

THE ANTHROPOLOGY OF SARS AND THE LEVERAGING OF CULTURAL LOGICS IN
VIETNAM

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By

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ABSTRACT

With the accessibility of air travel, infectious diseases such as SARS, MERS, Avian Influenza, and Ebola have become extremely mobile. Although severe acute respiratory syndrome (SARS) originated in China, it wasn't diagnosed there. Chinese-American businessman Johnny Chen was diagnosed on his arrival to Vietnam from China in February 2003, spurring the WHO to issue an unprecedented global alert. An acute and mysterious respiratory disease was ravaging Vietnam. Dr. Carlo Urbani, the doctor who first diagnosed SARS, leveraged the cultural logics in Vietnam to mobilize the European Union, the WHO, and the communist government into action with such rapidity that Vietnam stayed ahead of the curve, and was the first country to eradicate SARS. From the perspective of critical medical anthropology (Singer 2016), utilizing a theory of cultural logics (Enfield 2000), and Foucauldian biopower (1982), I explore Vietnam's embedded cultural traits and the interaction between the state and the population "the conduct of conduct" (Rabinow, Foucault 1984:18) through the Ministry of Health and the central government of the Socialist Republic of Vietnam during the pandemic outbreak. Vietnam is a case-study in disease containment; the first country – as a developing nation – to control a mass contagion in the contemporary age.

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DEDICATION

To the Fahlmans, for their unspoken support. A family of pioneers, in a harsh climate we homesteaded the prairies. As members of the Saskatchewan vanguard – and after more than a century – we stayed, to reap the soil’s never-ending harvest.

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CHAPTER 1

INTRODUCTION

1.1 Research Questions and Context

SARS shook the world. By some standards, the first emerging and readily transmittable disease of the 21st century was not a big killer, but it caused great fear and social disruption (WHO 2006:vii). In this thesis, I analyze the social aspect of infectious disease, which is often ignored, or is only assessed or reviewed after a serious health event. To do this, I use the lens of critical medical anthropology (CMA) which Singer (2015) describes as the intertwined biological, environmental, social, and cultural worlds in which infectious diseases are set. I address three central questions: (1) What cultural logics were leveraged in Vietnam's SARS outbreak? (2) How did the WHO global network and WHO Country Representative Dr. Carlo Urbani influence Vietnam's SARS response? (3) In what ways does an analysis of Vietnam's SARS response highlight the importance of the sociocultural and biopolitical aspects of infectious disease? I outline how participants recall making sense of, and responding to the SARS pandemic, within a communist political context and in light of Vietnam's political history.

Severe Acute Respiratory Syndrome (SARS) originated in China. In November of 2002, reports surfaced in the media of a rare pneumonia outbreak in southern China. A 45-year-old man in Foshan City, Guangdong, became ill with fever and respiratory symptoms, and passed on the infection to four relatives. He was retrospectively identified as the first SARS case (Xu 2004:1030). China's closed system of reporting led to a growth period for the as yet unnamed virus. It spread throughout Guangdong province. Doctors from the mainland and Hong Kong made frequent visits to the area to address the mysterious killer contagion. The Chinese government attempted to contain information on SARS, even though news reports were making their way to

the outside world. The government control of information demonstrates an important biopolitical aspect to the SARS pandemic that requires critical analysis. I argue here that state control of information proved to be important in the development and migration of SARS. This aspect to the disease is rarely accounted for within the biomedical realm. Government control exists outside the framework of the doctor, lab, patient axis, but is no less important in the progression of infectious diseases, and ultimately disease control.

In China, many people complained of a government cover-up. Media silence only encouraged the criticism to flourish, and in the case of SARS, it exploded onto the world stage despite the Chinese government's efforts to hide it (Fong 2006:533). The WHO sent a team to China to investigate how to work with the Chinese government to get accurate reporting of the situation. As the New Year of 2003 approached, deaths rates rose. The WHO made repeated requests for transparency, based on increased news reporting of deaths and local pandemonium related to SARS.

The WHO (2006:76-77) described the lack of media coverage and suspected underreporting in China at a critical juncture in the rise of the SARS pandemic:

The disease was barely covered by the media, creating a fertile environment for the spread of rumors. Chinese journalists say they were dissuaded. At a press conference on 11 February, Guangdong health authorities announced that the outbreak of atypical pneumonia had started on 16 November 2002 and had affected 305 people, only five of whom had died. Then they quickly focused attention on the National People's Congress in Beijing in March, where a new president, premier, and Government would be chosen. Outsiders found the information that was filtering out of China hard to believe. They feared the outbreak was far worse.

Assistants at a Chinese medicine shop prepare traditional medicines for clients worried about the SARS virus. The media turned to the WHO office for information that the Ministry of Health and Chinese Center for Disease Control and Prevention (China CDC) were unable or unwilling to provide. By the first week after the initial report on 10 February, the local media had identified the WHO office as a potential source of information on the new disease. It appeared that the potential spread of a new and deadly disease was of great concern to their readers and listeners.

Panic broke out. Local residents stocked up on medicines and food in preparation for the worst. The Lo Wu border (Hong Kong) is directly south of the Luo Hu border (Shenzhen). This is the busiest foot traffic crossing in the world. One-hundred million people move through this area each year. It is therefore a mega-conduit of human foot traffic from the most populous nation in the world, to one of the busiest air travel hubs. An infectious disease in Guangdong province benefits from a constant flow of people to Hong Kong for daily shopping and holiday visits to the former British colony. SARS proved to be no exception. It migrated from mainland China's Guangdong province to the global hub of Hong Kong. From there, air travel out of Hong Kong took SARS global.

On February 21, 2003, a Chinese doctor who unknowingly carried the disease visited Hong Kong. SARS spread to other travelers who then spread it throughout the world (Fong 2007:532). The WHO (2006) reported that at least four hotel guests on the doctor's floor were infected through the air conditioning system. Two days later, one of those infected travelers – Chinese-American businessman Johnny Chen – arrived in Vietnam.

SARS first gained attention outside of China in March 2003, when Dr. Carlo Urbani, a WHO official based in Vietnam, reported several cases of “atypical pneumonia” at the hospital

where he worked (Mendoza 2012:1). After months of mysterious deaths in China, SARS appeared in Vietnam. Johnny Chen was first diagnosed at the privately-owned Hanoi French Hospital after doctors and nurses recognized something was very strange with a patient afflicted with an atypical influenza. They immediately called in the WHO's resident doctor to bring global expertise to the fore in a very dangerous situation. The hospital staff and Vietnamese foreign-trained doctors along with French clinicians responded immediately. Their actions precipitated an unprecedented global alert that began with Dr. Carlo Urbani's key diagnosis. With close connection to the global healthcare systems of the WHO, Vietnam is an open and transparent country that strives to integrate with the rest of the world. Vietnam's response to the atypical pneumonia was one of solidarity and international cooperation. The biopolitical positioning of Vietnam as an open and cooperative nation is a key feature in the global narrative of SARS.

Vietnam's society was shaped under one-thousand years of Chinese rule, a millennium that plagued Chinese regimes with countless village-linked rebellions and regime expulsions. Interlaced among the struggles against Chinese rule were attacks from the Mongols, striking a weakened Vietnam after the expulsion of protracted Chinese regimes. France's colonialization of Vietnam spanned a century, followed by decades of the American occupation of southern Vietnam. Fending off all foreign invasion culminated in the American War (1955-1975), and the push West through Chinese-backed Cambodia to topple the Pol Pot regime in 1979. With that, colonialism was officially over in Vietnam, a communist country that earned the ire of its neighboring countries. Vietnam was forced to deal with the biopolitics of isolation.

Isolationist policies and defaulted reparations after the American War devastated the Vietnamese economy. The country endured a decade of starvation and great national need, as it was left to grapple with taking care of its own people. As a result, in 1986, Vietnamese leaders

initiated the *doi moi* era, a national interest in renewal and openness to cooperation with foreign governments. The city of Hanoi, the same city that stood resilient against Chinese, Japanese, French and American encroachment, adopted a new moniker for the coming millennium, “*Thanh Pho Hoa Binh*” (City of Peace). A history of isolation from the outside world tempered a city and a nation that, to compensate and ‘catch up’, aggressively sought – and continues to seek – foreign assistance and expertise.

Vietnam’s early containment of the SARS virus is a case study on the impact of society’s cultural logics and biopolitics on global pandemics. As Enfield (2000:36) states, cultural logics exist among individuals in a group, referring to what is mutually known by those who share a local environment and/or a common heritage. Further, cultural logics are dynamic, and exist in the everyday, similar assumptions people make in interpreting each other’s actions. On the other hand, as Taylor (1990:139) states, biopolitics, involves governmental decisions made in response to prevailing health of its citizens. Both concepts emerge clearly in an anthropological analysis of SARS in Vietnam. This is important because Vietnam was the first country to diagnose the SARS epidemic for the danger that it was. On April 28th, 2003, Vietnam was also the first country to be removed from the World Health Organization’s (WHO) list of SARS-affected countries (Le 2003:265). This was accomplished by Vietnam in the face of this millennium’s first global pandemic. By July 5, 2003, when WHO declared the outbreak over, it had received reports of 8,439 cases and 812 deaths from 32 countries and areas (WHO 2006:185).

Sociocultural and biopolitical dimensions were major factors in the SARS pandemic. These include the suppression of information about the SARS outbreak in China, and the movement of air travelers into Hong Kong and around the world. Colonialism, war, and isolation in Vietnam gave rise to the cultural logics of solidarity and resilience. These logics influenced Vietnam’s

successful containment of the epidemic. Vietnamese recollections of the response to the SARS pandemic highlight the importance of sociocultural and biopolitical aspects that shaped the path, and ultimately the containment of SARS. Singer's (2016:225) assertions of the importance of cultural origins of disease are therein confirmed.

In this research, I explore the ways in which people in Vietnam recall and explain the events of the SARS pandemic, and the extent to which various aspects of Vietnam's sociopolitical history informs those explanations and recollections. I explore the cultural logics at play during the SARS pandemic, drawing upon the responses of Vietnamese doctors and nurses as well as staff from the Ministry of Health and media participants who found themselves at the heart of the outbreak. These cultural logics developed generationally through Vietnam's history to influence the way participants conducted themselves during the outbreak, and how they responded during research interviews. I also examine if and how Dr Urbani, as a galvanizing figure in the SARS pandemic, figures into health community's explanations and recollections of the fight during the installation of the disease protocols. Finally, by focusing on the sociocultural and biopolitical dimensions of SARS, I identify the ways in which this study contributes to health-related ethnography of Vietnam and Southeast Asia. There has yet to be an ethnographic study of the SARS outbreak in Vietnam, a developing nation that at the time had limited technological advancements in healthcare, but benefitted from its national effort at global integration since 1986's *doi moi*. This thesis offers an ethnographic account of how residents of Hanoi recall the SARS outbreak, framing it in terms of war, an us-them dichotomy, and Vietnamese solidarity.

1.2 Theoretical Framework

1.2.1 Critical Medical Anthropology

I adopt a critical medical anthropological (CMA) analytical framework to explore the sociocultural and the biopolitical aspects of the SARS pandemic in Vietnam. Critical medical anthropology dates to the mid-1980s when the sociocultural and the biopolitical dynamics of disease were increasingly addressed. Medical anthropologists such as Merrill Singer and Hans Baer emphasized the social and political dimensions of disease as a way to problematize the representations of ill-health as a primarily natural phenomenon. As CMA developed over the decades, the broad political focus has narrowed to pertain almost exclusively to inequities at the community and national levels. In my research, I am using CMA to guide my analysis of how Vietnam's political history and current political structure influenced the SARS epidemic in Hanoi. Singer (2016) argues that social and cultural origins of infectious disease are of comparable importance to biological pathogenesis. In Singer's (2016) view, infectious agents such as bacteria, viruses, and helminths are the necessary and immediate causes of infection. But who gets infected, under what conditions, and with what health and social outcomes are culturally constructed and politically determined. Infectious diseases, therefore, involve far more than biology.

If we are truly suspended in Geertz's (1973:5) webs of significance that we ourselves have spun, then these webs of culture and politics are important determinants of health-related issues. Baer (1997:1567) states that CMA allows us to account for those webs by examining how illness unfolds in different sociocultural settings. As Leatherman and Goodman (2011:29) state, the question is not whether health is more biological or more cultural, but how health processes emerge and intersect as part of the "biocultural dance". Human health and wellbeing is biocultural.

Infectious disease, and all responses to it, therefore, must be understood beyond biological givens. Political, cultural and social factors mediate and shape the impact of, and the fight against infectious agents on humans in the Socialist Republic of Vietnam. In this light, I use CMA to draw out several levels of analysis with regard to how Vietnam's social and political history impacted the SARS epidemic in Hanoi: Vietnam's socialist-oriented biopolitics; its stratified political levels in society; and its long history of colonialism. A critical medical anthropological theoretical framing will establish the connection of global health-related issues with political and social order.

My analysis of the biopolitics of SARS in Vietnam is informed by the Foucauldian view of biopower. The communist state enacts the "conduct of conduct" (Foucault, Rabinow 1984:18) and this is illustrated during the SARS outbreak. As I will argue later in my thesis with specific examples, participant interviews revealed a high respect for, and adherence to government protocols for healthcare workers and patients. There was a palpable solidarity with decisions from Vietnam's Ministry of Health *and* among the private Hanoi French Hospital healthcare workers who diagnosed the arrival of the atypical pneumonia. Both public and private hospitals have a different level of accountability to the communist government of Vietnam. Public hospitals are most closely controlled by the government, while private hospitals have a level of autonomy, coupled with the added dimensions of foreign expertise and global connections. Ultimately, both public and private hospitals must adhere to the central government directives during times of crisis. The Vietnamese government was lauded for its governing over the conduct of both public and private hospitals during the fight against SARS.

