Health promotion in South-East Asia: Indonesia, DPR Korea, Thailand, the Maldives and Myanmar*

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SUMMARY

The state of health of South-East Asian nations depends as much or more on extranational forces beyond their control —global warming, economic boom and bust—as it does on their own policies and practices. Nonetheless, the political systems of the region, the scope that these allow for community participation, and their attitudes to human rights, are also key determinants of health status. Governments in the region hold different attitudes to the desirability of a monopoly of effective power in government hands, and therefore vary in their commitment to concepts of community empowerment for health promotion and the involvement of non-governmental organizations. Health promotion in these nations is inextricably linked with the creation of social capital.

Key words: health promotion; South-East Asia: Indonesia, DPR Korea, Thailand, the Maldives and Myanmar

INTRODUCTION

Context

Perhaps the clearest possible example of the inter-relation of globalization, the environment, and health is given by the situation of the Maldives. The Maldives is made up of a series of atolls in the Indian Ocean. Two of these islands—Madefushi and Haa Alif Berinmadhoo—are no-smoking islands, with a 0% smoking rate (Siddiqui, 1997). On the other hand, the highest point of the Maldives is 24 m above sea level. If there is any appreciable sea rise effect as a result of the global warming caused by the over-consumption of fossil fuels to feed the insatiable energy demands of the developed world the Maldives will largely cease to exist. There can be no clearer illustration of the difficulties involved in applying conventional health promotion methods to the basic needs of people in the developing nations.

While most other nations in South-East Asia are not at risk of actually leaving the map, global warming is affecting them in other ways [e.g. the distribution patterns of such diseases as dengue and malaria are changing under climactic pressures (McMichael et al., 1998)]. More generally, their dependence on external forces across the board is large enough to render many of the usual rubrics of health promotion largely irrelevant (the extent to which this is true of all modern nations lies outside the scope of this paper). Most countries in the region have recently been

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affected by an investment boom resulting in raised per capita incomes followed by an economic collapse that threatens to return the majority of the population to the poverty levels of 10 or 20 years ago. In Indonesia, e.g. the proportion of the population classified as living in poverty fell from 57% in 1970 to 16% in 1990 and has since jumped back up to ~50% (Griffith-Jones et al., 1998). While the Democratic People’s Republic of Korea (DPRK) has been largely exempt from the effects of the boom, its well-established public health system has instead been devastated by the combined effects of natural disasters, poor economic management and international blacklisting.

While the upheaval across the region is too recent to make any firm predictions, it would appear that the much-discussed epidemiological transition from a predominance in mortality and morbidity statistics of acute infectious diseases to one with increasing rates of chronic cardiovascular and cerebrovascular diseases and cancers may be slowed.

It is also true, of course, that the damaging effects on health of these harmful global forces have been abetted and worsened by exploitation by local interests. Kuala Lumpur has been bathed by the choking smog caused by forest burning for land clearing in Indonesian Borneo because the political structure of Indonesia under Soeharto favoured ‘crony capitalism’ and suppressed public protests (Waluyo, 1998). If health promotion projects are to be confined to mopping up operations after man-made environmental disasters, health promotion will only smooth the path of the developer.

When the economic boom was at its height, many governments in the region boasted of the virtues of ‘the Asian way’, a model that was supposed to favour order, consensus, discipline, family values, filial loyalty and deference to authority. These concepts place greater emphasis on family and community than individual aspirations. Neither the concept of self-maximizing individual behaviour that in the developed world underlies modern health education or the concept of organizational empowerment that underlies modern health promotion fitted well into this official schema.

Some regional governments believe they can simply instruct their people to observe certain norms and have those instructions followed. These governments thus do not necessarily value highly either modes of persuasion, e.g. social marketing, or modes of capacity building that strengthen independent power centres—bodies, e.g. non-government organizations, local communities, or advocacy groups. In both command economies like the DPRK and paternalist societies like Indonesia under the Soeharto regime, cultural and political emphasis on consensus discouraged debate on alternative approaches to population health. In countries where power is tightly held, the concept of empowerment is not the rhetorical flourish it so often becomes in the West. Such governments are likely to look at the rhetoric of empowerment and ask who is to be empowered, who is expected to give up the power that is gained by these newly empowered folk, and who they are to be empowered against.

