

United Nations

Division for the Advancement of Women (DAW)

Expert Group Meeting

Enhancing Participation of Women in Development

through an Enabling Environment

for Achieving Gender Equality and

the Advancement of Women

Bangkok, Thailand, 8-11 November 2005

Gender, Public Health, and Human Security Policy in Asia

Prepared by

Lynn Thiesmeyer

- * The views expressed in this paper are those of the author and do not necessarily represent those of the United Nations

Last June in at the Women's Congress in Seoul, I headed a group of speakers that had decided to call our panel "Women's Security is Human Security." The participants and audience were women's studies and gender studies experts as well as practitioners; three of us, including myself, head NGOs in South and Southeast Asia that work with rural and indigenous women in development. Within both the Asian region, and developed countries, the concern with Human Security has overtaken and assimilated previous U.N. concerns with Basic Human Needs and gender equity and is fast becoming the leverage to move policy discussions and revisions on an international scale. Yet as potentially beneficial as this new policy framework appears to be, it nevertheless was quite obvious to us that it had, like many new frameworks in the past, suddenly developed amnesia about gender. Not of least concern is the fact that it informs policy on the global level in terms of international legal frameworks and agreements. Yet what I have found in years of research and practice is that when national-level policy mechanisms are justified by their conformity to international ones, especially those addressing global political, security and economic concerns, they can have the reverse effect of disempowering the people, especially the women, who are directly impacted by these remote policies in their daily lives.

We are asked here to consider, rather, an 'enabling environment' – one comprised, presumably, of a set of interrelated and interdependent systemic conditions such as policies, laws, institutional mechanisms, resources. Yet it is precisely in the three broad areas of the Millennium Development Goals – capabilities, access, and agency – that we see very clearly how deeply and consistently local institutions and organizations affect the daily lives of women. For women in developing regions, the capabilities of education and health are less dependent on progressive national policies, though these are necessary, and more dependent on the existence, capability, and gender sensitivity of whatever health services are within walking distance. Similarly, their degree of access to resources in terms of employment, income, and land will be determined mainly by the household and the village economy and society, with higher-level institutions and policies functioning mainly to reinforce the denial of such access to them. And lastly, in terms of agency, their social and political participation in their own communities, where the vast majority of them will participate if at all, will in turn be facilitated by their access to the status-conferring resources of income and land. So we see that even before those women who know in reality the daily lives and needs of local women can ascend to the national policy arena, they must first somehow be empowered within their communities of birth. The example I focus on is public health, HIV and gender in resource-poor areas.

The most basic aspect of human security in any area of the world is health, whether in urban, exurban, or rural areas, because health is directly impacted by other elements of

human security and of poverty. The 1946 WHO definition of health stated that it is not only the absence of disease, but includes all kinds of well-being. Disease, injury and mortality, however, are first on the list of both developed and developing countries as the most serious threats to human security because they threaten to do away with the human him/her self. For similar reasons, the U.N.'s and ILO's promotion of 'Basic Human Needs' in the last 30 years has also stressed the prime importance of physical health as the most basic need because it is equated with the survival of the human race.

Moreover, four of the seven aspects of human security as given by the first Human Development Index of the UNDP in 1994 impact directly on human health: food security, health security, environmental security, and personal security. Food security is currently compromised in most rural regions of developing countries, not only in southern Africa. Health security is likewise compromised in such regions and health threats are threats that have a cumulative effect on the rural poor. Environmental security is directly impacted by environmental degradation, the use of toxic chemicals to temporarily boost agricultural productivity, and by wastes from industrial parks that are built on rural land. Personal security is threatened whenever there is personal violence. What is striking about all four of these is, of course, that they impact on women most directly and most abundantly. Health is human security, undoubtedly; but even more, women's health is human health and human security. When women's health or strength is negatively impacted, household health and community health also deteriorate. But it is important to recognize here that women's health status is a composite of their social, institutional, and environmental situations that may not conform to existing policy frameworks. Specifically, it is common for women around the world to have less access to the components of health that are normally undertaken by legal and policy approaches: appropriate quantities of safe food and water, appropriate nutrition, non-toxic work and living environments, appropriate health care, and safety from personal and political violence. Rural men suffer from the threats inherent in the absence of these social and environmental conditions, but women suffer differently, are cared for differently if at all, and survive, if at all, differently. These differences can be directly linked to their climate, environment, and ways of producing or earning food, shelter and other health-sustaining conditions within their specific communities, and not so directly to the national policies that, of necessity, conceive of women as an aggregate mass.