In summary, critical medical anthropology takes into account how disease is shaped by underlying social and political forces. CMA is therefore an appropriate lens to assess the meaning of Socialist Republic of Vietnam's accomplishment as the first nation to contain SARS. Following

Singer, Baer, and Newman (1995, 2016), this framework will allow me to focus on the micro-experience of the individual, within the context of macrostructures that influence political and social life in Vietnam's successful response to the SARS pandemic.

1.2.2 Cultural Logics

Cultural logics are collectively held principles that 'make sense' to community members as a framing of, and foundation for solutions to issues and problems that arise. They are resources that guide reasoning, explanation, and problem-solving. Using cultural logics as an analytical tool throughout this analysis sheds light on how and why the Vietnamese people responded to the pandemic the way they did, and highlights key aspects of the successful response in Vietnam. Cultural logics reflect the prevailing communist political climate and protracted colonialist and warring history of Vietnam. Cultural logics also reveal how these macro-level forces play out in the everyday lives of Vietnamese citizens. A focus on cultural logics, therefore, contextualizes the way in which healthcare workers and the government address the mysterious and dangerous viral threat of SARS.

Enfield (2000) suggests that the process of people collectively using similar assumptions in interpreting each other's actions, that is hypothesizing as to each other's motivations and intentions – may be termed *cultural logic*. Fischer (1999) defines cultural logics as generative principles realized through cognitive schemas that promote intersubjective understanding. These logics are conditioned by the unique contingencies of life histories and structural positions in political-economic systems. Vietnam has endured three thousand years of war, and I argue this has fostered a unique set of cultural logics within its subset as a human group.

The history of Vietnamese people cooperating to survive, from collective rice cultivation to fending off three-thousand years of foreign invasion, has galvanized unity in Vietnam. As

Kirmayer states (2018:84-5), exploring cultural meanings requires attention to overarching discourse, embodied practices, and everyday engagements with an ecosocial environment; a shared and predictable social world. Enfield (2000:35) describes cultural logics as a process of establishing conceptual convention where people collectively use similar assumptions to intervene and redirect the course of events during crisis. I argue that in an exclusively biomedical response, the cultural logics of non-biomedical practitioners are largely ignored. Critical medical anthropology, on the other hand, allows us to link human biology and health to social, cultural and political-economic dynamics. Foucault's (1982) notion of biopower is relevant here. Biopower is a force that disciplines, shapes, and redefines individuals through the state's health apparatus. Responses to newly identified pandemics require navigating uncharted territory, but it is territory that is defined, and in a large part, controlled by those wielding biopower. It is in this context that cultural logics emerge.

Vietnam's cultural logics are shaped by the country's tumultuous history of war. The rigors of war and rebellion yield cultural logics of solidarity, resistance and cooperation. Solidarity is seen as an internal "solution" to foreign aggression and encroachment. These logics were recalled during the SARS pandemic, and came to the fore with the virus cast as a contemporary foreign invader. This fight is a primary cultural logic, an ideal that 'makes sense' as framing of, and a solution to all foreign entities – including viruses – trying to enter Vietnam.

Isolation during and after the American War stymied socioeconomic development on all fronts in Vietnam. Resources were diverted to the fight against foreign aggression. However, the long history of resistance to foreign invaders is not only a history of conflict. Vietnam consistently seeks to cooperate with other nations as well as global systems of governance. Vietnam's history yields a contemporary Asian society receptive to outside influence, a galvanized sense of

solidarity, and an internal innovative drive that is open to foreign cooperation. Hanoi, for example, is well-connected globally through a bustling expatriate community of diplomatic missions and foreign corporate and global aid institutions such as the World Bank, the United Nations and the WHO. The cultural logics of solidarity and cooperation play significant roles in Vietnam's response to SARS. I argue that these critical sociocultural aspects of Vietnamese society are essentially ignored in a biomedical analysis of the response to the SARS pandemic.

1.2.3 Biopower

The SARS outbreak was first diagnosed in the private Hanoi French Hospital (HFH). As government involvement increased, patients were required to follow disease protocols established at the nearby Bach Mai public hospital under the authority of the Ministry of Health. Government control over the population of Vietnam was a critical component to containing the SARS epidemic. The state influences the population through public health programming such that citizens become healthy subjects of the state. This is biopower in action. The direct result of biopower is the increased role of government in patient health, disease containment toward mediating public health, and government control and power over international containment through border control and global alerts. Foucault (Rabinow 1984) refers to biopower as the art of government, exercised through biopolitical control of health and other institutions. The biopolitical landscape in Vietnam shifted as the Vietnamese politburo – the seat of government and power in Vietnam – was convinced of the dangers of SARS. Reports from the HFH, followed by Dr. Carlo Urbani's presentation of the disease to the Ministry of Health brought SARS to the forefront of the political agenda. Something had to be done.

Control and containment were the immediate response. Douglas (1966) contends that when a community experiences itself as threatened, it will respond by expanding the number of social

controls regulating the group's boundaries. Protocols were put in place at the HFH which was at the center of the disease outbreak, along with patients, the public, and at borders and air terminals.

This initial response changed the course of events in Vietnam, and Carlo Urbani played a key role in establishing those controls. After being called in from the WHO to the HFH, Urbani quickly realized that the progression of the contagious disease was inordinately rapid in the index patient and healthcare workers who attended to him. Urbani reported to his superiors immediately that “something was terribly wrong” (Fahlman, Urbani, Scialdone 2003). The HFH and Urbani set up quarantine zones in the hospital. Urbani alerted the European Union nations in Hanoi, who pressed for a meeting with Vietnam’s Ministry of Health. With the Vietnamese government convinced, his actions set into course a chain of events that closed the HFH and locked down the country. Through the WHO network, Urbani’s alert set off warnings that united the response globally. Knobler (2004:7-8) explains:

Responding to Dr. Urbani’s alert and other reports of atypical pneumonia in Vietnam and Hong Kong, WHO sent GOARN [WHO Global Outbreak Alert Response Network] teams to Hong Kong and Hanoi to join investigative and containment efforts already underway. The early detection of SARS in Vietnam, prompt sharing of that information with the international community, and aggressive containment efforts by the Vietnamese government, in partnership with a GOARN team, enabled the Vietnamese to eradicate SARS by the end of April. This was accomplished before SARS was contained in either Canada or Singapore, despite Vietnam’s comparatively limited healthcare resources and lower education levels among its population.

Urbani died from SARS on March 29, 2003 in Bangkok, Thailand. He was posthumously awarded the Socialist Republic of Vietnam's highest honors for a foreign national: The Gold Medal of Friendship, and the Award for Public Health.

1.2.4 War

Vietnam has been at peace since 1979. Vietnamese sovereignty emerged after Chinese, Japanese, French and American occupation and the subsequent wars toward independence. War is part of the historical conscience of Vietnam. Streets, parks and monuments throughout the country bear the names of past war heroes and generals. Vietnamese politicians, themselves victors of the War against America, use icons of past battles to remind Vietnamese citizens of this history. Repeatedly glorifying the icons of past battles in all of Vietnam's cultural and political ceremonies emboldens the communist party's ethos of solidarity. Just as Enfield (2000) describes, the public maintenance of a system of assumptions and counter assumptions among individuals about what is mutually experienced provides human groups with common premises for predictably convergent inferential processes. Solidarity in the face of adversity and perseverance in the face of invasion are cultural values that become leveraged as cultural logics during the SARS outbreak. Almost all of the participants made reference to war and solidarity with the fellow workers in their interviews, and I will pick up on these themes to argue their prevalence in Vietnam's cultural logics later in the thesis.

Given its military history, it is not surprising that war figures so prominently in the descriptions of SARS in Vietnam. After a decade of US occupation ending on April 30, 1975, the Vietnamese army moved east to the Cambodian capital of Phnom Pen, concerned with Chinese involvement with the Pol Pott government. They advanced West through the jungles of Cambodia and defeated the Chinese-backed Khmer Rouge after reaching Phnom Pen. The Chinese

government was deeply angered by this demonstration of Vietnamese aggression. China launched a limited attack on Vietnam's northern border. China held fast to newly claimed northern border land in protest of Vietnam's removal of the Khmer Rouge. A "fight" mentality was clearly prevalent in Vietnam at that time. So much so that large militias of non-military, including many women were formed in the absence of the Vietnamese army occupied in Cambodia. Female author and Vietnamese war hero Duong Thu Huong was one of the leaders of the women's militia against the Chinese. The Chinese retreated, ripping up the railroad track that they had navigated to enter Vietnam, and destroying towns in their wake. Vietnamese troops remained in Phnom Pen for a decade until 1989, and any advancement of the Chinese troops in an invasion of Vietnam went quietly unrealized.

Three-thousand years of war have left a deep imprint on Vietnam. This is documented in major war museums and it is evident in the conversations of families, some of which were torn apart by the conflict between the North and the South. However, as the country was sewn back together by a single-party leadership and a people's steely resistance to colonial powers, a cultural logic of resistance to foreign invasion took root.

After three thousand years of conflict, it was the Socialist Republic of Vietnam's single-party communist rule that led the country out of war. The communist party of Vietnam has named the capital city of Hanoi, the City of Peace (*Thanh Pho Hoa Binh*). Although Vietnam is a united nation now enjoying a time of peace, the cultural logics of resistance to foreign invasion, solidarity, innovation, and earnest global cooperation persist. These are the logics that were leveraged in response to the SARS outbreak.

1.2.5 Us versus Them

Fischer (1999:488) agrees that cultural resistance rests on a sense of solidarity in opposition to an opposing force. This gives rise to a dichotomy between “Us” versus “Them”. This is a key logic in the Vietnamese response to SARS. In this case, SARS is the other. As I will discuss in more detail later in the thesis, this metaphor was referenced by the participants in several interviews. One of the participants discussed Vietnamese lore, the bamboo thicket that surrounds the entrance and perimeter of the traditional village. This demarcation divides those outside the village from those inside; the metaphorical “Us” from “Them”. The village is the defining unit of society, a nation shaped and unified by the collective labour of wet rice cultivation. Vietnamese communities are linked together not only through their shared history of war but also through their subsistence labour and village life. The bamboo thicket at the entrance of the village is not easily traversed; the barrier that defines “Us” inside. Villagers inside the thicket cooperate in communal food production and protection. Much as Vietnamese history dictates, the fight against and resistance to those outside the thicket, or “Them”, is a deeply engrained cultural logic that pervades society.

As I will discuss later in the thesis, the theme of “Us” versus “Them” was prevalent throughout participant interviews, and is a key cultural logic that figured in the fight against the SARS pandemic as it entered from outside Vietnam. Fischer explains (1999:474), that any given cultural logic is realized through practice, the dynamic interaction of individual intention. A cultural logic is an amalgam of cultural norms variably enforced through reflexive social interaction, encompassing structural positions in global systems of political economy. SARS crossed the bamboo thicket barrier to create chaos and confusion in the early stages of the

pandemic; a metaphoric intruder within their midst, rearing the well-founded resolve of the Vietnamese people.

1.2.6 Solidarity

In Chapter two, I will discuss how participant interviews revealed that the cultural logic of solidarity figured in Vietnam's response to SARS. Gaztambide-Fernández (2012:46) argues that solidarity refers to unifying social relations between individuals as well as groups. Solidarity is used in reference to a vast range of social phenomena, from social cohesion to social movements, from political to civic organization, from religious duty to ethnic obligation. The cultural logic of solidarity refers to strong social cohesion among Vietnamese. As participants stated, this may be due in part to prolonged wars, causing people to band together in times of resistance. One can resist alone, but it is the perpetuation of resistance through the group that promotes unification.

Solidarity among the Vietnamese people is noticeable in day-to-day living in Vietnam. In March of 2000, when I first arrived to Hanoi from Canada, I took a motorbike taxi on one of my first mornings as a fresh intern arriving at my new post. When I went to pay the taxi, he required change to reconcile the Vietnamese *đồng* note I had handed him. To my surprise, he turned to a complete stranger in the street, who noticed me immediately as the rich foreign client. I was Fischer's (1999:488) the "Other". The complete stranger quickly provided the required change. Only later, after conferring with locals at my new work place did I realize the two had quickly conspired, having never met, to ensure that I was moderately overcharged. A harmless lesson, but a quick lesson on the palpable solidarity of Vietnamese in their daily lives.

As Gaztambide-Fernández (2012:46) states, solidarity hinges on similarities in characteristics, political interests, social needs, or moral obligations. It is clear from the

participant interviews that the HFH staff exhibited similar social needs and moral obligations during the outbreak. They believed that all must stay together and all must continue the fight.

In the microcosm of the hospital, the traditional Asian hierarchy, or honorifics (Sir, Uncle, Aunt, Older Brother, Older Sister) are used as a sign of respect for elders and those in higher position did not diminish this solidarity. As I will discuss later in this thesis, participant interviews revealed that all worked together to protect public health and serve patients regardless of their position at the hospital, or status as an elder during the lockdown. Conversely, outside of the hospital, the hierarchies of the political party, the military, the police, and the stratification of society in general remained firmly intact and played a very important role in patient tracing. This stratification of society was routinely discussed by participants at the interviews; it has been a way of life in Vietnam in the communist era, and provided a lattice on which to build accurate patient tracing, quarantine and isolation during the early days of the pandemic.

