HEALTH STUDIES

ATAR course examination 2017

Marking Key

Marking keys are an explicit statement about what the examining panel expect of candidates when they respond to particular examination items. They help ensure a consistent interpretation of the criteria that guide the awarding of marks.

Section One: Multiple–choice 20% (20 Marks)

Question	Answer
1	b
2	c
3	d
4	a
5	b
6	c
7	a
8	d
9	a
10	b
11	d
12	a
13	b
14	b
15	d
16	c
17	d
18	a
19	c
20	d

Section Two: Short answer **50% (50 Marks)**

Question 21 **(8 marks)**

(a) What are the main messages being conveyed in the infographic? (2 marks)

Description	Marks
One mark for any of the following	
• That people living in inner regional and outer regional/remote locations have higher rates of illness and disease such as arthritis, diabetes, cardiovascular disease and mental health conditions **or** there are inequities in health between people living in major cities and those living in inner regional and outer regional/remote locations. • That people living in inner regional and outer regional/remote locations are more likely to smoke, do insufficient physical activity and drink at risky levels **or** engage in health behaviour that results in illness and disease. • That people living in outer regional/remote locations are more likely to be smokers, do insufficient physical activity and participate in risky drinking than people living in major cities or inner-regional areas. Note: where a candidate mentions the differences between two conditions as their whole answer, allocate **one mark** only.	1–2
Total	**2**

(b) Identify **three** risk factors for disease included in the infographic. (3 marks)

Description	Marks
One mark each for any of the following	
• smoking • insufficient/ low levels of physical activity • harmful alcohol use across the lifespan (lifetime)	1–3
Total	**3**
Note: terminology must be accurate. No marks awarded for physical activity, or alcohol use **without the relevant adjective** (i.e. insufficient, harmful). E.g. alcohol consumption **would not be** awarded a mark.	

(c) Outline **three** ways in which the data provided in the infographic could be used to improve health outcomes. (3 marks)

Description	Marks
One mark each for any of the following	
Answers could include but are not limited to; • To measure or detect areas of health inequity between urban and rural areas i.e. who is impacted the most. • To inform resource allocation – that is where to allocate resources based on areas of need. • To inform prevention/intervention programs/health promotion strategies (e.g. education) that target harmful risk factors identified in the data. • To identify and target determinants of health in urban and rural areas which may contribute to illness and disease and/or the occurrence of risky behaviours. • To advocate for improved healthcare services and facilities for people living in regional/remote areas.	1–3
Total	**3**

Question 22 **(5 marks)**

(a) What are **two** of the primary roles of the World Health Organisation? (2 marks)

Description	Marks
One mark each for any of the following	
• Build better, healthier futures for people all over the world. • Direct and coordinate international health within the United Nations system. • Provide **leadership** to world health authorities on critical health matters. • Influence/shape the **research agenda** for public health and disseminate critical knowledge. • **Monitor** health situations (e.g. epidemics) that threaten public health and safety (such as the Ebola crisis). • **Risk management** for public health crisis Note: Eradicate poverty or other specific health promotion strategies are the domain of individual nations and therefore not acceptable responses. Refer: http://www.who.int/about/what-we-do/en/	1–2
Total	**2**

(b) Provide **three** reasons why a life–course approach to promote health is important.

(3 marks)

Description	Marks
One mark each for any of the following reasons	
Answers could include, but are not limited to; • Foundations of good health are laid down before birth and in the early years and influence adult health. • Slow growth and poor emotional support in the early years increases the risk of poor health later in life. • Healthy habits (e.g. eating sensibly and being physically active) are best learned in childhood. • Exposure to social determinants throughout the life–course shape adult health. • Maternal (infant) mortality in certain population groups is at highly unacceptable levels – these areas need to be addressed to reduce inequity and improve health outcomes for at risk populations. • It is easier for children/young people to acquire social and cognitive skills, habits and coping strategies that support good health than it is at older ages. • A life–course approach focuses on primary prevention. It is easier to prevent disease, than to treat/rehabilitate. i.e. identifies health needs or problems early in life. • It is a cost effective approach (particularly in relation to chronic conditions).	1–3
Total	**3**

Question 23 **(8 marks)**

(a) Explain why these priorities were chosen. (2 marks)