Modern health and health promotion concepts involve varying relations with institutional structures. Traditional public health measures, e.g. mass immunization and water purification are entirely consistent with extensive state power. Health education through social marketing involves an assumption of individual responsibility that is most consistent with social individualism (and which is therefore sometimes seen as a cheap alternative to state health provision). Since the Ottawa Charter, health promotion has involved the building of strong communal institutions within civil society. The political systems of the region, the scope that these allow for community participation, and their attitudes to human rights, are key determinants of health status.

A society in which human rights are promoted and protected, and in which human dignity is respected, is a healthy society (Mann, 1995).

The DPRK is one of the last of the communist command economies. Indonesia is vigorously capitalist. Thailand and the Maldives have elected governments, Myanmar is ruled by its military. Given the extent of these differences between societies in the region, no single approach to health promotion is feasible. All these countries share, however, a vulnerability to external influences on their health. Myanmar and the DPRK have been severely affected by sanctions from countries and individuals opposing their governments, and Thailand and Indonesia have been battered by capricious policies of countries and individuals investing in their economies as well as by their own internal problems.

The end of the boom has also thrown into doubt much of the accepted political and economic
structure of these societies. It is impossible to predict what the eventual consequences will be, but the sharp rise in poverty that is already evident is likely to affect health status for a generation. While it is not within the power of the health promotion sector to reform the international economic system, and while governments can undoubtedly contribute to the better health of their people, we must continue to emphasize that the health of these nations does not by any means lie entirely in their own hands.

**HEALTH TRENDS**

The problems faced by peoples of the region also fall at different points along the much-discussed epidemiological transition from a predominance in mortality and morbidity statistics of acute infectious diseases to one with increasing rates of chronic cardiovascular and cerebrovascular diseases and cancers. Health, by the rough measure of mortality rates, has increased in these nations since the end of the colonial era after WW II due to the combined effects of increased nutrition, improved public health, and greater access to primary health care (Frankenberg, 1995). However, improvements in infectious disease rates since the Pacific War have not yet eliminated the threat to health from malnutrition, respiratory diseases, tuberculosis, hepatitis and other infections, while at the same time increasing rates of urbanization, an increasingly prosperous middle class, and changing age profiles have increased the rates of non-communicable disease.

Life expectancy is (or is reported by governments to be) 60 years in Myanmar, 64 years in Indonesia and the Maldives, 69 years in Thailand, and 72 years in DPR Korea (World Health Organization, 1999). The falling death rate and a slowing birth rate together involve an ageing of the population profile. In Thailand, e.g. the over-65s increased from 1.21 millions in 1960 to 4.02 millions in 1990, and will reach 10.78 millions in 2020. This shift will alter disease patterns decisively towards cancer and cardiovascular disease.

The other element in the demographic shift—the proportion of the population born in the last 20 years—will also ensure that the proportion of mortality attributable to cardiovascular disease (and therefore tobacco) will continue to rise.

**TRANSNATIONAL FEATURES**

A further example of the health significance of globalization is the sustained campaign conducted since the early 1980s by US trade officials to open markets for American tobacco in Japan, South Korea, Taiwan and Thailand. In 1995, e.g. the US Embassy in Thailand intervened on behalf of US tobacco companies when the government proposed regulations that required the disclosure of ingredients of all brand-name cigarettes sold (Frankel, 1996).

The increasing reach of multinational corporations and Western advertising images, coupled with increasing prosperity, has now resulted in an explosion of smoking rates across the region. Even recession is unlikely to result in any return to the status quo ante. Even where corruption is not a factor, many governments all over the world still see tobacco as a revenue source, hindering moves to take any strong steps to discourage the habit.

Indonesian preferences for clove-scented kretekts over imported cigarettes provide some barrier to internationalization, but may also embed tobacco use more deeply into the nation’s economy, culture and politics. No major move could be made against smoking under Soeharto, e.g. while a member of his family held the clove monopoly (Theones, 1998).

The phenomenon of rapid urbanization, the globalization in trade and financial market all help to diminish further the importance of the geographic boundaries of traditional food supply, leaving the region to be faced with new threats, e.g. food security, as well as new nutrition challenges typified by the presence of both under-nutrition and over-nutrition in different groups within the same country.