Outside the hospitals, the solidarity that ties Vietnamese citizens together meant that they followed national directives to protect public health during the outbreak. This commitment to solidarity developed from decades of national directives guiding citizens during military action and in response to sirens that signaled incoming air raids. Vietnamese citizens are unified in following national directives for the protection of public good as well as individual survival. There is a national pride in full compliance as a civic duty. SARS containment provided evidence of this. Solidarity played a major role in the galvanization of the Vietnamese healthcare workers at the HFH hospital in the resiliency in the face of SARS.

1.3 Thesis Significance and Outline

There are few ethnographies of health in contemporary Vietnam. Some earlier analyses suffered from data limitations or interpretative biases (Chen 1994:1). Porter (2013:132) spent two years with rural families in Vietnam that raise chickens to understand the plight of farmers and government-led controls that prevails over livelihoods. She considers outbreaks of SARS, swine flu and avian influenza with a focus on “One Health” multispecies interactions. Efforts to address human health problems are increasingly rooted in understanding our links, not only to each other, but to other species as well. Montoya (2013) explores the collection, compilation and circulation of contested quantitative data within an emerging HIV/AIDS apparatus in Vietnam. His ethnography shows that in Vietnam, as in many places, biological and behavioral surveillance data are virtually always incomplete and contestable, even as such data have become an essential driver of funding and programming. McClelland (2004) did a comparative research analysis of public health strategies associated with the SARS response in several countries, including Vietnam. Specifically, I hope this thesis will contribute to setting the groundwork for future studies that could offer a comparison between the cultural logics of a pandemic response in two different political contexts: a single-party communist state with a socialist-based market economy and a democratic market-based economy. The results of this research will also contribute to the health ethnography of Vietnam. One particular significant contribution that this study may make is to present the understanding of Dr. Carlo Urbani as a galvanizing figure who tips the balance to urge the Vietnamese Ministry of Health into action against the SARS pandemic.

SARS is a highly infectious, acute, and atypical respiratory disease (Fahlman, Urbani, Scialdone 2003). After an alert from the HFH, the WHO’s Dr. Carlo Urbani’s attempted to diagnose and treat the disease. He quickly came to the realization that it was both unknown and

extremely dangerous. The WHO global network was alerted through his actions, and national mobilization was legislated in Vietnam. Solidarity in Vietnam forms the societal lattice that supported the rapid legislation of national mobilization of healthcare workers. Solidarity represents a deep respect for, and defense of, public good. By examining the outbreak and response from a critical-interpretive anthropological perspective, I identify the cultural logics and biopower apparatus in play in Vietnam. This study lays the ground work for the future incorporation of a developing nation's leadership in the containment of infectious disease.

In this introductory chapter, I have summarized the primary arguments of my thesis. Each theme derived from the data is given one numeric section for discussion. I also present research questions and a literature review of the theoretical approach to this thesis. My background and work in journalism during the outbreak, and over the ten years that I lived in Vietnam gave me a privileged perspective to the news wires. In April of 2003, I co-authored a novelette on Carlo Urbani posthumously, in accordance with the WHO, and the wishes of Urbani's family and medical colleagues.

In Chapter Two, I discuss ethnographic methodology and the context in which I interviewed participants. I also begin to analyze the data in support of the most prominent themes. I have lived in Vietnam for eight years, and have worked in the country for a total of eighteen years. I have an intermediate level of understanding of the Vietnamese language and a comfortable understanding of Vietnamese culture. I also discuss the long history of war in Vietnam and its influence on the cooperation and solidarity of Vietnamese society. I then examine the cultural logics of Vietnam that were leveraged toward early containment of the SARS virus. Leatherman and Goodman's (2011) "biocultural dance" between the pathological and biopolitical realities

parallels with the SARS virus in Vietnam's communist context. The dancers need not be separated, but rather fully understood toward a complete story on the global SARS response.

Chapter Three takes this further with an analysis of the "Us" versus "Them" cultural logic. Vietnam's tumultuous history impacts society, as does its communist government. I explore how this historical and political context informs the dichotomy between "Us" and "Them" that emerges in this research. Vietnam's political and economic isolation after 1979 was pronounced and enduring, resulting in starvation and economic ruin. As a result, the value and appreciation of foreign expertise, the propagation of innovation, and the propensity to look outward are prominent in Vietnamese society. I also discuss how Vietnamese communism and solidarity unite in national mobilization and respect for foreign health expertise. I explore the "Us" versus "Them" dichotomy, a duality that is amplified in a Southeast Asian nation that was once shunned by most of the world. I employ the SARS chronology of events to reinforce the positives in Vietnam's infectious disease response. Emphasis is put on the inseparability of social and political aspects with the biological reality of an infectious disease. As Singer (2015:58) states, the anthropology of infectious disease begins with the understanding that these conditions are at once pathological reality and social construction.

In Chapter Four, I explore the analysis of power as it pertains to the Foucauldian theme of biopower and biopolitics during the critical stages of the SARS pandemic. This is a dynamic analysis that ebbed and flowed through the Urbani diagnosis of the atypical virus, the immediate crisis of rapid death of healthcare workers, government involvement precipitated through the Ministry of Health, and the government's control and penultimate lock down of the country that led to the WHO's global health alerts. In each of these phases, power and thus biopower was impacted through the HFH and the WHO, and the influence of the state on the health of the

population. This is Foucault's "conduct of conduct" (Rabinow, Foucault 1984:18), the state's guidance of the population to maintain healthy bodies.

In the conclusion, I tie together the sociocultural and biopolitical aspects of the disease response in Vietnam. I endeavor to capture three vital facets of this research: (i) the major contributions of the research to existing literature in medical anthropology; (ii) the primary limitations of the research; and (iii) directions for future research. It is my hope that this ethnography takes us much further afield than just the epidemiological approach to SARS, and becomes part of the public record as so.

CHAPTER 2

METHODOLOGY AND SARS IN VIETNAM

2.1 Ethnographic Context

2.1.1 Vietnam

Vietnam is a modern-day Asian Tiger economy, meeting its United Nations Millennium Development Goals. The middle-class in Vietnam is growing at an exponential rate. A gregarious and efficient work force draws international investment and the tourism industry draws over fifteen million holidaymakers annually. Some eighty percent of the population is dependent on agriculture for employment. In 2003, just prior to the SARS outbreak, tourism was burgeoning and economic indicators were strong. The country's economy and tourism were brought to a screeching halt in March of 2003 when the WHO issued its unprecedented global alerts from Hanoi, Vietnam. The central government closed its border due to the SARS outbreak, sacrificing a positive economic environment due to a highly contagious and dangerous atypical influenza.

In March of 2000, I undertook a six-month internship to Vietnam with Saskatchewan Polytechnic, which led to work as a journalist at Vietnam Television's English Department, and the Vietnam Daily Newspaper. In February of 2003, when SARS broke, I was employed at both news outlets, and had access to the newswires and colleagues who worked for the Italian Embassy as well as the WHO. Carlo Urbani was an infectious disease specialist with the WHO, the primary clinician who first diagnosed the atypical pneumonia. Immediately after his death, the Italian embassy and the WHO commissioned me to co-author a memorial novelette in his honor. I interviewed the UN Representative, the WHO Representative, and the Director of the Center for Tropical Diseases at the Bach Mai hospital in Vietnam as a part of the project. This gave me access to news media, diplomatic missions, ministerial contacts, and medical

professionals close to the outbreak. The Urbani novelette was the starting point for this thesis in medical anthropology, as it contains the story of Vietnam's battle with the first major pandemic of the contemporary era.

2.2 Methodology and Analysis

As Singer (2015:56) suggests, the methodological backbone of the anthropology of infectious disease is ethnography – the long-term observational and participatory field of study of people and issues in social and environmental context. I have lived and worked in Vietnam since March of 2000, and I continue to work there each year to date. For the purposes of this research, I conducted ten semi-structured interviews between October and March of 2015. Participants were at the heart of Vietnam's SARS outbreak in 2003. They included healthcare workers from the Hanoi French Hospital, Vietnam's Ministry of Health, communications staff at the United Nations (UN), Vietnam's Oceanographic Institute as well as staff at the Vietnam Daily News and Vietnam Television. The recruitment criteria consisted of participants between the ages of twenty-five and sixty-five who lived in or near Hanoi during the SARS outbreak of February and March of 2003.

I recruited participants through personal connections, posters at desired outlets (Appendix, page 78), and snowball sampling. Following Lecompte and Schensul (2010), the data collection process was guided by a "formative theory". I allowed the data to inform the process, responding to participant comments with follow up questions, and tailoring my analysis to the data. Thus, I spent a large volume of time categorizing data and forming themes to develop a theoretical approach. Using inductive, thematic analysis of the interview data, I analyzed: (1) the links between participants' experiences and the societal and government forces acting upon them; (2) how Vietnam's tumultuous history and sense of nationhood impacts cultural logics; (3)

the extent to which various aspects of Vietnam's sociopolitical history informs participant's explanations and recollections of the SARS epidemic; and (4) the ways in which Carlo Urbani fits into the narrative of the leveraging of cultural logics and SARS containment.

An open-ended interview guide (Appendix, page 76) was used and interviews lasted an average of thirty minutes. Each interview was transcribed and thematically coded. I used a grounded-theoretical approach to induce meaning, and used open-ended questions to probe for meaningful narratives. I analyzed concepts, connections, and participant word usage, identifying thematic commonalities and differences across the transcribed texts. I then chose the most repeated and meaningful themes to complete the research. Initially, I began with approximately 30 codes from the analysis. "War", "Solidarity", "Biopower" and "Us" Versus "Them" were the four most prominent themes in terms of both frequency as well as narrative elaboration. "Biocommunications", "biopolitics" and "societal hierarchy" emerged as important themes as well, but they played a more limited role in the research, and could be accommodated within a discussion of the four more prominent themes.

The fact that I speak intermediate Vietnamese and have lived and worked in Vietnam for nearly two decades helped to minimize the gap between the research participants and me. Because of the long period of time I spent in Vietnam, I remained cognizant of the fact that I must interpret the data in as unbiased fashion as possible, and to look back on the data through this lens. I did this by adjusting my questioning to appear naïve to the SARS outbreak while interviewing participants to try to allow each participant to "teach" me their version of events. People love to teach, so this worked quite well throughout the lines of questioning. Ultimately 90 pages of transcribed interviews resulted. These were supplemented with my observational notes that documented the participants' behavioral responses to questions as well as their general level

of engagement. I realize that this put me in a position of trust that may not have occurred with other researchers. Thematic analysis was the primary strategy used in this research. Participants situated themselves in the stories in telling ways. My guiding analytical question was: “What is it the person is trying to present by the way in which they are telling their version of the story?”

There was marked differences in interpretation of the SARS epidemic offered by the admittance staff, nurses and doctors at the fore of the outbreak, compared with the senior management of the hospital and the Ministry of Health. Stories tended to be more frontline in admittance and nursing, while the Ministry of Health and leaders of the Hanoi French Hospital were more broadly analytical in scope. For example, it was an admittance staff who related the most detailed story of the index patient’s mood of irritability, uncharacteristic of the occidental patients she saw most. Whereas the high level leader of the HFH spoke of SARS on an institutional level in reports to the Ministry of Health and the central government. There were differences in the level of authority, with senior management relating the macro structure influence on the crisis. Their recounting of the events of the SARS outbreak were much more broad based on an institutional level as an international battle against the pandemic. Admittance staff and nurses tended to relate the concerns of their department and the frontline, with patient concerns at the fore. All staff, regardless of their position in the institution, spoke of the solidarity of all members at the Hanoi French Hospital. Each related the coming together of the group to help fallen colleagues regardless of their position at the hospital.

Near the end of my research period, I had a chance to visit the Hong Kong-Guangdong province (Ho Lu) border crossing. Here, I conducted a video log of the border crossing, the busiest walkway crossing in the world, between mainland China and Hong Kong. It is at this site where the massive train system of mainland China meets at Ho Lu and connects with the trains

and buses of the Hong Kong transit system. The purpose of the video log was to capture the sheer immensity of the crossing and the massive movement of people each day. I spent four hours recording the walking traffic to and from mainland China and Hong Kong. The high concentration of people in the area suggests an equally high propensity for the spread of disease, especially as a bottle-neck conduit for infectious disease. Indeed, this area has attracted the attention of the WHO, because of the crowded and transient nature of the Ho Lu border crossing. Masses of people create the perfect vector with which to spread disease, and this is the pathway that delivered SARS from Guangdong Province to Hong Kong, and then on to Vietnam, and the rest of the world. As one of the largest air travel hubs in Asia, Hong Kong International Airport (HKIA) is an advantageous center for the intercontinental movement of infectious disease. SARS demonstrated that HKIA is a global transfer site for infectious disease (WHO 2006:86,151).

2.4 Timeline

After receiving approval from the University of Saskatchewan Behavioral Research Ethics Board in September (Appendices), I traveled to Hanoi, Vietnam in early October of 2015. Once there, I conducted seven interviews, five of which were at the Hanoi French Hospital on October 27. I then returned to Hanoi in March of 2015, and conducted three more interviews for a total of ten interviews. In March of 2015, I began transcribing written versions from the recording. The transcription process was completed in March of 2016. I then completed my course load in April of 2016. I coded interviews by hand and completed the analysis by April of 2017. I began writing in May of 2017 and have continued to December of 2018. I took part committee meetings with my advisors each year, with the last one in January of 2019, with plans for defense in March of 2019.