Description	Marks
One mark each for any of the following	
• They contribute significantly to the **burden of illness, disease and injury** and associated **costs** in the Australian community. • They **provide specific areas of focus**, for **coordinated action** for all States and Territories of Australia. • By focusing on these priorities e.g: (applying preventative strategies, health promotion activities/campaigns), there is the **potential for significant gains in health** for all Australians e.g. increased life expectancy, better quality of life, less risk of chronic disease. • The majority of these conditions are preventable.	1–2
Total	**2**

(b) Choose **three** action areas of the Ottawa Charter. For each action area, describe **one** action to address childhood obesity. (6 marks)

Description	Marks
For three actions; **Two** marks for a well–developed description of each action **One** mark for a less well–developed description	
Answers could include, but are not limited to; **Building Healthy Public Policy** • Introduce a junk food tax/ tax on sugary drinks. • Compulsory physical education in schools. • Ban advertising of junk foods during children's television viewing time. • Provide a subsidy on fresh food (fruit and vegetables). • Introduce traffic light policies for food environments such as school canteens, recreation centres, or other places where children attend. • Restrictions on number of fast food outlets in areas/councils. **Creating Supportive Environments** • Provide sufficient spaces and facilities for physical activity (e.g. in schools, in the community). • Modify food environments where children purchase/access food such as school canteen, community recreation centres, childcare centres so there are the majority of healthy choices. • Support children to walk/ride a bike to school by providing bike racks and safe places to walk. • Provide stand up desks in school classrooms for students. • Remove vending machines with unhealthy options from food environments where children gather. **Strengthening Community Action** • Communities are proactive in encouraging and empowering local champions to take up the issue e.g. lobby governments for additional facilities which promote physical activity such as playgrounds. • Community fundraising to pay for facilities which encourage physical activity. **Reorienting Health Services** • Encourage health services to work with school nurses/school staff on prevention programs. • School staff to refer families to professional services which address overweight/obesity. • Provision of additional resources from Governments to address overweight/obesity. • Additional money provided for research into the issue and effective prevention and intervention approaches. **Developing Personal Skills** • Run healthy eating courses/education sessions for parents. • Compulsory education for school aged students about healthy eating/the importance of physical activity. • Improve health literacy skills through strengthening health education in schools.	1–6
Total	**6**

Note: Only three action areas required.
No marks for identifying action area, without description of action.

Question 24 **(10 marks)**

(a) Define resilience and outline **three** reasons why it is an important protective factor for mental health. (4 marks)

Description	Marks
One mark for correct definition	
Resilience • The ability to bounce back from adverse circumstances, trouble or trauma and return to a normal state of functioning **or** • The ability to cope with life's challenges and to adapt to adversity.	1
One mark for accurate and well–developed outline of reason	
Answer could include but is not limited to; • Reduces likelihood of engaging in risk–taking behaviours which could impact upon mental health • Increases ability to set realistic goals to focus on and to actively work towards achieving them • Provides the ability to recognise and manage one's own emotions and take action to manage/cope with set–backs and remain mentally healthy/resilient/manage stress. This could include learning from previous experiences and better recognising and managing stressors. • Increases ability to solve problems, make informed decisions and accept responsibility for own actions • Increases capacity to form and maintain positive relationships with others critical to ensuring good social support.	1–3
Total	**4**

(b) Identify **two** other skills that could be used to support positive mental health. For each one, describe how a young person could apply the skill to prevent problems associated with the pressures of Year 12. (6 marks)

Description	Marks
One mark for correct identification of each skill	
Two marks for well–developed description of each skill **One** mark for less well developed description of each skill	
Answers could include but are not limited to: Assertiveness (no marks for *assertion*) • Assertiveness means standing up for your own personal rights and expressing thoughts, feelings and beliefs in appropriate ways without disrespecting other people thoughts, feelings or beliefs • Someone who is not frightened to say what they want or believe Application of skill • Assertiveness could be used to manage the demands of Year 12 by ensuring that workloads are managed effectively; candidates could say no with confidence to ensure that they do not over commit.	1–3
Stress management (no marks for *coping* or other such terms) • Stress management encompasses techniques/skills which enable a person to use effective coping mechanisms to deal with stress • Ability or strategy to cope with stress or turmoil Application of skill • Stress management could be used to cope with the demands of busy times by ensuring that stress management strategies were used to avoid/prevent/manage stress. For example, using breathing and relaxation techniques, positive imagery and self–talk.	1–3
Total	**6**

