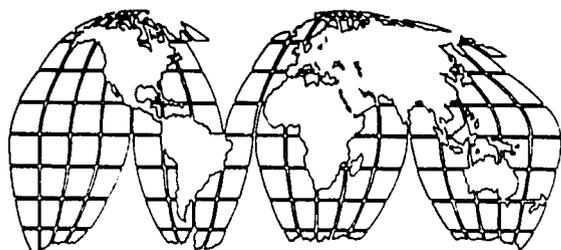


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USAID-Sponsored Social Services  
Projects in Thailand - were they  
Responsive to Macro-Economic  
Development

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

USAID-SPONSORED SOCIAL SERVICE PROJECTS IN THAILAND -  
WERE THEY RESPONSIVE TO MACRO-ECONOMIC DEVELOPMENTS?

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USAID-SPONSORED SOCIAL SERVICE PROJECTS IN THAILAND  
- WERE THEY RESPONSIVE TO MACRO-ECONOMIC DEVELOPMENTS?

SUMMARY

This paper examines AID's support for social services projects in Thailand to assess whether and how it took into account changes in the country's economy. It concludes that over the past three decades, the objectives of AID-funded social services projects reflected two major changes in the Thai economy i.e., rapid growth during the 1960's through the early 1970's; and slower growth in the late 1970's and 1980s.

During the rapid growth period, AID supported the development of education, health and population planning services in areas where the Thai government lacked resources or commitment to do so. Grant assistance was used effectively to finance pilot projects and to encourage government and other donor support for follow-on projects to develop education and health services in rural areas. As economic growth slowed in the late 1970's and early 1980's, AID supported efforts to increase the efficiency of existing services and to develop self-financing strategies to reduce government expenditures. In recognition of Thailand's "middle income status", the AID program in recent years has focussed on strengthening Thai capacity to finance and implement future economic and social development with minimum assistance from the U.S..

The paper also points out that U.S. support for social service projects in Thailand also has been driven by political and social development objectives. The level of funding for social services projects corresponded closely with the degree of U.S. concern for Thailand's political stability. Furthermore, AID projects targetted primarily on the North and Northeast, areas that are the poorest in Thailand and considered most vulnerable to communist insurgency.

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USAID-SPONSORED SOCIAL SERVICE PROJECTS IN THAILAND  
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INTRODUCTION

The AID administrator has recently commissioned a study team to review the Agency's experience in the social service sector (population, public health, education and public housing), and in light of its contributions, to identify strategies for the Agency to continue its support for projects in this sector.

PPC/CDIE was asked to examine six countries at different levels of economic development where AID provided substantial support for social service projects. They include Thailand, the Philippines, Tunisia, Ghana, Botswana and Bolivia. The CDIE team decided to conduct a separate study for each country. Each study examines U.S. assistance for social service programs in a particular country to assess whether and how it took into account changes in the country's economy.

This paper concerns AID's support for the Thai social sector in key areas: education, health and population. Section 1 outlines trends in economic and social development in Thailand between 1960 and 1987 and reviews the Thai Government's investments in, and the performance of, the social service sector. Thailand's recent political history and the role of other donors and private foundations - are briefly discussed. Section 2 reviews the overall U.S. assistance program in Thailand. Section 3 traces the evolution of U.S. support for social service projects in respect to the development of the Thai economy. Section 4 assesses whether and to what extent USAID/Thailand's support of social service projects in Thailand has reflected macro-economic changes in Thailand.

1. TRENDS IN THE ECONOMIC AND SOCIAL DEVELOPMENT OF THAILAND

Over the past two and a half decades, the Thai economy has gone through roughly two stages of development: a period of rapid expansion in the 1960's and early 1970's, and a significantly slower rate of growth since the late 1970's.

1.1 1960's and Early 1970's: Transition to a Modern Economy

During the 1960's, the major source of economic growth in Thailand was agricultural production. Annual rates of growth averaged 3.4% in the early 1950's and rose dramatically in the sixties to average 5.5% in the 1970's (World Bank, 1982). The accelerated growth was due primarily to a combination of government investments and private initiative. Government investments in rural road construction and irrigation facilities provided necessary infrastructure. This facilitated the expansion of farmholdings, and in turn, led to increased rice cultivation

(for subsistence as well as export) and diversification into other commercial crops (maize, kenaf and rubber). A comparable extension of the Bangkok-based marketing system complemented the development of Thailand's rural economy. The government also invested in projects (many sponsored by USAID and U.S. private foundations) to transfer technology, e.g., development and use of improved seed, to the private sector. Throughout the period, favorable commodity prices in the world market also spurred increased agricultural production. The value of agricultural output peaked in the early 1970's as a result of the global commodity boom of 1973/74; averaging an increase of 10% per annum.

The rapid growth in the agricultural sector has been a major factor in stimulating growth in the rest of the Thai economy, particularly in agriculture-related activities in the industrial and service sectors (e.g., agricultural processing and marketing activities). Revenues from heavy taxation of agricultural exports, particularly rice, were an important source of government funds for industrialisation programs.(1)

In the early 1970's, government investments and policy emphasized encouraging the private sector to establish labor-intensive, export-oriented industries such as food processing, clothing, textiles, footwear, electronic components and light consumer goods. Import tariffs were imposed to protect these industries while exports of industrial products were actively promoted. These policies generally favored the development of an industrial sector consistent with the country's comparative advantage (cheap labor and low capital resources). The result was a phenomenal increase in manufactured goods, estimated at a compound rate of 30% between 1970 and 1976. (World Bank, 1980).

By the mid-1970's, the Thai economy as a whole was evolving from a traditional agrarian society to a modern agricultural and industrial economy. One indicator of this shift is the relative importance of agriculture, industrial and service sectors of its economy from 1966 and 1986. In 1966, agriculture, industry and services contributed 36%, 23% and 41% to GDP respectively. By 1976, although all three sectors expanded, the share of agriculture dropped slightly, to 31%, while that of industry increased to 26% and services accounted for 43% of the GDP (in 1976). By 1986, agriculture accounted for 17% of the GDP compared to 30% for industry and 53% for services. However, these figures understate the continuing primary role of the agricultural sector. The agricultural economy remains the primary source of employment: the labor force engaged in agriculture was 81% in 1966 and 71% in 1980. In 1984, it accounted for approximately 60% of all export earnings.

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1. Between 1955 and 1966, taxes on rice amounted to as much as 40% of the f.o.b. price (World Bank, 1980).

## 1.2. 1980's: Slowdown and Emerging Problems

Two major developments in the world economy in the 1970's have slowed the Thailand's economy. First, because the Thai economy is heavily dependent on imported oil, it has been adversely affected by the two oil price shocks of the 1970's. Oil imports will continue to drain its foreign exchange reserves unless reduced by substantial increases in production of domestic energy resources, (oil, gas, and lignite). Second, the world recession that followed the oil shocks, particularly the steady decline in commodity prices in the world market since the late 1970's, has substantially reduced foreign exchange earnings from agricultural and other exports. Although Thailand's exports between 1981 and 1985 increased in volume by 35%, the gains from sales were offset by a 30% decline in commodity prices during the same period. Consequently, over the five year period, Thailand's terms of trade deteriorated by 15%. (World Bank, 1986)

Growth in agricultural production also has dropped significantly since 1980: from an average of 5.1% in the previous two decades to an average rate of 3.5% since 1980. This decline also has been attributed in part to the fall in commodity prices on the world market and to significant decreases in yields of major crops (rice, sugarcane, and cassava) (World Bank, 1982).

Thailand's economic downturn since 1980 has been aggravated by substantial increases in government spending and imports in the late 1970's. The government was funding economic and social development programs by borrowing from external and domestic sources. Nominal growth of medium and long-term debt increased almost 50% in 1979 and 1980. The ratio of debt to GDP more than doubled, from less than 10% in 1974 to approximately 20% in 1981. At the same time, imports which constituted less than 19% of GDP during the 1960's rose to over 25% in 1980. Domestic inflation, fueled by uncurtailed spending in both the private and public sectors, was running at 20% in 1980, compared to 4.2% in 1976. Between 1976 and 1980, while exports doubled, imports tripled, with the trade account doubling between 1982 and 1983 to a record high of \$3.9 billion (World Bank, 1983. CDSS, FY83.) In short, the government incurred an increasing external debt and debt service burden and faced a growing balance of payments problem at a time when the economy was least able to sustain them.

The above scenario provided the basis for the government to embark on a ten-year program (1981-91) to regain a sustainable balance of payments while maintaining economic growth. It includes a structural adjustment program undertaken with IMF-World Bank guidance to implement fiscal reform (Thailand devalued its currency in 1984), improve public administration, mobilize private resources to finance development activities, and address constraints to future economic growth.

### 1.3 Overall Economic Performance and Present Status

Notwithstanding its current problems, the Thai economy ranks as one of the largest and fastest-growing economies among AID recipients. In the 1987 CDSS, USAID/Thailand describes Thailand as having attained "middle-income status" following two decades of sustained economic growth. The CDSS cited the following World Bank statistics on Thailand's economic performance between 1960 and 1982, and compared them with other AID recipient countries:

	Thailand	Rank vs all USAID Recipients
GNP per capita (\$) in 1982 :	790 (a)	13th of 43
Avg. annual growth of GNP ( 1960-82):	4.5%	4th of 43
Avg. annual growth of GDP (1960-82)	7.1%	4th of 43
Avg. annual inflation rate (1970 - 82)	9.7%	14th of 43

Note: (a) The per capita GNP in 1985 (most recent figure) was \$800.

The sustained growth trends in the economic performance of Thailand are summarized in the graph depicting the GNP per capita since the 1960's - see Figure 1.

### 1.4 Distribution of Economic Benefits: Regional Disparities

The vast majority of the Thai population have benefitted from the country's economic growth, as indicated by the dramatic decline in the proportion of households living in poverty. The incidence of poverty nationwide has been reduced by half, from 50% in 1960 to 25% in 1980 (CDSS, 1985). However, as is typical of many developing countries, the distribution of economic benefits is uneven, and generally skewed in favor of urban areas, with urban households gaining, in absolute and relative terms, a higher increase in incomes than rural, especially farm, households. Real incomes of rural households on average, are half of the median urban household income (CDSS, 1987). It is estimated that in 1976, of the eleven million people in Thailand who lived in absolute poverty, over 90% were located in rural areas, and 75% of this population is located in the Northeast Region. These were people least affected by the economic and social changes associated with the country's economic development (World Bank, 1980). Eighty per cent of Thailand's population in 1980 was classified "rural", suggesting that the disparity in

income distribution will be a continuing pattern in the society.