2.5 SARS in Vietnam

2.5.1 History and Healthcare in Vietnam

Vietnam's agrarian and turbulent sociopolitical history informed participants' explanations and recollections of the fight against the pandemic. Vietnamese people have a history of solidarity to unify and fight foreign intrusion. How were these cultural logics of solidarity and the fight for resistance shaped? Karnow (1983:99) explains the shaping of a nation versed in solidarity and resistance:

Rice cultivation, which is dependent on the vagaries of weather and on complex systems of irrigation, requires cooperative labor. Vietnamese communities thus developed a strong collective spirit, and though autonomous, villages could be mobilized as a unified chain of separate links to fight foreign intruders. Their country's frequent wars also infused into the Vietnamese a readiness to defend themselves, so that they evolved into a breed of warriors. Centuries later, during France's war to preserve its hold on Indochina in the 1950s, the French sociologist Paul Mus warned against the "convenient notion" that Vietnamese peasants were a "passive mass, only interested in their daily bowl of rice, and terrorized into subversion by agents. Their commitment to nationhood had been forged long before".

Several participants went into detail on the fact that Vietnam is a nation shaped and unified by farming families and villages and the collective labour of wet rice cultivation. One participant remarked, "We just stay together and work. Our customs and traditions are families close together, happiness together. But when we have a problem we have to stay together and

fight it.” Almost all of the farm work is done by hand, with many in Vietnam employed in the agrarian sector. In the past, Villages worked together to unify and resist foreign aggression. This is significant. Vietnam was built on the cooperation and hard work that yields harvests and survival. It is also built upon the unifying force of resilience to aggression. As was explained in interviews, repeated wars throughout history meant communities and laborers were counted upon to enlist and repel intruders. With this base of forged resistance, intruders into the country have all met the same fate. For generations, invaders have been repelled, engraining a deep sense of nationhood and solidarity. Fighting enemy intruders is central to Vietnamese history and nationalism. From the data collected from participant interviews, I argue that the SARS virus is a contemporary foreign intruder. The Vietnamese people, led by global healthcare workers and the government, united to fight the virus. This fight was, and is a cultural logic – an ideal that ‘makes sense’ as framing of, and a solution to all entities trying to enter Vietnam. This parallels the Vietnamese Ministry of Health’s legislation of national mobilization of healthcare workers in response to the SARS outbreak. Under government directives, there was a regimented and unified response to protect the public, and reestablish public health. Vietnamese solidarity is an example of a health determinant in the fight against SARS.

The cultural logic of solidarity has its roots deep in Vietnam’s history. The Southeast Asian peninsula, which the French labeled Indochina, and which encompasses Vietnam, Cambodia and Laos, has been a battlefield for centuries (Karnow 1983:ix). The Chinese ruled Vietnam from 200 BC to 800 AD. Revolts against the Chinese were repeatedly successful. But these rebellions left Vietnam weakened to attack from Mongol invaders, first in 1257 and again in 1284 (Corfield 2008:16-17). Vietnamese revolts were frequent during the one thousand years

of Chinese rule. Over the centuries, they [Vietnamese] would repeatedly challenge Chinese domination. And that hostility entered their historic consciousness (Karnow 1983:99-100).

The French colonized Vietnam in 1846 and held rule until their expulsion in 1954 at the battle of *Dien Bien Phu*. American intrusion began quietly in the years following French expulsion, to stem the southward flow of communism from China. The US ramped up military operations to thwart the perceived communist threat with the first troops arriving to Vietnam in 1965. After a long and politically unpopular war, the US was expelled from Vietnam on April 30th, 1975. Three thousand years of recorded history reveal that all attempts to intrude on Vietnam's soil ultimately failed. Throughout this thesis, I argue that the coming of the SARS virus in Vietnam is perceived by society, the government and the healthcare community as another invader, destined to suffer the same fate of expulsion as all those invaders of the past.

Sovereignty came at a cost for the Socialist Republic of Vietnam. Isolationist policies kept the Southeast Asian nation from joining global trade agreements and organizations to purvey its rich and abundant natural resources. I argue that this contracted isolationism is a driver behind Vietnam's respect for, and eagerness to engage with international expertise. The 1980s ushered in a difficult era of poverty and famine. After millennia of isolation and fending off foreign aggressors, the Vietnamese government began the difficult transition of looking outward to join the global community. In doing so, Vietnam, as a communist country, took a bold step in 1986. It undertook a process the government termed *Doi Moi*, a renovation of its economic policy into a socialist-based market economy.

Vietnam also began decentralizing its healthcare system. It reduced subsidies to the healthcare system from the central government. Along with all sectors in the economy, Vietnam's healthcare system undertook a dramatic transformation. Thirty years ago, it was

firmly controlled by the central government. But over time, the ability of the Ministry of Health to shape activities has diminished significantly due to the rapid growth of the private sector, the much larger role of out-of-pocket expenditures, and the ongoing process of fiscal decentralization (Adams 2005:2). Vietnam's population is nearing 100 million in a country about half the size of Saskatchewan. An interesting aspect of pay-per-use healthcare in Vietnam is that in times of illness and suffering, Vietnamese people are very demanding of services for the cost. Interview participants went into great detail to describe Vietnamese patients as unruly and somehow entitled. They must not only pay bribes to doctors and admittance staff as in the public healthcare system, but also pay top dollar for basic health services in a private hospital. In a communist country, providing health services for money has quite predictable outcomes. It suits those that can afford the services, such as foreigners in Vietnam with access to health insurance. But for the majority of Vietnamese people, the costs are enormous to the point where they may never use a private healthcare provider. To say that this breeds an irritated and volatile patient within healthcare is an understatement. For all of the solidarity in Vietnam, it would seem that money contravenes this cultural logic, especially in times of illness and suffering.

The 2003 SARS outbreak occurred in the midst of this transformation at the privately-owned Hanoi French Hospital (HFH), in a healthcare system that Vietnam's Ministry of Health (2012) calls, "a highly unregulated public-private mix". There are four administrative levels in the public system: national, provincial/municipal, district, and commune or community level. The Provincial Health Bureau, under the Provincial People's Committee, is responsible for overall administration of the provincial health system, including provincial services and the district, commune, and private services within the province (Ministry of Health, Vietnam 2012:2). The HFH, where Vietnam's SARS index case was diagnosed, is governed by the

Provincial Health Bureau. But during a crisis, and once the Health Ministry is aware, all directives would originate from the highest levels of the central government and the Ministry of Health.

It is in this biopolitical and socioeconomic climate that institutions like the HFH were formed, bringing in foreign expertise with a fee-for-use system. As participant interviews revealed, the HFH was the first private pay hospital in a predominantly socialist public healthcare system. The hospital is small in comparison to the larger public hospitals and is staffed with French doctors that bring in international expertise. It is a much coveted but expensive healthcare facility. Participants said that staff numbers are small and colleagues are close-knit. During the SARS outbreak, staff stated that solidarity rose as healthcare workers died. As the Deputy General Director had stated in his interview, the Vietnamese government closed the HFH and healthcare workers were not allowed to leave for fear of spreading the disease. Participants revealed in their interviews that they had responded quickly to SARS, and relied on each other throughout the enormity of the pandemic response.

2.5.2 SARS and the WHO

SARS is an aggressive viral illness that is believed to have mutated after making the zoonotic jump from animals to humans. Zoonoses are infectious disease agents that successfully transfer from an animal population host to a human population host (Singer 2015:91). Two independent groups of researchers have now identified bats as a natural reservoir of coronaviruses from which the SARS viruses that infected humans and civets likely emerged (Normile 2005:2154). Himalayan palm civet cats are a wild delicacy in China, and the SARS corona virus (SARS-CoV) may have entered the human food chain from this vector. The common fruit bat, then, is the SARS virus reservoir in nature. And there it remains, being passed

as a disease between the bats and the civet cats. As wild delicacies become more fashionable worldwide, wet markets that sell rare animals flourish. This introduces more pathogens into the human system that can make the zoonotic jump to humans. In his definition of the parameters of zoonosis, Singer (2015:101) states an important consequence of these close relationships is that although microbes adapt biologically and behaviorally to the bodily conditions inside the species they inhabit, they also migrate, jumping to new species and adapting to somewhat different conditions within their new hosts. Researcher Rui Heng Xu (Xu 2004:1030) zeros in on the origin of the SARS-CoV:

Cases apparently occurred independently in at least five different municipalities; early case-patients were more likely than later patients to report living near a produce market but not near a farm; and 9 (39%) of 23 early patients, including 6 who lived or worked in Foshan, [China] were food handlers with probable animal contact. Seroprevalence of immunoglobulin (Ig) G antibody to SARS-CoV is substantially higher among traders of live animals (13.0%) in Guangzhou municipality than among healthy controls (1.2%), and the highest prevalence of antibody is among those who traded primarily masked palm civets.

From living in Vietnam, and according to the participant interviews, it is well known that the traditional practice of using wild animals for food and medicine is common in South Asia and Southeast Asia. SARS owes its global notoriety and mobility to the aforementioned zoonosis, and to droplets of human respiratory fluid, coupled with a symptomatic phase that looks no different than a common respiratory ailment. Healthcare workers that diagnosed the cold-and-flu-like disease would be unaware. The atypical pneumonia had a peculiar hallmark:

health care workers were being stricken at an alarming rate (Drazen 2003:319). Under the camouflage of the common cold or flu, SARS spread rapidly from patients to healthcare workers as they attempted to diagnose and treat unknowing virus carriers. With a latency period of ten days, asymptomatic SARS-infected travelers could fly to the other side of the globe before becoming symptomatic. Even if air travelers or healthcare workers did manifest symptoms, the cough or fever could easily be attributed to the usual cold-and-flu-like symptoms expected during the winter months of the SARS outbreak (November of 2002 to February of 2003).

Human migration has been a key means for infectious disease transmission throughout recorded history. However, the volume, speed, and reach of travel today have accelerated the spread of infectious diseases (Health Canada 2003). The dramatic increase in worldwide movement of people is the driving force behind the globalization of disease (1994 Mann:xv). It seems as though the more humanity relies on technology, the faster we travel. This dramatically increases the mobility of infectious diseases. Analyzing global travel as a predictor of infectious disease surveillance is a key sociocultural component to the study of human health. Coupled with the increase in expansion of the human population, we may be poised to be dealing with zoonotic jumps and emergent infectious diseases in the near future. Indeed, this is what we see happening, with the emergence of Middle East Respiratory Syndrome. Singer (2015:174) states that the first appearance of an emergent corona virus was reported in Saudi Arabia, and is associated with severe acute infection of the lungs and resultant breathing problems. In this case, the use of camels for transport allowed MERS to make the zoonotic jump to humans. This kind mutation and zoonotic jump to humans is a serious concern.

2.5.3 War and Solidarity in Vietnam

Interview participants at the Hanoi French Hospital, when recalling the battle against the SARS virus in Vietnam, repeatedly referenced war and solidarity. Within the interviews, phrases such as, “It was like a war”, “joining the battle”, “fallen comrades”, or “continuing the fight”, were common. Three thousand years of colonialism and conflict suggest Vietnam has embedded cultural logics linked to war. *The Art of War* (Sun Tzu 1971), a translation of ancient Chinese military texts from the fifth century BCE, links culture and war. War is underpinned by cultural differences, pitting one political force against the other. These texts have survived and been revered for millennia, simple but direct analysis on how to exploit the culture of the enemy toward victory. As Garro (2000) states, by participating in social and cultural groups, individuals develop an active tendency to notice, retain and construct meaning and mutual understanding specifically along certain directions. Renowned Vietnamese scholar Hữu Ngọc (29:2016) states that the Vietnamese identity has been forged through a tradition of resistance to foreign aggression. This theme leads Hữu Ngọc to conclude that modern Vietnamese can be defined as members of the Việt ethnic community who resisted becoming Chinese under nearly one-thousand years of Chinese colonial rule. As explained by multiple participants, repeated conflict is part of Vietnam’s history. Indeed, several participants made reference to the fact that the Socialist Republic of Vietnam owes its sovereignty to its ability to withstand repeated conflict. They discussed that most families have a connection to the American war. I argue that solidarity, resilience, and innovation are a part of the nation’s historical conscience. Key examples of this solidarity are evident in the language used in participant interviews. The doctor in charge of the general ward and the index patient when he arrived stayed at the HFH from the first evening to the end of the outbreak, well over a month’s time. She put her version of solidarity in explicit

terms. She stated, “A lot of staff, a lot of doctors and non-medical staff became nurses’ assistants for the first time ever. There was a professor of orthopedics, he did not know about treatment or management [of SARS patients] so he helped us to bring food, clothes and provided bed side assistance for patients. Neurologists, surgeons, engineers, other specialists and non-medical staff became nurses’ assistants.” This is the same doctor who when asked to describe the beginning of the outbreak stated, “It was like a war.”

Sun Tzu’s ancient texts point out that solidarity within the army is critical to the exploitation of enemy weakness. I reference these texts to argue that war is underpinned by culture; humankind relies on similarities to organize into groups. Military leaders in Vietnam rely on a similar ethos of solidarity, and have done so throughout millennia of tumultuous colonialism and war. I argue that Vietnam is a nation of counter-colonial strategists, with history, and their resulting sovereignty, as the penultimate proof of their success in repelling intruders.

