2022 ASSESSMENT REPORT
HLT315118 - HEALTH STUDIES

Section A - **Introduction to Health / Personal Health**

GENERAL COMMENTS

Many students did not provide figures from the data to back up their answers despite the highlighted heading at the beginning of the data section.

Question 1 – Criterion 8

Item a)	Which driving risk taking behaviour has the highest number of participants?	/1

- Driving 10km over limit (1/2)
- 1184 participants. (1/2)

Item b)	In which 'number of trips' category does 'affected by illegal drugs' have the highest percentage across all risk factors?	/1

- 5-6 trips (1/2)
- 18% (1/2)

Item c)	Which risk taking behaviour occurs most in:	/2

- 1 trip? Affected by alcohol (1/2)
  - 58% (1/2)
- 10 trips? No seat belt or helmet at all (1/2)
  - 17% (1/2)

Item d)	In which number of trips category is a young driver least likely to be involved in any of the identified risky driving behaviours?	/2

- 7-9 trips (1)
  - with a range from a high of 6% (1/2)
  - to a low of 1% (1/2)

Item e)	Which risky driving behaviour shows the biggest increase from 7-9 trip to 10 trips	/1

- Driving >25km/h over the speed limit (1/2)
- Plus any other piece of relevant data
- e.g. 7-9 trip at 2% to 10 trips at 15% (1/2)
- overall increase of 13% (1/2)

Item f)	Describe a general trend across all trips in the speeding over the limit categories.	/3

Need to identify a clear trend then back up with DATA

e.g. Generally, as number of trips increased the overall percentage of participants in that risk taking behaviour decreases,

- For all 3 categories the highest percent was recorded on 1 trip – lowest 7-9 trips
    - 10km/h = 37% to a low of 6% on 7-9 trips
    - 10-25kim/h = 43% to a low of 2% on 7-9 trips
    - >25km/h = 47% to a low of 2% on 7-9 trips
- In all three categories there was in increase in % from 7-9 trips to 10 trips
    - 10km/h = 6% on 7-9 trips – 10% on 10 trips
    - 10-25kim/h = 2% on 7-9 trips – 10% on 10 trips
    - >25km/h = 2% on 7-9 trips – 15% on 10 trips
- As km/hr over the limit increases, so does % of drivers in 1 trip category i.e. 10 km/hr over = 37%, 25 km/ hr over = 47%, overall, an increase of 10%
- Overall, the % of young drivers in 7-9 trips category decreases as km over the limit increases. I.e. 10 km/hr over = 6%, 25 km/hr over = 2%, an overall decrease of 4%
- Overall, as km/hr over the limit increases, % in 5-6 trip category decreases. I.e. 10km/hr over = 11%, greater than 25 km/hr over = 6%, a decrease of 5%

Question 2 – Criterion 1

It is important that students do not waste time repeating the question in their answers e.g., 'Risk taking is important for growth and development'. This is already stated in the question and therefore does not gain any marks.

Item a)	Why is risk taking such an important part of adolescent growth and development?	/2

Adolescents is the period of significant growth from childhood to adulthood where young people participate in a wide range of positive and negative risk-taking experiences. Better answers will include an example to go with the reason. These experiences are important because they help:

- Skill building e.g., learning to drive or going for a job interview
- Learn from mistakes – e.g., fined for speeding
- Establish individual boundaries e.g., in relationships or use of alcohol or drugs
- Personal growth through experience – resilience, ability to work with others and ask or help
- Build knowledge – rules for road use
- Test own limits e.g., want to jump or not?
- To learn own capabilities e.g., might be good at public speaking
- Try new things e.g., rollerblading
- Forming self-identity, what do they enjoy
- Meet new people – grow social group e.g., attend college

Overall this item was answered well. It is important that students read the whole question, as a number did not include an example to go with each reason.

Item b)	Give 2 (TWO) reasons why adolescents might put themselves and others at risk. Provide an example for each reason.	/2

- Curiosity – never tried bungy jumping – want to have a go
- Encouraging friends to have a go when friends aren't comfortable – Peer Pressure
- Limbic system takes over as frontal lobe isn't developed e.g. speeding = fun
- Lack of skills – e.g. when learning to drive – may not see the danger in a wet road
- Lack of knowledge – about a particular drug and its potential impact
- Lack of experience – when driving at night

- Lack of support – lack of positive role models
- Lack of resources – don't have enough money to get a taxi so take a ride with a stranger. Don't have easy access to contraception

Again, answered well in general terms but many students still didn't really understand the concept of low and high profile issues. The strongest answers gave a clear example of a high-profile issue, indicating reasons for its profile, and did the same with a lower profile issue, providing a good example of how that issue could raise its profile.

Item c)	Give **2 (TWO) reasons** why one health issue might have a higher profile than another. Provide an example of how a lower profile issue might raise its profile.	/2

One issue may have a higher profile because: (2)

- Affects a lot of people e.g. chlamydia
- Costs the government a lot of money
- Could increase profile through social media, talks in schools, advertisements on tv/ radio, posters in public places, brochures in different languages
- More people have the issue therefore the profile is higher - CVD
- Issue has recently arisen and therefore less information available - COVID
- Risk factors associated with the issue have a preventable factor therefore raising awareness can help reduce the issue e.g. smoking, inactivity and obesity are all largely preventable risk factors for many of the major burdens of disease including diabetes, cancer and CVD
- Increase in the number of incidences of a particular issue may see its profile increased to raise further awareness e.g. car accidents/deaths

Profile of an issue can be raised in many ways including: (1)

- Awareness campaign – e.g. Big Freeze MND
- Use of Role Models – Neale Daniher MND
- Use of Icon associated with the disease e.g. pink ribbon for breast cancer, beanie for MND
- Introduction of new laws – e.g. new P plate laws
- Support groups working with communities to raise awareness – e.g. Headspace and adolescent mental health.
- Media saturation – COVID
- Use of technology – APPs, UV indicator

A number of students provided a good example of a political environment factor that impacts adolescent health but were very vague on how it influenced health.

Item d)	Choose 1 (ONE) **political environment factor** and explain how it can positively influence the health of adolescents	/3

Examples might include but not be restricted to: (**must include how it positively influences health of Adolescents**)

- **Laws** – e.g. alcohol/smoking laws – not allowed until 18, speed restrictions for L and P plate drivers plus number of people under age allowed in a car. This reduces the potential for accidents and injuries, stress both short and long term and also the potential for future long term health issues such as addiction, diabetes, CVD.
- **Support groups** – e.g. Headspace supporting young people with mental health issues. Public finding for Headspace can improve mental health by offering treatment for mental health conditions, spiritual health as teenagers will feel as though they are important and belong, social health as they will feel more able to interact with others due to improved mental health, physical health as teenagers might then exercise with friends.
- **Vaccinations** – helping reduce incidence of communicable diseases such as COVID (not only helping young people reduce the risk of the disease but also reduce its spread and increase potential for less time off school). Gardasil reducing risks associated with cervical cancer by giving to young people before they become sexually active.
- **Youth Allowance** – encouraging young people to stay on at school to improve their education and thereby improve their chances of a well-paid job. Wealth equals health.
- **Crisis accommodation** – for those young people struggling in domestic violence situations. Provides a safe and caring environment and chance to re-start, reconnect and get back into school.

Question 3

This question assesses Criterion 4.

