the TRANSFORMATION of NA NGOO

INTERNATIONAL MAIL POUCH

Na Ngoo is like tens of thousands of other villages in Thailand. Its 49 families own a few pigs, a scattering of scrubby chickens, and some buffaloes. They use bamboo, palm leaves, and rice straw from the surrounding country to build their houses. Those who can afford flooring timbers raise their houses on stilts, Thai fashion, always with an odd, never an even, number of steps to confuse evil spirits. Their household possessions are essential clothing, a few pots and pans, sleeping mats of woven grasses, and large clay jars for storing a day's water supply.

Despite the historic agricultural abundance of the country, the people of Na Ngoo, like millions of other farm families in Thailand, battle poor soil, a scarcity of water 7 or 8 months of the year, and the inaccessibility of markets for their rice crops. No more than $30 or $40 pass through their hands in a year of back-breaking toil. They cannot afford even a dollar or two for insecticides to prevent the loss of a crop or to build a tank for storing scarce drinking water.

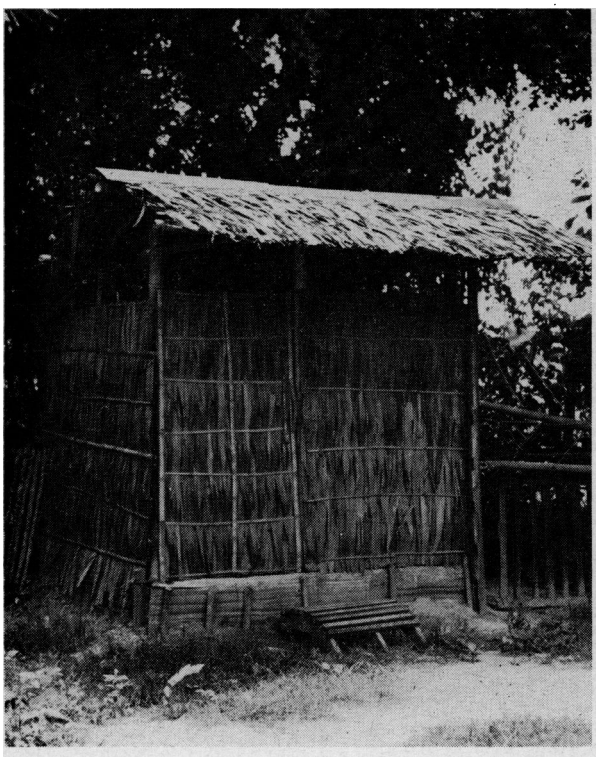
Na Ngoo has no public facilities. Even its water hole, a stagnant pool during the dry season, is a kilometer away. The people send their children to a school nearly 2 kilometers distant because schooling is compulsory for the first four grades, but ignore the district health center, an equal distance away.

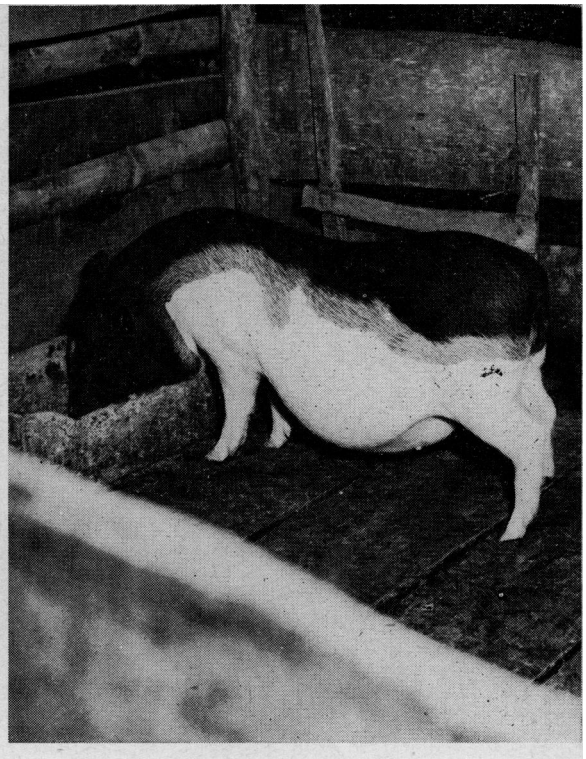
Na Ngoo's health committee meets. Headman (*1st left*) and school teacher (*3d right*) are members. *Below:* Wife pours rice into milling machine.

As one of the poorest communities in a fairly prosperous district, Na Ngoo was chosen to be one of a number of village pilot projects in health and sanitation. These projects were designed to find out if even the poorest villages could be induced to change old ways and if the individualistic Thai would work with others on community projects. This was the difficult task of Alexander A. Robertson, American sanitarian, when he began work in Na Ngoo in March 1957.