As noted by Collins and Malesevic (Malesevic 2011), war is a highly complex, historically contingent and socially embedded process that requires organizational and ideological reinforcement. Thus, the expression of war exhibits the hallmark cultural components, as in Tzu’s ancient texts, that develop and reinforce solidarity in Vietnam. As Keegan suggests (Malesevic 1991), war is an expression of culture with occurrences and character determined by different ethno-cultural, national, and civilizational traditions. Malesevic (2011:146) and Collins (2010) argue that the link among war, nationalism, and social cohesion constitute a kind of homogeneity that functions as solidarity. Thus war is built on the lattice of learned behaviors and their similarity, and more importantly, war can erupt between divergent human groups. Individual agents make rational choices to exploit shared cultural markers and in the process, foster the creation of intense national solidarity. In Vietnam, nationalism and intense

group solidarity, once the product of kinship, evolve further out of prolonged intergroup confrontation.

In direct relation to war, Nairn (Malesevic 2011) notes that to maintain solidarity, the Vietnamese communist party “invites the masses into history”. They do so by selecting war heroes from historic battles and making them national icons. Vietnamese have a reverent relationship with their dead war heroes. They are worshipped at temples and dominate street, park, and city names throughout the country. These icons of past conflict are reflected back to society, embedding and reinforcing solidarity. For example, after expulsion of the southern regime and the American army from the south of Vietnam in 1975, the name of its most populous city was changed from *Sai Gon* to *Ho Chi Minh City*. *Bac Ho Chi Minh* (Uncle Ho Chi Minh) was the heralded socialist leader that led the country tirelessly through the war years. Ho passed away in 1969 before the end of the American War. The memory of Ho’s passing inspired the Vietnamese military, in the name of its ultimate icon, to complete the expulsion of the American military from Vietnamese soil. His image is the symbol of a united Vietnam today, present at all communist meetings, city halls and socialist institutions throughout the country.

Malesevic (2011:147-8) advances the idea that external threats impact social cohesion, suggesting a neo-Durkhemian approach that social cohesion and solidarity are ‘cemented’ by collective representation and commemoration of past wars. Nationalism operates as a civil religion that entails periodic worships of totemic and sacrificial symbols, normalizing them within society. The commemorations of ‘glorious dead’ set up moral parameters for the behavior of future generations. In the process, these behaviors perpetuate a strong national bond grounded in ethical responsibility towards ancestors. It is through the rituals and practices of collective

remembering of national martyrs that nationhood is maintained and national solidarity reinforced.

The Communist party of the Socialist Republic of Vietnam is renowned for its propaganda art and military songs. These cultural artifacts rally the troops, reinforce its victorious past, and unite society under the monikers of glory and single-party leadership. Propaganda art has enjoyed a resurgence among Vietnamese youth as vintage art. The flag of the Communist party of Vietnam is the hammer and sickle, a symbol of brotherhood among communist nations. Art is an abstract expression of cultural traits, an anchor to Vietnam's warring past and communist government. One of these anchored traits, is Vietnam's strong vein of solidarity. Throughout their history, solidarity forms part of a cultural logics that makes sense, and to which Vietnamese society returns to, in dealing with modern day challenges. At the center of the art's influence on cultural ethno-social solidarity, the Communist Party of Vietnam occupies a central role in all areas of government, politics, and society.

The Socialist Republic of Vietnam is a single-party state, one of just five remaining, including China, Cuba, Laos, and North Korea. Celebrating the glories of past military victories is an important sociocultural aspect of the Party. Political organizations not affiliated with the communist party are not allowed to take part in elections in Vietnam, thus the Communist Party has unilateral control of the country. This control is stratified down through state hierarchy and into the ministries, wards and communes in each city and province. Vietnamese society is also stratified, at the workplace, in the community, and in the family. Hierarchy is a cultural trait that is respected nationwide. Not respecting this hierarchy is seen as rude and, for the most part, the hierarchy is maintained regardless of stature or wealth. It follows, then that when instructions are

given from the Vietnamese Politburo, they followed without exception by the citizens, police and the military in Vietnam.

Repeated foreign attacks have galvanized solidarity in the Vietnamese people. As several of the participants noted in their interviews, the respect for hierarchy and the absolute power of the Vietnamese government yields civic compliance. With this in mind, one of the participants, when discussing Vietnamese society, stated, “In terms of communicable diseases, because it is top down, it has its advantages in terms of provisional information and people follow instructions and people have access to information in a systematic way. And because of the long history of Vietnam having a very good grassroots level and a very community-based mobilization of people and resources.” The participant from the Ministry of Health surmised that when ministries nationwide were informed of the atypical pneumonia virus and the protocols that were recommended by the WHO team, they were enacted swiftly and effectively. He said, “The Government was working as a coordinator to request other ministries to get involved to help with SARS control. I know that at that time even the media, police and the soldiers were involved. The local government informed us on loudspeakers. If you come in contact with a foreigner and get sick, report it to the authorities immediately. We mobilized all the society to control SARS.”

Government directives spurred immediate action, a key feature of the biopolitical environment in Vietnam during the SARS outbreak of 2003. Vietnam’s history yields a cultural logic of solidarity ubiquitous in society. So much so, iconic propaganda art and war heroes are the norm, considered by Malesevic (2011:155) as a routine nationalist narrative. As Barthes and Bordier note (Malesevic 2011), solidarity in its routine is rarely questioned; it embeds as the historic conscience of society.

National solidarity owes much to its organizational and ideological embeddedness. This was exemplified during the SARS outbreak, and especially through the results of the participant interviews. The politburo acted expeditiously, in hand with the WHO, to contain SARS. Border control, patient quarantine, hospital shut down, and the national mobilization of healthcare resources were all vetted, then enforced through the communist party. The cultural logics of war and solidarity shaped the pathology of SARS containment.

CHAPTER 3

“US” VERSUS “THEM” AND THE RESPONSE TO SARS

3.1 “Us” versus “Them”

In Vietnam, the “Us” versus “Them” duality is amplified through the events of the American war and the global ostracism that followed. Ostracism is an enforced separation from a society or a group, of “Us” from “Them”. After the defeat of the US and the southern regime of Vietnam on April 30, 1975 and the subsequent invasion of Chinese-backed Cambodia in late 1978, Vietnam was boycotted. Southeast Asian nations readily accepted American proposals to shun Vietnam because they feared Vietnamese expansion in the region. Virtually the entire Western world joined the boycott (Wallace 1992 LA Times). Vietnam was isolated from the West and its closest neighbors, both socially and economically. The new communist regime and its people were forced to endure starvation and a halt in development during the globally prosperous 1970s and 1980s. In Vietnamese lore, the bamboo thicket that surrounds the villages, demarcating “In” from “Out”, or “Us” from “Them”, now surrounded the nation. The language in participant interviews reflected the division between Vietnamese citizens and those not from Vietnam. For example, foreign experts were spoken of as those from a world free of the strife and resulting poverty that Vietnam had endured. They bore a connection to development and education in nations unencumbered with the “fight” against foreign aggression. Foreigners or overseas Vietnamese were spoken of as from developed countries and not from Vietnam.

Until recently, Vietnamese citizens could not leave their country due to communist emigration policy. Those that left after the American war were cut off from family and their homeland. There was a distinct separation of those in Vietnam from those outside, impacting the generations immediately following 1975. This sense of separation is evident today with those

who remained in Vietnam after the war and those who left, nationally referred to as *Viet Kieu*, or “overseas Vietnamese”. They are treated as outsiders by the Vietnamese government, despite their documented ethnic connection to the country. The *Viet Kieu* are those that left, they are distinctly “Them” to Vietnamese that stayed in Vietnam.

Foreign nationals have similar rights as *Viet Kieu* in eyes of the communist government of Vietnam. Both *Viet Kieu* and the Vietnamese phrase for foreigners, *Ong/Ba Tay* or “Respected Westerner” verbally identified these groups as “Them”. *Ong and Ba* are very formal honorifics reserved for respected elders such as grandmothers and grandfathers. Thus although foreign nationals are identified verbally as “Them”, they are given the most respectful honorific in the Vietnamese language. *Tay* “Westerner” can also be used in the negative sense as well as in *Tay Ba Lo* “backpacker” with a slightly negative connotation of a person with living day to day without life savings or a nuclear family. In professional circles, *Ong Tay* is used with the utmost of respect. The fact that these words of respect for foreigners are embedded in the Vietnamese language demonstrates respect for Western foreign nationals in Vietnam and the expertise and wealth that they may represent. Language used in participant interviews reflected this reverence. French doctors, Dr. Urbani and his WHO colleagues from abroad who entered Vietnam to assist in the initial diagnosis and strengthening of infectious disease protocols were spoken of in this manner. At the participant interviews organized by the HFH secretary, I too, was accorded this honor, even though the participants had to take time out of their work day to take part.

The Vietnamese perspective of other Asian cultures, especially that of China, constitutes another expression of the “Us” versus “Them” dichotomy, as revealed by participant interviews. When asked, participants stated that the SARS virus came from those outside Vietnam. The virus came from “Them”. Foreigners brought the disease across the border, the disease did not have its

origins in Vietnam. Viewing the Chinese as the infected “Them” fits well with in the biopolitics and challenging relationship between Vietnam and China. Language from the participant interviews reflected Chinese aggression toward Vietnam, something that pervades much of the relations between the two Asian neighbors.

Currently, China has laid claim to the Spratly Archipelago islands as sovereign territory. This has greatly angered the Vietnamese, as the islands are within their territorial waters. Vietnam has always believed they have a claim on sovereignty to the Spratly Islands. The much more powerful China refers to these waters as the “South China Sea”, while Vietnamese national maps defiantly refer to them only as the “East Sea”. The Spratly Archipelago and border demarcations on territorial waters are adversarial negotiations between China and Vietnam. Armed skirmishes continue to be a regular occurrence at sea, with trade and tourism sometimes suffering between the two. The difficulty with its large and powerful neighbor to the North aligns with “Us” versus “Them” that pervades contemporary Vietnam’s international relations. The SARS pandemic reinforces the dichotomy. It came from beyond the thicket, beyond Vietnam’s borders, it came from “Them”. The frontline healthcare workers interviewed for this research referred to the index patient as an occidental, *and* someone of Chinese origin, which is in essence, categorizes the index patient as a *double* “Them”. The index patient, Johnny Chen, was an American-Chinese, of Western origin and of Chinese descent. Healthcare workers discussed the crisis situation when their colleagues were dying at the onset of the pandemic. HFH medical doctors spoke of frantic online research that brought up sporadic reports of an atypical pneumonia emanating from China, the adversarial “Them” in Vietnam. Participants discussed China as the more powerful nation, the controlling “big brother”, but also as the source of the disease state invading Vietnam.

In terms of the West, Said (1978) notes that western imperialism constructed ‘the Oriental’ (initially the Middle East and later East Asia) as the inferior Other. According to Said, the categorization of the ‘Oriental’ as mysterious, intriguing and eccentric, at the same time primitive, despotic and cruel, served to justify and advance European imperialism. Healthcare workers spoke of the index patient as a Chinese-American businessman, from the developed West, entering Vietnam as a diseased guest. He came from outside Vietnam, “beyond the bamboo thicket” and precipitated the deaths of their colleagues. The superior occidental was infecting Vietnam, in opposition to Said’s primitive “Oriental”. As noted by Liu (2017:801), this social construction of ethno-cultural difference between social agents is at play between Vietnamese and citizens of the western world. Healthcare workers spoke of the index patient as both a Western and a man in a diseased state, coalescing both social constructions of “Us” and “Them” and “East” versus “West”. For Vietnam, the division between “Us” and “Them” is heightened by a regional and global politics that could only be overcome by the Vietnamese admitting their isolation, and promoting the previously mentioned *Doi Moi* (renewal, opening) policy in 1986. Participant discussions reinforced the separation of the Vietnamese “Us” from those of the West or “Them”. Vietnam was looking to the developed West for assistance with health services during the SARS outbreak. Now the West was infecting Vietnam.

Due to the sudden onset on SARS and resulting crisis, the Ministry of Health, the HFH, and Dr. Urbani were forced to make due with an underfunded healthcare system. As the healthcare workers discussed in their participant interviews, the HFH relied on the 19th century protocols of quarantine, patient tracing, and isolation wards. Thus, the limited socio-economics of Vietnam impacted containment. There was no time to employ Koch’s postulates to categorize the virus. In fact, the WHO (2006:30) states that the eventual sequencing of the genome of the

SARS CoV played no role in containment. Despite contemporary healthcare's advancing technologies, the WHO (2006:243) states that the number one "Lesson Learned" from the SARS pandemic was the value of the techniques of isolation, quarantine, and patient tracing. This broke the chain of transmission, and is an important environmental intervention in Singer's (2016:265) unavoidable relationship between humans and mutagenic pathogens.

One of the participants explained her version of solidarity this way, "Okay culturally, there is a popular saying that the bamboo trees in Vietnam are the symbol of Vietnamese community strength, and how the Vietnamese people defend ourselves. If you go to the countryside in Vietnam, and you can notice the beginning of the village, there will be a line of bamboo trees. The trees are the symbol of the barrier to the community inside protected by the line of bamboo trees and the outer world."