Students needed to clearly differentiate between a risk-taking issue and a health issue. They also needed strong data to back up the significance of their issue. Many students did not do this or their data was vague and not always related to adolescents. Many students chose the following issues: accidents and injuries from road trauma, alcohol, binge drinking and drugs, depression and other mental health issues. Stronger answers identified the source of their data e.g. AIHW. The question clearly called for strategies that raised awareness around the issue. Many responses gave strategies without explaining how awareness was raised using the strategy. Others used vague answers such as 'use social media'. This is not specific enough for pre-tertiary standard.

Choose an adolescent health issue you have studied this year.

- Briefly describe the issue citing evidence to reinforce its significance.
- Identify 2 (two) key strategies that are used to help raise awareness around this issue.
- How effective have these strategies been?

Answers to this will depend on the topic studied in class

e.g. Chlamydia – a bacterial infection that is passed from person to person through unprotected sex. Anyone who is sexually active is at risk. There are often no symptoms. Risk factors include multiple partners and unprotected sex (sex without a condom). Can cause infertility if untreated. Can be avoided by regular checks, using a condom and effective communication with a partner.

- **Data** – it is the most frequently reported STI in Australia, it is more common in women than men, the rate of infection is 2.8 times higher in Indigenous Australians, there are about 97,000 cases in Australia every year, people who are most at risk are young, less than 30 years old.

Strategies – Campaign - TakeBlaktion – uses indigenous language and actors to help reduce the rate of chlamydia in the indigenous population, gives key messages about safer sex and regular check-ups, they have a website with videos and information that is fun and informative, they also offer workshops on sexual health. A second stage to this campaign is being planned.

- **Effectiveness** – this campaign has reached over 850,000 people across the country, 4000 condoms were distributed, there was a 38% increase in sexual health knowledge following specific workshops.

Family Planning Tasmania – located in Glenorchy Tasmania, young people can make an appointment online to get free, confidential information from a health professional about a range of STI's and sexual health. They also have a website that offers a broad range of information and advice on a range of reproductive and sexual health topics. They support a diverse range of individuals no matter their income, language or background.

- Effectiveness – FPT has over 50 employees Tasmania-wide delivering reproductive and sexual health services, it has been in operation since 1973.

Question 4

This question assesses Criteria 1 and 7.

A significant majority of students chose this question. Many students repeated their answers from Q3 without specifically relating their information to the question. Evidence to back up the issue was often vague or non-existent. It was clear that some students used pre-planned answers, which often lacked depth and did not necessarily reflect the question. Students could generally explain how the issue impacted health, but simplistic answers do not reflect high level investigation. Only a few students discussed the potential for positive influence on health. The students who provided more thorough responses had the opportunity to delve deeply into the strategies, such as laws. This allowed them to explore various laws around the issue. Personal strategies were not strong. 'Organising a designated driver' was a common solution for a personal strategy. More depth is needed for higher marks.

Adolescents are said to be more at risk because they lack skills, knowledge and experience.

- Choose a common adolescent risk-taking activity, **providing evidence to reinforce its significance**.
- How might this activity impact the **physical, social, emotional, mental and spiritual** health of an adolescent?
- Discuss in detail, **one community** and one **personal strategy** that aims to reduce the risks associated with this activity.

Students could choose from a range of issues including unsafe sexual health, alcohol, tobacco and/or drug use, accident and injury including dangerous driving, metal health e.g., depression, mood disorders, eating disorders, self-harm, anxiety disorders, diet, nutrition and sedentary lifestyles, sun safe behaviours.

Stronger answers would include:

- data as proof of evidence that this issue is significant.
- detailed reasons that describe the impact of the risk-taking behaviour on the dimensions of health.
- details regarding one community strategy (e.g. Headspace for mental health issues) and one personal strategy (journaling).

e.g., Learning to drive is an exciting rite of passage for adolescents as it allows increased independence, mobility and freedom. However, it is a high-risk activity as adolescents lack skill, knowledge and experience, plus the frontal lobes of their brain (where decision making, risk analysis takes place) are still developing. This increases their chances of making a decision based on emotion rather than good judgement. These factors, when combined with other risk factors such as speeding, drink driving, fatigue, distractions (mobile phone usage and peers in the car), road conditions, and hooning, lead to higher-than-average rates of accidents, deaths and injuries

in this age group. This in turn leads to emotional trauma and social issues, such as loss of licence and jail time for injuring others.

- More than one in five drivers killed in 2016 were aged 17-25 years and one in four drivers seriously injured belonged to this age group.
- Drivers are at their highest risk of being involved in a crash during their first year of driving unsupervised.
- Across Australia, around 45 percent of all deaths of young people can be attributed to road accident, with a 17 year old P-plate driver four times more likely to be involved in a fatal road accident than a 26 year old driver. Close to 80% of P-platers and 55% of learner drivers aged 16-17 have engaged in some form of risky driving on at least one of their 10 most recent trips.
- Almost 4% of teens had driven while under the influence of alcohol or drugs in the past year. About one in 10 teens had been the passenger of a driver who was under the influence in the past year 90% of adolescent road deaths associated with alcohol are male.
- Excessive speed is a factor in higher crash rates among 17-18 year-old drivers.
- Failing to wear seatbelts is responsible for fatal injuries in a high proportion of car accidents that would otherwise have been survivable. Teenagers generally are less likely to use safety belts than adults.
- Young people are particularly vulnerable to fatigue when driving at night. Night driving is a high-risk activity for beginners. Per kilometre driven, the crash rate for teenagers driving at night with passengers is four to five times more likely than teenagers who drive alone during the day.
- Studies have shown that using a mobile phone while driving increases the risk of crashing by four times. Fatal crashes among teens are more likely to occur when other teenagers are in the car. The risk increases with every additional passenger.

What is the impact of learning to drive on Physical, Social and EMS health?

Some of the common impacts of driving and accidents include:

- Physical – cuts, burns, fractures, loss of limbs, brain injuries, spinal injuries and death
- Social – loss of job, connections, isolation, police record, jail
- EMS – anxiety, depression, sleep disorders, post-traumatic stress disorder, guilt, shame and self-blame

Personal Risk Reduction strategies

- Skill building/Knowledge – practise, know and follow the road rules including speed limits and alcohol limits, don't use your phone in the car, reduce number of passengers and have boundaries for them to follow, do a defensive driving course, drive to the weather conditions, take a rest on long trip, use cruise control to reduce speeding, have your car regularly serviced, be assertive

Community strategies might include:

Government Laws & Policies

Towards Zero Road Safety Strategy 2017-2026 has set a short-term, ambitious target of reducing the number of annual serious injuries and fatalities on Tasmania's roads to fewer than 200 by the year 2026 (from current 300). The strategy focuses on:

- **Safe road users** – improving the licence system to reduce serious casualties in 17-25 year old group. Restrictions on hand-held mobile phone use while driving, restricted number of passengers in cars are all aimed at targeting the big risk factors associated with young people and driving.
- **Safe roads–** reduce run off road and head on collisions through improved infrastructure such as lane dividers.
- **Safe vehicles** – increase the number of motor cycles with ABS and improve the star rating of Tasmania's vehicle fleet.
- **Safe speeds** - Establish speed limits that are more appropriate to the safety features of individual roads. Increase enforcement through technology to reduce speed related serious casualty crashes.
- **Keys2Drive** is a government funded program that provides young people with a free lesson. The lesson goes for 60 minutes during which time the Keys2Drive instructor provides both theory and practical examples to assist young people as they develop their driving skills. It does not replace normal driving lessons but provides information on the best ways to practice and gain confidence. Parents/supervisors also join in the session so that they can come away with the tools to help their learner gain a good foundation for lifelong safe driving.