There are also disparities among rural regions. Increases in farm household income generally reflect the degree to which the households were able to respond to opportunities to increase and commercialize agricultural production. In this respect, farmers in the Central Plains have fared better than their counterparts in other rural areas. Better land and access to improved technology and irrigation facilities led to greater production increases in the Central Plains than in other parts of the country. Moreover, because of their proximity to Bangkok, farm households in the Central Plains are, compared to other farm households in the country, better served by the transportation, marketing and social services systems. The result is reflected by increases in household income: farm households in the Central Plains have doubled or tripled their income, a level twice that of the average farm household in the country.

The Northeast region, with approximately one third of Thailand's population, remains the poorest area in the country. Real income increases did occur, especially following the commodity price boom in 1973/74. Nevertheless, the region's inferior soils, drier climate and limited potential for expanding irrigation systems puts it at a distinct disadvantage to benefit from agricultural production alone.

#### 1.5 The Thai Social Services Sector - Government Investments and Performance

In the 1960's and 1970's, the Thai government emphasized confining non-military public sector investments to constructing basic infrastructure and adopting appropriate policies to encourage the private sector to take advantage of economic opportunities. As indicated above, this policy has worked in so far as it encouraged farmers and private entrepreneurs to spearhead economic development in the 1960's and 1970's.

This development strategy underlies the Thai Government's approach to providing social services. In general, the government emphasized addressing problems as they emerged, and which, if unresolved, would constrain economic development (e.g., an uneducated or unskilled labor force) or undermine economic gains (uncontrolled population growth). Therefore, historically, the Central Government focussed its attention on a) providing at least basic education for a large and growing segment of the population born in the 1950's and 1960's; b) relying on public awareness campaigns and donor-supported efforts to introduce voluntary family planning to reduce population growth rates (3% in the 1960's and early 1970's) and c) establishing a health system primarily providing hospital services and local health clinics.

Education received Central Government support since the First Five-Year Development Plan (1961-66). The Central Government has financed virtually all public expenditures on education. The

government's budget for education has been consistently high, averaging 16% to 20% of the total budget between 1963 and 1981. Between 1963 and 1981, allocations for primary education have averaged 56% of the total education budget (Chew, 1984).

In contrast, population planning and health issues have not received much attention until the 1970's, and, in relation to the total Central Government budget, public sector expenditure for health services has averaged less than 5% between 1967 and 1986. (CDSS, 1976-81, World Bank, 1983). The per capita government expenditure on health services in Thailand ranks very low in comparison with other developing countries. In 1975 dollars, Thailand's government expenditure per capita averaged \$2, that of countries with a lower per capita income was \$5, and that of other middle income countries was \$9 (World Bank, 1983).

However, Thailand's public expenditures on education and health were accompanied by the significant role played by the private sector. Private educational facilities are available at all levels of education up to the college level, thus providing an alternative to the public system (Chew, 1984). Similarly, private medical care is available, ranging from traditional medical practitioners to urban-based, modern hospitals and western-trained private doctors. Individuals are also willing to spend on health care: in 1970, private spending on health services comprised 87% of total health expenditures. In short, the private sector seems willing and able to meet the demand for educational and health services unmet by the public system.

In general, the combination of public and private initiatives to provide education and health care has worked for Thailand. Standard indicators of aggregate social development have shown significant, positive changes: population growth rate has been reduced from 2.8% in 1970 to 1.8% in 1987; enrollment in primary school has steadily increased since the 1960's to reach almost 100% for the appropriate age group; the adult literacy rate in 1980 was 88%, and since the 1960's trends in life expectancy and infant mortality have moved in the desired direction. The statistics are summarized in Figure 2. By 1980, Thailand had achieved an adult literacy rate of 88% (male: 92%, female: 84%), enrollment in primary school was 99.5% of the population, in the relevant age groups. In short, Thailand's social development has generally paralleled its economic development.

Nevertheless, by international standards, Thailand has not performed as well as expected in maintaining its progress in reducing infant mortality and providing adequate nourishment for the young. In the past decade, infant mortality rates have not declined as steadily as they did in the 1960's (see Figure 2). Two possible causes include the recurrence of easily preventable diseases such as malaria and diarrhea. Although the occurrence of malnutrition among children less than five years old is still a point of debate among experts (estimates range from 2% to 10%), there is a general consensus that children in urban slums and in rural areas are most likely to suffer from

serious malnutrition.

The coverage and quality of education and health services also are uneven, and significant disparities closely reflect the spatially skewed distribution of economic benefits, i.e., in favor of urban over rural areas. For example, indicators of the urban-rural differences are reflected in such measures as life expectancy and school attendance (10% lower in rural areas) and sanitary installations and piped water (10 times less likely to be available in rural areas).

Since the mid-70's, the Thai government has tried to improve the health and education systems, committing increased funding for programs aimed at improving facilities in rural areas. Since 1975, the Central Government expenditures in all four rural regions have exceeded the revenue collected; and of the four regions, the share of the Central Government for the Northeast increased.

As will be discussed later, since the 1960's, USAID/Thailand's social service projects have focussed on diminishing urban-rural discrepancies in access to and the quality of education, family planning, and health services.

## 1.6 Other Factors

### Political Developments.

Three major events in the political history of Thailand in the past three decades are relevant to the discussion of social service development.

First, from the 1950's through the early 1970's, the Thai government was preoccupied with a perceived threat from communist insurgents operating in remote rural areas in Thailand and its neighboring countries in Indo-China. The border area Thailand shares with Malaysia had been used as a hideout for remnants of the Malayan Communist Party since the Second World War. As a consequence, a substantial amount of public sector resources were spent on defense: as a proportion of the total government expenditures between 1962 and 1965, defense expenditures accounted for an average of 21.9%. (Over the same period, expenditure on development activities constituted an average of 35.8% of the total government budget. CDSS, 1976-81.) A second consequence is that the potential threat from communist insurgents drew substantial military and economic assistance from the U.S. Government. From the 1950's until the end of the Vietnam war in 1975, U.S. assistance strengthened Thailand's capacity to invest in security-related and development activities. Moreover, military spending related to the presence of 50,000 U.S. troops (en route to Vietnam or on "rest and recreation") in Thailand and to the operation of air and naval bases servicing the troops greatly boosted the Thai economy (Steinberg, 1986).

Second, from 1932 until 1973, the Thai government was dominated by a leadership appointed and headed by military officials. Their constituency among the civilian population was primarily urban - the Bangkok-based business community and the Thai government bureaucracy. This political relationship partially accounts for the encouragement given to the private sector (which is dominated by Bangkok-based entrepreneurs) to invest in development activities.

Third, in 1973, a student uprising led to the overthrow of the military-led government. This was followed by a three-year period when unstable civilian coalitions headed the government. Subsequently, from 1976 until August 1988, an army general was appointed by the Thai King to head the government. (The general retired recently and was replaced by a civilian, also appointed by the King.) The government leadership since 1973 - civilian or army-led - has been consistent in expressing a commitment to address inequities in Thailand's economic and social development. One example of this was mentioned previously - increasing development expenditures at the provincial level for education and health services. The government also launched an ambitious development program financed largely through foreign and domestic loans. As mentioned above, such expansionary fiscal policies of the Thai government since 1975, combined with setbacks in the export and agricultural sector, contributed greatly to the budget deficit problems encountered in the 1980's.

#### Role of Donor Funding.

It should also be noted donors have played a major role in financing development projects in the public sector. Between 1968 and 1975, Official Development Assistance (ODA) ranged between 100 to 150 million per year. Over the period, AID contributed approximately 75% of ODA grants while the World Bank provided 60% of the loans. By 1982/83, ODA loans had increased dramatically to total \$1.1 billion, most of which were loans from the World Bank (38%), Japan (30%) and the Asian Development Bank (20%). AID by this time had substantially reduced its assistance which in 1982, comprised less than 3% (grants and loans). Between 1981 and 1983, average ODA per year from each major donor was the World Bank (\$505 million), Japan (\$355 million), ADB (172 million) and AID (31 million). Of the additional \$160 million given as grants from bilateral donors between 1977 and 1982, Japan's share surpassed that of AID's, i.e., 51% versus 10%, (EEC countries and the U.N. accounted for 10% and 8% respectively.)

The Thai government's policy in using loans and grants has been consistent throughout the last three decades: ODA loans have been primarily used for capital development, commodity procurement and services in the following sectors: energy, transportation and communications, agriculture (especially irrigation facilities), public utilities and since the 1970's, heavy industry and education. ODA grants have been focussed on

providing technical assistance and training related to the activities listed above and projects in the social services sector.

### Role of Thai Royal Family and Private Foundations

The Thai education and health sector has also benefitted from the patronage of the Thai Royal Family and projects funded by private foundations. The latter include the Rockefeller Foundation, the Ford Foundation, the Fulbright Foundation and the Mitraparb Education Foundation (founded by two military officers, one an American and the other a Thai). Projects sponsored by the foundations ranged from the establishment of Thai medical schools and university faculties and scholarship programs to building schools in rural areas. (For an account of the contributions of these foundations, see Bhongbhibhat et al. 1982.)

### 2. Evolution of Overall U.S Aid Program 1950-87:

The U.S. assistance program in Thailand began in 1950 as part of a larger foreign assistance agenda - the Point Four Program - to help Third World countries recover from the post-Second World War economic situation. The Point Four Program in Thailand was implemented between 1950 and 1954. During this period, U.S. assistance totalled approximately \$28 million - primarily for technical assistance and equipment - for agriculture and infrastructure development, (seed research, irrigation, transportation, communication and power generation). Approximately eight per cent of program funding was for training programs in education and public administration as well as a malaria eradication program. Achievements attributed to the successful transfer of U.S. technology through the various projects implemented during this period include increased rice yields and livestock production, roads and irrigation works in rural areas where none existed previously and a substantial reduction in deaths and illnesses due to malaria (Caldwell, 1974).