Yet despite these basic and well-known findings, the rural areas of mainland Southeast Asia show a startling lack of bridging initiatives between gender research and policy on health and development issues. Unlike economists, engineers, and inventors, health researchers, whether they are medical researchers or academic researchers, quite often work in isolation from the policy-making environment. Why? First, both sides may unconsciously wish it to be

so. Medical and health research is highly skilled, delicate, and sometimes confidential. On the policy side, policy-makers often do not take 'medical' issues to be inherently policy issues. Once public hospitals are established and supported by government revenue, issues defined as medical are traditionally undertaken by hospitals and other medical facilities without the detailed 'intervention' of national governments, either for fact-finding or treatment policies, except in cases of emergencies or wide-ranging epidemics.

Second, we see the absence of specific, disaggregated information on human health, especially in developing regions where funding for surveys may be inadequate. The specific levels of information that could impact on policy, such as knowledge-based village, district, and provincial data collection, are either absent, are in a very nascent stage of development, or lack the appropriate technology and language to transform their findings into comprehensive and clear positions that could be transmitted through the appropriate policy channels. As health policy and access, especially in a gendered analysis, require a great deal of fact-finding, funding, and policy implementation to make them work, policies that provide for closely researched and proven local needs issues are needed. For example, women in villages of Thailand and Vietnam report to me that they face three daunting conditions that are based on, or impact on, their health and the health of the whole community. These are the lack of infrastructure such as sanitation; the lack of health care, such as basic hospital care for reproductive health as well as the lack of time and transportation to existing health care facilities; and the lack of appropriate nutrition for sustaining periods of time. These concerns reflect the fact that policies are not made only to address social and political issues, but also to address basic needs and material and economic conditions. With this in mind, I would like to mention two conditions within development policy that strongly impact on health and gender. One is Structural Adjustment and related economic policies undertaken by a government on its own initiative or in partnership with an aid-donor country. The other is a condition that is in part due to such economic restructuring, in part to economic development and political modernisation, and in part simply to endemic poverty: the role that lack of access to basic resources, especially land, plays in food insecurity and the resultant deterioration of health and life for women in development.

Even with sensitive and wide-ranging healthcare policies, the lack of healthcare funding in developing regions and thus of appropriate care can be due to three major factors. The first is SAPs. Structural adjustment programmes, it has been shown, have been responsible for a large number of the cuts in government health-care spending since the two financial crises of the 1990s (see Bakker, Elson, Brodie, and Shirai). Unfortunately structural adjustment programmes place the receiving government in a difficult position, as such cuts in social welfare must be made in order to obtain loans from such institutions as the World Bank

and the IMF. Bakker and Brodie have shown, in particular, that such adjustments impact not only on the poor who depend on some form of social welfare, but more specifically on poor women. The withdrawal of subsidies for health care in particular has meant that women themselves suffer poorer reproductive, nutritional and general health. But it also means that as primary caregivers women are hampered in obtaining medication and treatment for other family members, who then suffer as well.

Another mechanism that challenges existing health policies and drains off adequate healthcare funding is the outbreak of epidemic disease. In the case of HIV, despite the reduction in cost of ARV medications, they are still beyond the reach of at least two-thirds of the infected population in developing countries. Despite reductions in new infections in countries like Thailand, Ghana and Cambodia, there is no health care system in any developing country in Africa or Asia that has been able to adequately even half of the HIV+ population. The proportion of the infected population to the annual amount that can possibly be budgeted for health care is simply too high. Further, with 'health' in healthcare policy still being defined as a question of pharmaceuticals, medical treatments and facilities, rather than of environmental, community, and personal conditions and practices, the costs will continue to be high and the policy implementations inadequate.