Awareness Campaigns:

- **'Don't be a Goose'** – focuses attention on the importance of not using mobile phones while driving. Research conducted in 2017 showed that nearly 40% of respondents said the campaign had changed their attitude to driving distractions with 10% reporting a significant change.
- **'Real Mates don't let their mates drink drive'** – was launched in 2018 by the Road Safety Advisory Council. It targets 17-25 year old men. It uses humour and shows a variety of ways that mates can stop their mates from drink driving. Since the campaign first ran there has been 60% fewer injuries in this age group.

- **Other awareness campaigns include** 'Speeding Shatters Lives' (targeting speeding), Driver Reviver Stations during long weekends (targeting fatigue), Belt Up (targeting the importance of wearing seat belts).
- **Technology** – includes both in-car and environmental changes that make road safety a priority.
    - **Car** – airbags, car will not start without seatbelts on, seatbelt alert, in-car breathalyser, blue tooth for mobile phones, ABS brakes, lane keeping assist ensuring cars stay within lines.
    - **Environment** – signage, road humps, lane dividers, breathalyser testing (drug and alcohol), safer roads, electronic stability control for heavy vehicles, driverless cars, speed cameras – permanent and mobile.
- **Role Models:**
    - **RADD – Recording artists, actors and athletes against drink driving** use their voices to deliver the important message of 'if you are going to drink that is ok but don't take it out on the road'. Australian celebrities involved in the program include: Pat Rafter, Delta Goodrem, Jess Mauboy and Ricky Ponting.
- **Support Groups**
    - **RYDA – Rotary Youth Driving Awareness** is a program (Awareness Campaign) that is sponsored by Rotary and developed by the Road Safety Education Limited (Support Groups). The RYDA program is the largest road safety awareness intervention for students in Australia & New Zealand with over 50,000 students and 2,300 teachers attending each year. The one-day program is accessed in high schools as this is the time that young people are starting to 'learn to drive'. The program produces substantial increases in understanding of road risk factors, such as speed, following distance, distractions, car safety features, hazard perception and the role of personality and mind-state. A study by RSE found there were significant changes in intentions to change personal behaviour - reducing speed, choosing responsible passengers, and not using phones (including hands-free) while driving. The highest impact being increased intentions to keep a safe (3 second) following gap, with knowledge more than doubling across the respondents on this strategy. Awareness of the consequences of crashes on individuals, and the ripple effect of these to friends, family, and the community was another area of significant increase (87% of students were more or much more aware). The Study shows significant increased awareness of, and intention to use (between 70-80%), strategies practised at the Program Day for avoiding risky driving, dealing with distracting passengers, safe strategies for phones, speaking up as a

passenger in concerning situations, planning car trips, being aware of mind-state, staying under the speed limit and being cooperative on the road.

Question 5

This question assesses Criteria 1 and 7.

Very few students chose this question and of those students, a majority did not produce strong answers. Students did not seem to see the link between the health issue they had studied and how they might use community strategies from that to discuss in detail in their answer.

Adequate personal and community protective factors are essential for positive adolescent health.

- Identify 2 personal and 2 community protective factors and explain how they can positively influence an adolescent's health.
- Why might these protective factors be useful/important for an adolescent when trying to advocate for an issue of concern?

Personal skills: - could include first aid qualifications, decision making skills, good communication skills, good research skills, problem solving, positive attitude, values or beliefs, conflict resolution skills, good mental, physical, spiritual and emotional health, positive self-esteem, success at school, having strong/positive social connections, ability to seek help, capacity to reflect, resilience.

Community Services: - could include Headspace, Family Planning Tasmania, Holyoake, Beyond Blue, Reach Out, Cancer Council of Tasmania, Butterfly Foundation, Government actions and services e.g. Centrelink, housing, Family - supportive, Police, Access to health care, Parents – positive parenting, Teachers, Role models, Friends, Support groups.

Specific reasons as to how they positively influence an adolescent's health – could link to the dimensions of health, encourage positive behaviours, increase a sense of belonging, increase knowledge and therefore positive behavioural actions, help improve positive social interactions, allow access to specialist services, improve mental health, build resilience, improved health literacy.

Why might these skills and services be useful/ important for an adolescent when trying to advocate for an issue of concern?

Examples:

- Counselling provided by services might help to improve a teenager's communication skills – allowing them more opportunity to engage in advocating, services might help put them in touch with personnel who can help them to promote a certain issue, services might increase self-assurance which gives them the confidence to go ahead with advocating.

- Skills and services encourage young people to come out of their comfort zone, be brave, less fearful, to be able to resolve conflict in a positive and pro-active way.
- Gives confidence to seek help and assistance as required e.g., in a domestic violence situation or relationship issues.
- Community services provide access to a wider variety of community members who may be able to assist in the advocacy process, provide a better standard of living e.g., improved housing arrangements, better transport to school/work.

Section B

GENERAL COMMENTS

Similar to section A, many students did not include figures from the data in their answers. With data like this, students need to take care when lining up the figures (a ruler should be taken into the exam). When asked to provide a trend, students should state this at the beginning of their answer and then back up with figures. A number of students simply rewrote all the figures without providing a trend.

Question 6 – Criterion 8 (10 Minutes)

Item a)	Which age group has the highest percentage of men in aged care?	/1

- 85-89 year group(1/2)
- Approx 23% (1/2)

Item b)	Which age group has the highest overall combined percentage of men/women in aged care?	/1

- 85-89 years (1/2)
- Approx 23% men & 25% women (1/2) (combined 48% also accepted)

Item c)	What is the difference in percentage between men and women at age 75-79? Who has the higher percentage?	/2

- Difference in percentage is approximately 4% (1)
- Men have the highest with men (14%) and women (10%) (1)

Item d)	At which age group do women begin to have a higher percentage in aged care than men?	/1

- 85-89 years (1/2)
- women approximately 25% and men approximately 23% (1/2)

Item e)	Compare the men using aged care in the 70-74 years and the 95-99 year age groups.	/2

M 70-74 years have 10% in aged care, M 95-99 years have 5% in aged care, M95-99 years have 5% less in aged care

Item f)	Describe and compare the trend for male and female in aged care	/3

Any 3 points with back-up data e.g.

Men enter aged care in greater percentage at an earlier age whereas women have a greater percentage in older

- 0-49 and 50-54 both have low numbers of less than 1%.
- From 60-64 men (3%) begin to outnumber women more significantly up to an including 75-79 age.(M – 14% & W 9%)
- M have a greater % in permanent residential aged care than women up until 85-89 years, when W overtake them e.g. M 80-84 years = 19%, W = 18%, 1 % more than W

As the age groups increase up to 85-89 years, the % of both M and W in permanent aged care increases.

- W 0-49 years is less than 1%, W 85-89 years is 25 %, an increase of 24%
- M 0-49 years is less than 1% M 85-89 years is 23% an increase of 22%

Percentage for men overall decreases from 85-89 to 90-94 onwards whereas women do not begin to decrease overall percentage until 90-94 to 95-99. (Reinforcing that women live longer than men)

Significant decrease for both men and women in permanent residential aged care from 90-94 years.