U.S. capital and technical assistance to Thailand increased substantially during the late 1950's in response to U.S concerns over the defeat of the French, and subsequent communist ascendancy, in Vietnam, and over reports that communists were attempting to establish another stronghold in rural Thailand. (There were reports that communists operating in rural areas in Thailand had assassinated several Thai government officials.) The U.S. Congress regarded Thailand as the bulwark against further communist incursion into Southeast Asia. Therefore, assistance to Thailand was viewed by Congress as strengthening the Thai government's defense capability and helping it win the support of the rural population through development projects. Between 1955 to 1959, funding for the program averaged 36 million per year, a dramatic increase from the 7.8 million yearly average for the previous five years

(Caldwell, 1974). Funds were channelled primarily into large-scale public works projects - construction of roads, airports, railways, and telecommunication and power-generation facilities - aimed at linking Bangkok to the rural provinces. However, the U.S. mission also increased support for activities with "nation-building" objectives. These were primarily participant training programs, ranging from training programs for the border police patrol to staff development programs for the civil service, schools and universities.

From the mid-1960's through the early 1970's, the U.S. assistance program was expanded further as the U.S. became actively involved in the Vietnam War, and as the U.S. armed forces began to use Thai military facilities to support their operations in Vietnam. Between 1965 and 1970, the aid program - excluding direct military assistance to Thailand - increased rapidly, to total \$257 million (an average of \$42.8 million per year, almost all in grants). Approximately 55% was allocated for "counter-insurgency" activities, primarily to continue support for the Thai National Police Department's operations in the border areas (Caldwell, 1974). However, the increase in funding levels also enabled the U.S. mission to provide technical assistance to the Thai government to establish a central development planning unit and support for the Thai government's "Five-Year Development Plans". As mentioned previously, between 1968 and 1975, Official Development Assistance (ODA) ranged between 100 to 150 million per year, 40% of which were grants from bilateral donors. The U.S. accounted for approximately 75% of grant assistance (CDSS, 1987). A.I.D. continued to sponsor capital development and training programs implemented by line ministries, but also began funding agriculture and rural development, education and health projects primarily in rural communities considered most vulnerable to communist insurgents, i.e., those in the North and Northeast regions. U.S. assistance over this period significantly contributed to the Thai government's limited investments in two areas: institution-building and community-level development in remote rural areas.

As the Vietnam War drew to a close in the early 1970's, funding for the U.S. program in Thailand was progressively reduced. By 1973, the annual funding level for U.S. sponsored projects amounted to \$12.5 million, compared to \$31 million in 1970 and \$57 million in 1967 (CDSS, 1976-81). The mission and AID/W even considered phasing out economic assistance to Thailand. It was argued that given Thailand's remarkable economic growth since the 1960's, the country should be able to sustain its economic development without concessional aid from the U.S.. Since 1970, the World Bank, Asian Development Bank and the Japanese aid agency had been more than willing to extend loans for development projects. This argument was preempted by the 1973 overthrow of the military-led government, subsequent changes in leadership of the government, and macro-economic problems in the 1980's (See Section 1), that renewed concerns about the political and economic stability of Thailand. It was decided that continued U.S. economic assistance to Thailand would follow AID's "New

Directions" mandate, i.e., focusing on non-capital development such as agricultural production, rural health and education projects, and targetting on the rural poor. Between 1978 and 1982, twenty-four new projects were funded. By 1983, A.I.D.'s portfolio amounted to \$93 million of which 48% were loans. Nearly 60% were for projects emphasizing the alleviation of poverty in the North and Northeast regions. The Thai government also borrowed heavily from other donors, so that A.I.D.'s assistance after 1985 only constituted roughly 3% of total ODA to Thailand (CDSS, 1987).

Beginning in the early 1980s, A.I.D.'s program strategy shifted to emergent institutional and policy issues related to Thailand's efforts to sustain its economic growth. Program, rather than project assistance in areas where Thailand lacks the scientific and technical knowhow, and where U.S. expertise could be utilized, became the major focus. Program assistance reduced A.I.D.'s involvement in development at the project level, and lower management demands on the mission, in line with the mission's reduced staffing levels. Where direct project-level interventions were necessary, private sector initiatives were encouraged.

Additions to USAID/Thailand's 1986-1990 portfolio followed this new strategy. Programs were initiated to address "emerging problems" related to the slowdown in Thailand's economic growth; to promote the exchange of technical knowledge in science and technology and in rural industries and employment; to co-finance PVO-managed projects to deliver extension, health and education services to rural areas; and buy-ins to centrally funded AID/W programs to fund population and health studies.

### 3. U.S. Support for Thailand's Social Service Sector

#### 3.1 General Strategy and Impact

The U.S. mission's support for Thailand's social service sector has been guided by two key considerations. First, given the security concerns underlying U.S. assistance to Thailand, it has consistently focussed on improving education and health services in rural areas (especially in the North and North East regions). Second, the availability of grant assistance has allowed the U.S. mission to fund technical assistance, training and experimental components to strengthen the capacity of the Thai education and health ministries to expand and improve services to rural communities - activities for which the Thai government has been reluctant to incur foreign debt. This aspect of U.S. aid has been instrumental in encouraging the Thai government to support activities initiated under U.S. sponsorship. In short, U.S. support for the Thai social service sector helped draw the government's attention to urban-rural disparities in the coverage and quality of the public education and health systems. In this respect, A.I.D.'s assistance has clearly contributed to improving

the standard of living in rural areas.

The U.S. mission also has been quite aware of the economic implications of its activities in the education and health sectors. Although the language articulating support for education and health projects has changed considerably since the 1950's - from their being considered "fundamental positive requirements for the preservation of individual and national liberties" (DAP, circa late 1950's) to being "remedial action taken to combat poverty" (CDSS, 1983) - the underlying rationale has remained constant. That is, A.I.D.'s assistance contributes, directly and indirectly, to the productivity and well-being of the rural labor force and to the agricultural and rural economy as a whole. Over the years, the specific development constraints addressed by the A.I.D. program changed, corresponding to structural changes occurring in the Thai economy. These changes also reflected the increasing commitment of the Thai government and AID to mitigate urban-rural disparities in economic and social development.

### 3.2. 1960's and early '70's: Issues Related to An Expanding Agricultural and Rural Sector

As mentioned in Section 1, rapid growth in the Thai economy in the the 1960's and the early 1970's was primarily driven by the development of the agricultural and rural sector. An indirect contribution to this development process can be attributed to A.I.D. projects to address "human resource development" issues and to improve living conditions in rural areas.

#### Educating Farmers and Rural Youth

A central issue that guided the design of AID education projects in the 1950's and 1960's was how to expand and improve the Thai education system in rural areas, and specifically, how to teach basic education and simple technical skills to otherwise illiterate farmers and rural youth. A.I.D.'s program funded construction of more schools in rural areas. It also provided skills training and non-formal schooling to those who could not attend, or had dropped out of, the formal school system.

Major activities funded by AID included:

-- A \$4.1 million "Rural Training Program" centred on three activities: a) deployment of "Mobile Trade Training Units (MTTU)" to remote villages, offering five-month courses on practical subjects (sewing, home economics, mechanics, radio repair, industrial arts, modern farming techniques etc.); b) a similar training program for primary school graduates and dropouts at the Thai UNESCO Fundamental Education Center in Ubol, located in Northern Thailand; and c) a radio education program for farmers.

-- A \$3.9 million project that provided technical assistance and teaching equipment to the Northeastern Technical Institute to train skilled craftsmen who were subsequently employed in construction work for other rural development projects, such as the government's "Accelerated Rural Development" program.

-- Funding a 1.3 million technical assistance component in conjunction with a \$20 million World Bank loan for a \$38 million "IBRD Vocational Education" project. An additional 3 million was provided for a follow-on project, (Loan for Improvement of Vocational Education), for technical assistance and commodities for fourteen trade and industry schools.

(See Annex 1 for a full list of AID-funded education projects.)

There has been no systematic study of the impact of AID's education projects on the subsequent development of the Thai educational sector. However, information from secondary sources suggests the following. First, the projects developed curricula, trained personnel and established infrastructure (school buildings, equipment, etc.) that were incorporated into the education system as the Thai government increased its investments in the rural education sector. Second, trainees of A.I.D., projects acquired technical skills that opened opportunities for non-agricultural employment (e.g. part-time construction and land clearing jobs, services and manufacturing). Third - and most important - studies of the Thai farming population have indicated a significant correlation between improving the functional literacy of farmers and their willingness to adopt new agricultural technologies. The study results show that the rate of return to primary education for the farm population in Thailand is high, ranging between 18% and 29% (World Bank, 1983).

#### Improving Health Conditions in Rural Areas

AID-funded health projects initially concentrated on improving living conditions in rural areas where health facilities were lacking. A.I.D. funded construction of provincial hospitals; control of malaria, tuberculosis and other common diseases, (especially where land was being cleared for cultivation); and installation of potable water facilities and instruction of rural residents in sanitation and public health practices. The achievements of these early projects in improving living conditions in rural areas were remarkable. In 1950, when AID initiated the malaria eradication program, sickness related to malaria affected an estimated 15% to 25% of the rural population and killed 57,000 people. The annual death rate due to malaria was halved between 1950 and 1954, and by 1954, the spraying

program to control mosquito breeding routinely covered 21% of the Thai population per year (Caldwell, 1974). The economic benefits of the malaria eradication program were equally significant. Prior to the program, it was estimated that 15,000,000 farm-work days per year were lost due to malaria, and that malaria epidemics usually occurred during the planting and harvesting seasons (Caldwell, 1974).

By the late 1960's, A.I.D. recognized the need for "a more permanent health infrastructure" to maintain health services (DAP, 1968). From 1967 through the 1970's, and as the Thai government became more willing to invest in the health sector, A.I.D. increased its support for health projects that included institution-building components. This included technical assistance to the Ministry of Public Health and construction of new medical faculties and schools, participant training programs and grants for in-country research, and pilot activities. Between 1967 and 1973, health projects constituted a significant portion of the total AID non-capital development assistance portfolio, averaging 42% of the total disbursement for agriculture, education and health projects implemented during this period (CDSS, 1976-81). (See Annex 1 for list of projects).

As with the education sector, the institution-building aspect of AID assistance to the health sector provided a basis for transferring relevant technologies and improving health service delivery in rural areas. Major accomplishments of projects implemented from the 1960's through the 1970's included the following:

- The Village Health and Sanitation project implemented from 1966 through 1968 was the first in a series of "Rural Health" umbrella projects that introduced health services (see mobile medical teams below) and utilities (wells for villages and schools, water seal latrines) to thousands of residents in rural communities in the North and Northeast regions. Training methodologies and "primary health care models" developed under the projects were subsequently adapted by the Ministry of Public Health in the 1970's to develop a national primary health care system and train paraprofessional staff and village health workers (see next paragraph and section 3.4 below).
- A program that created "Mobile Health Education Units" and "Mobile Medical Teams" to provide medical information and services respectively to remote rural communities over a large area at relatively low cost. The mobile education units were staffed by health workers and the medical teams were composed of doctors, nurses and paramedical workers from provincial hospitals. Their mobility allowed them to cover a large area at relatively low cost. As the

program evolved, mobile clinics were replaced by health clinics located at the district and village levels, staffed with paramedical workers and villagers trained to serve as auxiliary health workers (village health volunteers and village health communicators).