A third mechanism that interferes with appropriate health care policy is economic policies. Two years ago, Thailand introduced the "30-baht health card scheme." This is a type of health insurance card, similar to an identification card, which is issued at the place of residence and allows the bearer to receive care at a public hospital for a total cost of no more than 30 baht (less than 1 U.S. dollar). This scheme was introduced by Prime Minister Taksin as a way of relieving the cost burden of the poor, and has resulted in more use of public health facilities by the poor. Because of the transfer of the cost burden to the hospitals themselves, however, the outcome has been decidedly mixed. The public hospitals, already overloaded, have in some cases refused or drastically shortened the course of treatment to the poorest patients. Second, the card covers hospitalization and treatment within the hospital. Outpatient care, rehabilitation, and most importantly of all, medications, are not covered by the card. Thirdly, the card is issued at the district of residence and can normally be used only at the one public hospital of that district, or, if a long wait is feasible for the patient, at the one provincial-level hospital. The poor, who often move to neighbouring (or distant) districts in order to seek work, cannot use this low-cost card even one district away from their village of origin without going through a re-application procedure.

With these present obstacles in mind, I would like to return to the specifics of gender, human security and health policy in rural settings, where social and environmental factors

play a decisive role¹. As one of these non-medical factors, I would like to turn our attention to a defining factor in the environment of absolute poverty in Asia. That factor is the unavailability of the primary resource of food-producing land, and in particular its unavailability to women.

Without land, the moneyless, uneducated rural poor (and most rural women are uneducated and without money) have no means of subsistence. Tenant farming on another's land is subject to the variations of season, export market prices, and labour competition, of course, and these costs are passed on to the worker in terms of offering less-than-subsistence amounts of daily wages or in-kind food payments. In a decade in which we have concentrated urgently on the links among food security, health and catastrophic illness, we still need more empirical research on the fourth factor in this equation: starvation. Smith points out that rural families frequently undergo malnutrition and starvation periods to make insufficient income and food stretch within the household, and we know from various studies, including those by Amartya Sen, that it is most frequently women within the household who starve to a greater degree². Not only is land the determinant for food, it is also the determinant for every other necessary resource, including those of social and human capital. Those who have parcels of land can belong to village groups, ask for or give help in need, and mobilize others to increase local productivity and employment. Land is thus important to the woman as collateral for other forms of social and political bargaining. When she cannot own or use land, then the tenancing of land, the only employment option available to a large proportion of Asian rural poor, subjects her to the political and social power of the hiring landowner, and disempowers her from free agency in a wide range of social and political memberships and activities.

Productive land and its role in health are also, of course, dependent not only on its availability and size but also on its usability, in terms of climate and environmental status. At this juncture we begin to see the not only beneficial, but deleterious effects of development policies that manipulate ecosystems to increase economic profitability. Gommel, du Guerny, Glantz and Hsu point out that deforestation, flooding, drought, food insecurity, and changes in water supply all affect human health quite directly. In the Asian region, many examples of these ecological disasters have, in recent years, been linked to national and international development policies that led to environmental mismanagement. It is little wonder, then, that new and catastrophic illnesses such as HIV have taken hold precisely in those areas where such environmentally-unfriendly policies have caused environmental degradation. Further,

¹ At the November 2003 Conference on Human Security chaired by the Chairman of the Human Security Commission, Anand Panyarachun, the importance of human security and non-medical factors to 'medical' issues was emphasised by Dr. Suwit Wibunponpraset, Thailand's Deputy Minister of Public Health: 'AIDS and other catastrophic (and common) illnesses relate to Human Security and should not be "medicalized".'

