.

One woman synthesized this outlook on street vendors with an environmental hypothesis, a behavioral hypothesis, and a humoral model of disease causation, suggesting that for some, the commercial, physical, and social environment of outdoor food consumption constitutes the grounds of pathogenesis.
ML

Cô Vân

Do you know what habits can lead to cholera infection?

Men often eat blood pudding and drink alcohol. Beer and alcohol cause a lot of heat. Right? Beer and spirits out at a street restaurant (quán), eating improperly (bây bà). Out at a street restaurant, the food they make isn’t clean and fresh. They buy it cheap and sell it dear, so it’s easy to get sick.


As Mrs. Vân suggests via the terms bày bà (improper, nonsensical) and bừa bãi (indiscriminate), the purchase of certain kinds of foods from certain kinds of vendors can be perceived as forms of erratic or improper commerce and consumption. Hanoians also often characterized the purchase of snacks or cooked food on the street as individualistic, irrational, or “subjective” behavior. Meals prepared and eaten at home were cited approvingly as a source of reliably safe and healthy food.

As its alleged association with vended food, the informal sector, and recreational eating practices suggested, cholera in popular and “expert” models of causality was used to signify disorderly sociality and behavior. Respondents explaining how to prevent cholera, or describing its causes, relied on prescriptive social geographies to explain safety and danger: Food purchased and eaten outside (ở ngoài) is dangerous; cooking and eating food at home is considered safe. Food sold by a trader one knows (mua ở quê quen) is safe; food sold by a stranger is less so. Eating meals en famille is normative; eating recreationally (ăn chơi, đi nhậu) is suspect. Safe food purchase and preparation were mediated by the institutions of established relationships with familiar food vendors and, more significantly, family: Meals prepared and eaten at home were cited by many respondents as a source of safe and healthy food.

These rules for “safe” food use rest on schemata such as outside versus inside and public versus private, implicitly supporting a vision of public health as bound within normative gender and kinship relations. This model of family-based health resonates with an ideology of the “happy and civilized” family, which has been extensively promulgated in the post-transition period (Pettus 2003). This model of society prescribes family members carrying out gender-specific labor to maintain a household that is “civilized” (văn minh) and healthy.

Figure 1, from a handbook for rural health workers, depicts this ideal of public health as family health: individual women and children drawing water, sweeping a courtyard, and listening respectfully to a cadre. Consumption outside these strictures was often characterized both as uncivilized and unsafe. Consumption in a public sphere outside both the space of the family and the control of the state was particularly problematic. Leveraging these perceptions to commercial advantage, Vietnamese food manufacturers and supermarkets frequently offer fulsome guarantees of hygienic (đảm bảo vệ sinh) and high-quality (chất lượng cao) products, which are inevitably more expensive than unbranded merchandise sold on the street.
Tainted Commons, Public Health

Many explanations of the cholera outbreaks were underwritten by the anxious belief that outdoor environments, commonly held resources, and relations transacted in public\(^5\) pose cryptic and ungovernable risks to health. These accounts evoke an imaginary I call “the tainted commons”: a belief that resources, institutions, and relations once stabilized by the state and the interpersonal norms of socialism have been opened to chaotic forces inflected by the logic of profit. Indeed, since the market transition of the mid-1980s, Vietnam’s formerly constituted commons of land, public space, and society, once imagined as the property of “the people” (người dân), although remaining subject to state control, is increasingly influenced by the private ambitions of individual and corporate actors, including those outside national borders.

Although the tainted commons is imagined to threaten both biological and social forms risk, its threats have repercussions beyond questions of immediate physical well-being. To critique the negative consequences of the demise of the planned economy and its revolutionary project—including globalization, Westernization (or reconquest by China), pollution, commodification, corruption, incivility, and the corrosion of tradition—is to speak of a more generally tainted commons.