### 3.3. Drawing Government Attention to Population Planning

In the late 1960's, AID - as well as other donors - were concerned that the Thai Government was tacitly following a pro-natal policy when population planning was clearly needed. Thailand's annual population increase during the 1950's and 1960's averaged 3.3%, a rate that, combined with declining mortality and rising fertility, had almost doubled the 1947 population by 1968. Unabated, the size of the population would double again in 1980, and reach 100 million by 2000. Population experts predicted that at that rate of increase, the size of the population would have catastrophic effects on Thailand's natural resource base and undermine the government's efforts to sustain its socio-economic development.

In 1968, AID drew the government's attention to the population issue by providing technical assistance and commodity support for a pilot family planning project. This initial project was well-received by the Thai King, under whose approval the Thai government formulated the National Population Policy in 1970 and adopted a "National Family Planning Program (NFPP)". The Ministry of Public Health was charged with the responsibility for implementing the NFPP, essentially based on the ministry's pilot project experience. AID contributed to the initial phase of NFPP with an \$8.3 million grant to finance the purchase of oral contraceptives, medical kits, participant training and technical assistance. This was followed in 1976 by a five-year \$16.5 million "Population Planning Project" to extend NFPP services to rural communities, to include voluntary surgical contraception (VSC) and other contraceptive methods, and to provide related training, technical assistance and equipment. In 1977, an AID/Washington centrally funded project (the Family Planning Health and Hygiene Project) provided additional assistance to NFPP by developing "community-based family planning services models" to provide contraceptive supplies and information through some 6,000 village distributors covering eighty rural districts in Thailand. AID efforts spawned other offers of assistance. In 1978, additional support was provided by a \$68 million "Population Project" co-financed by the Thai government and other donors - the World Bank, Australia, Canada, Norway. In the 1980's, AID funded a second phase of the "Population Planning Project" providing technical assistance for population-related studies (see discussion below in section 3.4.).

The impact of NFPP is best indicated by the dramatic decline in Thailand's population growth rate since 1970. The economic

significance of NFPP was demonstrated in an AID-supported study which estimated that, with respect to public savings on education and health services from births averted, the NFPP benefit-cost ratio is over 12 to 1; and the internal rate of return (in terms of savings on all social service expenditures that would otherwise have been incurred) is 110 %.(Project Paper, Population Planning II Project, 1982).

#### 3.4 Late 1970's and 1980's : Improving Efficiency of Education and Health Systems

By the late 1970's, encouraging the Thai government to invest more in rural and social development was no longer a major issue. The government had expressed its intentions to address urban-rural inequities in economic and social development, and was prepared to increase government investments in social services. Central government expenditure on the education sector increased significantly, from an average of 16% of the total development budget in the 1960s and early 1970's to 20% between 1975 and 1980 (Chew, 1984). Although expenditure on the health sector remained relatively small, it did increase from 4-6% in the 1960's through the early 1970's to almost 8% in the late 1970's. Moreover, by 1976, the Thai government had indicated that it was willing to use foreign loans to fund new projects aimed at improving health services to rural areas.

However, despite the good intentions of the government, macro-economic developments in Thailand during the late 1970's forced the government to trim its expenditures and reduce its development program for the rural sector. In response, Thailand's three major donors - i.e., the World Bank, the Asian Development Bank, the Japanese aid agency - assisted the Thai government in implementing a structural adjustment program and made more loans available for development activities. A.I.D. identified a complementary role for itself, i.e., as one "advancing Thai development (in ways) .. not easily assumed by international financial institutions or other donors". A.I.D. assistance was then concentrated on developing appropriate technologies and effective service delivery systems (CDSS,1983).

With regard to the social services sector, the U.S. mission focussed on improving the efficiency of the existing education and health systems, especially on addressing inadequacies in serving target groups in the North and Northeast regions. The following projects were funded:

##### -- Non-Formal Education for Ethnic Minorities:

In 1978, the Thai government adopted measures to improve the administration, coverage and quality of public education services. This included non-formal education for ethnic minorities living in remote mountainous areas in Northern Thailand. The U.S. mission supported this effort by funding two pilot projects -"Functional Literacy for Hill Areas" and a

"Planning Secretariat for Hill Areas Education" - to develop a plan to improve existing services provided by various government agencies. Based on the findings of these projects, USAID/Thailand subsequently funded a five-year \$2.5 million "Hill Areas Education Project" to assist the Ministry of Education's Department of Non-Formal Education "develop and test, through inter-agency involvement, ... a community-based and replicable non-formal basic education model more appropriate to the needs and conditions existing in remote hill areas than presently available education". A 1982 mid-term evaluation of the project reported that the project was likely to achieve its objectives, although it would probably take longer than the five year project lifespan to replicate the model beyond the project area. Subsequently, the project implementation period was extended another year to 1986. A central issue yet to be resolved is how to cost-effectively replicate the model in serving non-project areas.

-- Rural Primary Health Care Expansion Project (1978-1986)

A key component of the Thai government's Fourth Five Year Health Development Plan (1977-1981) was to increase the effectiveness of rural health services established by the Ministry of Public Health (MOPH) i.e., a network of provincial, district and village health clinics providing "primary health care" in rural areas (see section 3.2). A major concern was that the system lacked adequate facilities, management capability and trained staff to be effective, especially in areas of family planning and maternal child nutrition. The Thai government requested donor assistance for a project to help the MOPH train management and additional paramedical staff, and to increase the availability of contraceptive supplies, equipment for mobile sterilization units and other family planning and health services in twenty rural provinces. In response, a \$68 million project co-financed population project was developed. A.I.D.'s contribution was a \$5.5 million loan for a separate, three year project - the Rural Primary Health Care Extension Project - that would provide specialized training for health workers and paramedical personnel of the Ministry of Public Health and improve the management of the health care delivery system in the target provinces. The final evaluation of the USAID project concluded that its paramedical staff training component had been completed successfully. By 1985, the Ministry of Public Health had established a "Primary Health Care" system integrating health services at the provincial, district and village levels. The system is supported by 18,500 instructors

and over 500,000 auxiliary health workers at the village level and covers 85% of Thai villages (75% of total Thai population).

Additional technical assistance is being provided under the "Emerging Problems of Development Project II" to conduct operations research and health finance studies needed to identify "ways and means of minimizing costs while improving the efficiency and performance of key MOPH programs.

#### -- Population Planning II (1982-1987)

This project was designed to increase the coverage and sustain the achievements of family planning services provided under the Thai government's National Family Planning Program. In conjunction with the "Hill Areas Education Project, the project extended family planning services to ethnic minorities in the North region. Additional participant training and technical assistance to the MOPH are currently being provided under the "Emerging Problems of Development II Project" (1985-1991). The technical assistance component supports studies and activities to improve the coverage of NFPP through the private sector and to introduce self-financing mechanisms (e.g., charging user fees) to reduce NFPP's need for donor funding for contraceptive supplies.

#### 4. CONCLUSION: RESPONSIVENESS TO MACRO ECONOMIC CONDITIONS

The central question addressed in this report is whether AID assistance to develop the education and health sectors in Thailand was responsive to macro-economic developments in Thailand. The preceding sections have presented evidence to indicate that the answer is a qualified "yes". During the period when the Thai economy was growing rapidly (1960's through early 1970's), AID supported the development of social services in areas where the Thai government lacked resources or commitment to do on its own. AID used grant assistance effectively to finance pilot projects and to encourage government and other donor support for follow-on projects. In the late 1970's and through the early 1980's when the Thai economy was growing more slowly, AID responded by supporting efforts to increase the efficiency of existing services and to develop self-financing strategies to reduce government expenditures on social services. Finally, in recognition of Thailand's "middle-income status, the AID program has shifted to supporting technical assistance, training and technology transfer programs aimed at strengthening Thai capacity to finance and implement future economic and social development activities with minimum assistance from the U.S..

As indicated in Section 3, an important contribution of AID support for social services projects is that it drew the Thai

government's attention to rural education and health issues which were largely ignored until the 1970's. The value of that contribution in fiscal terms is also considerable. Until the late 1970's, virtually all U.S. funding for education and health projects was in grants, and therefore a "free good".

The U.S. development assistance program in Thailand has also been driven by political considerations. The level of U.S. funding for development activities in Thailand corresponded closely with the degree of U.S. concern for Thailand's political stability. The same concern fueled support for social service projects. More than two thirds of AID-funded social services projects were implemented between 1967 and 1971, i.e., when the U.S. was heavily involved in the Vietnam War. Furthermore, AID's assistance for social service projects targetted primarily on the North and Northeast, areas considered most vulnerable to communist insurgency.

A caveat should also be noted. Despite the millions invested by the U.S. not only on social services but also on agricultural production projects in the North and Northeast regions, they are still the poorest regions in the country. Seventy-five percent of the "poorest of the poor" in Thailand are located in these two provinces. This is not due to a lack of attention on developing the two regions. Rather, the poverty of these two regions stem from severe limitations imposed by their poor natural resources. This factor underscores the social development objectives of AID education and health projects in these two regions, i.e., these projects were designed to respond to the plight of the rural poor.

ANNEX 1. USAID/THAILAND EDUCATION, HEALTH, AND  
POPULATION PLANNING PROJECTS, FY 1967 - FY1987.

Between 1967 and 1987, USAID/Thailand provided development assistance support, totalling approximately \$75 million, for the following twenty-five projects in the Thai social services sector.

EDUCATION/TRAINING SECTOR

Rural Training (FY67 - FY69; \$4.1m.)

This project provided training and other educational instruction to functionally illiterate villagers in remote rural communities in the Northeast region where other development projects were being implemented, e.g., AID's "Accelerated Rural Development Project" and the World Bank's Vocational Education Project. The project introduced mobile trade training units; provided paper for printing textbooks; and introduced in-service training for rural teachers and administrators at the district level.

Technical Training for Accelerated Development (FY67-FY69;\$3.9m.)

This project trained instructors and participant trainees of another AID-sponsored project, the Accelerated Rural Development Program, in construction trades.

Royal Thai Army Agricultural Training (FY 67-FY69; 1m.)