Question 25 **(10 marks)**

(a) What are **two** aims of health promotion advocacy? (2 marks)

Description	Marks
One mark for each correct response	
Answer could include but is not limited to; • To raise awareness about a particular issue/to encourage support for a cause. • To improve health, ensure better quality of health. • To influence or encourage changes in policy/target policy makers to enact change. • To challenge norms, stereotypes and stigmas. • To lobby for funding. • To highlight and reduce inequity e.g. for disadvantaged and/or marginalised groups/populations.	1–2
Total	**2**

(b) Identify **four** advocacy strategies which could be used effectively in the above scenario. For each one, outline how it could improve immunisation rates in the community.

(8 marks)

Description	Marks
For four strategies: **One** mark for identifying advocacy strategy **One** mark for accurate outline	
Raising awareness • Could improve immunisation rates by educating people/improving people's knowledge about immunisation and why it is important, and outlining the benefits for the broader community.	
Lobbying • By targeting decision–makers, or by arguing in State Parliament, the local member could lobby for free mobile services to travel to the community.	
Creating debate • The local member could initiate debate in State Parliament, or throughout the media to generate support for improved services in the community.	
Mobilising groups • The local member could approach other people of influence (e.g. politicians, community elders) in neighbouring communities for their support, and therefore make lobbying efforts more powerful.	1–8
Using champions • The local member could approach local champions – well known individuals to support and speak out about the issue, raise awareness and inspire and motivate change with decision–makers.	
Developing partnerships • Local agencies could work together to draw attention to/raise awareness of the issue and/or attract additional health services to the region.	
Framing issues • By presenting the problem or issue in a way which challenges and/or changes the mindset of the community or local agencies; increased support for immunisation could be achieved.	
Total	**8**
Note: Only strategies listed are acceptable The remaining strategies - building capacity, influencing policy, are not acceptable.	

Question 26 **(9 marks)**

(a) Identify which type of need is described in the above scenario. (1 mark)

Description	Marks
Normative	1
Total	1

(b) Outline **three** other types of need used in health promotion. For each, state a means of collecting data to assess need. (6 marks)

Description	Marks
For three types of need: **One** mark for each accurate outline of need **One** mark for each accurate method of data collection	
Felt need • Needs perceived by an individual or by individuals within a community. What an individual believes is a need, or a problem in the community. Data can be collected through interaction with the public using surveys (oral or written), interviews, focus groups and observation.	1–2
Comparative • Needs which arise from comparing populations. Data can be collected through comparison of statistics for different populations using existing data sources.	1–2
Expressed • Felt needs turned into action, which have been expressed in a different way. Such as putting felt needs in writing, visiting a health professional. Data can be collected through public submissions, or other requests for information from the community; frequency of health service use such as hospitals admission data, GP clinics, screening services, waiting lists etc.	1–2
Total	6

(c) Explain the key purpose of collecting data to ascertain needs within a community.

(2 marks)

Description	Marks
One mark each for any two of the following	
Answers could include but are not limited to: • To determine **priority health issues/health inequities** in a population. • To determine the **causes of health issues**/problems in a population, through a detailed analysis of the factors contributing to the issue. • To identify **gaps in services** to address identified issues (what is needed). • To determine the **most appropriate/effective actions and strategies** which could be implemented to target identified needs. • To identify and **set goals** to improve health issues. • To identify **existing resources** which could be used to address issues.	1–2
Total	**2**

Section Three: Extended answer 30% (30 Marks)

Question 27 (15 marks)

(a) Explain the impact of **three** social determinants that contribute to health inequities experienced by people living with a significant, permanent disability. (6 marks)