- 95-99 years M = 7% whereas 100 years + = 1% (6% less)
- 95-99 years W = 12% whereas 100 years + = 2% (10% less)

Very small percentages for both men and women in the 100+ age group reflecting low percentage of life expectancy beyond this time

Question 7 – Criterion

The term 'alternative health care service' confused many students and many did not see it as asking for an 'alternative therapy service'. A variety of answers were accepted, but not Medicare or the PBS.

Item a)	Briefly outline an example of an alternative health care service and explain how it might benefit an individual's health.	/2

Any alternative therapy with brief description/definition. Clear indication of how it might impact various aspects of health (Physical, social & EMS)
e.g. Yoga – a series of poses that aims to help with flexibility, strength and relaxation.

- Strength poses – massage/squeeze organs associated with Type 2 diabetes (T2D) i.e., pancreas
- Relaxation – reduces stress, stress is linked with the onset of T2D
- Postures – help to increase glucose uptake in cells

Students struggled to define diversity accurately and many could not provide a specific strategy in their answers. Better answers provided a clear strategy outlining how it positively reflects the diversity within a community.

Item b)	Define diversity. Briefly describe an example of a positive community action that reflects diversity.	/3

Diversity is about the acceptance of difference regardless of race, religion, occupation, sexual identity, disability etc. The practice or quality of including or involving people from a range of different social and ethnic backgrounds and of different genders, sexual orientations, abilities/disabilities, states of mental health (1)
Positive community initiative or action – Pride Week, NAIDOC week, RUOK day,
Examples might include: Dream Time at the G. Indigenous football round, Harmony Day, Pride Week, special access for people with disabilities to music events (2)

Very few students knew how DALYs are calculated or the specific purpose/value behind them. Many left this question unanswered.

Item c)	How are DALYs calculated and why are they an important factor in understanding health?	/2

DALYS refers to disability adjusted life years and is a useful tool in describing the overall burden of a particular health issue. It is calculated by adding YLL –

years of life lost plus YLD – years of life lost/living with a disability. The higher the DALYs the greater the burden. (1)

Why important?

- Useful tool to identify increasing/decreasing health issues, areas where funding need to be directed, success or identifies which diseases are a significant burden on health. Cancer has the highest overall disease group DALY at 19% g
- Identifies which groups of people are more burdened by a particular disease
- Identifies areas where there needs to be more Health Promotion focus – e.g. those diseases which have preventable risk factors
- Identifies diseases which are increasing in number and need more research funding (1)

NDIS responses were generally sound. Stronger answers were very specific about their example and how it supported people and the positive impact this has had.

Item d)	What is the NDIS? Provide an example of how it supports someone with a disability?	/3

The NDIS (National Disability Insurance Scheme) aims to improve health for those who are born with or who acquire a permanent and significant disability.

- By 2020 460000 people under 65 in Australia had access to the NDIS with participants provided with the choice and control of the necessities they need to live a life they want. (1)

(Example to clearly show what and how NDIS supports)

- NDIS builds independence – e.g. specialised housing, increases opportunities such as employment and increases social participation, for example suitable sporting facilities. It does this through the provision of funding, information and capacity building. The NDIS can provide all people with disability with information and connection to services in their community such as doctors, sporting clubs, support groups, libraries and schools. (2)

Question 8 – Criterion 4

GENERAL COMMENTS

Students were able to identify an issue, but few students actually explained what the issue was. Many students did not include evidence to reinforce the significance of the issue. Stronger answers explained the link between risk actors and the cause of the condition. Some students confused risk factors with outcomes. A number of students did not balance out the weight of the question well, spending too much time describing the issue and not enough time spent on focusing on the strategies. Strong answers linked reducing the risk factors through improved health literacy.

Questions 8

Choose one major burden of disease in Australia.

- Briefly describe the issue citing evidence to reinforce its significance.
- Identify modifiable risk factors associated with this burden of disease.
- Identify 2 (two) strategies that are currently being implemented to build health literacy around the modifiable risk factors you have identified. **(10)**

Conditions described will be wide and varied and could include Type 2 diabetes, heart disease, obesity, cancer, injury and accidents, dementia and Alzheimer's, musculoskeletal conditions, mental health, substance abuse, respiratory diseases.

Example 1 Type 2 diabetes develops when the body does not use insulin efficiently and gradually loses the ability to make enough insulin. Insulin is a hormone that controls the amount of glucose in the blood. Insulin helps glucose produced by the digestion of carbohydrates move from the blood into the body's cells where it can be used for energy.

- 1.3 million Australians have been diagnosed with T2D,
- it is estimated that another ½ million are undiagnosed.
- It is the fastest growing chronic condition and costs the economy $6 billion a year.

Risk factors – lack of exercise, age, being an Aboriginal or Torres Strait Islander, genetics, increased blood pressure, being overweight or obese, smoking, eating a low fibre/ high GI diet.

Two Strategies - Take Diabetes 2 Heart – Encourages informed discussion and action for individuals towards better heart health i.e. encourages more activity, improved eating habits and regular consultation with a GP. There is a website with information and factsheets.

National Diabetes Week runs from 10 – 16 July, 2022, This year it focussed on challenging diabetes related stigma. Research conducted by the Australian Centre for

Behavioural Research in Diabetes (ACBRD), found that four out of five people living with diabetes have experienced stigma at some point. People living with type 1 and type 2 diabetes both reported feeling this way. It can lead to people not sharing their diagnosis with others, getting the help and support they need, being interested to learn more about their diabetes or doing what they need to do each day to manage their diabetes and stay well.

These two campaigns will lead to a better understanding of the condition and will improve health literacy surrounding T2D.

Example 2 - Cardiovascular disease (CVD) includes a range of conditions that affect the heart and blood vessels. The most common and serious types of CVD include coronary heart disease, stroke and heart failure but also includes peripheral vascular disease. Cardiovascular disease can occur when arteries that supply blood and oxygen to the heart muscle and other organs (such as the brain and kidneys) become clogged with fatty material called plaque. This process is called atherosclerosis. If a blood clot forms in the narrowed artery and completely blocks the blood supply to part of the heart, it can cause a heart attack. A stroke occurs when there is a blockage to the brain.

- In 2020-21, an estimated 8.7% ($11.8 billion) of total disease expenditure in the Australian health system was attributed to cardiovascular diseases (AIHW 2021).
- Cardiovascular disease accounted for almost 13% of the total burden of disease in 2015,
- CVD was the underlying cause of death in 43,500 deaths in 2018 (25% of all deaths)
- CVD generally has a greater impact on males, the elderly, Indigenous Australians and people living in remote and socioeconomically disadvantaged areas. CVD is around twice as high among men (3.8%) than women (1.9%).

Risk Factors

90% of Australians have at least one risk factor for heart disease. These include:

- **Smoking** - Smokers are almost twice as likely to have a heart attack compared with people who have never smoked.
- **Cholesterol** - Excess cholesterol can form plaque between layers of artery walls, making it harder for your heart to circulate blood, increasing you risk of heart disease and other cardiovascular diseases.
- **High Blood Pressure** - High blood pressure can overload the heart and coronary arteries, and speed up the artery-clogging process.
- **Medication** – in some people, medicines, including the oral contraceptive pill, contraceptive 'depot' injections, steroids and arthritis medicines can also raise blood pressure which increases the risk of CVD.