The objective of this project was to prepare army conscripts from rural areas for civilian life by providing them agricultural training. The project provided commodity support and U.S. expertise to develop curricula.

Technical Assistance to the IBRD Vocational Education Project.  
(FY67-69; 1.3m.)

The World Bank (IBRD) provided a \$20 million loan to the Thai government for equipment purchase and construction of vocational schools, on condition that technical advisory assistance be included as a component of the project. Upon the request of the Thai government, the U.S. mission provided \$1.3 million in grant assistance for technical assistance.

Manpower and Educational Development (FY67-69; 0.4m)

Through a contract with Michigan State University, U.S. educational advisors were provided to strengthen the educational planning capacity of the Thai government.

Educational Television (FY67-FY69; 1.1m.)

A T.V. pilot research project that developed an education and practical skills (e.g., agricultural techniques, health education) program for broadcast to Northeast rural communities.

Farm Short Course Training (FY67-FY69; 0.3m.)

Trained farm youth in the North and Northeast who had dropped out of school in modern farming techniques. The Department of Vocational Education utilized the curricula nationwide.

Special Participant Training Project (FY67-FY69; 0.4m.)

Provided training for RTG officials in the U.S. in fields related to development activities supported by the U.S. mission.

Loan for Improvement of Vocational Education (FY67-FY73; 3m.)  
(LIVE Project)

This project, co-financed with the World Bank, expanded, and improved teaching facilities at, 25 Vocational Schools, including 14 trade and industry schools. The U.S. contribution (43m) funded a team of specialists to train teachers and students at the trade and industry schools.

Rural Education - Teacher training (FY 70-FY71; 0.63m)

Sponsored participant training program in the U.S. for teacher trainers.

Hill Areas Education Project (FY 80-85; 1.6m )

The project supported the Thai Government's 1978 Education Reform Act by helping the Department of Non-Formal Education develop and test a community-based nonformal basic education curriculum for ethnic minorities living in remote hill areas in North Thailand. Following the recommendation of the mid-term evaluation report, the project implementation period was extended for one and a half years. The Project Completion Report indicated that the project achieved all its objective, and directly

benefitted 7,000 people in the project area. The education model developed under the project is being employed by several government agencies besides the Department of Non-Formal Education as well as non-governmental organizations.

## HEALTH SECTOR

### Mobile Medical Teams (FY67-FY69; 1.9m)

Provided equipment and technical advisors to train the paramedical staff of "mobile medical teams" serving remote rural communities in the Northeast. Mobile medical teams were also equipped to assist villagers install wells and latrines.

### Rural Health (FY67-FY69; 2.9m.)

A follow-on of the Village Health and Sanitation Project implemented in the 1950's, this project provided equipment for provincial hospitals, and "Mobile Medical Teams" (see below). It introduced in-country training programs for paramedical workers such as dental assistants, midwives, sanitarians and village health workers and volunteers. Paramedics are the mainstay of the Ministry of Public Health's existing rural primary health care system. Participant training for middle-level medical personnel was also provided. The "village sanitation" sub-project installed thousands of wells, piped water supplies and water seal latrines in approximately 6,000 villages in the Northeast region.

### Protein Food Development (FY67-69; 0.2m)

Supported the above project by providing a full-time advisor to upgrade the MOPH family nutrition program and develop an inexpensive protein-food intake plan for school children in rural areas.

### Family Health (FY67-FY69; 2.7m)

Helped the Ministry of Public Health (MOPH) introduce a birth control program in conjunction with its existing family health service (maternal and child care). Physicians, nurses and midwives were trained. The project provided oral contraceptives and IUDs.

Malaria Eradication (FY67-FY69; 7.8m)

Provided commodity support and technical assistance to the Ministry of Public Health to take over the house spraying and surveillance program initiated in the 1950's under an earlier project.

Chienomai Medical School (FY67-69; 1m)

Provided technical assistance through a contract with the University of Illinois for a staff and curricula development program at the Medical School of Chiengmai University.

Potable Water (FY67-69; 1.7m)

Provided additional support for an ongoing MOPH program to help villagers install potable water systems.

School of Public Health (FY 67-69; 0.3m)

The project had two components. The first developed the faculty of Public Health in the University of Medical Sciences through technical assistance and training programs through a contract with the University of North Carolina School of Public Health. The second developed a field practice and demonstration areas in the Northeast region for rural health workers and trainees.

Population Planning I (FY70-75; 8.3m)

First major donor-financed population planning project that supported the Thai government's National Family Planning Program. It financed participant training, technical assistance, oral contraceptives and medical kits for IUD and sterilization clinics. Oral contraceptives were offered free through 6,000 government outlets.

DEIDS Sub-Project - Lampano Health Development  
( Thailand Sub-Project of Development and Evaluation of  
Integrated Delivery Svstems (DEIDS) Project )  
(FY74-FY79; 2.7m)

This was an experimental sub-project of the centrally funded DEIDS project, designed to develop and evaluate a low-cost health delivery system to provide maternal and child health, family planning and nutrition services. Pilot activities of the project, such as the use of village volunteers and paramedical staff and social

marketing of contraceptives, were subsequently adapted by the Ministry of Public Health for nationwide use (see Rural Primary Health Care Expansion Project below.)

Health and Population Planning (FY75 only; 0.93m)

This one-year project (PROP) provided funds to continue commodity support, training and technical assistance to the Ministry of Public Health and for studies to design follow-on projects - see Population Planning II and Rural Primary Health Care Expansion.

Population Planning II (FY 82-87; 18.3m)

This project extends family planning services developed under the highly successful Population Planning Project to rural areas where fertility rates were still higher than the national average. It also introduced new contraceptive technologies (e.g., injectables and minilaparotomy) and village-level services utilizing village health workers and volunteers.

Rural Primary Health Care Expansion (FY 78 - 81; 6.4m loan)

This project was AID's contribution to the Population Project a 68 million Thai government project financed by the World Bank and other donors. The Population Project was aimed at expanding and accelerating the implementation of the MOPH primary health care system. USAID-sponsored activities focussed on training the cadre of medical and paramedical personnel implementing the system, including village health workers and volunteers. MOPH management personnel at the national and provincial levels were also trained. The final evaluation of the project reported that the training program had been completed successfully, and that by 1985, the primary health system was supported by 18,500 trainers and 500,000 auxiliary health workers serving 75% of the Thai population.

Emerging Problems of Development II (FY85-FY88; 18m)

This umbrella project is designed to provide grant funding for technical assistance, studies and seminars on topics relevant to policy analysis and understanding of development issues. It addresses inadequacies in the Thai Government's institutional capacity to conduct research and analysis of a range of problems that have surfaced in the 1980's. With respect to the social service sector, the project provides technical assistance and funding for health and population planning:

Health (0.4m): Establishment of a Health Economics and Financing Policy Study Center; operations research and related studies to assist the Ministry of Public Health identify strategies for self-financing mechanisms for health services delivery; and support for strengthening the health economics curricula in Thai universities and the MOPH Health Planning Division.

Population (0.45m): Short-term advisors will be made available to guide operations research and studies to improve the efficiency and effectiveness of the National Family Planning Program. A participant training program is also included.

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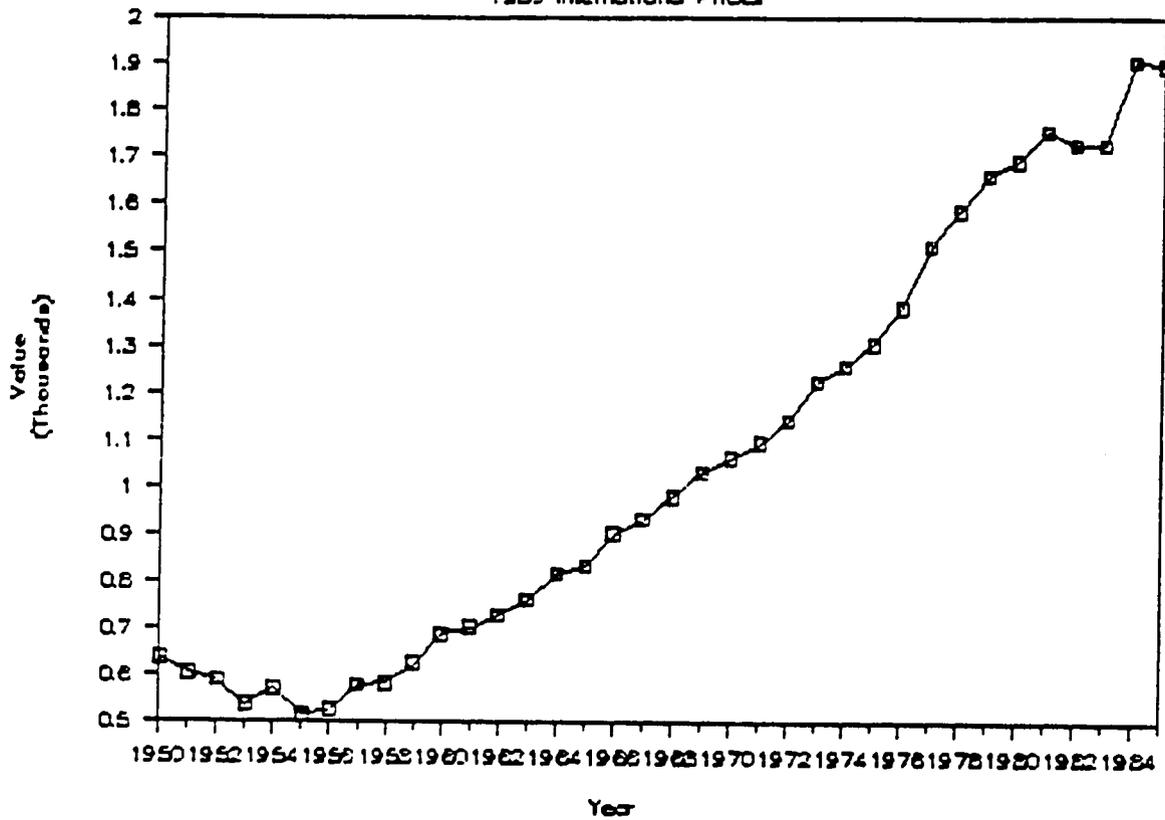
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## Statistical Annex

Note: The tables and graphs in this annex were derived from various AID, World Bank, and other sources. A list of sources is being compiled.