This trope can express an argument for a more paternalistic state, but it may also register as a complaint regarding a decline in moral norms—as, for example, in the nostalgic memories
of older Vietnamese people who describe how horizontal affect formerly structured social relations: During the socialist period and especially wartime, apparently even strangers addressed each other with a warm, comradely *tình cảm* (sentiment). Lacking this foundation of trust, Hanoians often told me that they attempt to ward off the danger of anonymous market transactions by purchasing food from familiar vendors or eating only at venues where food preparation areas are in view. This mistrust of the public sphere extends upward to the state: where the people in socialist Vietnam were formerly privileged as symbols of dynamism and modernity, the government now often envisions crowds and public spaces as a source of instability rather than a negentropic resource of national identity (see Thomas 2001).

As Wald suggests, one of the key functions of the outbreak narrative is to “catalog the spaces and interactions of global modernity” (2007:2); the cholera outbreak narratives, in the media and in lay accounts, imagined the routine spaces of modern city and rural hinterlands to be animated by the risky byproducts of capitalist consumption and exchange. This perspective may not be not entirely mistaken, though I suggest it misrecognizes the primary drivers of public health risk in contemporary Vietnam. By naming petty capitalists as the primary source of risk, these accounts refused to recognize how large-scale forms of privatization and deregulation have compromised socialist institutions for securing collective health.

During the turbulent decades that have followed market transition, health disparities have increased alongside socioeconomic inequity. Vietnam’s state health sector has adopted a cost recovery system, such that the right to care at the public expense has largely been replaced by the obligation to pay. In 2001, the World Bank reported that “a single visit to a public hospital takes up 22% of all nonfood expenditure for a year for a typical person in the lowest quintile” (World Bank and Vietnamese Ministry of Health 2001:149). Even studies that acknowledge the macro-social benefits of economic growth concede that reform has contributed to stratified health outcomes (see Witter 1996).

In turn, local ideologies of health are changing. Whereas public health was formerly (ostensibly) guaranteed by the state, it is now less and less the responsibility of anyone in particular: The national health sector has become a slippery public–private hybrid. The increasing commodification and pharmaceuticalization of health, the appreciating popularity of non-state health care, and the rise of an urban gym and fitness culture (see Leshkowich 2008) all suggest the suasive power of a vision of health as a phenomenon of private and self-responsible bodies, a commodity, and the counterpart of economic well-being. Health is increasingly envisioned as a middle-class achievement, not a revolutionary project.6

Much as cholera was deployed symbolically to express interclass strife in 19th-century Europe (Hamlin 2009:82) and in Latin America in the early 1990s (Briggs and Mantini-Briggs 2004; Nations and Monte 1997), cholera in Hanoi in 2007–2010 also provided a proxy for the expression of preexisting intrasocietal rifts. Cholera was a venue for differing expressions of a tainted commons: both as the consequence of market economics run amok and the failure of certain groups to conform to expectations regarding class and gender. Less frequently but more critically, some observers deployed stories regarding official responses and the probable causes of the outbreaks as evidence of the state’s dysfunction: a tainted commons propagated by failures of government.

Overwhelmingly, however, the cholera outbreak narratives articulated in lay commentary as well as in public health discourse imagine the consequences of violating the conventions of family-based health centered on the home. This view of a tainted commons divides safe, familiar social geographies and practices from their risky counterparts and shores up the class- and
gender-normative home as the locus of safety, with danger increasing as one travels further in social and physical space. Such beliefs about safety and danger suggest the imperative people feel to enforce social hierarchies that manage the risks of interactions with individuals who personify the chaotic qualities ascribed to public places.

**Dog Meat and Men; Street Food and Women**

Although street food in urban Vietnam has been linked to health risks, food preparation and consumption at home may also be unsafe—a fact largely not acknowledged in lay and official models of cholera risk. Consumption in more elite venues could also be dangerous—in fall 2007, a chef at a five-star hotel reportedly tested positive for cholera (Dân Trí 2007), but there was no publicity about the risk to elite and presumably foreign diners. Given the potentially arbitrary boundaries between safe and dangerous consumption, I suggest that outbreak narratives may be read not only as literal accounts of biological processes, but also for the encoded prescriptive visions they contain. The latter regards matters such as how men and women should conduct themselves vis-à-vis public and private spaces, the risks entailed by a market economy, and what health means and how it can be secured in the post-transition period.