- **Being inactive** - Two in every three adult Australians aged over 18 and over are either sedentary or have low levels of exercise. Being inactive increases the chance of heart disease – second only to smoking as a risk factor. People who are inactive, are almost twice as likely to suffer coronary heart disease, compared to those who get enough exercise.
- **Diabetes** - Over time, high blood glucose from diabetes can damage blood vessels and the nerves that control heart and blood vessels.
- **Being overweight** - In Australia, 1 in 4 children and 2 in 3 adults are overweight or obese.
- **Unhealthy diet** - saturated and trans fats increase blood cholesterol and heart attack rates. High-salt diets increase blood pressure and the risk of heart attack and stroke.
- **Social isolations & depression** - Studies have shown that people with depression, people who are socially isolated, and people who do not have quality social support are at greater risk of developing CVD.
- **Age**: As you get older, your risk of heart disease increases.
- **Gender**: Men are at higher risk of heart disease. Women's risk grows and may be equal to men after menopause.
- **Ethnic background:** People of some origins (e.g. from the Indian sub-continent) have higher risk. Aboriginal and Torres Strait Islander people have more risk because of lifestyle factors.
- **Family history**: If someone in your family has cardiovascular disease, the risk for other family members is increased.

Two Strategies to improve health literacy around CVD:

The Heart Foundation Helpline provides access to free, personalised heart health information and support to help build health literacy for:

- People living with heart disease.
- Those looking for information about heart conditions or reducing their heart disease risk.
- Medical professionals caring for patients with heart disease or a heart condition.
- In 2019, the Helpline answered calls from more than 24,000 Australians – a 22 per cent increase on 2018. A health care professional (such as a cardiac registered physiologist) answers each call. Support is also available to people who speak languages other than English.

Heart Foundation Walking is Australia's largest, free walking program. The program supports people to start and to keep walking because walking can help lead to a healthier heart. People can join up by using the Heart Foundation Walking smartphone app. In 2019,

the walking program reached the significant milestone of supporting 70,000 Australians to get walking for better heart health. Helps improve health literacy by raising awareness about the risk factors and ways to reduce.

Rate of heart attacks continues to fall, and survival from them continues to improve thanks to improved technology and a multi-pronged public health approach to prevention. The number of CVD deaths have declined substantially (22%) between 1981 and 2017.

Questions 9 - Criterion 2 and 7

GENERAL COMMENTS

A significant majority of students chose Q9.

Unfortunately, answers on the whole were inadequate. Many students chose homelessness or ATSI but could not back up with data that reinforced the health issues that these group suffer from or why they are disadvantaged. Some very strong answers involved the Rural and Remote, disability and men's groups. Strategies that were explained clearly and in detail were well rewarded.

Question 9

Australia is considered to be a 'lucky' country with an overall high level of health. However, some people are not so 'lucky'.

- Choose one group who is disadvantaged.
- Identify key reasons why this group is disadvantaged.
- Include health indicators to reflect the disadvantage.
- Choose 2 (TWO) strategies – at least one Government – that aims to reduce the disadvantage of this group. Link these examples to at least one of social justice principles.
- Evaluate the success or otherwise of these strategies.

Groups that are affected by disadvantage could include: rural populations, prisoner groups, veterans, indigenous Australians, refugees, low socio-economic status, men, the elderly, homeless population.

e.g., Homelessness can be described as is the condition of lacking stable, safe, and adequate housing. Primary homelessness refers to living without conventional accommodation e.g., sleeping rough or in an improvised dwelling. Secondary homelessness is when people frequently move from one temporary shelter to another e.g., emergency accommodation or 'couch surfing'. Tertiary homelessness is people staying in accommodation that falls below minimum community standards e.g., boarding houses and caravan parks.

Of the people who were 116000 homeless in Australia (Census night 2016) , approximately 8000 sleep rough every night. 1 In 10 Australians will have slept rough at some stage in their lives. 20% of this figure are aboriginal or Torres Strait Islander with NT has the highest rate of homelessness with 600 per 10,000. LGBTIQ groups are twice as likely to be homeless as other groups. Transgender groups, in particular regularly suffer more physical and verbal abuse and discrimination. TAS had 1,622 (31.8 people per 10,000) which is an increase of 6% since 2011.

Almost one in every 28 Indigenous Australians is homeless i.e., 20% of all homeless. This is roughly 10 times the rate of homelessness for non-Indigenous Australians. Out of these, four in 10 are 18 or under.

Key Reasons for disadvantage –

Domestic violence is the biggest reason for homelessness. Australians known to be at particular risk of homelessness include those who have experienced family and domestic violence, young people, children on care and protection orders, Indigenous Australians, people leaving health or social care arrangements, and Australians aged 55 or older.

- Other reasons for homelessness can include a chronic lack of public housing and rental stress where the cost of rent is beyond the capacity especially for those groups

surviving on Centrelink assistance. Loss of employment (this was a significant factor during the recent COVID crisis)

Health Indicators

- Homeless people living rough have a current life expectancy of 48 years with half of this group experiencing physical and sexual violence at some stage. They are at far greater risk of age acceleration, discrimination, mental health issues, drug and alcohol dependence.
- Depression, poor nutrition, poor dental health, substance abuse and mental health problems. Recent studies have also found that people experiencing homelessness also experience significantly higher rates of death, disability and chronic illness than the general population (Australian Human Rights Commission 2008).
- In 2014, an estimated one in four (26%) people in Australia who had ever experienced homelessness assessed their health as fair or poor, compared with 14% of those who had not experienced homelessness (ABS 2015). People who had experienced homelessness were more likely to report having a mental health condition or a long-term health condition, with depression, back pain or back problems, anxiety and asthma the most commonly reported long-term conditions.
- Other health issues include substance use, skin and foot problems, poor oral health, and infectious diseases such as tuberculosis, hepatitis C and HIV infection.
- These health issues are further impacted by a lack of transport, limited knowledge of support networks, nowhere to store medication, lack of funds to afford medical appointments, living conditions exacerbate medical conditions, less likely to access primary health care, drug use, unsafe living conditions, fear of being judged.

Two strategies – There will be a range of these depending on the group chosen. Homeless strategies could include Orange Sky Laundry, Jireh House, Kids Under Cover, Louis Van, Bethlehem house, Hobart Women's Shelter, National Homeless Strategy, Annie Kenney Young Women's Emergency Accommodation, The Link, Mission Australia, Backpack bed, Grans Van – food and showers/washing facilities.

The success or otherwise of the strategies – could include number of visits/customers, how long the service has been in operation, funding e.g. To date, Orange Sky has provided Australians doing it tough with over 1.9 million kilograms of free laundry, 20,000 showers and 330,000 hours of genuine and non-judgemental conversation across 36 service locations.

Question 10 Criteria 2 and 7

GENERAL COMMENTS

Not many students chose this question and responses were often very brief and not very strong. Reasons for focus on prevention and early intervention tended to be limited. Students were generally able to provide one or two strategies but not a wide range overall. Stronger answers included different aspects of the health care system and health campaigns.

Question 10

While the Australian Government spends a lot of the health care budget on hospital care and treatment, there is also a strong focus on prevention and early intervention.

- Why is prevention and early intervention so important?
- Discuss a range of prevention and early intervention strategies either directly linked to the health care system or Government funded that aim to improve the health of Australians.
- Evaluate the success or otherwise of these strategies.

This should give students the opportunity to talk about a wide range of community actions – as long as they are directly linked to the Australian Health Care system or Government funded, anything is acceptable.