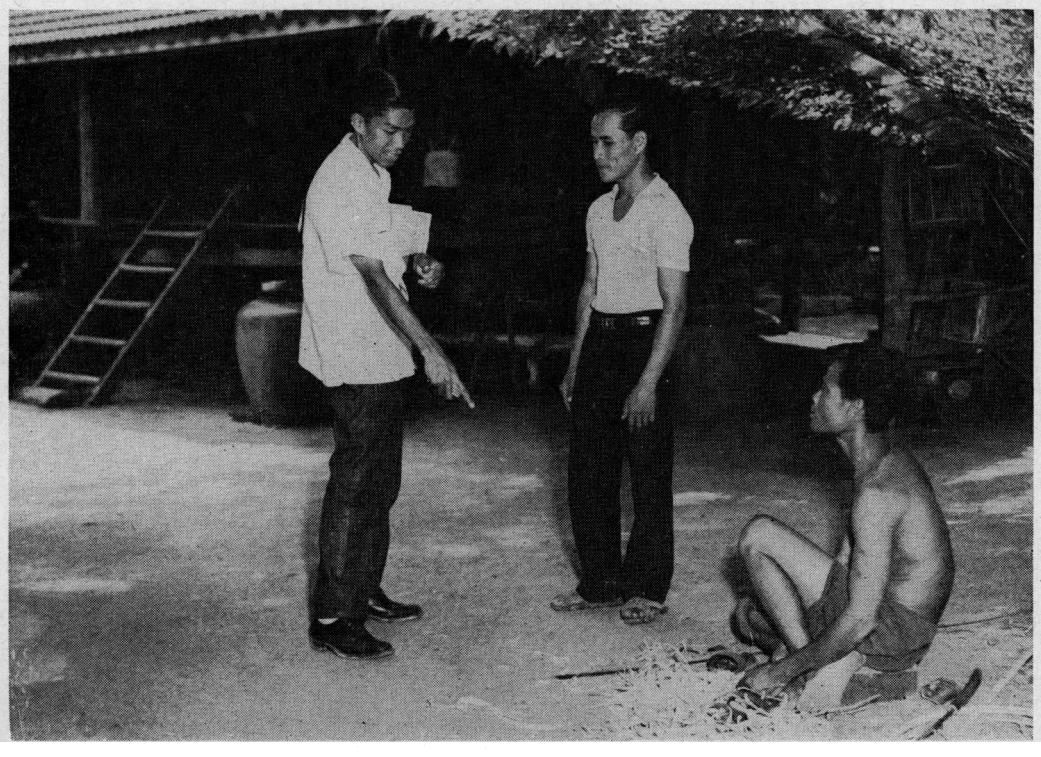
Three months later, the Public Health Office of the United States Operations Mission in Bangkok got a report from Robertson that 19 sanitary privies were installed in the village and 6 more were planned for completion the next month.

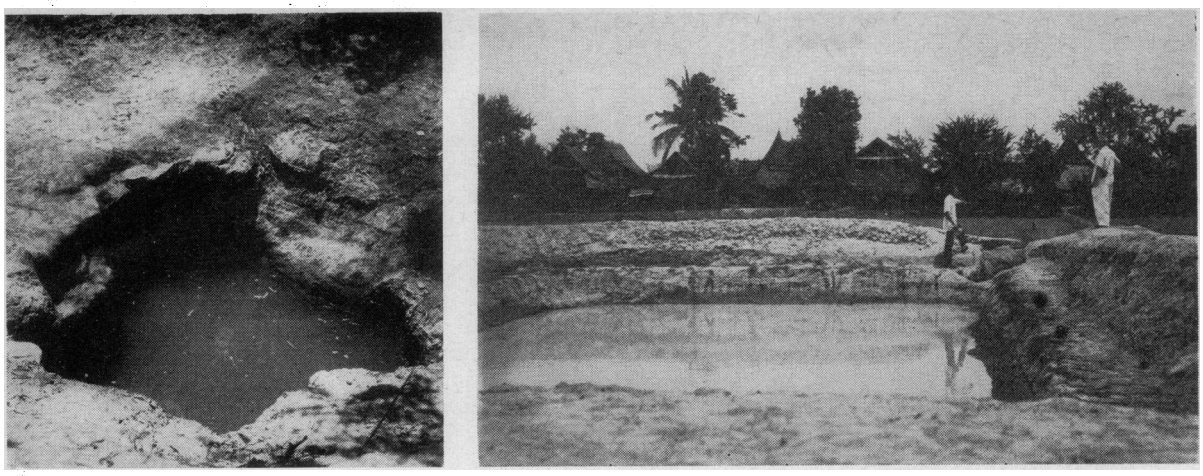
Curiosity drew us to Na Ngoo in early July. Three hours' travel from Bangkok over a fairly good, hard-surfaced road brought us to within a kilometer of Na Ngoo, but we had to make the rest of the way on foot over the rice paddy embankments. Our guides were Robertson, Dr. Khien Kraivichien, director of Cholburi Health Training Center, and Nai Chit Chivonge, sanitarian instructor.