As the interviews and news articles quoted above suggest, the cholera epidemics provided a venue for public expressions of distrust of street vendors—poor, female, rural-to-urban migrants making a living by occupying public space without a license (Figure 2). The association of cholera with migrants conflated rural places and people with filth and ignorance, especially insofar as workers penetrated “modern” urban spaces. These models of causality represented informal workers as what Briggs and Mantini-Briggs, in their analysis of the Venezuelan cholera outbreaks of the early 1990s, term “insanitary subjects”: “intrinsically linked to a particular package of premodern or ‘marginal’ characteristics—poverty, criminality, ignorance, illiteracy, (…) filth” (Briggs and Mantini-Briggs 2004:33).

These disparaging representations are continuous with historic portrayals of independent petty traders, who have been stigmatized in Vietnam since before the socialist period. As anthropologist Ann Marie Leshkowich shows, prior to market transition, these women were represented as a “pariah capitalist class,” whose activities “dramatized state failures to provide for citizens’ material needs”; in the post-liberalization period, traders have been stigmatized as a symbol of premodernity and a “backward subsistence economy” outside state control (Leshkowich 2005:187). What is novel about the representations of traders in the cholera outbreak narratives is their literalization of the threat that rural women are imagined to pose to the body politic. They naturalized the vendors’ alleged association with the power of the market to diffuse risks as broadly as it purveys goods. Street vendors were therefore made to personify some of the most ambivalent and negative attributes ascribed to the concept of public: contamination, deregulation, and the corrosion of traditional forms of authority. As the woman quoted below suggests, rural-to-urban migrants are imagined by some to represent the principal source of low standards for food safety in the informal sector.

Even when they say [street food] is safe, I think it’s not safe. (…) Generally, the kids working there [các cháu phụ] have come up from the country, they don’t make things clean like I do.

—Phan Thị Lý, female, 51 years old, Hoàng Mai district, Tương Mai ward, 7 March 7, 2010.
It is clarifying to consider the cultural logic of this outbreak narrative in the context of market transition’s influence on gender relations in Vietnam. Following the retreat of the state from mass movements in preventive health care and education, the burden of securing public health has come to depend ever more on the efforts of enlightened women in their capacity as mothers and wives. In this view, health requires a family with the material security to dedicate female labor to the maintenance of middle-class standards of hygiene, nutrition, and comportment. Street vendors in Hanoi—thousands of poor, young, and uneducated rural women confound this expectation. Considered a source of moral and material disorder, they are readily imagined as a public health risk.

During the cholera outbreaks, state scientists also insistently attributed the persistence of cholera to the consumption of dog meat, a culinary tradition historically practiced in northern Vietnam. Dog-meat eating, while controversial, is also rich with cultural, political, and religious significances, especially for its partisans, who sometimes refer to it as expressive of the “national spirit” (Vũ Thế Long, personal communication). For individuals who disapprove of dog meat eating, the practice is “playboy-esque” (ăn chơi) and associated with the corruption of the new middle class. During the epidemics, health authorities targeted dog slaughterhouses, vendors, and restaurants; dog meat eaters, believed to be at high risk for cholera, were warned away.
The apparent lack of logic in this model of causality drew criticism from some scientists. However, this theory made sense in light of a family-based model of public health that privileges a vision of class- and gender-normative behaviors. Dog-meat consumption in Vietnam is strongly associated with other practices of middle-class masculinity, including collective indulgence in alcohol and visits to prostitutes. Recently in Hanoi, the U.S.-based NGO Family Health International produced a billboard that underscored the implied connection between men drinking alcohol in groups and extramarital sexual activity. This image, part of an HIV/AIDS awareness campaign, metonymically connected a group of men enjoying beers to the possibility that they will be exposed to disease in the sexual encounters that are implied to follow.