# Thailand Real GDP per Capita

1980 International Prices

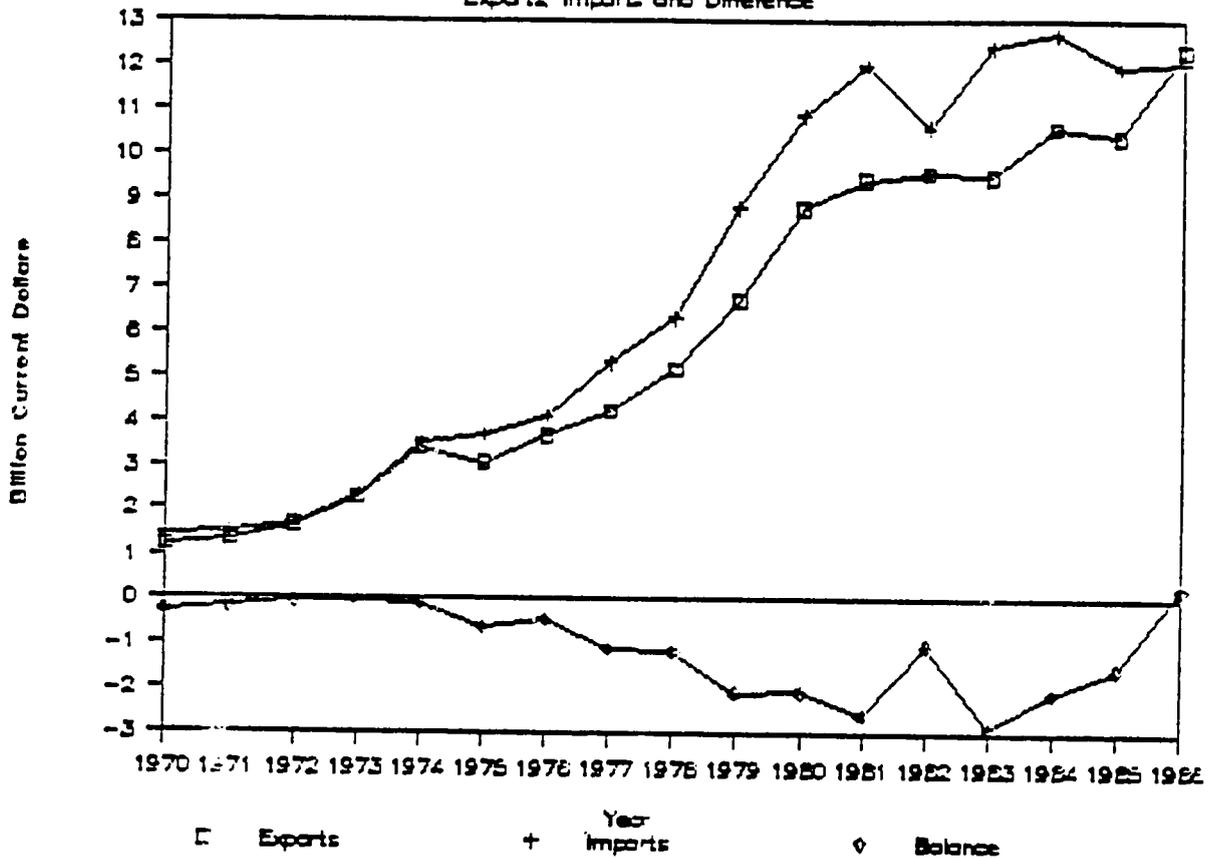


Year	RGDP per capita	Percent Change
1950	638	
1951	605	-5.2%
1952	591	-2.3%
1953	537	-9.1%
1954	571	6.3%
1955	516	-9.6%
1956	526	1.9%
1957	578	9.9%
1958	583	0.9%
1959	625	7.2%
1960	688	10.1%
1961	702	2.0%
1962	729	3.8%
1963	761	4.4%
1964	816	7.2%
1965	833	2.1%
1966	901	8.2%
1967	933	3.6%

Year	RGDP per capita	Percent Change
1968	981	5.1%
1969	1033	5.3%
1970	1063	2.9%
1971	1096	3.1%
1972	1143	4.3%
1973	1226	7.3%
1974	1260	2.8%
1975	1307	3.7%
1976	1384	5.9%
1977	1515	9.5%
1978	1590	5.0%
1979	1662	4.5%
1980	1694	1.9%
1981	1757	3.7%
1982	1730	-1.5%
1983	1730	0.0%
1984	1907	10.2%
1985	1900	-0.4%

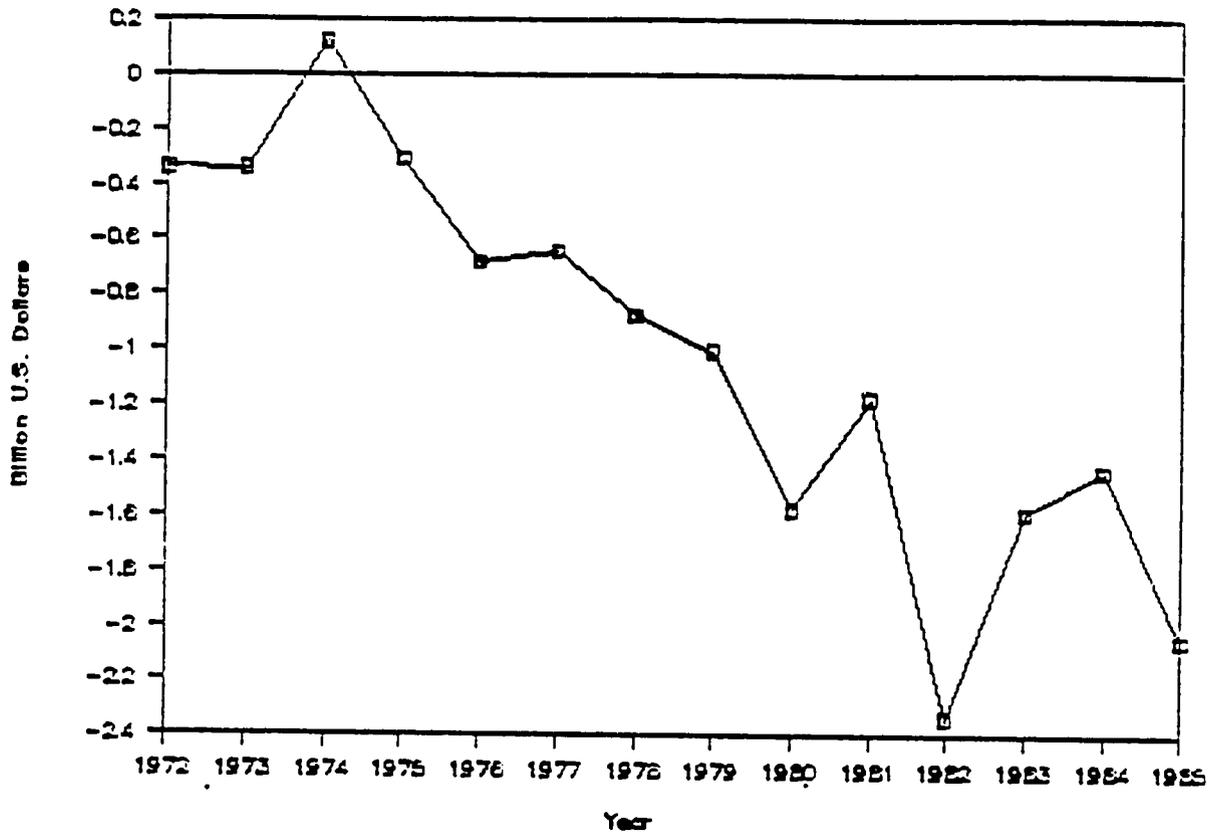
# Thailand Trade Balance

Exports, Imports and Difference



Year	Exports	Imports	Export/Im Balance	Percent Change
1970	1220	1470	-250	
1971	1322	1496	-174	-30.4%
1972	1649	1700	-51	-70.7%
1973	2277	2323	-46	-9.8%
1974	3415	3501	-86	87.0%
1975	3051	3676	-625	626.7%
1976	3668	4108	-440	-29.6%
1977	4218	5313	-1095	148.9%
1978	5166	6321	-1155	5.5%
1979	6721	8804	-2083	80.3%
1980	8794	10860	-2066	-0.8%
1981	9421	11995	-2574	24.6%
1982	9586	10606	-1020	-60.4%
1983	9504	12391	-2887	183.0%
1984	10590	12697	-2107	-27.0%
1985	10395	11948	-1553	-26.3%
1986	12328	12079	249	-116.0%

## Thailand Budget Surplus

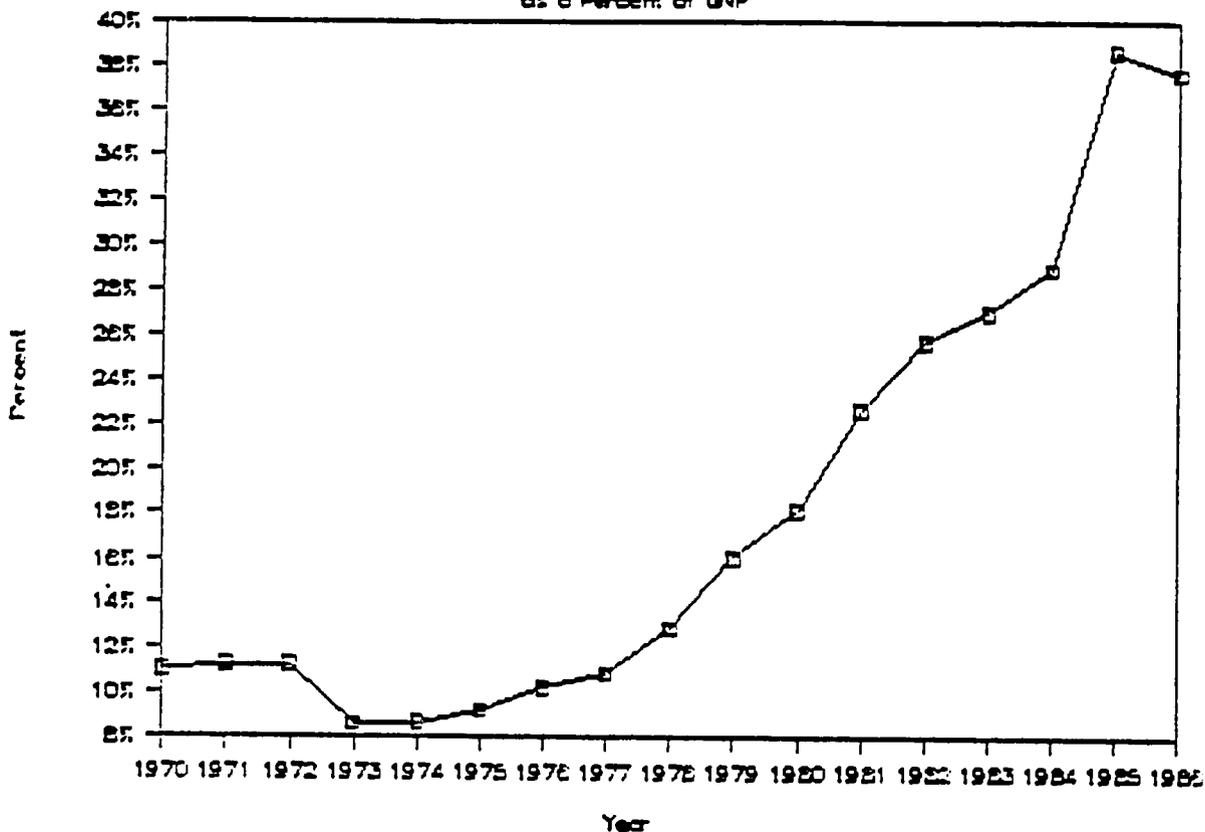


Year	Budget Deficit
1972	-340.9
1973	-341.4
1974	120.7
1975	-307.2
1976	-679.9
1977	-644.1
1978	-873.6
1979	-1003.4
1980	-1575.7
1981	-1176.4
1982	-2337.0
1983	-1592.6
1984	-1439.1
1985	-2054.1