Manufactured cigarettes represent only the most damaging end of a drive to shift from traditional social patterns to full participation in a Westernized consumption-driven society. While the older forms were certainly often consistent with a high degree of poverty, oppression and ill-health, it is nonetheless the case that the upheavals in traditional social relationships that this transformation involves have their own effects on health through a loss of cultural coherence and a rise in personal insecurity.

Today the modes of production and social structure have experienced rapid change, but the set of values that have been fundamental to village life have tended to remain largely unchanged. Popular wisdom thus loses its dynamism and appears to have little power in
the encounter with the new values of modern society. ... This is a crisis of identity and a crisis of transition (Phongphit and Hewison, 1990).

Worker migration to urban centres not only increases the population’s susceptibility to AIDS but contributes to an atomized mass searching for new elements of community.

Asian societies have demonstrated both enormous resilience and tremendous capacity for change. The powerful links that exist throughout the region between individuals, their family and their community represent a large potential ... may prove to be a major source of strength ... as long as its realization avoids the two extremes of promoting unconsidered social transformations and resisting change through rigid adherence to traditions that have become irrelevant (Tarantola et al., 1994).

Information networks in these nations are extensive, facilitated by generally high literacy rates and good coverage by radio and television networks. In many of these countries, however, the media are or have till recently been under some form of government control, which in nations where governments do not seek feedback or criticism can severely limit the type of information disseminated to the public. Health promotion requires ‘greater and more liberal use of the media as an open, two-way information channel’ (Tarantola et al., 1994).

The most notable recent feature of communications developments in the countries surveyed has not been any leap forward in technology but the re-emergence in Indonesia of a free press able to raise health issues that are not dictated by the government. Without the independent perspective on the needs of a community that a vigorous free press can provide, the line between ‘social marketing’ and ‘government propaganda’ can be sufficiently unclear to lead to difficulties with translation.

Even the World Bank now supports the development of a free press, recognizing that its lack was a major contributing factor to poor financial regulation and the eventual regional economic meltdown (Gray and Kaufman, 1998).

INFRASTRUCTURES AND STRATEGIES FOR HEALTH PROMOTION

In Australia, as in much of the West, traditional public health based on state responsibility for water, sewage and immunization developed from the 1950s to include mass media campaigns targeting the so-called ‘lifestyle’ diseases. These campaigns are largely individually focused and rely on individuals to take responsibility for their own health. More recently there has been a movement towards the ‘new public health’ approaches, focusing in addition on the community and environmental level. This medicophilosophical movement has not proceeded at the same pace in Asia.

Governments that have been accustomed to think in terms of primary health care and public health have been pressured towards health promotion largely by the impact of the AIDS epidemic. AIDS programs were initially largely managed by ministries of health and directed towards:

- mass information campaigns, surveillance, health personnel training and central project management ... because government programs were uncomfortable dealing with NGOs ... the national AIDS programs provided very little funding for their support, despite evidence of their effectiveness in other health areas and their clear role in confronting HIV/AIDS. Finally, government programs were highly centralized (Tarantola et al., 1994).

This institutional rigidity failed to reach the people most at risk, and produced a reaction that at least enabled alternatives to be raised.

Because of the resistance by some ministries of health to create and enlarge a true partnership on HIV/AIDS programs, major international or national NGOs and international agencies bypassed these ministries to create their own programs outside the national plan (Tarantola et al., 1994).

The example of the AIDS programs aroused some interest in the region in applying health promotion to other health areas, e.g. maternal health or dengue control. At governmental level an understandable uncertainty remains, however, as to what health promotion is and what it requires.

Organizational and administrative structures

Per capita expenditure on health in these nations is relatively low by Western standards. Traditional public health approaches, e.g. sanitation and mass immunization programs are of course essential to maintain the basic health of the population. Correspondingly, traditional public health and primary health measures (which have
the extra advantage from the governmental point of view of being able to be organized through a centralized public health system) are properly given priority. Health promotion generally operates as part of the duties of a poorly funded primary health sector.

In Indonesia, e.g. the Government has been attempting to build primary health at the village level through Integrated Health Posts (Posyandus) that were in theory established and managed by the community.