Description	Marks
For three social determinants: **Two** marks for identifying determinant accompanied by a well–developed explanation.	
One mark for identifying determinants accompanied by a less well–developed explanation.	
Answers could include: Stress • People living with a disability (PLWD) may experience harmful levels of stress. This could be made worse by discrimination which can have a negative effect on health by increasing stress and anxiety, and increase the risk of mental health problems. Social exclusion • Living with a disability can result in limited opportunities to engage with/participate in community activities. Further it may result in discrimination and contribute to exclusion from social interactions. Social interactions are an important protective factor for positive mental health. Work • Living with a disability may impact on a person's ability to work, or to work in an occupation of choice. Without satisfying, meaningful work opportunities, a person's mental health may be affected and their economic security may be affected. Unemployment • Living with a disability may impact on a person's ability to find employment, and therefore contribute to unemployment and affect economic security and the ability to afford goods and services that support good health. Not having a job also impacts on opportunities for social interaction. Social support • Having a disability may limit social support/social relations which have a protective effect on health. Without sufficient social support, individuals may be more prone to depression and poorer health outcomes. Addiction • People classified with having a disability generally have poorer mental health. Addiction may be the result of inefficient coping mechanisms. PLWD are also more likely to smoke or drink at harmful levels. Addiction may be exacerbated by the existence of other determinants such as social exclusion and unemployment. Transport • PLWD may not have access to independent transport, which can impact on their ability to be involved in community activities. PLWD may be unable to cycle, walk or use active transport which are all recommended means of ensuring sufficient levels of physical activity are achieved. Public transport options for PLWD may not adequately meet their needs and may also limit their ability to access vital health services. Social gradient • PLWD may be subject to adverse social and economic circumstances putting them lower down the social gradient and	1–6

therefore at risk of poorer health and/or premature death (reduced life expectancy). **Early life** • PLWD who do not receive adequate prenatal and early childhood care and access to health services/resources may suffer inequities. E.g. not ready for school, effects on cognitive growth and development, the potential for behavioural disruptions/social functioning. Carers who are unable to provide adequate care and support for PLWD may contribute to poorer health outcomes and ongoing inequity. **Culture** • PLWD may have difficulties identifying and accessing appropriate health services/resources. There may be language barriers or other cultural traditions and habits that perpetuate inequities.	
Total	**6**
Note: no marks for identifying determinant without an explanation **Food** is not an acceptable response.	

(b)   Identify **three** principles of social justice. Explain how each principle can improve the health of people living with disabilities.   (9 marks)

Description	Marks
For three: **One** mark for identifying social justice principle.	
Two marks for well–developed explanation – must link to how principle can improve health of people living with a disability. **One** mark for less well–developed explanation.	
Access and equity (*'access'* or *'equity'* on its own is not an acceptable response) • Equity means ensuring that resources to support people living with a disability (PLWD) should be allocated in accordance with their needs. • Access refers to ensuring appropriate access to healthcare, information and education is a high priority for PLWD. How access and equity can improve health • By specifically allocating resources based on the needs of PLWD • By ensuring that priority groups receive appropriate funding to improve health outcomes without discrimination • By ensuring access is equal regardless of the nature of disability. • By ensuring that PLWD have the opportunity to be involved in planning and decision–making about their health (i.e. active participation).	1–3
Diversity • This refers to ensuring that information and healthcare is relevant and appropriate for all people, including those living with a disability. How diversity can improve health • By ensuring that the differences between types of disability (mild, moderate, severe) are considered in decisions related to healthcare. • By being adaptable/flexible and not using a one size fits all approach. • By adopting personalised and meaningful approaches to acknowledge the range of disability.	1–3
Supportive environments • These include environments in which people live and work and how they protect people from threats to health and encourage healthy behaviour. How supportive environments can improve health	1–3

• By providing opportunities for healthy choices and behaviour by making community facilities easily accessible (ramps, railings etc.) to encourage engagement in community activities and opportunities for physical activity. • By providing opportunities for involvement with health services, e.g. making facilities accessible. • The provision of the NDIS allows PLWD to receive financial incentives which can support greater independence and involvement within the community, thereby leading to improvements in mental health.	
Total	**9**

Question 28 **(15 marks)**

Choose **three** of the UN Sustainable Development Goals studied in this course. For each goal, describe what it strives to achieve and explain why it is important. (15 marks)