*56*

# Thailand External Debt

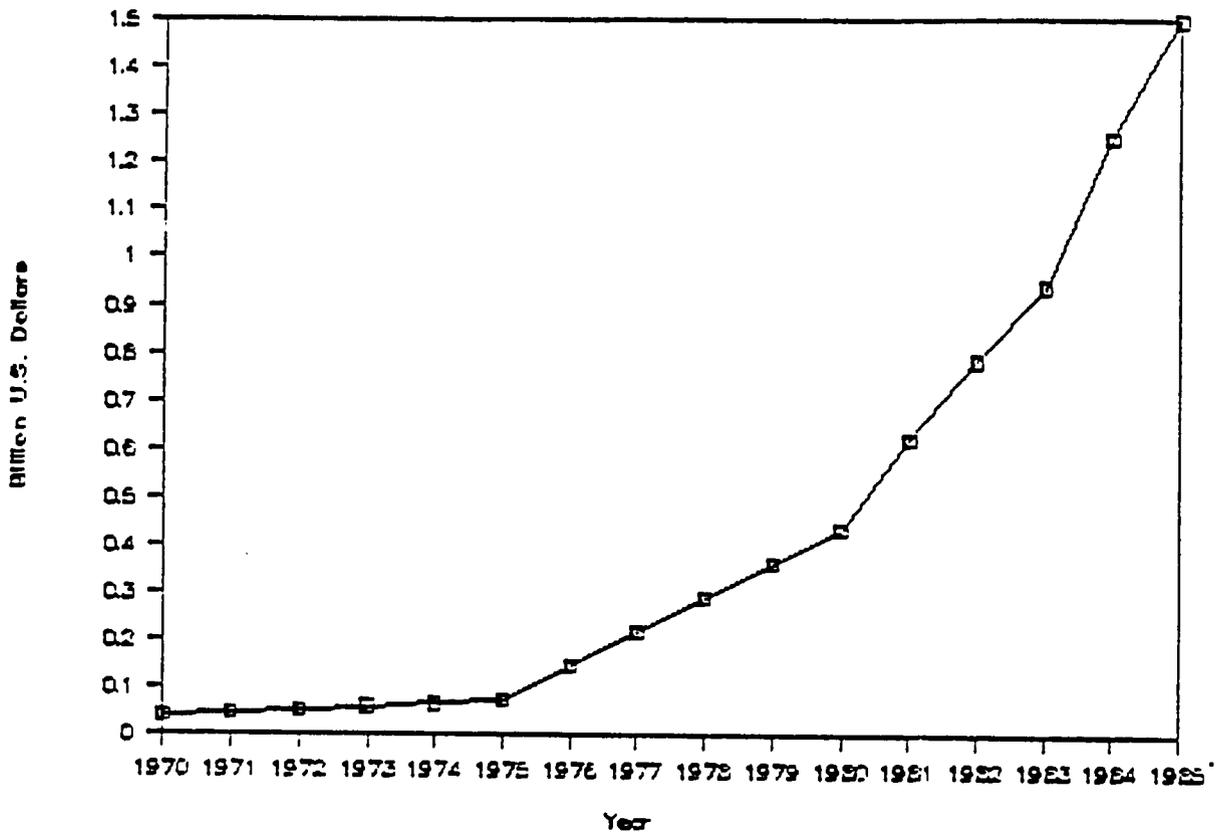
as a Percent of GNP



Debt as  
Year % of GNP

1970	11.06%
1971	11.25%
1972	11.28%
1973	8.62%
1974	8.68%
1975	9.23%
1976	10.23%
1977	10.85%
1978	12.85%
1979	16.01%
1980	18.14%
1981	22.64%
1982	25.69%
1983	27.01%
1984	28.91%
1985	38.63%
1986	37.65%

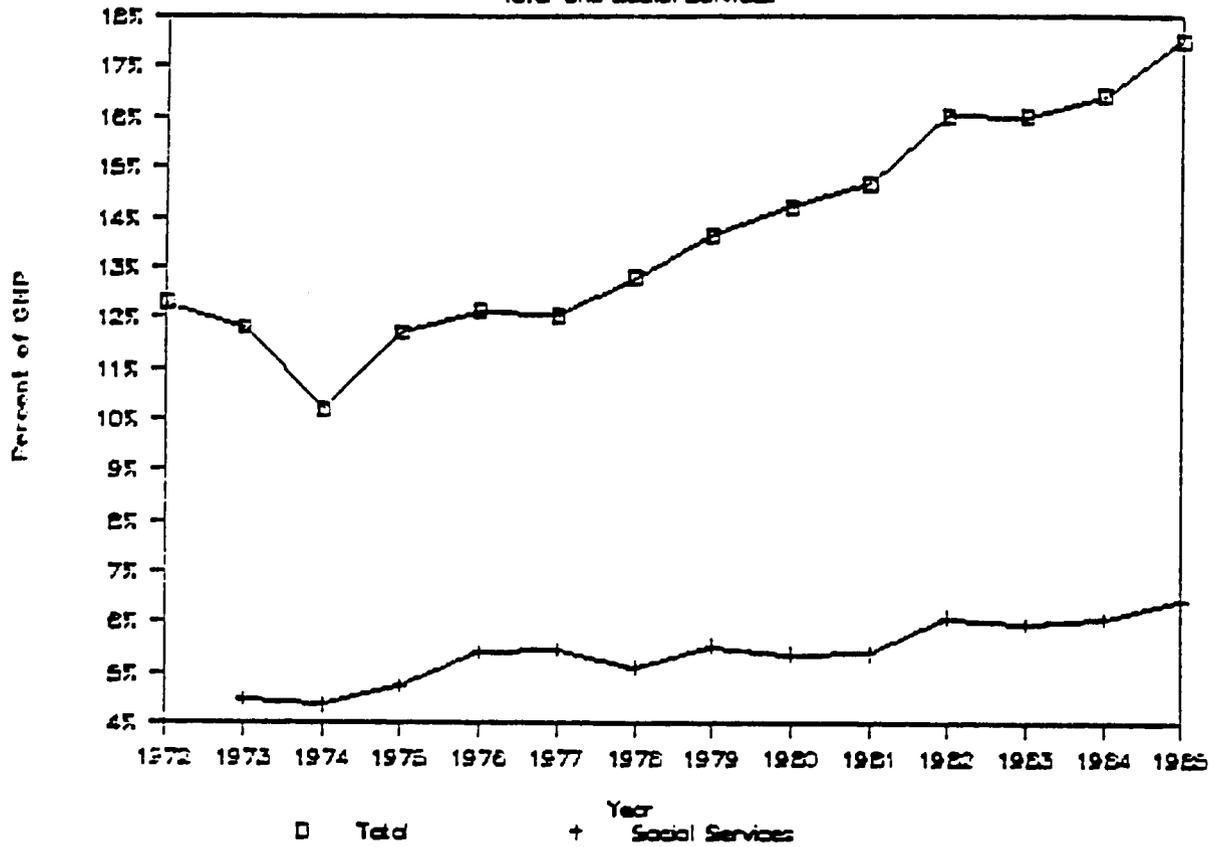
## Thailand Debt Service



Year	Debt Service
1970	39.4
1971	45.98
1972	52.56
1973	59.14
1974	65.72
1975	72.3
1976	144.62
1977	216.94
1978	289.26
1979	361.58
1980	433.9
1981	621.4
1982	784.6
1983	939.1
1984	1251.2
1985	1499.1