The Indonesian bureaucracy, including its primary health care system, has, however, been highly centralized, and primary health services in the villages were in the past expected to support government parties and government policies (Kennedy, 1994). This reduced their capacity to act as centres of community development, and there was in practice little scope for local communities to propose their own priorities.

Health promotion was often incorporated in programs simply through redefinition.

... there is no significant difference between health education and health promotion. Although we in Indonesia perceived that what we have been doing is health education, practically we can say that we are doing health promotion as well (Mantra, 1995).

The new regime is, however, committed to a decentralization of health programs to province and district levels that may open up the possibility of genuine community initiatives. While Myanmar appears to have experienced some relief from several decades of the endemic civil war that placed difficulties in the way of public health campaigns (Kidson and Indaratna, 1998), health promotion efforts are still constrained by political isolation, competing domestic priorities, and weak infrastructure (Tarantola et al., 1994).

As a result, public health programs are less well provided for than in other Asian nations. According to UNICEF, which has compiled some of the most complete health statistics in the country, the national infant mortality rate in 1996 was 105 per 1000 live births, due largely to lack of good water and sanitation. One million children are reportedly malnourished, 9–12% severely so. Childhood vitamin and mineral deficiencies, particularly of iron, iodine and vitamin A, are major public health problems. Diarrhoeal diseases in children under 5 years account for ~18% of all deaths. Cholera outbreaks still occur. Infectious diseases, including tuberculosis and malaria, are widespread. Leprosy is still endemic (although a national program has made some impact). Conditions are worse among minority groups, e.g. the Shan and the Karen.

... the economic situation and the health status of the population continue to deteriorate, and may worsen with the current financial crisis in southeast Asia (Chelala, 1998).

Myanmar also lacks (and does little to encourage) sufficient numbers of the NGOs that have had a dual role as innovators and advocates in health promotion programs elsewhere. UNICEF now takes as one of its central objectives building capacity in local NGOs, but the political context makes this a difficult task.

The DPRK, too, has suffered from international sanctions. New international involvement has been drawn in only by natural catastrophes. During 1995 and 1996, severe flooding in the DPRK caused hundreds of deaths, rendered half a million people homeless, and damaged a million tons of crops; 1997 brought drought. In combination with systemic economic problems in DPRK and overspending on the military, these natural disasters have been associated with reports of a severe, ongoing food shortage and increased risks to public health. There has been a recent substantial decline in the health and nutritional status in DPRK; even the sanitized government figures sent to WHO record a fall of almost 2 years in life expectancy since 1993 (World Health Organization, 1999).

While Thailand has been a successful innovator in many areas of health promotion practice, particularly in its approach to HIV/AIDS, its government’s health promotion efforts have until recently suffered from the common regional problems of centralization, bureaucratic compartmentalization and a rigid budgetary system. Generally, existing programs aim at the provision of preventive services (e.g. immunization, maternal-and-child health), and attempts to mobilize potential forces within the community to help improve health have been few and poorly funded (Buasai, 1997). However, the country has a more open and less directive system of government and administration than some other countries in the region, and is consequently more ready to engage with empowerment theory.

Thailand has also benefited from grassroots efforts from local NGOs. The Thai AIDS
program, e.g. has drawn heavily on the input of advocacy groups of people with AIDS groups. The Thai Association on Smoking and Health (ASH) has had considerable influence on the progressive Thai tobacco control legislation. The Population and Community Development Association has attempted to develop a structural approach to health enhancement that focuses on the health effects of urban migration (Viravaidya and Sacks, 1997), e.g. the Association of Rural Doctors. Having been active for many years in the integration of health care into community development, the Association was recently able to topple the nation’s Health Minister over a scandal involving kickbacks on the pricing of medicines for rural hospitals (Business Day, 1998)—an incident that demonstrates a political system responsive to popular concerns in a manner that is becoming increasingly common.

Thailand has developed a ‘Master Plan for Social Development’ which aims for financial decentralization and the empowerment of community organizations for local development. While until recently government health programs have aimed largely at the provision of such preventive services as immunization, there is now a deliberate government policy to decentralize the bureaucracy (including health services), and the Ministry of Finance has joined the Ministry of Health to offer genuine budgetary support for the mobilization of potential forces within the community for improved health.