The solidarity in protecting "Us" on the inside of the bamboo thicket involved following the rules of quarantine, patient tracing, and protective personal equipment (PPE) protocols, as outlined by the WHO. The healthcare workers to a person all stated that they followed these rules in solidarity with those that were sickened, to contain the disease in Vietnam. Being that the disease was brought inside the country by foreigners, following the quarantine, patient tracing and protocols religiously would contain and kill it, saving "Us" on the inside and containing the damage brought into Vietnam by "Them".

In the microcosm of the HFH in the initial phase of the outbreak, a prominent theme was looking to the healthcare practices of the technologically advanced "Them" of the West. The HFH staff stated in participant interviews that they looked to the French doctors and Urbani as the Italian WHO specialist. They led doctors and technicians in Vietnam who gained firsthand experience in dealing with patients that contracted SARS. But just as Said (1978) pointed out,

this juxtaposition is a colonial relic that does not always hold true. The deputy director at the Hanoi Center for Tropical Diseases felt that he understood the outbreak as well as clinicians from the West (Fahlman, Urbani, Scialdone 2003). Doctors at the Tropical Disease Center felt that Urbani should not have left for Thailand after contracting SARS, and stood a better chance of survival in Vietnam. Although that outcome is unpredictable, there was a perceptible interplay between “Us” and “Them” that manifested during the crisis period of the SARS pandemic.

At an editorial meeting with the Vietnam Economic Times (VET), a national business monthly in Vietnam, I was asked to do research for an article on a specific topic related to the discussion of “Us” and “Them”. The editorial board asked me to research Vietnamese companies to explore whether or not Vietnamese companies more readily accept, and put into use foreign expertise as compared to other Asian nations. This was at a time when Vietnam was actively seeking foreign investment into the manufacturing sector. But the fact that the article topic was requested at a business monthly editorial meeting suggests the Vietnamese see themselves in this manner. I was told that compared to Japanese, Korean and even Chinese companies, Vietnamese businesses actively pursue and implement foreign expertise and are open-minded to this approach. I conducted the research interviews and wrote the article. Many American, Taiwanese, and even Canadian multinationals did agree with this assessment. In their experience, more Vietnamese businesses aggressively sought and implemented foreign expertise in comparison to operations in other Asian nations.

This parallels with the Vietnamese response to SARS. Participant explained in interviews, when Vietnamese healthcare-worker deaths plagued the HFH, staff mobilized to fight, but also turned to international expertise. The first doctor involved with the index patient explained that the expert at hand was Dr. Olivier Cattin, one of the French doctors on staff at the

HFH. She said, “He told me he saw on the WHO website that there was an outbreak of pneumonia in Hong Kong. That’s why Olivier Cattin told me to call the WHO and the US Embassy because Chen [the index patient for Vietnam] was American.” She stated that when they decided to call the WHO, they were put in touch with Dr. Carlo Urbani. She explained her relief when he finally showed up to support the HFH. She said he made notes of his careful analysis of the situation, and perspectives that they may have missed under the pressure of the crisis of healthcare workers becoming ill. In contrast, China’s handling of the SARS virus was later revealed to be the opposite of that in Vietnam. As the WHO (2006:73) described it, China failed to issue a warning as the virus spread across the country and outside its borders. The Chinese Ministry of Health provided little or no information to the foreign experts at the WHO. China changed their stance dramatically (WHO 2006:78), allowing unprecedented visas on arrival for WHO experts, and developing a reporting framework almost immediately, after Vietnam set off global alerts and began releasing all information on the disease through the WHO network (Figure 1 pg. 49). SARS reporting is a clear example of how Vietnamese quickly utilize foreign expertise and networks. The majority of the healthcare workers who participated in this research made mention of their solidarity, but also remarked on the teamwork with international specialists, not only with their French counterparts at the HFH, but also Dr. Urbani and the GOARN team from the WHO. Participants stated they were keenly aware that this international teamwork in the initial phase of the SARS pandemic was vital to containment.

One of the healthcare participants articulated the Vietnamese cultural logic of “Us” versus “Them” clearly through her depiction of the index patient in Vietnam. Upon initial diagnosis, the doctor, nurse and admittance staff noticed the foreign patient – Chinese-American businessman Johnny Chen – was acting strangely for a foreigner in Vietnam. It was, and is, very unusual for

foreign patients in Vietnam to be difficult to handle, but Chen was. In fact, foreigners in Vietnamese hospitals are often overtly respectful. The participant explained that Vietnamese patients, who must pay in advance to get health services, are difficult and demanding with their fellow Vietnamese hospital staff. But the opposite is the case for foreign patients. They are more understanding, and are well acquainted with health services. Westerners often have health insurance so their healthcare is paid for. In Chen's case, he was tired and difficult. The virus had put him out of sorts and the Vietnamese staff had picked up on this very clearly and discussed it. The participant clarified a cultural logic in terms of two different patient types: Vietnamese as the difficult and expectant patients, and foreigners as the understanding and thoughtful patients. Of course this is not always the case, but since the admittance staff member took time to explain this, I took note of her description.

The participant had a long history of work in healthcare. She formulated her opinion after seeing thousands of patients. The nurse, like other healthcare staff, was delineating the cultural logics of "Us" – the difficult Vietnamese patient, and the "Them" – the understanding and polite Westerner. The American patient exhibited too many unexpected idiosyncrasies and the healthcare workers picked up on that and were concerned. The HFH staff, and in turn, Carlo Urbani, had deciphered metaphorically that something was terribly wrong with Johnny Chen. His response to treatment was abnormal.

Another participant nurse was also keenly aware of the international specialists as "Them", that were participating in the resistance to the pandemic once the crisis set in. She recounted how happy they were to see the Italian specialist, Dr. Carlo Urbani come to their assistance from the WHO. Since the WHO was well connected globally to modern healthcare, she felt this assistance was critical, calling Urbani, "a thorough, careful doctor." She remembers the first day she met him

and the smiles he exuded upon meeting all of the healthcare staff for the first time. So sensitive was she to the emotions of the international specialist that she vividly recounted how the next day, when he returned to follow up, the smile was gone. The gestures of emotions sent a wave of fear through the healthcare staff. They realized that if the foreign experts were showing deep concern, they were facing something very dangerous, an infectious illness that was not yet well understood.

3.2 Cultural Logics

The deputy director at the HFH stated that Vietnamese solidarity, among staff, government and country, was key in SARS containment. Although he acknowledged that the French doctors and Urbani had a large measure of influence, he felt that Vietnamese healthcare staff were effective partners in containment. The deputy director made note of the fact that he was with Urbani on most of his rounds, and was only absent at one or two of Urbani's visits to the HFH on behalf of the WHO. Whatever the combination of Vietnamese and foreign expertise, after the migration of SARS from China to Vietnam, the end result was containment, and heightened global surveillance. Containment was accomplished in Vietnam only after monitoring and intervention in this migration of potential SARS carriers. The movement of infected travelers and their migration are a representation of Singer's (2016:265) pathological *and* social construction of SARS.

Several of the participants noted that innovation was a key cultural logic in Vietnam's response to SARS, a disease the WHO (2006:vii) described as the first emerging, readily transmissible and deadly disease of the 21st century. Crisis drives problem solving. Although Vietnam at the time lacked the Biosafety Level 3 laboratories needed to handle the contagious virus, healthcare staff stated that crisis drove the exploration of alternative approaches. The

SARS virus caused airspace edema, the lungs fill with fluid in a single afternoon, which intervenes in lung capacity and function, causing death. The biomedical approach was to use laboratory technology to discover the virus agent and work backward to find a cure for that agent. Healthcare staff stated that there wasn't time for this approach. Vietnamese doctors at Hanoi's Institute for Tropical Diseases innovated by using mechanical ventilators to keep the lungs moving despite the fluid buildup, extending the lives of many SARS patients. When doctors at the HFH discovered that the closed air-conditioning ventilation system in their modern hospital was circulating the virus, they turned it off, opened the windows and began isolation, quarantine and patient tracing. Air system and window ventilation checks are now part of WHO's regimen of disease response protocols. As Omi WHO (2006:vii) stated, Vietnam led the way. Without the technologically advanced approach of developed nations, the Vietnamese were using 19th century protocols to stem a 21st century disease. Several staff revealed that Vietnam's innovative nature has its roots in Vietnam's history of war and isolationism. Generations at battle created a breeding ground ripe for the novel trajectory of innovation. Nothing was known about the SARS virus in its initial diagnosis. The first thing that Vietnam's medical community knew about SARS was that it killed healthcare workers. These alarming deaths provided the crisis that drove rapid and innovative solutions within Vietnam's means.

The SARS pandemic served to unite health ministries and labs from around the world who had never worked together before, culminating ultimately in the intervention of the SARS pandemic and eventually its genome sequencing. An unprecedented unification of countries, cutting across huge sociocultural differences brought together labs and researchers from around the world toward containment. Vietnam led the way, acts of solidarity and innovation mentioned in my participant interviews were, at the time of the outbreak, reported on through the WHO

network. They influenced the unity of the global response. Researchers around the globe were inspired by the original Vietnamese healthcare workers that had agreed to live at the HFH during the critical stabilization phase of the pandemic.

3.3 Galvanized Response

To illustrate a country-comparison of progress combatting the SARS pandemic in Vietnam, I utilize the WHO (2006:3) SARS chronology in Figure 1, page 49. I present China as the counter-example to contrast a separate set of challenges to the SARS response. The annexing of Vietnam from the West reinforces the Southeast Asian nation's historic conscience with a strong sense of "Us" versus "Them". A communist nation annexed from the rest of the world from the end of the American War, April 30, 1975 to the reopening of the American and Canadian embassies in 1995, Vietnam has developed on its own trajectory, as a socialist-based market economy. Participant interviews revealed consistent themes of "solidarity" towards one's country, the "innovation" to "fight" the intruding virus, and a great respect for "foreign expertise". These cultural logics were galvanized and leveraged during Vietnam's SARS response. One of the admittance nurses on the frontlines was quite vocal in this regard. "We needed to work very close together, the team was strong and solid more than ever. [The crisis] made us feel the need to stay and help colleagues. If we were on the work roster tomorrow, maybe we become a patient [in that time]". She went on further to say, "We are, many years during the war hardworking, people that stay together to fight against [the enemy]. When we have a problem, we stay together and fight it. To run away is not good. We know that two nurses passed away without time to talk to family. We learned from them and wrote letters to family. If something were to happen to me, my friend would deliver the letter". Another nurse, bedridden and awakening from coma confided, "They came to help, they came from France, with blue eyes

and blond hair. And I thought, oh this is very lucky, they came to help. And I thought, do not be afraid.” So respectful were the Vietnamese healthcare workers of their expert French counterparts, the deputy director of the HFH, when trying to convince the Ministry of Health of the serious nature of the atypical virus stated, “I asked them, if they don’t help us, I think a lot of people will die. For example, if our French doctors die here, what do you we do?” It seems the deputy director is positioning a foreign doctor’s death in Vietnam as a worst case scenario, even worse than Vietnamese healthcare workers dying!

The fight against SARS was led in part by Vietnamese doctors and healthcare workers at the HFH, French doctors on staff, and Dr. Carlo Urbani from the WHO. In order to support this, I refer to Figure 1, with information gleaned from the WHO’s SARS Chronology (WHO 2006:3-49) as follows:

Table 3. 1: Chronology of SARS response in Vietnam and in China (WHO 2006:3-49).

VIET NAM	CHINA
<p>  - DISEASE ONSET – critical need for int'l transparency  - PROGRESS TOWARDS CONTAINMENT  - DISEASE CONTAINMENT </p>	<p>16 NOVEMBER 2002 China: A 45-year-old man in Foshan City, Guangdong, becomes ill with fever and respiratory symptoms, and passes on the infection to four relatives. He is retrospectively identified as the first SARS case.</p>
<p>21 FEBRUARY 2003 Viet Nam: Index case arrives to HFH Hanoi from <u>China</u>. WHO offices notified the next morning, advice sought.</p>	<p>12 FEBRUARY 2003 China: WHO receives emails, media reports of deadly virus in Guangdong, but receives no response from the Chinese Ministry of Health.</p>
<p>3 MARCH 2003 Viet Nam: Dr Urbani examines Hanoi index case, sends a report to WHO's Regional Office, emphasizes the need for strict infection controls.</p>	<p>17 FEBRUARY 2003 China: No response from the Ministry of Health, despite WHO's request and offer of assistance.</p>
<p>9 MARCH 2003 Viet Nam: Twelve Hanoi-French Hospital staff hospitalized. The WHO writes to the Ministry of Health and HFH, urging them to control the outbreak. Carlo Urbani meets with Ministry of Health. The next day, Vietnam is locked down and on high alert.</p>	<p>20 FEBRUARY 2003 China: The WHO's Regional Director calls the Ministry of Health to request permission for team investigation. China demands a Terms of Reference to cooperate.</p>
<p>14 MARCH 2003 Viet Nam: The WHO team, mobilized through GOARN, starts arriving.</p>	<p>24 FEBRUARY 2003 China: Limited cooperation with WHO in Beijing only.</p>
<p>19 APRIL 2003 Viet Nam: No new cases. The 1,130-kilometre border with China, officials say, may be closed to prevent the risk of importation.</p>	<p>3 MARCH 2003 China: The WHO team begins discussing Guangdong outbreaks with China's Ministry of Health. Ground zero of SARS outbreak</p>
<p>28 APRIL 2003 Viet Nam: First country to contain SARS, as WHO removes Viet Nam from its list of affected areas (the last case was isolated on 7 April).</p>	<p>10 MARCH 2003 China: The WHO team informs the Ministry about the Hanoi outbreak, connection to the index case who traveled from Hong Kong. Cooperation increases.</p>
	<p>26 MARCH 2003 China The WHO team concludes Guangdong outbreak of "atypical pneumonia" was SARS, and the origin of the multi-country outbreak.</p>
	<p>23 MAY 2003 China: WHO removes its travel advisory for Hong Kong and Guangdong Province, which have successfully contained their outbreaks.</p>

Table 3.1 represents empirical evidence from the WHO that SARS originated and spread throughout China unchecked for four months, from November 16, 2002 to February 26, 2003. The atypical virus was only outed to the global health community after an infected traveler left China for Hanoi. In contrast, the Vietnamese initiated international cooperation with the WHO only hours after the infected traveler was diagnosed. The relay of information through the global network in Vietnam proved vital in saving lives. Figure 1 parallels the position taken by participants during interviews, of Vietnam's tendency toward rapid acceptance of international expertise and facilitation of international cooperation. Clearly, Vietnam's cultural logics were not the only reason for the Southeast Asian nation's successful containment, but the outward looking trend for collaboration played a central role. The leveraging of these cultural logics was nuanced, but progressive toward SARS containment in Vietnam. This critical aspect of Vietnam's SARS response demonstrates the necessitation of transparency during the crisis of pandemic response. This transparency ensures that the whole of the international healthcare community's repertoire of response mechanisms can be utilized to mitigate Singer's (2016:265) future for humanity shared with significant mutagenic pathogens.