Importance of prevention/ early intervention

- Increases the chances of recovery, reduces suffering, saves the community $$ in the long run due to decreased long term illness/ disability, can improve life expectancy, reduce the BOD and DALY, improve quality of life, protect people from harm, raises awareness about risk factors
- Increases health literacy which allows people to better navigate healthcare system, engage in self-care including correct taking of medications, keep up a healthy lifestyle, be more aware of probability and risk e.g., you are more likely to get lung cancer if you smoke, find the right services and doctors.

Discuss a range of prevention/ early intervention strategies – Could include:

- Medicare, PBS, NDIS – ensuring links are made to question
- Strategies that aim to build health literacy i.e., the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions.
- Health campaigns which aim to raise awareness, health awareness days or weeks (RUOK day, daffodil day, Diabetes Week), e.g., Posters in all shops, doctors, newspapers and through social media that advertised that latest rules re COVID

including how to wash hands properly, use hand sanitise, social distancing, coughing into elbow.

- Tax on cigarettes, pictures on packets, COVID laws and policies, laws around speeding, alcohol levels while driving.
- May include strategies that target those more at risk including Indigenous, elderly, low SES, rural and remote communities (breast screen bus), those living with a disability (support worker at medical appointments) and those whose first language is not English (interpreters/health info in a variety of languages) as these groups are more likely to report poor health, have higher rates of hospitalisation, less likely to use preventative health care strategies and are more likely to have higher rates of chronic disease e.g. CVD.
- Technology –phone apps, provide information related to various health issues e.g. COVID app provided regular updates as well as providing a reminder about positive health actions such as regular hand washing. Vaccine has now been developed for COVID reducing death numbers significantly.
- Media – social media, in particular, is an effective way to get messages out to a large number of people in a short space of time. Government funded campaigns e.g. 'Don't be a Goose', 'Speed Shatters'.
- Role models – people of influence are often used to get health messages out to the public.

Success of strategies – could include a decrease in the number of cases recorded of a condition e.g. number of smokers in Australia has steadily decreased since 1995 from 25% to 14% of the population. Number of CVD deaths have declined substantially (22%) between 1981 and 2017. COVID death rates lower due to vaccinations. Stigma around mental health issues is now less – bringing the issue out into the open.

Section C – Global Health

GENERAL COMMENTS OVERALL

While this data question was more difficult than recent years, generally most students were able to achieve a C or above. Despite the question clearly asking for students to include data to support their answers, many students did not provide any data. This significantly impacted their marks. When data was provided it was of a general nature. Students are reminded not to use data approximations when the specific information is provided. Items a) and c) were answered well. Items b) and d) required a great deal more thought and as such, were not answered as well. Many responses repeated the same trend twice in their answers (using different wording) and there was often no data to support their answer. Stronger answers provided two clear trends and supported these trends with specific information. Many students struggled to read and interpret Figure 2, and this resulted in weak responses for this question. Students are encouraged to carefully read the tables and graphs provided for interpretation in Criterion 8 questions.

Question 11 – Criterion 8

Item a)	What does the size of the bubbles represent	/1

Population size i.e. the larger the bubble the bigger the population

Item b)	Using **figure 1**, identify 2 key trends	/3

As income increases the number of babies per woman decreases (1½)

(Trend = 1 mark, data = .5 x2)

- Highest UN country income is over $120K with number of babies approx. 1.7 per woman (less than2)
- Lowest LDC country income is approx. $600 with number of babies approx. just under 6 per woman
- For example: Left most dot = about 6 babies per woman, income = $700 per person (GDP/ Capita, PPPS$ inflation adjusted) compared to the right most dot = babies per woman less than 2 and income about $116,000 (GDP/ Capita, PPPS$ inflation adjusted)

Women from least developed countries tend to have more babies than those from other UN countries (1)

- Significantly more LDC countries in the level 1 or 2 income levels with many of these countries having 4 or more babies per woman
- More Other UN countries in the level 3 and 4 income level having under 4 babies per woman
- For example: The most right-hand green dot has less than 2 babies per woman and an income of $116,000 (GDP/ Capita, PPPS$ inflation adjusted) whereas the most right-hand red dot has 2.5 babies per woman and an income of $8000 (GDP/ Capita, PPPS$ inflation adjusted)

Item c)	What categorises income level 1? Is this the highest or lowest income level?	/2

- 0-approx $2700 GDP/capita PPP (1) ($2500-$2900 acceptable)
- It is the lowest income level (1)

Item d)	Compare the trends for the two identified countries from 1800-2021. Do they fit the overall trends? (Any 2 trends with data) (1 mark for trend, 1 mark for data x 2)	/4

In 1800 both Afghanistan and Australia were in the low-level income categories with a high number of babies being born per woman (2)

- Afghanistan income = approx. $500pp Number of babies per woman = 7.5
- Australia income = approx. $900 pp Number of babies per woman = 7
- Therefore in 1800 both Afghanistan and Australia fitted the trend of low incomes and high numbers of babies being born per woman

In 2021 – Afghanistan was still a LDC and in the low-income category (approx. $2000) - but the number of babies per woman had reduced to approximately 4) (2)

- Australia had moved into the high-income category (approx. $55000 per person) and under 2 babies born per woman.
- Therefore in 2021 Afghanistan did not really fit the trend of low income and high number of babies. While it was still low income there was a significant number of other LDC countries with a higher number of babies. Australia on the other hand did fit the trend of higher income and lower number of babies per woman.

Both countries show that, as babies per woman decreases, income increases. (2)

- For example: In 1800, Afghanistan had 7.5 babies per woman and an income level of $500 (GDP/ Capita, PPPS$ inflation adjusted) whereas in 2021 they had 4 babies per woman and an income of $2000 (GDP/ Capita, PPPS$ inflation-adjusted). This is a decrease of 3.5 babies per woman and an increase of $1500 (GDP/ Capita, PPPS$ inflation adjusted).
- Similarly, in 1800 in Australia there were 7 babies per woman born and the income was $700 (GDP/ Capita, PPPS$ inflation adjusted) whereas in 2021 they had 2 babies per woman and an income of $50,000 (GDP/ Capita, PPPS$ inflation adjusted). This is a decrease of 5 babies per woman and an increase of $49,300 (GDP/ Capita, PPPS$ inflation adjusted)

The income for Afghanistan starts to decrease in the last few years before 2021 whereas the income for Australia continues to increase from 1800 onwards. (2)

- For example: the income for Afghanistan finishes at approx. $1950 (GDP/ Capita, PPPS$ inflation adjusted), below the highest income of about $2050 (GDP/ Capita, PPPS$ inflation adjusted) whereas the income for Australia hits it peak in 2021 at about $55,000 (GDP/ Capita, PPPS$ inflation adjusted)

Question 12 – Criterion 3

Generally most students were able to gain a C or above in this question.

a) – Answers needed to include a phrase that indicated Bilateral Aid was aid given from one government to another. Some answers described the incorrect type of aid and were marked accordingly.

Item a)	What is bilateral aid? Provide a specific example of bilateral aid provided by the Australian Government.	/2

- Bilateral aid is aid provided from one government directly to another **(1 explanation)**
- For example: Australia Government provided $479.2 million in bilateral aid to New Guinea Government in 2021 with part of this funding being in the form of COVID vaccinations and personal protective equipment, hand sanitization. **(1 example)**
- or Assistance from Australia to Cambodia in 2022-2023 included $43 million to help with health through clean water, sanitation and hygiene for vulnerable people. This helps to decrease disease.

b) – This question was answered well overall. Students were generally able to identify two reasons why Least Developed Countries were likely to suffer more from the impact of climate change and natural disasters.