Thailand is also prepared to recognize the difficulties caused by the lack of effective co-ordination among vertical and cross-sectoral programs, both governmental based and non-government organization (NGO) based.

There is no mechanism to ensure a commitment from partners to work collaboratively on projects. Indeed, any collaboration which does exist to a large extent depends on the personality of the officers in charge (Buasai, 1997).

It is thus seen as important to develop a framework for effective co-ordination among multiple vertical interests. Towards this end the Thai Health Promotion Foundation, based on the model of the Australian health promotion foundations, was established in 1999 to serve as a catalyst for health promotion. Thailand’s Health Promotion Fund (known as ‘ThaiHealth’) is a financial mechanism to pro-actively mobilize existing and potential players into the promotion of good health and to enable pertinent innovations and concerted efforts (Buasai, 1997).

Policies, laws and regulations

Most government policies have health consequences. Female literacy rates, e.g. have been shown to correlate strongly with population health (World Bank, 1993; UNICEF, 1999), emphasizing the importance of education to health. Economic policies have both direct and indirect health effects. Income distribution relativities apparently affect population health (Wilkinson, 1997). Despite this, health workers, and even more so health promotion workers, are seldom consulted on activities outside the health sector.

Any consideration of the legislative picture on issues of economics, environment and education in these countries would enlarge this chapter insupportably. Even on directly health-related issues, however, legislation is not always considered a priority. In 1996 the Indonesian Minister for Health stated that ‘the government had no intention of trying to regulate health through legislation’ (Reynolds, 1998). Currently, cigarette advertising is allowed on Indonesian television as long as cigarette packs and smoking scenes are not shown.

PRIORITY HEALTH PROMOTION PROGRAMS

Settings—health-promoting brothels

The threat of an uncontrollable AIDS epidemic has induced reactions in the region ranging from denial to cultural adaption. One innovative intervention in northern Thailand built on the ambiguous but accepted status of the sex industry in Thai society (Knodel et al., 1996) to target sex workers, brothel owners and clients. The program attempted to promote co-operation between these groups and between both groups and the public health office. A free condom supply was provided for sex establishments. Nearly 500 women from 43 establishments took part in the program, encompassing nearly all direct sex workers in urban Chiang Mai.

The intervention included repeated small-group training sessions for sex workers in which experienced women (‘superstars’) acted as peer educators. The ‘model brothel’ component encouraged all brothel owners in Chiang Mai to insist on mandatory use
of condoms by sex workers and to encourage clients to use condoms. Before and after the intervention, specially trained volunteers posing as clients tested a subsample of sex workers to see whether they insisted on condom use.

The intervention was well received by sex workers and obtained strong support and cooperation from brothel owners. Before the intervention, only 42% (10/24) of women surveyed by volunteers posing as clients refused to have sex without a condom, even when the client insisted and offered to pay three times the usual fee. Following the program, 92% (72/78) refused; 1 year later, 78% (69/85) refused during the same scenario (Visrutaratna et al., 1995).

This may be contrasted with the Indonesian situation, where despite the existence of quasi-official brothel complexes in many major Indonesian cities, publicly promoting condom use is still ‘culturally difficult’ (Sedyaningsih-Mamahit, 1997). Policies that will promote condom use in brothel complexes are critical to the prevention of the spread of HIV throughout this community, as well as from it to the greater community.

Population groups
Issues of societal vulnerability—and in particular the scope, intensity and nature of discrimination against particular groups—are often ignored or dismissed. Even during the boom years, wealth was unequally distributed across these societies, sometimes intensifying the marginalization of communities that have been for many years discriminated against on the grounds of ethnicity or religion. Here again the impact of the AIDS epidemic has drawn the attention of governments to the risks of concentrations of ill health; the Thai government, e.g. is making particular efforts to reach the hill tribes of the north. Thailand also has an extensive history of working with refugees from Laos, Cambodia, and, more recently, Myanmar.

In Myanmar, however, health care is even more deficient in the ethnic minority regions, although UNICEF is placing extra resources in these areas. Where risk populations overlap—members of minority ethnic groups who work as prostitutes and may inject drugs—such mortality and morbidity indices of health promotion as rates of HIV infection can rise staggeringly; HIV/AIDS rates among intravenous drug users in Myitkyina, capital of the Kachin State, are 91%, and the prevalence of HIV is up to 26.5% in urban prostitutes. Some experts believe that the real figures are higher (Chelala, 1998).