CHAPTER 4

POWER, BIOPOWER, AND BIOPOLITICS

4.1 Power and Vietnam

This chapter is dedicated to the analysis of power as it pertains to biopower and biopolitics during the SARS outbreak of 2003 in the Socialist Republic of Vietnam. Foucault (1980:141) notes that power is omnipresent in all social interactions, one is never outside it. He envisages power on two levels. The first is the empirical, a historic look at the state and its citizens as part of sovereign power. The second level is the theoretical, or the discursive chain of force relations in systems of power that exist in all social interactions. The empirical level, as the word identifies, considers a specific sovereign entity. For this research, we consider the communist government of Vietnam. The theoretical level is not specific. It transcends time across periods and epochs. For the purposes of this research I touch on the empirical, but employ Foucault's theoretical level of power "analytics" across time. I explore the power relationship and force relations among Vietnamese citizens, foreigners, healthcare workers, the Ministry of Health, and the state of Vietnam during the SARS pandemic of 2003.

In an empirical analysis of power, there is a pyramid of relations. In Vietnam, for example, the General Secretary of the Communist Party is the most powerful person in the Socialist Republic of Vietnam. The General Secretary presides over the work of the Central Committee, the Politburo, the Secretariat, and holds the post of Secretary of the Central Military Commission, the party's highest military position. The national congress and the ministries administrate below these government bodies, controlling the Ministry of Health in Vietnam. The people of Vietnam occupy the bottom of this pyramid. From this research, the citizens, in this case, the healthcare workers, influenced government. Participant interviews revealed that the

coordinated and unified efforts of the healthcare workers and the directorship of the hospital were able to influence the government of Vietnam toward containment once they realized the dangers of the atypical influenza that was killing their colleagues.

Foucault (1994:12) sees resistance as integral to power relations. If there were no possibility of resistance – of violent resistance, of escape, of ruse, of strategies that reverse the situation – there would be no relations of power. The SARS pandemic in Vietnam pitted the healthcare community, in Vietnam’s biopolitical milieu, against the atypical pneumonia. Public health stood in the balance. As Taylor (2011:25) suggests, these force relations are processes, not static, and are constantly being transformed. These transformations represent endless struggle and confrontation between the original forces and its resistance. Participant interviews revealed the fierce battle to prevent the death of more healthcare workers in competing power relations between the HFH, the WHO, and the central government in controlling SARS. This process produces tactical or local forces which gather in support or resistance to form much larger systems that constitute “institutional crystallizations”. These then become terminal and recognizable forms such as the State. Noticeable is the move from the micro-level to the macro, from the molecular to the everyday. As doctors and nurses worked together in defiance to contain the virus, support was required from the Ministry of Health and the central government of Vietnam. As healthcare workers united to call in international forces and lobby the government, institutions were motivated and mobilized toward virus containment. As the deputy director stated, the HFH was small and united, galvanizing staff and lobbying the Ministry of Health for assistance as a unified team, that included their foreign specialists, and those from the WHO. He stated that public hospitals would have been too bureaucratic to act quickly, and be open to foreign assistance and cooperation. The power dynamic for the small, private HFH favored quick

and decisive action. Individual force relations through their processes of transformation become networks or systems; producing larger, strategic manifestations in the form of laws. These actions resulted in clear explanations to the Ministry of Health and the central government and caused the rapid closure of hospitals, hotels, and borders, isolating and quarantining the virus to help establish control of the pandemic.

According to Foucault's description, power is not only top down. Power relations exist throughout the pyramid, expressed at each level. Foucault expands the notion of power as a much fuller understanding than the archetypal top-down view. Power arises from the people of Vietnam at the bottom. Thus, when healthcare workers at the HFH, representatives at the WHO, and the Ministry of Health have sufficiently made their case towards the Politburo – as was the case of the SARS pandemic – decisions thereafter come right from the top. National mobilization under direction from the singular and powerful communist party means immediate action is coordinated and follows quickly after decisions come down. Accordingly, in the participant interview with the hospital's deputy director, the participant made this relationship quite clear. As stated, The HFH, The WHO and Dr. Carlo Urbani manipulated this power dynamic. They insisted on a meeting with the Ministry of Health on March 9, 2003. Healthcare workers had succumbed to SARS and there were no answers for the atypical virus infections. If they could tip the power dynamic with the Ministry of Health up to the Politburo, they could then influence the top leadership of the country. The resulting influence of decisions from the top down would secure national mobilization and border security. Shortly after the March 9 meeting, Vietnam's leadership initiated a complete lockdown of all areas of the outbreak and well as border controls and traveler screening procedures.

Indeed, Foucault (1982:777) states the primary driving interest of all his research is the “subject”; how people and institutions strategize to situate themselves as subjects. Force relations, very broadly, consist of whatever is in one's social interactions that pushes, urges or compels one to do something. This can be characterized as a “network” of force relations throughout society. A description of power is not absolute, as power does not allow one to understand everything about social interactions. But power should be viewed as understanding the strategy of positioning oneself. Power can be used as an “analytic” to understand social interactions and predict outcomes. Foucault (1990:82) works toward an 'analytics' of power: that is, toward a definition of the specific domain formed by relations of power, and toward a determination of the instruments that will make possible its analysis. Social interactions are constantly permeated by these relations of force, power relations. Foucault (1990:93) thus describes force relations as a "substrate": it is the moving substrate of force relations which, by virtue of their inequality constantly engender states of power, but the latter are always local and unstable. As the deputy director of the HFH stated, his private hospital did not fit into the power dynamic of the public system, guided directly by the Ministry of Health. As a private hospital outside of the state-controlled milieu, HFH had sent several requests to the Ministry of Health for assistance during the initial phase of the SARS crisis. As he said, had it been a request from a state-owned hospital, relying on the bureaucratic power relations between state-owned facility and the Ministry of Health, the response would have been muted. But because of the French ownership and integration into global healthcare, there was a perceived autonomy to the private hospital operating in Vietnam and a much different dynamic to power relations between the two. The deputy director also stated that the fact that the hospital was smaller than the sprawling state-owned hospitals, such as the Bach Mai hospital nearby, the power relations and solidarity

among the relatively small number of staff was very high. When healthcare-worker deaths began to occur, the balance of surviving staff banded together rapidly to counter the crisis head on. All of the participants from the HFH made special note of this to me, referring to it as the “backbone” of the HFH response. Several stated that there was nowhere else to turn, while colleagues were dying, so they stuck together under the immense pressure to contain the pandemic, for the good of their fellow man and the country.

4.2 Biopower

Two modern forms of power are disciplinary power and biopower. Biopower is power over *bios*, or power over life. Disciplinary power is the micro-technology and biopolitics is the macro-technology of the same power over life. Foucault (1982:778) refers to biopower as the art of government, realized through biopolitical control of public institutions and public health. Disciplinary power includes laws exuded over the individual while biopower functions through societal norms rather than laws. Biopower is also internalized by subjects rather than only exercised from above. Further, Foucault (1990:138) states biopower takes hold of human life, a shift from sovereign power’s “right of life and death” to a “control over life”. Foucault’s discussion of government control of healthcare workers and the public as “subjects” of disease is relevant here.

Biopower is dispersed throughout society rather than located in a single individual or government body. The focus is diverted from the individual to the population, although a duality exists in the individual that makes up the group or population. Biopower forms on two basic levels, one is the power over the individual life, or *anatomopolitics*. During the SARS pandemic in Vietnam, the HFH and the WHO sequestered healthcare workers to remain at the hospital under the guidance of the Ministry of Health. Those that had left since the outbreak were

required to return to the HFH. This governing over individual lives worked to track the virus and contain the pandemic. The power over a group of lives, or a population, is the other, termed *biopolitics*. Closing borders and traveler screening, and other measures of guidance for the public regulated population flows and allowed monitoring of all who exited and entered the Vietnam during the SARS pandemic.

TABLE 4.1 A Schematization of the Two Levels of Biopower				
Type	Target	Aim	Institutions	Tactics
Regulatory power (biopolitics)	Populations, species, race	Knowledge/power, control of the population	The state	Studies and practices of demographers, sociologists, economists; interventions in the birthrate, longevity, public health, housing, migration
Disciplinary power (anatomopolitics)	Individuals, bodies	Knowledge/ power and subjugation of bodies	Schools, armies, prisons, asylums, hospitals, workshops	Studies and practices of criminologists, psychologists, psychiatrists, educators; apprenticeship, tests, education, training

As Foucault (2003:248-9) notes, we now have the power to keep people alive when they should be dead and to decide when to "let them die", or to regulate their lives even after, biologically speaking, they should be dead. Modern states have gained a biopolitical interest in fostering life, and state enactments of biopower are termed *biopolitics*. As Foucault (1990:139) states, population supervision is effected through an entire series of interventions and regulatory controls: a *biopolitics* of the population. SARS became a biopolitical concern for public health in Vietnam during the pandemic of 2003 after the index case for SARS flew on a business trip from Hong Kong, China to Hanoi, Vietnam. The index case made his way through the Ho Lu border crossing corridor from the mainland to Hong Kong, and then onto Vietnam. His arrival spread SARS among healthcare workers at the HFH. The pandemic necessitated

biopolitical action toward intervention and containment. Stakeholders included the central government of Vietnam, the Ministry of Health, the WHO and Dr. Carlo Urbani as their representative, citizens and expatriates, as well as the healthcare workers at the HFH.

The admitting doctor for the index patient explained how the HFH was shaken by the sick and dying healthcare workers. “We had to be very solid and very close because we had to fight the enemy, the SARS virus, to uh, win the enemy.” Vietnamese and French staff scrambled to deal with the initial swell of illnesses surrounding the index case. As she explained, the HFH sensed they were losing control of the situation and first searched the internet for information. Hospitals are a place where citizens find respite from pandemics, but in this unusual case, the hospital was the source of the pandemic.

Power relations existed among the WHO as the global authority for disease, the private HFH, Vietnam’s Ministry of Health, and the central government of Vietnam. Control of the country and the balance of power sits with the central government and the Vietnamese politburo. The only way to influence the politburo was through the Vietnamese Ministry of Health. Urbani and his WHO colleagues understood that they were considered ‘guests’ in Vietnam. Since they were a foreign organization with no status within the communist government, they had limited power to influence the situation in Vietnam. Their power to intervene in the path of the pandemic involved persuading the Ministry of Health of the dangers of SARS. If the Ministry of Health was convinced, they, in turn, would influence the politburo. As history dictates, this is precisely what happened. Urbani and his team met with the Ministry of Health on March 9th, 2003 and explained the seriousness of the situation, shifting the biopolitical state in Vietnam toward lock down and containment.

The politburo, the central seat of power in the Vietnamese central government then issued biopolitical directives down through the Ministry of Health that controls all hospital in Vietnam. The politburo also issued directives to the military and police who control the country's borders. This led to a domino effect. The state's biopolitical decisions perpetuated a series of interventions and regulatory controls to restore and protect the health of the population. These directives included the closure the HFH, the closure of the hotel where the index patient had resided, tightened border security, and signaled the WHO to begin global alerts through their network. The national mobilization that followed was typical of communist nations, a zero-sum result put into effect within hours. Patient tracing, isolation and quarantine that were already in effect were strengthened by directives from the Ministry of Health.

From Urbani's focus on the individual index case, the focus shifted to the population as a whole, and indeed the global population, by influencing the Ministry of Health. Directives reached the ministerial level and are disseminated, publicized and practiced by all citizens. The state was concerned with guiding and administering the norms of the population as a whole, and thus concerned with understanding and regulating public health. As the WHO (2006:247) states, it was this biopolitical environment that set the stage for Vietnam to lock down and speed containment of the invading virus. The WHO reported this successful approach to other countries dealing with the outbreak. According to the WHO (2006:247), possibly the greatest triumph from the SARS experience was how fiercely and well national governments and international public health institutions labored together for six months to control the outbreaks. Biopolitical events in each of the member states and coordination of this aspect, in retrospect, was, and is unprecedented today.