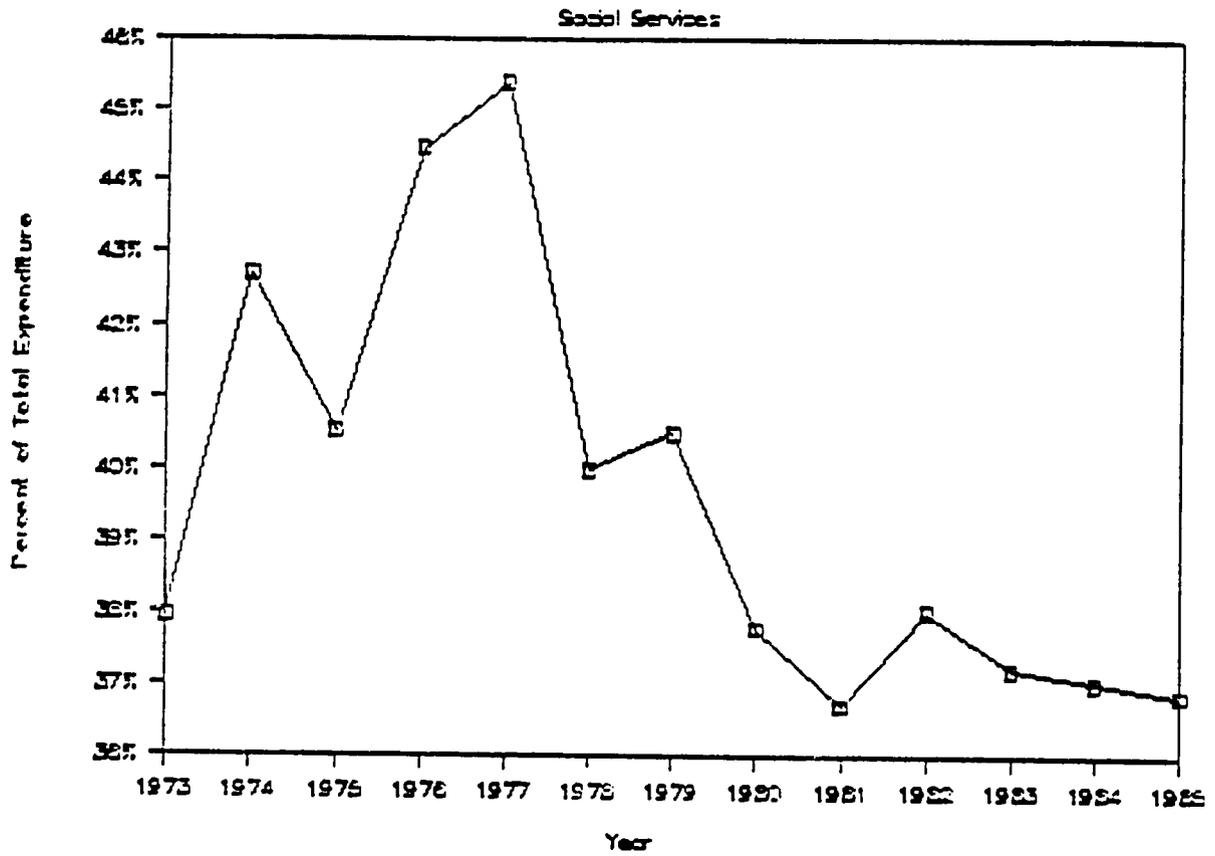
# Thailand Government Expenditures

Total and Social Services



Year	Govt Exp. as % of GNP	Soc Services as % of GNP
1972	12.29%	
1973	11.81%	4.48%
1974	10.19%	4.35%
1975	11.71%	4.75%
1976	12.13%	5.40%
1977	12.05%	5.47%
1978	12.82%	5.12%
1979	13.65%	5.53%
1980	14.22%	5.37%
1981	14.68%	5.39%
1982	16.02%	6.09%
1983	16.02%	5.96%
1984	16.43%	6.08%
1985	17.52%	6.46%

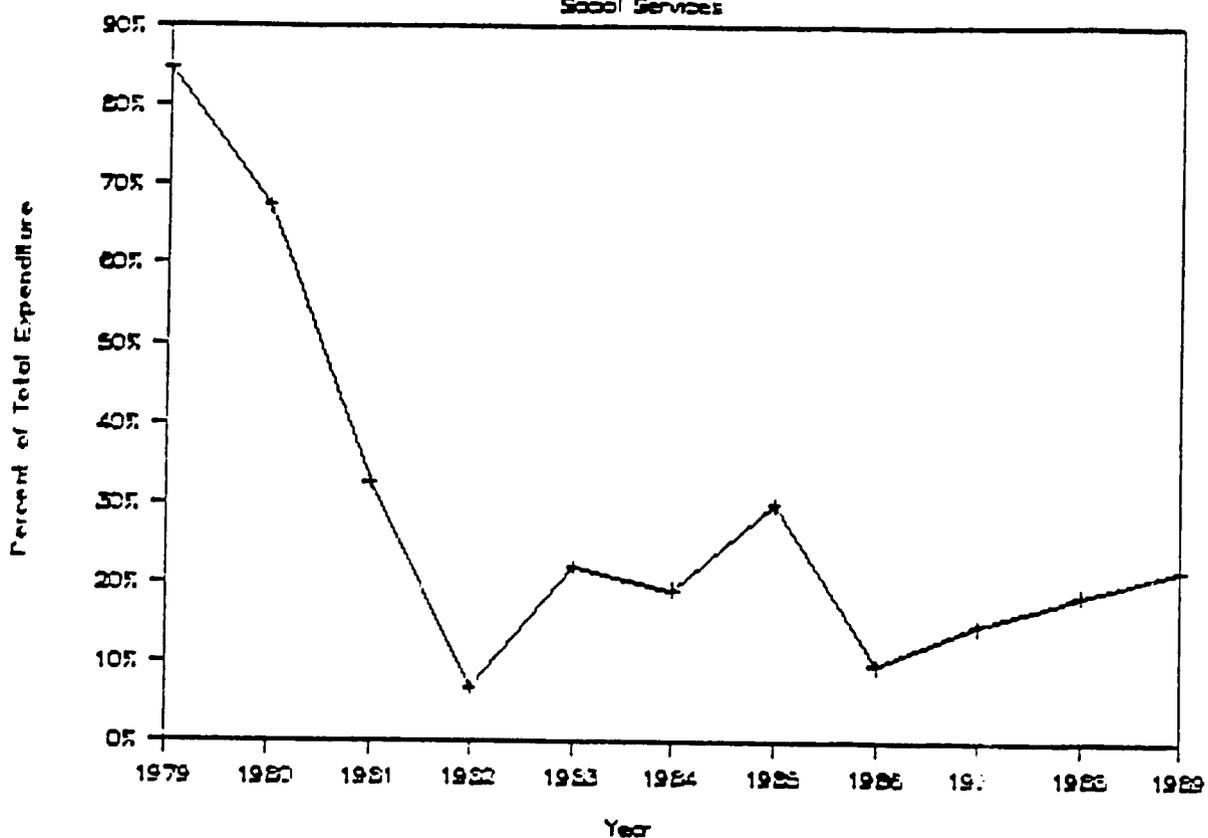
# Thailand Government Expenditures



Year	Soc Serv as % Expend
1979	84.62%
1980	67.34%
1981	32.55%
1982	6.76%
1983	22.06%
1984	19.19%
1985	29.83%
1986	9.61%
1987	14.60%
1988	18.51%
1989	21.56%

# Thailand A.I.D. Expenditures

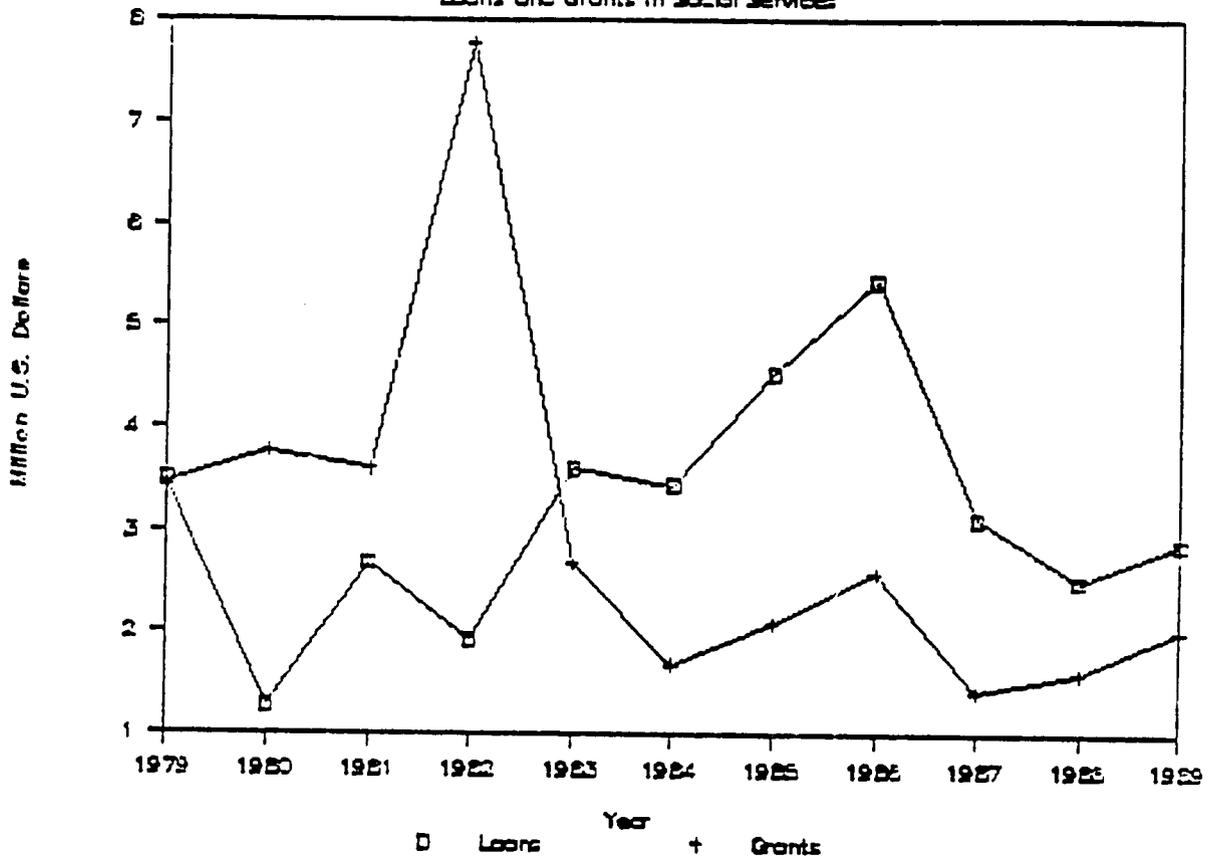
Social Services



Year	Soc Services as % of Total
1973	37.95%
1974	42.71%
1975	40.52%
1976	44.47%
1977	45.39%
1978	39.98%
1979	40.49%
1980	37.78%
1981	36.72%
1982	38.02%
1983	37.22%
1984	37.03%
1985	36.86%

# Thailand A.I.D. Expenditures

Loans and Grants in Social Services



Year	Soc Serv Loans	Soc Serv Grants
1979	3.499	3.449
1980	1.28	3.768
1981	2.683	3.608
1982	1.925	7.774
1983	3.602	2.691
1984	3.442	1.69
1985	4.53	2.095
1986	5.441	2.586
1987	3.116	1.42
1988	2.51	1.596
1989	2.869	2.025

Official Assistance By Donor

Year	B.R.D.	Japan	U.S.S.R.	E. Eur.	Other
1976	10.5	48.3	0	0	88.6
1977	12	58.4	0	0	17.66
1978	11.9	112.7	0	0	32.2
1979	49.2	188.3	0	0	53.3
1980	623	196.9	0	0	53.5
1981	50.4	226.2	0	0	37.9
1982	31.1	189.3	0	0	50.9
1983	28.9	272.6	0	0	47.7