Poor female street vendors were also envisioned as a cholera vector, via their bodies and/or the merchandise they sold. Reading into these accounts, I suggest that there is a link between the figure of the street vendor and the prostitute as they are commonly represented. Both social types subvert expectations for feminine domesticity. Both are imagined as public health risks: always already contaminated, workers in the capitalist public sphere who deceive their customers as they place them at risk of disease (see Nguyễn-võ Thu-hương 2008:120).

If there is a synthesis between the stories about street vendors and the stories about dog meat, ideationally if not epidemiologically, then it seems that the state’s model of cholera risk is informed by Douglas’s classic notion of pollution as “matter out of place” (2002 [1966]:44). Male and female bodies are understood as contaminating and liminal when they engage in certain practices: rural women when they travel to the city to enter productive roles by selling merchandise, and middle-class men outside their productive roles as workers and family members.

As Nguyễn-võ (2008) has demonstrated, a resonant cultural imaginary links Vietnam’s neoliberalizing economy and the rise of commercial sex, supported in part by the tendency of men affiliated with state-owned capital to seal deals with partners in the private sector with trips to prostitutes. Though cholera is not a sexually transmitted disease, I suggest that some of the anxiety articulated about cholera is a response to the threat posed by social groups who transgress gender roles and underscore how such behavior may be lucrative or pleasurable. These models of causality reveal one version of how the tainted commons is imagined in the post-transition period, illuminating how undisciplined, transgressive forms of social contact, public behavior, economic activity, consumption, appropriation of space, and “cultural” practice are framed as pathogenic. What is particularly troubling in this vision for its adherents is the notion of what I call the “contagious circuits of capitalism”: the sense that things provided by the market economy are inseparable from the hidden dangers they contain.

As I have suggested, stories about cholera risk were used to press home tenets of the post-socialist model of health and disease. Particularly, the individualization of risk and responsibility for disease prevention and the privileging of the private family as a site for health promotion signaled the demise of socialist public health and the era of mass health mobilizations. Preventive health behaviors are now expected to be implemented most effectively in the home. Conversations with friends, interview respondents, and state health workers emphasized that privatized solutions represent a common-sense strategy for managing the health risks that people perceive around them.

Unpopular Theories
Though the imaginary of a tainted commons contaminated by poor and socially marginal individuals, irresponsible individual behavior, and deviation from class and gender norms was widely broadcast in various forms of public communication, these were not the only accounts of the cholera outbreaks. The lack of more satisfying explanations and responses motivated a number of scientists and writers to publish critiques, some of which circulated widely. Outbreak narratives, which deployed the disease as a moral symbol, had proven to be a particularly powerful tool for state media and public health authorities. But during and after the cholera episodes, evocations of contamination were appropriated by dissident writers who reversed the direction of blame, portraying state policy as a source of contamination.

Most notably, the Australia-based scientist and prolific blogger Nguyễn Văn Tuấn published scathing appraisals of the flaws in the state’s outbreak investigation and the reporting of the epidemics in state media on his personal weblog. With titles like “Cholera: Water Is More Important than Shrimp Paste” and “Cholera: Call It the Right Name to Prevent It,” Tuấn pointed out that the use of the term “acute diarrhea” was spurious, that shrimp paste was an improbable vector for bacterial contamination, and that the Ministry of Health was conflating the concepts of risk factor and cause—a basic epidemiological fallacy. As a result, shrimp paste and dog meat consumption were designated the cause of cholera, though the data could only substantiate correlation. The lack of a control group in these early epidemiological reports, Tuấn argued, made the ministry’s conclusions meaningless.

Despite his disavowal of any interest in the political significance of the cholera outbreaks (Nguyễn Văn Tuấn, email to author), Tuấn used vocabulary that linked an explicit critique of state science with an implied critique of the state. He made somewhat facetious use of legal terminology, arguing for shrimp paste as “innocent” (vô tội) and employing terms such as “convict” (kết tội), “culprit” (thủ phạm), and “damages” (thiệt hại) (Nguyễn Văn Tuấn 2008a). In this way, Tuấn’s articles leveraged objections based in epidemiology and medicine to advance a critique of state power, especially as exercised through judicial means and via the manipulation of appearances. His critique was resonant with other protests against the state’s politically expedient revisions.