CHAPTER 5

CONCLUSION

Direct engagement with research participants allows us to see reality from the eyes of the actor and to grasp the meaning of their action; “it is to unravel and understand the world from the perspective of the acting persons situated in their own local context and therefore, understanding the society in which they live” (Chevrier 2014:25). Those that took part in this research were at the center of Vietnam’s biopolitically charged, and culturally nuanced response to SARS pandemic of 2003. The infectious disease went unchecked in China. But when one of the infected travelers flew to Vietnam for business, his infection spread among these very healthcare workers, who were dying. They were faced with diagnosing and containing the atypical and infectious virus. This research captures a snapshot of the pandemic, from ten participants of Vietnam’s biopolitical and sociocultural environment during the communist government’s response to the SARS pandemic of 2003. The process has revealed that infectious diseases are a part of our complex and intertwined biological, environmental and social worlds. For Vietnam, SARS was a biosocial and biopolitical phenomenon, as well as biomedical event. This is important as it was biopolitical and biosocial intervention, coupled with the biomedical intervention, that allowed Vietnam to become the first of many infected countries to contain the virus. To think about infectious disease as purely a biological event ignores far more than it considers. Who gets infected, and where and how the infection is spread depends on social systems, biopolitics, and the environment.

If Singer (2016:265) is correct, then virus-borne zoonotic events such as SARS, MERS, Avian Influenza and Ebola suggest the future of humankind will be shared with significant pathogens. The evolution of these pathogens and the zoonotic jumps of animal diseases to

humans is evolving in tune with the human biological system. These deadly pathogenic events are happening more frequently with time. This research captures biopolitical, environmental and sociocultural facets of the successful response to SARS in Vietnam, mediated outside the biomedical realm.

To date, there has been no ethnographic research directly on the SARS outbreak of 2003 in Vietnam, although there have been a handful of studies that are somewhat related to it. McClelland (2004) did a comparative research analysis of public health strategies associated with the SARS response in several countries, including Vietnam. Porter (2013) conducted an ethnographic dissertation covering H1N1 avian influenza in Vietnam. While there has been plenty of research into the science of the SARS pandemic, the exploration of qualitative research into the anthropology of SARS remains limited.

Conducting qualitative research in a communist country comes with a unique set of challenges. Information is not typically shared freely in such biopolitical environments for fear of reprisal. Getting participants to share information with a foreign researcher can best be described as, “out of the norm”. During this research, information was provided only after I received top-level approval from the director of the Hanoi French Hospital. This had far more to do with who I knew rather than what I was researching, or the aim of the research. It was through a well-connected gentleman who hosted my internship in Vietnam in 2000, that I received an introduction to the hospital fifteen years later. Once the director at the top gave approval, others at the Hanoi French Hospital took part in the interview process.

During the participant interview process and although I was familiar with Vietnam, I encountered a cultural and language barrier. For the most part, participants were fluent in English, or I used my limited Vietnamese to translate their responses. But I could not account for

what part of the interview data that was lost in translation. With the research limited to Vietnam, I could not broaden the scope of the analysis to multiple countries. I am, however, confident that the research data hit on the strongest themes that crossed multiple storylines, substantiated by the participants from Vietnam.

The data for this research was collected in October of 2015 while the actual events of the SARS pandemic in Vietnam took place in February through April of 2003. Timeframes of occurrence and recollection of events were subject to capacity of human memory. Participant responses during the interview process of this research did not allow me to go beyond their personal experience as they dealt with the pandemic from their specific post in the healthcare community, media, or Ministry of Health. I was unable to speak to high-level government officials that were decision-makers at that time. Perhaps further research into the Socialist Republic of Vietnam's high-level government response could widen the scope of understanding of the biopolitical climate for pandemic response strategies.

As I was conducting research for this thesis, I had the chance to do a video log near the site of the original SARS outbreak while working in Shenzhen of Guangdong province. When I watched the film I had taken, I was struck by the sheer amount of people walking the corridor between Guangdong province of mainland China and Hong Kong. The train stations from the mainland all link up with the metro system in Hong Kong at this terminal. I also walked and bussed across the border. The area is the site of a massive shopping and eating district in Shenzhen called Ho Lu. It is the busiest border crossing in the world. By the numbers, 100 million people cross this border each year. But in the ominous nature of its size lies the perfect conduit for disease, with thousands of travelers each day. SARS took this route out of China. From the countryside to Shenzhen, and then Hong Kong. From fruit bats that were the reservoir

for virus in the wild, to the wet markets for civet cats and other wild game in Guangdong province, the SARS virus moved on to the rest of the world. It is these types of massively used “bottleneck” travel spaces that could be the site of future research in terms of global migration, and must remain under global surveillance. As the WHO (2006:74) states, Guangdong had already invited special attention from WHO disease-control experts because of the crowded nature of life there, and because of concerns about avian influenza. Along with SARS, these viral agents are the biological cause of disease. But this research reveals that it is the crowded walkways and corridors, cramped seating of public transport, and many other social and environmental factors that *enable* disease propagation.

For example, affordable air travel means more citizens move vast distances in a short amount of time. As Omi states (WHO 2006:vii), without air travel, SARS may have remained a local problem. SARS broke out in November 2002 – February of 2003, just as winter weather around the world causes cold and flu symptoms. These are the same symptoms of SARS. Boarding a plane headed to another continent means these symptoms appear normal, while taking your seat in close contact with hundreds of passengers and crew. Thus SARS originated in China, but within hours, air travel allowed the pathogen to move well beyond its borders. The hardest hit countries include Indonesia, the Philippines, Thailand, Vietnam, Singapore, the USA, Germany, Ireland, and Canada. Once a carrier reaches the other side of the world, SARS symptoms akin to cold and flu quickly manifest, causing human lungs to fill with fluid in a few hours, with deadly effect. SARS has a ten-day latency period, and is spread through respiratory droplets. The close contact of air travel is the perfect environmental agent to allow for its spread.

It is interesting to note that the SARS response in Vietnam, a developing nation, fell back to isolation and quarantine wards, as well as patient tracing to track those who came in contact

with SARS patients. This is both a social and environmental intervention. As participants explained and this research revealed, it did not take a multimillion dollar lab or a high tech research center to intervene in the viral path. Vietnam did not have either of those. Patient tracing is essentially a social record of the disease path, which is an extremely valuable piece of information toward containment. It also happens to be a key feature of communist countries. Police and government are actively involved in household affairs. Housing residency permits log who lives in each dwelling and are meticulously kept by neighborhood police and neighborhood commune leaders. People live much closer and communicate more regularly than western societies. Citizens' knowledge of neighborhood affairs is high. This provides much social information that can be utilized in times of pandemic response. This was clearly recorded as part of Vietnam's SARS response, a social aspect that when coupled with the biomedical, proved prominent in stopping the spread of the SARS virus. As one of the index patient's admittance nurses stated in her interview, "Something was strange, very strange. Because we don't have one, two, three or four nurses sick at the same time with the same symptoms. We conducted the routine check for everything and then all nurses who had become sick were informed that they must come back to the hospital to have a checkup."

Another participant interview revealed that when the nurse fell too ill for her next shift, alarm bells went off in her surrounding community. The HFH "required" her to return to work and provide exact details on who she had been in contact with. She complained of being tired and constantly in need of sleep, or waking up with headaches and cold and flu symptoms. She returned to work only to fall ill with SARS, bed ridden and unconscious for a full month. One striking feature of her story was that her normal herbal steam and supplements which usually soothed her cold and flu symptoms, in this case, had no effect. She explained that that was very

unusual for her. Someone this sick in a non-communist country would not have returned to work but would rather have entered the local healthcare system, infecting a new wave of healthcare workers. This represents yet another biopolitical and social intervention that played a key role in containment. Loyalty to her work place, further action by the government and the police, as well as the close link between work and daily life are features of Vietnamese society that played a role in containment.

Participant interviews also revealed unwavering loyalty to the work place. Staff with young children were allowed to return to their families if they passed health examinations. That hospital staff remained at work for this extended period of time characterizes a unique level of solidarity, a commendable dedication to vocation and country. I suspect this is not possible in a developed nation, suggesting there is a lot to learn from Vietnam and the way healthcare workers fell in line for the betterment of the public good. It is my belief that willing worker solidarity and the state requirement to stay at work can co-exist.

I vividly remember the first information I received on SARS while living and working in Hanoi. In retrospect, it went from innocent to ominous. I read a photocopied note on a workplace bulletin board at an international school. It was dated February 26, 2003, and warned all expatriates living in Hanoi that there was a dangerous and highly infectious disease within the healthcare community. The Hanoi French Hospital was the most advanced of its kind in Vietnam, and all expatriates used this hospital as it accepted foreign health insurance cards. The note said it had been closed due to the deadly outbreak. Essentially, we were cut off from our recommended healthcare institution. In the vacuum of available news in Vietnam, a bulletin board informed of impending doom. Vietnam's system of megaphone speakers mounted on electrical poles broadcast updates we were told, but the updates were in Vietnamese. From what

we understood, the updates were keeping society safe with the latest reports. State control of media releases were translated to the English daily news but were muted and redacted at best. What we did not know was that the communist nation was locking itself down, and we would all benefit from this heightened level of security, well beyond our knowledge and perception. We were, in a sense, Foucault's "subjects of power", as Rabinow (1984:17) states.

With the contributions and limitations of this research in mind, future research could include interviews with more influential government decision makers, as well as those in global healthcare agencies like the WHO. This type of research could form an "official" record for future countries to benefit from the SARS pandemic response in Vietnam. The fight against future pandemics could profit from research into the benefits of international cooperation and transparency, as the Socialist Republic of Vietnam so clearly demonstrated through robust engagement with the WHO and other global stakeholders. This research focused on Vietnam, but future areas for ethnographic study could include multinational participation to provide perspectives that cross various cultural divides. McClelland's (2004) comparative research analysis of public health strategies in China, Canada, Singapore, Vietnam, and the United States was conducted primarily through document research. But moving further afield, ethnographies in those countries would yield a robust biopolitical and socioculturally sensitive global pandemic strategy. It would be interesting to chronicle a specific set of health determinants that cross several cultures, to yield useful information to combat future pandemics.

In hindsight, and after nearly two decades living and working in Vietnam, I have received plenty of assistance and learned a great deal from my Vietnamese colleagues. It is my hope that this ethnographic study of the SARS outbreak in Vietnam reveals the critical importance of the

sociocultural and biopolitical dimensions of pandemic response, and the potential to validate the contributions of developing nations to global healthcare.

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APPENDIX

Interview Guide for SARS outbreak February-March 2003 Hanoi, Vietnam

Explanations: to the questions are in bold, not to be spoken at interview.

Lighter Font: Questions and prompts

A. For each participant:

1. Were you in Hanoi during the SARS outbreak of 2003?

[Participant is Vietnamese and from Hanoi (2003), then interview continue as these are the primary informants for the category and research].

2. Where do you think SARS came from?

B. Initial questions followed by grand tour questions:

1. Can you describe what it was like during the SARS outbreak in Hanoi in 2003?
2. What if anything did the government and the media inform you about SARS?
3. What did you do during the outbreak?
4. What were the government controls instituted during the height of the outbreak?
5. What do you know about Carlo Urbani?
6. How did your organization handle its staff during the outbreak?
7. Why do you think Vietnam was the first country to contain the SARS virus?
8. What is it in Vietnam's history that might have well equipped the country to handle the SARS outbreak?

As stated, the participant interview was an iterative process and the above proved only to be a guideline to more substantive questions to dig deeper and access richer information.

**Department of Archaeology and Anthropology)
University of Saskatchewan**

**PARTICIPANTS NEEDED FOR
RESEARCH IN:**

**"The Anthropology of SARS and the Leveraging of
Cultural Logics in Vietnam".**

We are looking for volunteers to take part in a study of
(SARS in Vietnam).

As a participant in this study, you would be asked to take part in a
questionnaire and interview.

Your participation would involve one session,
each of which is approximately 45 minutes.

In appreciation for your time, you will receive \$20 Canadian dollars.

For more information about this study, or to volunteer for this study,
please contact:

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at

0912085114 in Canada at +13062609819

Email: mjf921@mail.usask.ca

**This study has been reviewed by, and received approval
through, the Research Ethics Office, University of Saskatchewan.**



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Behavioural Research Ethics

Certificate of Approval

PRINCIPAL INVESTIGATOR
Pamela J. Downe

DEPARTMENT
Archaeology & Anthropology

BEH#
15-172

INSTITUTION(S) WHERE RESEARCH WILL BE CONDUCTED
Hanoi, Vietnam

STUDENT RESEARCHER(S)
Miles Fahlman

FUNDER(S)
INTERNALLY FUNDED

TITLE
The Anthropology of SARS and the Leveraging of Cultural Logics in Vietnam

ORIGINAL REVIEW DATE	APPROVAL ON	APPROVAL OF:	EXPIRY DATE
	14-Sep-2015	Application for Behavioural Research Ethics Review Participant Consent Form Transcript Release Recruitment Poster Interview Guide	13-Sep-2016

Full Board Meeting

Delegated Review

CERTIFICATION

The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.



Certificate of Completion

This document certifies that

Miles Fahlman

*has completed the Tri-Council Policy Statement:
Ethical Conduct for Research Involving Humans
Course on Research Ethics (TCPS 2: CORE)*

Date of Issue: **8 September, 2015**