Description	Marks
For three goals: **One** mark for **full** description of goal	
Three to **four** marks for a well–developed rationale that contains multiple arguments supporting the need for the goal **One** to **two** marks for less well–developed rationale	
Goal 2 Strives to achieve an end to hunger, achieve food security and improved nutrition and promote sustainable agriculture. Rationale • Globally, millions of children are undernourished. • Rates of hunger are expected to increase in the future. • The food and agriculture sector offers key solutions for development and are critical to progress to reduce/eradicate hunger. • Climate change is putting great pressure on communities and their resources and their ability to provide an adequate supply of food, thus affecting food security.	1–5
Goal 3 Ensure healthy lives and promote well–being for all at all ages. Rationale • Rates of infant mortality are unacceptably high – particularly in developing nations where deaths of children under the age of five are highly prevalent. • Children born into poverty are more likely to die or have poorer health than children from wealthier families. • Children of educated mothers are more likely to survive than children of uneducated mothers. • Deaths in childbirth are high in developing nations. • Vaccinations to prevent infectious disease are essential, however are not routine for many of the world's children.	1–5
Goal 4 Ensure inclusive and quality education for all and promote lifelong learning. Rationale • Many children in developing nations do not have access to basic schooling and remain uneducated – particularly girls. • Many children lack basic literacy skills – education is crucial to develop these skills. • There are large differences in health status between those who are educated and uneducated.	1–5

Goal 5 Achieve gender equality and empower all women and girls. Rationale - Women and girls represent half of the world's population. - Gender inequality stagnates progress and economic development of nations. - Inequality related to gender means that some girls do not receive proper or adequate healthcare, or access to education. - Girls who marry early often miss out on critical education opportunities. - Gender inequalities can mean that girls do not participate fully in the workplace due to limited opportunities in the labour market, which inhibits economic growth. - Women are subject to physical and/or sexual violence, and female genital mutilation which can have consequences for health (infection, future childbirth complications).	1–5
Goal 6 Ensure access to water and sanitation for all. Rationale - Dirty, contaminated water remains the major cause of death in children under five – worldwide. - Poor quality water is linked to diarrhoea and other infectious disease related to poor hygiene. - Managing water sustainability means better management of food production (and improved food security) and a positive impact on biodiversity.	1–5
Total	**15**
Note – Three of the five goals required For a full mark, **candidates must include all parts of the goal,** however exact language is not required.	

Question 29 **(15 marks)**

(a) Describe why the socio–ecological model of health has been useful for addressing public health problems. (3 marks)

Description	Marks
One mark each for any of the following	
Answers could include but are not limited to: • A model which recognises the linkages and relationships between the multiple factors (determinants) that influence health (i.e. multiple factors influence health behaviour). • A model which helps health professionals to better understand reasons underlying human behaviour/ why people behave in certain ways. • A model which recognises that efforts to change behaviour need to take into account the multiple influences on health.	1–3
Total	**3**

(b) Outline **four** levels within the socio–ecological model of health. For each level, suggest **two** strategies that could be applied to improve levels of physical activity. (12 marks)

Description	Marks
For four levels: **One** mark for outlining each level; No marks for identifying level, without outlining the level. **One** mark for each strategy (maximum of 2)	
Individual The individual is at the centre of the model. This level includes personal factors/choices that increase or decrease participation in physical activity such as knowledge, attitudes, beliefs, perceived barriers, motivation, age, gender, level of education and self–efficacy. Strategies at this level include; • Education to improve knowledge of the importance of physical activity for good health. • Education about how much physical activity is needed for good health and ways to be physically active. • Education to develop positive attitudes towards physical activity. • Education to reduce perceived barriers to physical activity.	1–3
Interpersonal This level relates to the impact of interpersonal relationships and norms on behaviour and how this might influence physical activity behaviour. Strategies at this level include; • Parent education programs about the importance of physical activity. • Working with parents to encourage positive role modelling about physical activity. • Health care providers making recommendations about physical activity to patients. • Peer based programs promoting physical activity.	1–3