² Smith, *Human Rights and Choice in Poverty*, chs. 3 and 4. Sen, *Commodities and Capabilities*, ch. 6.

although developed countries' food supplies are also and more indirectly affected, it is the women food producers in rural, developing regions that are in closest contact with the consequences of deforestation, drought and food shortages, and thus it is their health that is also most directly impacted. Unfortunately, today's famines are linked to development policies at the national and international levels that went wrong by pushing the monoculture of single, unsustainable crops and export-led growth. As Gommaes et al. point out, it is such "background vulnerabilities that create the conditions for increasing the risk" of diseases including HIV. One primary reason for this is that lack of access to land pushes labour mobility, and mobility induces a high risk for HIV. But in terms of all health and reproductive issues faced by women, Smith shows that one "vulnerability" is precisely the malnutrition that results from poor access to land, and the resultant weakening of the immune system.

In Thailand, Vietnam, and Indonesia, there are two factors that increase the shortage of land and its resultant rural health risks. Both of them are, in fact, policy attempts to equalize, or at least modify the inequalities between, the rural and urban populations and the propertied and propertyless. All three countries have undertaken land redistribution and land reform acts, Thailand since the 1930s and Vietnam since independence. All have also undertaken the decentralization of government power to the local districts and villages, Thailand since 1994, Vietnam since 1992, and Indonesia since 2001. Yet paradoxically, both of these policies have sometimes been used in ways that disenfranchise, or threaten human security, including health security, especially that of women. The reason is simple: policies that arise during development and democratization very often do not look at gender, and do not take the social, material, and environmental, situations of women into account. One might even conclude, from looking at the numerous occasions on which 'democratic' policy reform actually worsened the lives and the access to human security of women, that women are still not considered a part of the national population that such policies claim to empower.

Yet these policies in Thailand, Vietnam, and Indonesia have not yet benefited women or the rural majority. Decentralization as well has run into extreme budgetary problems for the local governments, especially in regards to health and welfare, where fiscal arrangements for health and welfare must be made by the impoverished local districts, resulting in budget shortfalls. Yet in these countries it is the local districts that have half to two-thirds of the population. Further, in Vietnam it was noted that the variations in amounts of yearly transfers to local governments made long-term planning for health and welfare unfeasible³. In Thailand, agricultural land became available for private ownership by its cultivators in 1975, but the Land Reform Office required monetary payment for land that had been traditionally cultivated,

³ United Nations System (December 1999). "Looking Ahead: A Common Country Assessment of Vietnam." Ha Noi, Vietnam.

and in the modern system of wage-earning, only a man, if anyone, would have enough currency to purchase the land he wished to continue cultivating. In Vietnam and China, the state recently enacted laws to allow private ownership, but both are societies in which assets are inherited only by sons, not by wives or daughters. In Indonesia, recent surveys have shown that the greatest disputes, as well as the greatest corruption, still occur over the ownership, use of, and access to land.

From these cases it can be seen that recent attempts to impose modern, democratic policies on traditional areas did not first consider ways to modify the burden the new policies would automatically place on the impoverished local district, its untrained, underpaid staff, and the local population, who may be unaccustomed to open and non-mercenary discussions with persons in positions of authority. This has made possible the loopholes in, or corrupt use of, modern laws, which led to the limiting or denying of individual access to land and food production as well as of hamstringing the local governments' budgetary resources for health. Here it is well to keep in mind that 'Reformation of politics which confers more opportunities on political parties without being accompanied by efforts to enhance people's capacity to control the behaviour of political party elites is a recipe for their deeper involvement in [corruption]'⁴.

Further, it is not national policy that directly mandated the gender discrepancies in land ownership and in access to appropriate health care in the three countries under discussion, nor the increase in HIV among Asian women to nearly 60% of all HIV+ cases. It is the presence of 'policy'-making within the local institutions of village or district councils, hospitals, education, employers, army, police and the like, that directly impacts on the local population and thus on the gender bias in access to human security. As these are the organizations that will deliver almost all of the services that women will want throughout their lives, they need to become the locus of policy proposals, change, and implementation. For example, the actual contents of a person's knowledge and skills will not be decided by a national government, but by her school, the choice of which is, in turn, decided by her ability to pay. The actual status of a person's reproductive health will not be decided by a national policy but by the exigencies of local hospitals, their status as to up-to-date equipment and medicines, the knowledge possessed or not possessed by their staff, and again, her individual ability to pay. In reality, the 'policies' we are looking at and attempting to reform should not be policies only at the national level. Few of the majority populations of developing countries are impacted by more than the establishment of such local institutions through government policy. Once established, institutions tend to make their own rules and these rules are