Item b)	(Climate change and natural disasters continue to have a huge impact on the lives of many people throughout the world. Briefly explain two reasons why people living in Least Developed Countries suffer more from the impact of these issues?	/2

- Lack of medical infrastructure.
- Poorer building infrastructure – therefore greater damage.
- Poorer communication infrastructure e.g., roads, electricity, internet.
- More natural disasters occur in LDCs.
- More LDCs in tropical/high temperature areas therefore increasing impact of Climate change.
- Greater number of people living in rural and remote areas increasing the lack of access to medical and other support structures.
- Greater reliance on 'one economy' e.g., agriculture or tourism means that disasters can have a very big impact on GDP – therefore much harder to come back from a disaster.
- Lower levels of education therefore less understanding about the potential impact and ways to reduce potential impact of disasters e.g., importance of crop rotation/planning for climate change.
- Higher levels of corruption means that sometimes aid does not actually get to the people for whom it is intended.
- Many LDCs are already highly in debt and do not have the ability to increase loans to rebuild and plan for the future.
- More babies per woman = more people to feed when disasters strike.

c) – Most students were able to identify this type of aid as being Emergency or Humanitarian aid. While most were able to provide appropriate examples of aid provided in this situation, some students clearly didn't have a strong understanding of the question. These answers didn't provide a clear list of the appropriate aid provided by this type of assistance.

Item c)	What type of aid do Least Developed Countries need immediately after a natural disaster? List three (3) examples of appropriate aid.	/3

- Immediate type of aid has a focus on saving lives and reducing further health issues.
- Humanitarian or relief aid – it has a short term 'survival' focus (1½ for description).
- 3 examples might include food, water, peacekeepers/troops to remove bodies and reduce looting, medical personnel and supplies, communication infrastructure, money, clothing, clearing roads/other transport channels to allow aid to get through, tents, temporary sanitation, transportation e.g. helicopters (½ per example).

d) – The responses for this question were generally quite weak. Most students couldn't make a clear connection between the role that sustainability has in reducing poverty. Stronger responses indicated that programs that are sustainable are able to reduce poverty on a long-term basis and allow people to plan for the future and reduce their reliance on external assistance.

Item d)	The Sustainable Development Goals (SDG's) have a strong focus on sustainability. Why is this important in terms of reducing poverty?	/3

A wide range of answers would be acceptable

- Reduced reliance on external aid therefore can better cope when disasters such as COVID or global financial crisis strike leaving MDCs less able to provide aid i.e. can better stand on their own two feet.
- SDGs are about improved governance – less corruption meaning that wealth is more evenly spread and greater focus on education and health. Increased education and health lead to greater productivity and less poverty.
- What we do to our planet today will impact the future of others. Therefore we must ensure that we do not use all of the resources today e.g. water, fishing, cutting down trees. This will allow all countries to have strong economies into the future.
- Climate change is having a big impact everywhere but more so for LDCs therefore important that sustainable processes such as crop rotations, drought resist seeds, bores for water etc are provided/developed to ensure future viability.

- Better levels of education will lead to longer, healthier lives for those living in LDC's. Helps to reduce the impact of the poverty cycle as governments will be able to offer more support for their citizens.
- If countries implement research and use technology to implement a zero-carbon future, it can help to reduce the effects of climate change (sustainability) – therefore they can produce more crops to sustain their own population and for export – this will help to bring people out of poverty.
- Programs such as Farmer Managed Natural Regeneration help to use the natural crops of the country to produce more food and have a big focus on sustainability. This program gives people goods to sell as well as more food to eat and even carbon credits to trade. This helps to reduce poverty.
- Will improving access to sustainable livelihoods, entrepreneurial opportunities and productive resources.
- Will progressively develop social protection systems to support those who cannot support themselves e.g. women, elderly and disabled.
- Sustainable water sources, such as piped water and bores, help reduce the risk of water borne diseases. They also ensure that crops and animals can flourish, which increases food and money for families.
- Reducing CO2 emissions. Reducing impact of climate change.

Question 13 – Criterion 4

GENERAL COMMENTS

A wide range of answers were provided for question 13 and a large percentage of responses were not able to achieve a C or above.

Most students who did not score well in this question didn't identify a specific cause of morbidity and mortality in LDCs. Instead, these responses often discussed the underlying risk factors that cause these conditions. A good example of this was safe water and sanitation. Individuals don't actually die from a lack of access to safe water and sanitation; they die from the diseases and conditions that this situation causes. In this case a lack of access to safe water and sanitation is a risk factor to developing diarrhoea or cholera.

Stronger answers were able to identify a clear cause of morbidity. and mortality i.e., diarrhoeal diseases, provide appropriate supporting data and identify the relevant underlying risk factors.

Some students also discussed risk factors as an impact on the health dimension rather than as a cause to ill-health – this showed a lack of understanding of the theory.

There was a general lack of Primary Health Care theory as well, with many students not being able to accurately identify an element of PHC that would reduce the impact of the identified risk factors.

Many answers were also did not provide a clear explanation of how effective the PHC response identified had been. Stronger answers for this dot point were able to provide data to support their claims.

Question 13

Choose a major cause of morbidity and mortality in LDCs (Least Developed Countries) citing evidence to reinforce its significance.

- Identify key risk factors associated with this health issue.
- Provide an example of primary health care that is being implemented in an LDC to try to reduce at least one of these risk factors.
- How effective has this strategy been?

Major Cause – TB, HIV, Malaria, Ebola, Diarrhoeal disease, malnutrition e.g., Diarrhoeal disease (DD)

- Persistent loose stools, abdominal cramping, pain, watery stools, fever, bloating.

Evidence:

- Childhood diarrhoea (under 5) is the second most significant cause of infant mortality in LDC's.
- 8% of all deaths globally under 5 were caused by DD in 2017.
- 1400 children per day/ 52,000 per year die due to DD.

Key risk factors:

- It can be caused by lack of access to clean water and adequate sanitation, lack of hygiene practices such as handwashing, not being breast fed, lack of vaccination (e.g., rotavirus), low levels of education.

Primary Health Care Example

- OmniMed Village Health Teams (VHT's) in Uganda, provide safe water supplies (protected water sources) in areas where water is contaminated, scarce or too expensive. They aim to build 1-2 each year. Water is filtered through pipes which makes it 50 times cleaner. Each water source provides between 30-300 households with safe water. There is 1/50th of the bacteria in this filtered water. They have built 30 protected water sources to date (safe water and sanitation is a component of PHC).
- They also provide ORT provisions to assist with DD (curative care).

Effectiveness?

- 5% of all lives saved were due to protected water sources.
- 27% were due to ORT.
- ORT – Village Health Teams (VHT's) provided 175 ORT tubes over 38 villages.
- OmniMed has been operating since 2008 and has trained over 1250 VHT's.

Question 14 – Criterion 3 and 7

GENERAL COMMENTS

Generally most students were able to achieve a C or above in this question.

Answers were at times too brief to show a depth of understanding.

- Generally, students were able to identify the determinants that have impacted their chosen LDC. Most were able to correctly discuss these factors and make connection to poor health outcomes in individuals and communities in dot point 2.
- Students often did not provide information on a range of health indicators. Often answers would mention an indicator but failed to provide appropriate data.
- Stronger answers provided data for five or more health indicators and some also compared this information for their country with that of Australia's.
- Most answers were able to discuss their chosen country's progress towards achieving the SDG in general terms (good, poor) but few responses gave comprehensive overviews of the progress achieved.