Organisational/institutional This level relates to the impact of organisations/institutions on physical activity participation and how practices and policies can support physical activity participation. Strategies at this level include; • Workplace policies which encourage physical activity within the work environment. • Workplace physical activity programs. • School based compulsory physical activity programs/policies • Workplaces encouraging active transport e.g. providing subsidised smartriders for employees; providing showers and lockers for employees who walk/run/cycle to work. • The use of stand up desks or other ergonomic furniture which encourages movement/ reduced sitting.	1–3
Community This level refers to the broader community context within which people reside and how communities can influence physical activity levels. Strategies at this level include; • Community education about the importance of physical activity. • Social marketing/ public awareness campaigns to improve community awareness and promote positive attitudes towards physical activity. • Collaborations between agencies to develop/implement programs to increase levels of physical activity participation. • Promotion of physical activity by local government/ councils to encourage participation throughout the community. • Structural changes in local government environments e.g. cycle paths, attractive parks and recreation centres, skate parks etc.	1–3
Society/policy This refers to the broader social and political environment which creates a climate in which physical activity is seen to be valuable and is encouraged through policy which supports access and equity for all. Strategies at this level include; • Urban planning and/or transport policies which influence active transport. • Education policies which mandate physical activity/education in all schools. • Subsidies for disadvantaged groups to access and use active transport. • Subsidises for lower socioeconomic schools to participate in sports clubs/recreation centres.	1–3
Total	**12**
Note – four of the five levels required	

Question 30 **(15 marks)**

(a) Describe **three** ways in which the 'shoey' incident could reinforce social and cultural norms related to alcohol use in Australia. (6 marks)

Description	Marks
For each of three ways: **Two** marks for a comprehensive description; demonstrates excellent understanding of social and cultural norms as they relate to alcohol use **One** mark for a less–well developed description; shows some understanding of social and cultural norms as they relate to alcohol use	
Answers could include but are not limited to: • People may associate alcohol use with winning and/or success, thus contributing to the already well established norm in Australia that alcohol is commonly used to celebrate (or even commiserate). • Younger people may be subject to the influence of the actions of Riccardo. He is also male, and an influential role model for young boys/men. His behaviour may influence the attitudes and values of young men/boys related to alcohol use, which in turn contributes to social and cultural norms. • Given the behaviour is being shown on a world stage, a global audience are being exposed to the accepted Australian cultural practice of drinking alcohol to celebrate success thus reinforcing social and cultural norms to other nations/cultures. • Labelling the practice a 'shoey' contributes to the casual/informal way in which Australians approach alcohol use and shows an acceptance of an easy going drinking culture. • The other characters in the photo are smiling and celebrating which can reinforce the popular norm of using alcohol at these events and that using alcohol to celebrate is the 'Australian' way.	1–6
Total	6

(b) Aside from social and cultural norms, define **three** other types of norms that influence alcohol use among young people under the age of 18 in Australian society. Use examples to explain how each of these norms influences behaviour for this population group. (9 marks)

Description	Marks
For three types of norm: **One** mark for definition of each type	
Two marks for detailed explanation plus relevant example **One** mark for less detailed explanation and example	
Proscriptive norms • Proscriptive norms describe behaviours that individuals should not perform, or those which society generally discourages • Deter people from behaviours they shouldn't perform Examples may include but are not limited to; • There are laws which prohibit/discourage alcohol use for those under the age of 18 years. There are generally consequences for contravening these laws. This laws may deter/discourage use; such as it is illegal to for adults to supply under 18 year olds alcohol. • Penalties apply if caught.	1–3
Prescriptive norms • Prescriptive norms describe behaviours that individuals should take, or those which society generally encourage. There is often reward associated with these behaviours. • The behaviours people are encouraged to perform. Examples may include but are not limited to; • The health of our body and mind is important, to maintain this alcohol use is not advisable for those under the age of 18 years. Alcohol and the growing body/mind do not mix well. • Zero alcohol means having money to spend on other things; a greater focus on school work or the pursuit of other goals.	1–3
Popular norms • Standards of behaviour that are generally expected by all members of the community, or a subgroup within the community. • The way people should behave according to popular belief. Examples may include but are not limited to; • Popular norms related to alcohol use for under 18 year olds may be that the peer group does not consume alcohol, and therefore individuals within the peer group follow this norm. • Conversely, popular norms related to alcohol use for under 18 year olds may be that within a peer group it is ok to drink at parties, or other social events and therefore individuals within the peer group follow this norm. Note: Examples should relate to the population group i.e. Australian under 18 year olds	1–3
Total	**9**

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