Left: Na Ngoo's privies repudiated skeptics who said they would never be accepted. *Right:* Even the pigs are well scrubbed. *Below:* Sitting villager tells sanitarian Nai Chit Chivonge (*left*) that the new privies saved time which he used to make baskets to sell.





Left: The old water hole, a kilometer from the village, became a stagnant pool in the dry season. *Right:* Men, women, and children dug the rain catch basin and two wells, separated from the basin by a filter system, to give the village a constant, safe supply of water.

No one expected us, and most of the people were at work in the rice fields. But when we arrived the village looked as if it had been prepared for an inspection.

We hesitated to flick a cigarette ash in the cleanswept compounds. The houses were scrubbed and orderly, with wood neatly stacked. Animal pens were as clean as living rooms and the animals themselves fairly shone; even the hogs looked as if they were ready for a State fair. Buffaloes, customarily sheltered under the stilted houses, were penned under the shade trees.

The privies were the repudiation of skeptics who said they would never be accepted because privies infringe on the Thai's historic right to relieve himself when and where he pleases. Na Ngoo had 33 of them, although 25 would have sufficed with families sharing. Not only were they clean with daily scrubbing and covered with neatly built housing of rush and bamboo, but many had been decorated with fancy grass weaving.

The pride of the villagers was also mirrored in flower and vegetable gardens, growing where none had ever existed before. Women and girls were weaving fly covers to put over food dishes. One woman, who was milling rice, told us the food value of the grain was in the bran, not the white kernel.

Close by was the village's biggest achievement, its new water supply system. Everyone, even the children, had worked on it. The headman donated a generous piece of land. On it they built a large catch basin and dug wells on either side. Now Na Ngoo's people would not have to walk a kilometer for their water, and their water was cleaner.

Under a huge tree in the center of the largest compound the village health committee built a shelter for its meetings. Adorning the building were colorful posters proclaiming, "Prevention is better than cure."

The health committee felt it was just starting its work. After the catch basin and wells would come a corral for the village buffaloes, to keep flies and manure a safe distance from the houses. Next they planned a community compost pit, a plentiful source of organic fertilizer for the tired land.

"How did it happen?" we asked. Na Ngoo was no hothouse project. Its changes had come from the heart and muscle of the people themselves.

Our three guides and Nangsao Vimoon Thongpoonsak, health educator, and Nai Thongkam Suwarnachitr, district sanitation officer, supplied the initial spark. One evening they pushed their jeep as close as possible to the village and strung a long electric cable from the jeep's generator. They showed an entertaining motion picture and a film on sanitation. Then Dr. Khien talked to the audience, everyone in Na Ngoo, about the services the

district health center offered. He explained the advantages and problems of sanitation in the village and urged the people to talk it over. If they were interested, there would be another meeting.

A week later, the head of every family in the village gathered with Nai Chit, Nangsao Vimoon, Robertson, and Nai Thongkam. The villagers agreed that water was their big problem. The nearest supply was a kilometer away, often muddy, and at the height of the dry season, almost nonexistent. They needed more and cleaner water, and, if possible, close by. If the villagers were prepared to undertake a village sanitation program, the officials said, the health center would help them get a safe, dependable water supply and a pump.

But privies would have to come first, because the water cannot be kept clean and safe without them. And after the privies and the water supply, the village needed a general cleanup. All three steps were necessary to health, and all must be agreed to if they were to get help, the officials explained. Help would include cement and forms for making the privy slabs at cost. Payment, roughly a dollar per privy, would be required but not until after the next harvest. Any family that could not afford the cost all at once would be allowed several years to pay.

The heads of the 49 households, with some dissent, agreed to take the three steps and form a health committee.

A few days later, the men and women voted to elect the health committee members. The village was divided into 7 groups of 7 families each, and each group elected a member. The headman of the village and the local school teacher each won a place on the committee of 5 men and 2 women. If Na Ngoo had had a Buddhist temple, the abbot would have been given an honorary place on the committee, but the village is too small and too poor to support a temple.

The committee decided to start the cleanup immediately, while privy sites were selected. They set Wan Phra, the Buddhist sabbath, as cleanup day, since it was the only day the people were not busy in their fields.