Other writers countered official versions of events by using cholera as proof of—or a metaphor for—the incompetence and dishonesty of the Vietnamese Communist Party. An editorial posted on an anti-Communist discussion forum in November 2007 accused the government of covering up cholera owing to its fear of a tourist exodus (Vietcyber.com 2007). An article titled “Why Is Vietnam Poor and Lowly?” excoriated the declining state of Vietnamese politics, accusing the upper leadership of not daring to announce the cholera outbreak publicly “because they’re afraid of offending those above them” (Dân Làm Báo 2011:5). In a more literary vein, an article republished on the state-censured blog Dân Luận figured two top political leaders as infectious diseases, casting Prime Minister Dung as cholera and the general secretary of the Communist Party as plague. As the commentary suggested, the only way to avoid infection by this “cholera” is to avoid consuming anything at all (Dân Luận 2012).

A rejoinder to this remark by user “Phong Uyên” questioned the logic of choosing between the two “diseases,” suggesting instead that a preventive health campaign was called for. Here, the use of socialist-era health rhetoric to suggest a political housecleaning was ironically apropos:
Why not inoculate against the disease? Clean the environment, eat and live hygienically in order to prevent sickness, to continue living in health? Would any Vietnamese person want to choose between plague and cholera? I choose the method of wiping my hands clean, cleaning the environment. Eating and living hygienically, ready for the injection. [Dân Luận 2012]

Of Post-Transition Infrastructure

Of the methods that Phong Uyên suggested in this simple model of “public health” promotion, environmental sanitation, hand-washing, and a comprehensive hygiene campaign stood out not only for their potential efficacy, but also for having been neglected in official communications during the epidemics. Instead, as I have discussed, models of risk and potential exposure focused on the behavior of certain social groups—predatory vendors and unwise consumers. As Nguyễn Văn Tuấn noted, the city water supply represented a more significant risk factor than the food sources that had been designated problematic (2008b).

Hanoi’s increasing population makes the provision of safe water and sanitation management critical considerations for public health. The rate of municipal groundwater abstraction has begun to overreach the carrying capacity of the water table; this contributes directly to increasing the pollution levels of the two main aquifers supplying the city, as intensive pumping “causes lowering of the groundwater table creating a cone of depression and a large hydraulic gradient” (Nguyen Van Dan and Nguyen Thi Dzung 2002:3). Groundwater is therefore more susceptible to pollution from surface water and surrounding soil. Further, Hanoi’s sewer system is “old and in disrepair and (...) significantly impeded by solid wastes” (Nguyen Viet Anh 2005:14). To date, no sewage treatment plants have been constructed in Hanoi; the city’s two pilot plants have the capacity to treat only 1% of urban wastewater. As a result, almost all of Hanoi’s wastewater is “directly discharged into lakes, ponds, and rivers” (Quan et al. 2010:47). Subsequent to the fall 2007 cholera outbreaks, “[V]ibrio cholera was found in Linh Quang Lake. (...) High values of total coliform in water bodies indicated high faecal contamination and implied poor treatment and maintenance in septic tank and direct discharge of black water” (Quan et al. 2010:50).

In the absence of publicly provided sanitation and safe water, city households develop work-arounds ranging from installing home wells to soaking vegetables in salt water and relying on septic tanks. The high prevalence of septic tanks across Hanoi, plus a low rate of desludging, in fact, threatens to contaminate groundwater and private wells. Home wells draw water from levels that are particularly subject to contamination through leaching from septic tanks. Spot tests have shown drilled wells in Hanoi to be universally contaminated with organic pollutants beyond permitted standards (Trinh Xuan Lai 2007:9).