⁴ Dwiyanto et al., eds. (2003), p. 21.

implemented directly on the local persons who seek their services. Further, employers also fashion their own rules and implementations, especially in the informal sectors where most women in development spend most of their time and where, especially in labour migration, according to every survey in the last 15 years, they are exposed to the greatest risk of HIV. In fact, for the health-deprived or health-threatened women *and* men of rural Asia, it is most of all the employment system, whether of the seasonally-hiring landowner, the local mill owner, or the ‘broker’ who takes labourers to distant work sites, that will decide if, when, what and how that person eats, with which group that person will have intimate contact, and thus how that person’s health sustains itself or not.

Public hospitals, village health stations, and public schools see nearly all the population of a given area over time. They are also places where local people gather to exchange new and old information, as well as new ideas, on risks, potentials, and successes. It is not only the staff and directors of these institutions who provide the necessary impetus for policy reform, but their constituents themselves. Communities where local women as well as men have sustaining work, incomes, and social services – where, in fact, they may become the providers and managers of these services – are communities that have so far impacted the most powerfully on national policies to recognize and sustain their own needs.

From the standpoint of the above examples, I would like to address the 4 questions of the EGM.

1. What is the interrelationship between health, education and work?

Women’s access to resources in general, and the elements of Human Security as applied to women’s situation, are closely interrelated. Access to work, as well as the appropriate work environment and a wage that can support the woman’s dependents, often determines key aspects of the women’s health and that of her household as well. Put simply, access to work determines access to food, and the consequent nutrition, immunity, and health.

Education in this context of course includes primary and secondary education for girls, which sometimes – but not in all environments – provides the potential for a better work environment. But it also includes lifelong education and adult education. In developing countries, women of the current adult generation have often had little or no access to education. Leaving aside the question of the kind of school education that leads to work opportunities, there is the more fundamental question of what sort of knowledge or information they need to access in order to manage their daily lives and increase their participation in local and district social and political institutions.

Finally, access to productive resources – mainly, in rural areas, land and all it implies – allow women to use and profit from basic resources as well as social belonging, which in turn allow them to access education for themselves and their children, the income from agricultural production, and finally, fundamental areas of health related to the nutrition and the health conditions they can produce or buy because of their access to productive land.

2. Which national policies, institutions et al. have been effective?

The spread of mandatory and free public education up through grades 6 in most areas and grade 9 in many; the spread of Primary Health Workers /Volunteers; the multi-nation agreement on Community Forestry, which is an area of expertise, work and food supply traditionally managed by women; private ownership of land in conjunction with inheritance laws that allow women to inherit property even when there is a son. Laws about environmental safety and workplace safety, because women are more likely than men to work directly with the natural environment (in rural areas) and in unsafe, unregulated work environments (in factory and urban areas).

Laws that mandate food sufficiency within the country for the domestic consumer and prioritize the fulfillment of food sufficiency over export production.

Policies that include regular, frequent, and direct collection of dis-aggregated data on the local levels, and that mandate the collection of reliable gender-specific data. These data should include land use status; contact with the environment, especially soil and water; educational level; labour mobility; workplace and household time use; and food intake should be measured along with gender disparities. We also need to include the life practises and limited ‘choices’ of women in resource-poor, choice-poor settings. They produce, in turn, the limited survival ‘choices’ of women within the household, within the community and within the job market.

On a broader level, any bill that mandates discussion of planning, policy, or extra-governmental development schemes (such as by transnational corporations) with the very persons concerned in the local area, in a responsive and empowering way. National and trans-national development policies that do not prioritize economic development in terms of the use or alteration of material and physical resources only, but that prioritize sustainability, human development and good environmental management, and are specifically about human development targets that are in line with the Millennium Development Goals⁵.