On the first cleanup day only five families worked. The second week seven more families joined them. Each week more and more people worked at the cleanup. Two families held out for almost 10 weeks, but finally they joined too. Whole families, working together, cleaned up their own compounds and then the public places. They dug the privy pits, built the housing over them, and learned to mold the slabs with the sanitarians' guidance. They built their health committee headquarters and dug the catchment and the wells.

We asked one man what part of the work was hardest. With a grin he replied, "Cleaning house," which to him meant cleaning the whole compound around his house as well. It was hardest because he did it every day after he came home, hot and tired from the fields. He didn't limit cleanup to Wan Phra.

He was eager to talk, so we questioned him. "Why is the program good for you?"

"I will make more money," he said.

"You mean save more money, don't you, by not getting sick and not having to spend money on medicines?"

"No. I will make more money. Not spend so much time looking for a place to relieve myself. Have more time to make things to sell."

Meanwhile, Nai Chit and the village committee were discussing something that seemed serious and important. The matter was finally settled with friendly smiling nods by these villagers who people said would never change their traditional easy, careless ways. On the way back to Bangkok we asked Nai Chit about it.

"The committee asked that another privy be built. A family who was sharing one with another would like to have its own. It will be built, of course."

—Harry L. Carr and Mrs. Jay S. Bohle,
U. S. Operations Mission, Thailand

Medical Care Responsibilities

Joint letter by the Surgeon General and Commissioner of Social Security to State and Territorial Health Officers and State Directors of Public Welfare, June 26, 1958

The fields of health and welfare administration offer many opportunities for joint action which can be mutually beneficial to the responsible agencies and result in improved services to the public. These opportunities have existed for years and in some States and communities have received considerable attention. Recent developments, however, have greatly expanded the opportunities for a concerted attack on the prevention and reduction of economic dependency due to illness. These developments accentuate the need for the closest possible working relationships between health and welfare agencies at all levels of government. Anything short of this aim is costly, both in terms of taxpayers' dollars and human well-being.

This joint letter is intended to focus on the growing need and to encourage mutual consideration of program objectives, plans, and resources by State health and welfare officials.

That illness is a major contributing factor to economic dependency and that low income breeds health problems are well-known facts. Public health departments have a traditional responsibility to provide and promote communitywide health services, such as immunization, public health nursing, and casefinding programs, nutrition and health education services. Many health departments have traditional responsibilities in regard to the medically indigent which sometimes involve diagnostic and treatment services. Special arrangements to ensure the fullest possible coverage of public welfare clients in all types of health programs should result in improved health and decreased dependency for this population group.

Provision of or payment for medical care services for public welfare clients is commonly a responsibility of public welfare agencies. Public health agencies have much to contribute to the successful operation of such services. This assistance can take the form of ensuring that welfare clients receive the direct services of the public health agency, such as services for crippled children or for tuberculosis control. In other instances, the assistance may be through professional consultation in the establishment of standards and procedures for making medical care available to the welfare client. In some States it might be desirable for the welfare department to contract with the health department to administer the medical care aspects of the public welfare program.

Obviously, the arrangements will depend upon the varying legal and operational potentialities in the States. Again, however, joint consideration of the problems is imperative to effective and efficient working relationships. This is particularly important when public welfare agencies are contemplating new or additional medical care responsibilities.

We all know that family finances and the ability and willingness of a family to seek to correct health defects are closely related. With increased emphasis on chronic disease programs and health services for older persons, the problems of economic security are becoming ever more apparent as major considerations affecting the success of public health programs.

Public welfare agencies, with their wide experience in administering financial assistance and welfare services related to the particular needs of the individual, can be of real help to health departments in problems of this kind. The welfare department can identify health needs of recipients and assist them to fully utilize public health facilities. Similarly, provision of social services and financial assistance to persons whose need is recognized by medical social workers and other staff of the health department frequently depends upon the resources and staff of the welfare department. Such interagency relationships cannot be maintained effectively unless each agency is fully informed on the programs and resources of the other.

These examples of mutual interest areas between health and welfare agencies could be multiplied many times. The most useful identification of such areas, however, is in relation to the program objectives and resources of an individual State and as a first step in the development of interagency planning.

We are confident that increased attention to opportunities for interagency cooperation will result in better health and welfare services to the public and will enable both agencies to carry out more effectively their respective legal reponsibilities.

The full resources of the Public Health Service and the Social Security Administration are prepared to provide technical assistance and consultation at your request to assist in accomplishing these goals.

L. E. BURNEY
Surgeon General

C. I. SCHOTTLAND
Commissioner of Social Security