These governments may not have embraced the need to establish constructive dialogues with those who, because of economic imperatives or self-determined choice, have adopted behaviours placing them at higher than average risk ... (Tarantola et al., 1994).

In Indonesia ‘Gay organizations … have been frozen out of the national dialogue’ (Kamil, 1997). In contrast, Thailand has again here served as a pioneer, adopting special programs directed at recruiting the support of sex workers and homosexual men.

INVESTMENTS FOR HEALTH DEVELOPMENT AND HEALTH PROMOTION

Health promotion efforts in the region have been patchy, and in many areas have been in response to external prompting rather than arising from national initiatives. The role of international NGOs has been important. The region has been influenced by the work of WHO in providing ‘a credible environment for advocacy’ (Buasai, 1997); in this region, however, WHO’s main efforts have until now necessarily been largely centred around medical and public health initiatives rather than the social directions of the Ottawa Charter. WHO’s material acknowledges the wider picture.

... a wide range of factors external to the individual, such as urbanization, industrialization, migration, and environmental changes in the course of development affect individual health. The problems involved must be tackled successfully in support of individuals’ efforts to better their own health (Han and Erben, 1993).

Its practice, however, has to date been largely restricted to support for interventions directed at informing and educating individuals in lifestyle health issues, although it has also been suggested that

Ironically, however, WHO’s most valuable influence is probably in the imperceptible shifts it causes in people’s thinking—away from doctors and nurses in hospitals towards primary health care and traditional birth attendants, from drugs to safe water, from health
service to intersectoral health promotion (Turner, 1997).

UNICEF supports such preventative campaigns as the Universal Child Immunization (UCI) program in Myanmar (although immunization rates in that country have been kept down by security concerns, transportation problems, lack of electricity and shortage of health workers, especially in remote areas).

The World Bank’s view that investment in health makes an appreciable contribution to economic growth (World Bank, 1993) has also played an important role; Health Ministries are rarely as influential in government policy making as Finance Ministries, and where (as in Thailand) these can be persuaded of the importance of health promotion then action is likely.

Buasai suggests that the establishment of ThaiHealth shows that the Thai government also now sees the need for re-orienting existing health promotion infrastructures toward a greater capacity for social mobilization (Buasai, 1997). The future development of ThaiHealth may well be hostage to the immense pressures on the Thai economy, but its progress nonetheless represents the most important and the most instructive health promotion initiative in the region.

Thailand’s example shows the way forward for health promotion in Asia. It is critical for the development and sustainability of a country’s health promotion effort that an organizational structure be developed as a foundation for health promotion efforts. Such a structure serves as a focus for health promotion development and supports the building of health promotion capacity. Ideally, such a body is formed as a response to the demands of health groups working in particular areas; if no such pressure exists within a country but there is nonetheless a feeling at the level of government that health promotion shows promise, the initial task of such a body will be to market its services and its concepts to other groups until there is a sufficient demand to give it some influence and some independence in relation to the government and the bureaucracy. Without this external support health promotion co-ordination can be seen as a means for the government to impose its priorities on the NGO sector.

It should also be noted that spending on health in many nations is severely restricted by the comparatively high national expenditure on defence and the army [in Indonesia, e.g. the Army’s 1990 budget was 43% larger than the combined health and education budgets (Brogan, 1994)].

COLLABORATION AND PARTNERSHIPS FOR HEALTH

It is perhaps ironic that the Fourth International Conference on Health Promotion, held in Jakarta, focused on the theme of Partnerships only a few months before the host government was swept from power by a people enraged at the network of influence and privilege that characterized its operation. Partnerships for health are only likely to be productive where all elements have a recognized and respected place in civil society, and across much of the world the relationships between governments, communities and NGOs are handicapped by suspicion and by struggles for ideological legitimacy.

The people-centred health initiatives in the region—characterized by their community-based approach, malleable strategies, effective planning, local resource mobilization, and need-based upscaling of programmes—have provided a viable alternative in an otherwise dismal health scenario (Siddiqui, 1997).

Health promotion in these nations both relies on and must be called on to help create social capital.

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