⁵ The nine strategic priorities identified by the Millennium Task Force on Gender Equality are:

- strengthening opportunities for post-primary education of girls;
- guaranteeing sexual and reproductive health and rights;

But most importantly, it is necessary to have a conceptual framework for policy and policy-making that allows a more flexible and wider-ranging specification of its *location*. By conceiving of ‘policy’ as an entity on the national or even international level, and as belonging to the persons who work on this level, we tend to ignore the policy needs of, and impacts on, persons within their local communities throughout the nation. In fact we are in danger of replicating the top-down structure characteristic of the sort of bad development schemes that the earlier economic growth-based policies were guilty of. Instead, we must re-focus policy-making itself to include the local institutions and organizations that constitute the daily activities of women, and men, in development.

3. At local and household levels, which strategies have ensured women seized opportunities?

The system of Primary Health Workers; Community Forestry; strategies that enhance the work and income of female family members; OTOP (the One District One Product initiatives in Thailand) and other community businesses; the Vietnam Women’s Union, which exists in every hamlet throughout a country of 70,000,000 people to enable participation of women in basic health care, income generation, and various kinds of information-sharing and training.

4. What factors facilitate or hinder an enabling environment?

The hindrances are encountered quite frequently in rural areas as a result of the fact that the “policies” and “institutions” that the majority of women deal with daily are those of the schools, the health care centers, and the police or military. At the district and local levels these institutions are far removed from national policy, supervision or evaluation, and tend to set their own policies and enforcements. Further, the very diverse cultural expectations even among the varying regions of one country, and among all developing countries, impact more strongly on rural women than do national policies, even when implemented. Vietnam and China do not normally allow women to inherit family assets, but neighbouring Thailand and Laos do. (Nonetheless many Thai women are pressured by husbands to put up the land as collateral for the husband’s expenses and thereby often lose the land.)

Factors in such situations that facilitate an enabling environment are women’s

-
- investing in infrastructure to reduce women’s and girls’ time burdens;
 - guaranteeing women’s property and inheritance rights;
 - reducing gender inequality in employment;
 - increasing women’s representation in political bodies;
 - combating violence against women;
 - gathering data and developing indicators for monitoring progress;
 - financing costs of interventions to achieve gender equality.

employment in, or other forms of participation in, these very same institutions or their affiliates. Even when women lack formal education they can receive training to become Primary Health Workers in rural areas. School settings have been used to encourage all community members, including those who received no schooling, to have meetings, open discussions of community issues, and delivery of information relating to their daily needs. It is often difficult to change family and household structures that disempower women, but community organizations and initiatives often act as mediators to familiarize the family members to new and unfamiliar practices. If they are *locally* established and staffed organizations, they often serve as the most efficient and non-threatening channels of new gender policies that would otherwise be distrusted or opposed.