These data suggest that the permeability of urban surface and ground water to poorly maintained septage systems and other sources of wastewater could represent a source of contamination diffused throughout the city. In the absence of universal provision of water and sanitation infrastructure, individual attempts to secure basic household necessities may perversely expose households and communities to serious health risks. The demographic and economic pressures of the post-transition period—urbanization, deregulation, and privatization—have translated into a form of urban development that, while featuring a landscape of new office buildings and residential towers, has failed to invest in the far less glamorous project of installing and maintaining adequate water treatment facilities and sewer systems.
In light of these systemic weaknesses, the displacement of health fears onto street vendors and dog meat eaters appears mystifying at best, and efforts to represent safe private interiors as separate from risky public venues seem quixotic. Insofar as the commons make up the material ground of life, they may spread everywhere. Health care transacted in private and meals eaten at home, despite fulfilling the imperatives of civilization, may not represent a source of health and safety after all.

**Discussion and Conclusion**

As a (possibly apocryphal) Chinese proverb advises, “There is no one to sweep a common hall.” Whereas the arrangements of socialist society previously guaranteed—at least nominally—state and party care for resources held in common, in the post-transition era, the Vietnamese state has radically reduced both its control over the national economy and its commitment to public health, leaving these projects in uncertain hands. Outbreaks of cholera in the national capital disrupted the appearance of national prosperity, progress, and well-being, raising the question of who was to blame. State discourse interpreted these episodes as evidence of the backwardness and abusive practices of female petty traders.

The displacement of these concerns, materializing in the imaginary of the tainted commons, ultimately resulted not so much in a successful effort to control disease, but in an argument for the amplification of state power, especially in its efforts to discipline public conduct. This account refused responsibility for more significant inputs to mass diffusion of disease, including especially an overtaxed civic infrastructure, crumbling under the weight of rapid urban transition. In this regard, the designation of Vietnam’s public health ills as evidence of a tainted commons reflects the state’s ambivalence toward the forms of civil society and market economy it has introduced and its reflexive interest in asserting control, reinscribing hierarchy, and managing the creative destruction of capitalism.

**Notes**

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1. Although this practice has been banned, many farmers in North Vietnam use human waste to fertilize crops and irrigate agricultural fields.
2. All interview respondents are identified by pseudonyms.
3. In the city, this category includes almost everything that one uses or eats, but people tend to conceptualize food bought at the market as different from street food (_thức ăn đường phố_).
4. As Melissa Pashigian notes, despite Vietnamese women’s high rate of participation in work outside the home, “care for the family is still highly vested in women” (2002:139). Public communications about health are almost always implicitly addressed to women; the Ministry of Health’s Health and Lifestyle website, for example, is targeted to middle-class women, with features about beauty, exercise, cooking, sex, and child care.
5. A number of terms are used to designate the concepts public, collective, common, or communal in Vietnamese. Given the historically specific formations of concepts of property and the public sphere (see Drummond 2000), these require some parsing: The term _công cộng_
references the publicly accessible property of the state—as in a public park or a public telephone; the term *chung*, meaning general, is used to designate arrangements of more nonmediated sharing. The term “public health,” sometimes translated as *y tế cộng công*, meaning something akin to state health, is more commonly recognized as *y tế cộng đồng*, or community health. During the collective period, yet another term, *tấp thở*, more frequently referenced collective or communal ownership; increased use of the term “community” is an artifact of anthropological research and the work of NGOs in the post-transition period (Dao The Duc, post to listserv, March 3, 2013).

6. During the socialist period (1945–1986), North Vietnam expanded its public health system, developed a national network of commune health stations, and mass vaccinated against communicable diseases. Cholera eradication after independence was particularly promulgated as a patriotic initiative.

7. Hanoian street vendors are almost exclusively female and mostly not permanent residents of Hanoi (Jensen and Peppard 2003:72).

8. Such measures to securitize food sources drew on Vietnam’s recent experiences of biosecuritization during avian influenza outbreaks (Guénel and Klingberg 2010).

9 As a recently translated volume on Hanoi’s colonial-era institutions for the detention of prostitutes suggests (Vũ Trọng Phùng 2011), governing sex workers’ threat to public health has an entrenched history in Vietnam. Though a recent study reported that female sex workers infected with HIV in Vietnam account for only 11% of all infections among women, state campaigns have largely attributed the spread of HIV to prostitution and injection drug use (Nguyen et al. 2008).

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