Question 14

Choose a Least Developed Country (LDC).

- What political, social-cultural and/or physical environment factors have impacted this country? (Historic and current)

- How have these factors influenced the health of this country both at an individual and community level?
- Use a range of economic, social and health indicators to reinforce your answer.
- Choose one (1) of the Sustainable Development Goals (SDGs) and briefly summarise your country's progress towards its achievement.

Students need to demonstrate a strong understanding of the issues in their chosen country with back up data to reinforce. Country should be from the UN Least Developed Countries list https://www.un.org/development/desa/dpad/least-developed-country-category/ldcs-at-a-glance.html

Profile could include some health indicators

- (Life expectancy, U/5 mortality rate, Infant mortality rate, number of the population with AIDS, GDP per capita, % of the population with access to clean water and sanitation, fertility rates, education levels, number of births attended by skilled attendants)

Determinants:

- Political e.g. effects of war, corrupt governments, levels of debt, trade with other countries, history of settlement, amount of funding directed to health and education.
- Socio-Cultural e.g. levels of education, income, access to employment, religious beliefs, size of families.
- Physical – access to clean water, clean air/ air pollution, heat/ humidity, mountainous regions/ desert plains, natural disasters e.g. earthquakes, mudslides, Ebola, COVID.

Influences on health – examples

- Lack of access to clean water could increase the rates of diarrhoea, therefore increasing the rates of under 5 mortality.
- Lack of education levels could increase the rates of HIV due to lack of knowledge about safe sex practices.
- Lack of funding to the healthcare system could increase the number of the population with malaria due to less long-lasting Insecticide infused malaria nets.
- War – fewer young and able people to farm the land and tend to crops and animals, unsafe to do this, therefore less food for the population, can lead to malnutrition.

Progress towards one SDG

- Answers will depend on the country and the goal. It is important that students paint a clear picture of the issues and outcomes associated with their country.

Question 15 – Criterion 3 and 7

2022 Health Studies Exam Feedback – Section C

GENERAL COMMENTS

Generally most students were able to achieve a C or above in this question.

- Most students were able to provide a few (2) barriers, stronger answers described the barrier and how it impacts education.
- There were a variety of answers regarding the reason to educate women, some were very general and basic in concept. Stronger answers discussed the role that women have as care givers within families and demonstrated how well-educated women had a flow on effect throughout families on numerous levels.
- Other stronger answers showed the positive economic impact that educated women have on families, communities and countries. These answers were also able to identify the specific data to support their claims i.e., 10% increase in the number of girls in school increases a country's GDP by 3%.
- On the whole the SDGs were correctly chosen although many answers were not able to clearly demonstrate how they would improve education rates.
- Students are reminded that if a question asks you to identify an SDG, then you must accurately do so by giving the SDGs number and correct name (not a general approximation).
- Answers for dot point four were generally quite weak. Few responses provided a comprehensive overview of aid programs from two SDGs that would help to achieve these goals.

Question 15

Education is said to be the key to breaking the poverty cycle and yet many people in Least Developed Countries (LDCs) have limited access.

- What are some of the barriers to education in LDCs?
- Why is educating women so important in improving LDC health?
- Choose 2 SDGs that, if achieved, will help improve education rates. Explain how they will help.
- For each of the two (2) SDGs you chose above, provide a specific example of aid that is being provided to LDCs help achieve each of these goals.

Barriers to education:

- Could include poor governance, government debt, poverty, poor infrastructure – roads/ school buildings, malnutrition, diarrhoea, illness, lack of funding for education, natural disasters, children having to help with household chores, lack of access, lack of reproductive health rights therefore many young girls are forced out of education, child marriage, gender based violence and ongoing cultural issues (gender inequality) that provide preferential treatment to sons, government policy that bans/restricts education for some groups e.g. Afghanistan, lack of safe water and sanitation in schools – restricts girls in particular when they have their periods.

Why educating girls is so important:

- Women and girls tend to be the caregivers and if they have a better level of education they are more likely to have fewer children, marry later, their children will be healthier, the girls and women will be able to contribute more financially to their community, more likely to get a job and earn an income.
- In MDCs, women have much higher access to equal rights therefore it can be implied that is equity is improved for women, the country has a greater chance of breaking the poverty cycle and making headway towards becoming a MDC.
- Increases their ability for employment, provides women with a voice and allows them to make decisions on their own account. This has a positive flow on effect for the future as they are able to have children when they wish too, babies are born into more stable families which makes them more likely to receive an education and thus within a few generations the poverty cycle can be broken.
- Receives more regular check-ups as these are provided free of charge in many schools.
- Earns 10% more for every year she is in school.
- Puts 90% of her income back into the family for food, health, schooling and other health basics for her children compared to 35% from the male.
- Influences the health of 15 others in her community through the spread of knowledge and skills.
- Will ensure her children go to school.
- Marries later - A woman with seven years education will marry on average four years later and have 2.2 less children and spaces them out more ensuring her body has time to recover ensuring that her baby is more likely to be born healthy. The rate of malnourishment will decrease by 43%.
- Improves a country's economy by 3% if 10% more girls go to school.
- Understands the importance of regular medical check-ups and immunisations for herself and children.

- Understands the importance of safe water and sanitation to avoid the transmission of water borne diseases such as diarrhoea, typhoid, cholera. Diarrhoea is one of the biggest killers of children under 5 worldwide so knowing how to avoid or treat is important for improving child health.
- Is less likely to get HIV/AIDS and subsequently pass it on as she understands about the importance of 'safer sex'.
- Can have influence in changing attitudes and laws e.g. Malala (fighting for the right for education, Lleymah Gebowee (peaceful activist that forced her civil war torn country - Liberia to sign a peace treaty).
- There are currently over 50 million women around the world who do not have access to education so given the facts about what education can achieve, it can be seen that educating these women would indeed be a powerful way for a LDC to break the poverty cycle.

Could choose any two of the first 6 SDG's and link them to improved education ratees

1. No poverty – Can better afford to get to school, pay school fees, purchase books and school uniforms.
2. Zero Hunger – can concentrate at school, less illness which means better attendance, more energy to get to school.
3. Good Health and Wellbeing – less chance of illness means better attendance, better access to sexual and reproductive health-care services, vaccinated against common health issues.
4. Quality Education – inclusive, equitable, lifelong education.
5. Gender Equality – better chance for girls to get an education, this is important (see above).
6. Clean water and sanitation – less illness, more chances to attend school.

Aid examples which help achieve 2 of these SDGs

Should allow students to use a wide range of possible answers regarding aid. Must reinforce how the example will influence the improvement of education.

- Farmer Managed Natural Regeneration (World Vision) – SDG 1, 2
- Ryan's Well – SDG 6
- WaterAid – SDG 6
- Against Malaria Foundation – SDG 3
- UNICEF WASH Foundation – SDG 6
- Global Fund for Women – SDG 5
- Obstetric Fistula Hospital – Catherine Hamlin – SDG 3, 5
- Save the Children – SDG 4
- One Girl and Care – SDG 4 and 5
- World Food Program – SDG 2
- UNICEF – schools food programs SDG 2 & 4
- Drought resistance crops – SDG 2
- Any Climate Change initiatives – SDG 1
- GAVI – world vaccination program – SDG 3