References

- Aggleton, Peter, Graham Hart and Peter Davies, eds. (1991). *AIDS: Responses, Interventions and Care*. London: Falmer Press.
- Bakker, Isabella, ed. (1994). *The Strategic Silence: Gender and Economic Policy*. London: Zed Books.
- Brodie, Janine (1994). "Shifting the Boundaries: Gender and the Politics of Restructuring." In Bakker, ed., pp. 46-60.
- Dwiyanto, Agus, et al. eds. (2003). *Governance Reform and Regional Autonomy in Indonesia*. Jogjakarta: Center for Population and Policy Studies, Gadjah Mada University, and the Partnership for Governance Reform in Indonesia.
- Elson, Diane (1994). "Micro, Meso, Macro: Gender and Economic Analysis in the Context of Policy Reform." In Bakker, ed., pp. 33-45.
- Fee, Elizabeth, and Nancy Krieger, eds. (1994). *Women's Health, Politics, and Power: Essays on Sex/Gender, Medicine, and Public Health*. Amityville, NY: Baywood Publishing Company.
- Gommes, Rene, Jacques du Guerny, Michael H. Glantz and Lee-Nah Hsu. "Climate and HIV/AIDS: A hotspots analysis for Early Warning Rapid Response Systems." United Nations Development Programme and South East Asia HIV and Development Programme, September 2004.
http://www.hiv-development.org/text/publications/climate_HIV.pdf
- Henderson, Sheila (1991). "Care: What's in it for Her?" In Aggleton, Hart and Davies, eds. (1991), pp. 261-272.
- McMichael, A.J., A. Haines, R. Sloof, and S. Kovats (1996, 2003). *Climate Change and Human Health*. World Health Organization.
- National Economic and Social Development Board, Thailand (2005). *Thailand in Brief 2005*. Bangkok: Office of the National Economic and Social Development Board.
- Porter, Fenella, Ines Smyth, and Caroline Sweetman. *Gender Works: Oxfam Experience in Policy and Practice*. Oxford: Oxfam, 1999.
- Razavi, Shahra, ed. (2002). *Shifting Burdens: Gender and Agrarian Change under Neoliberalism*. London: Kumarian Press.
- Rives, Janet M., and Mahmoud Yousefi, eds. (1997). *Economic Dimensions of Gender Inequality: A global perspective*. Westport, CN: Praeger.
- Rosser, Sue V. (1994). *Women's Health: Missing from U.S. Medicine*. Bloomington, IN: Indiana University Press.
- Santiago, Eden V. (2003). "Vietnam: Decentralization for Better Local Governance." In *Sourcebook on Decentralization: Vietnam*. Manila: Asian Resource Center for Decentralization.
- Seidel, Gill, and Laurent Vidal. 'The implications of "medical", "gender in development", and "culturalist" discourses for HIV/AIDS policy in Africa'. In Shore and Wright, eds., pp. 59-87.
- Shirai, Sayuri. "The Impact of IMF Economic Policies on Poverty Reduction in Low-Income Countries." In *International Economics* (Japan), 55 (Sept. 04), pp. 119-163.
- Shore, Cris, and Susan Wright, eds. (1997) *Anthropology of Policy: Critical Perspectives on Governance and Power*. London: Routledge.
- Smith, Alan G. *Human Rights and Choice in Poverty: Food Insecurity, Dependency, and Human Rights-Based Development Aid for the Third World Rural Poor*. Westport, CN: Praeger, 1997.

- Sophon Thangpet (2001). "The Impact of HIV / AIDS on Community-based Resource Management." Paper for the Overseas Development Group, University of East Anglia, August 2001.
- Straub, LaVonne A., and Lyle Harris. "Gender Differences in Health Care: The United States and International Comparisons." In Rives and Yousefi, eds., pp. 151-166.
- Strauss, John, Kathleen Beegle, Agus Dwiyanto, Yulia Herawati, Daan Pattinasarany, Elan Satriawan, Bondan Sikoki, Sukamdi, and Firman Witoelar (2004). *Indonesian Living Standards: Before and After the Financial Crisis*. Rand Corporation.
- Thailand Development Research Institute. *Land Reform in Thailand*
- Thiesmeyer, Lynn (2004). "Human Insecurity and Development Policy in Asia: Land, Food, Work and HIV in Rural Communities in Asia." Fujisawa: Keio University Policy and Governance Working Paper 12.
- Theobald, Sally. "Walking on a Tightrope: Women Workers' Perceptions and Reactions to Industrial Environmental Hazard in Northern Thailand." In Virada and Theobald, eds., pp. 187-212.
- United Nations System (December 1999). "Looking Ahead: A Common Country Assessment of Vietnam." Ha Noi, Vietnam.
- Virada Somswadi and Sally Theobald, eds. *Women, Gender Relations and Development in Thai Society*. Chiang Mai: Chiang Mai University, 1997.
- Whittaker, Andrea. "Birthing, the Postpartum and Development: Ideology and Practice in Northeast Thailand." In Virada and Theobald, eds., pp. 469-498.