**Health Studies WACE notes**

**Holistic Health;**

**Characteristics and needs of specific populations**

The characteristics of specific populations can be defined by researching information and the aspects that have caused them to be categorised as a specific population.

Eg; Rural and Remote populations will have low access to services such as doctors and pharmacists. They live far away from hospitals and ambulances will take longer to reach their location, so they are at higher risk of further injury, infection or even death. Other physical characteristics like weight and fitness could also be due to lack of resources and less access to food.

The needs of specific populations can be determined through epidemiological data and researching the health status of the population, and therefore determine what they need in terms of prevention, healthcare and support.

Eg; Rural and Remote populations have healthcare needs based on their characteristics. So, providing them with better access to healthcare, education and more employment opportunities will improve the health status of the population. Also working in substance abuse prevention (which has a high prevalence in these populations due to their lack of recreational activity choices) and mental health support for both the troubled individuals involved in substance abuse and those struggling with social isolation from urban sprawl.

* *Links to Social Determinants, Factors Creating Inequity, Access and Equity*

**Access and equity issues of specific populations**

Access and equity is about removing barriers for people in specific populations to have the same health outcomes as anyone else in Australia. These groups may experience specific barriers and inequities when accessing healthcare and education. Inequities are avoidable therefore they are most changeable factors and can therefore improve overall health status when healthcare services target these specific inequities.

Access; The ability to obtain or make use of a service or product

Equity; Fairness, consistency, inclusivity and justice for all people. The opposite of equity is inequity.; which refers to unfair or unjust treatment, policy or practice.

Eg; In Rural and Remote populations they have poor access to healthcare services and education facilities such as libraries, universities, and the highest calibre teaching staff. This creates the education barriers as well as overall health literacy and health status will be significantly lower than that of Urban areas. By increasing the resources and services in these locations, we can improve health status as well as increase the level of understanding and knowledge around the importance of healthcare and eliminate the barrier based on geographical location.

* *Links to Factors Creating Inequity, Characteristics and* *Needs of Specific Populations, Social Determinants and Social Justice Principles*

**Factors that create health inequities**

The most common reoccurring factors when researching specific populations and the barriers between these populations and good quality health status. These are most changeable and easiest to eliminate and when removed provide a more equitable Australia between all kinds of populations.

**Access to and level of education:**

How far along the education pathway an individual is and how reliable and adequate the teaching source is.

Eg; Does the individual have a high enough education level to get a good job?

**Geographic location:**

Your place of living and the residential society you are surrounded by.

Eg; Rural and Remote locations due to where they live will have less access to resources

**Racism:**

Prejudice, discrimination or antagonism directed against someone of a different race based on the belief that one’s own race is superior.

Eg; being denied healthcare or services due to the colour of your skin, or your ethnic background.

**Government economic and social policies:**

Governments laws surrounding money and social interactions.

Eg; How much support from the government will the individual have and what are their legal limitations?

**Health literacy:**

The degree to which individuals have the capacity to obtain, process and understand basic information and services to make wise health decisions.

Eg; lower health literacy = higher risk of making unhealthy and poor life decisions, and not knowing how to deal with it.

**Occupation:**

A job or profession. A source of income to the individual and their family.

Eg; higher income, higher socioeconomic status and opportunities to make better health choices.

**Socioeconomic status:**

An economic and sociological combined total measure of a person’s work experience and economic/social position, based on income, education and occupation.

Eg; poor socioeconomic status will affect your ability to make good health choices and develop health skills. Will also impact you access to healthcare.

**Gender:**

The state of being male or female (typically used with reference to social and cultural differences rather than biological)

Eg; denying a woman who has been waiting medical attention because a man has just walked in.

**Discrimination:**

The unjust or prejudicial treatment of different categories of people, especially on the grounds of sex, age or race.

Eg; not allowing an individual to make a doctor’s appointment due to their Indigenous Background.

**Access to healthcare:**

The timely use of personal health services to achieve the best health outcomes and prevent further damage to an individual’s health status.

Eg; people living in remote areas with the nearest hospital two hours away.

**Unemployment:**

The state of being without a paid job but able and willing to work.

Eg; having no money to pay for private health insurance, so emergency situations cost a significant amount.

**Social isolation:**

A state of complete or near complete lack of contact between an individual and society. Completely deserted in social support networks.

Eg; individuals living in rural and remote areas and having minimal social support while coping with crippling depression.

**Dislocation of land:**

To disturb the normal living environment of an individual or society.

Eg; moving to a place that is unknown or foreign, with a language barrier when accessing healthcare facilities and resources.

* *Links to Social Determinants, Epidemiological Data, Characteristics and Needs of Specific Populations and Access and Equity issues*

**Quantitative and qualitative measures for detecting health inequities and/or injustices**

Quantitative measures relate to the quantity of something rather than its quality. Refers to numbers and measurement data. For example; Life Expectancy, Mortality, Morbidity, Burden of Disease.

Qualitative measures refer to the measuring something by its quality rather than quantity. For Example, the social determinants of health, or quality of life.

* *Links to Epidemiological data, Social Determinants of health, Factors creating health inequity*

**Impact of the determinants on health inequities**

How having or not having the determinants of health in daily life affect specific populations and their characteristics and in turn their health needs. These determinants when addressed and administered should reduce the inequities in society.

**Social Determinants:**

**Food**

**Unemployment**

**Social Support**

**The Social Gradient**

**Social Exclusion**

**Work**

**Addiction**

**Stress**

**Transport**

**Early Life**

**Culture**

**Environmental Determinants:**

**Features of the natural and built environment**

**Geographical Location**

**Socio-Economic Determinants:**

**Family**

**Income**

**Neighbourhood/Housing**

**Education**

**Food Security**

**Access to Services**

**Migration/Refugee Status**

**Employment**

**Biological Determinants:**

**Birth Weight**

**Body Weight**

**Global and local barriers to addressing social determinants of health:**

The discipline and area of work that looks at improving the health status of all people in the world. These are the largest health issues creating barriers to start addressing and focusing on the social determinants.

**Poverty:**

The state of being completely poor, a condition where people’s basic needs for food, clothing and shelter are not being met.

**Disease Outbreak:**

The occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area or season. An outbreak can occur in a restricted geographical area or may extend over several countries. It may last for a few days or weeks, or even several years.

**Famine:**

A widespread scarcity of food, caused by several factors including crop failure, population imbalance or lack of resources.

**Drought:**

A period of below-average precipitation in a given region, resulting in prolonged shortages in its water supply, whether atmospheric, surface water or ground water. A drought can last for months or years or may be declared after as few as 15 days.

**Availability of clean drinking water:**

Unsafe water or poor sanitation facilities in a population causing severe dehydration and death, as well as extremely long treks to collect water, lasting up to days.

**Principles, Frameworks, Models and Theories**

**Socio-ecological model of health and its role in understanding and addressing public health problems**

The purpose of the Socio-Ecological framework is to outline how the health status of an individual is influenced not only by attitudes and practices, but also by their personal relationships as well as society and community factors. The framework considers human behaviour as the product multiple levels of influence in behaviour.

**Individual:**

Seeks to identify the biological and personal history factors that an individual brings to the situation. Focuses on the characteristics of an individual.

Eg; Demographics, early life, literacy level

Strategies; Education and life skills training. Interventions focused on the individual’s behaviour change

**Interpersonal:**

Demonstrates and explores how close social relationships (friends, intimate partners, family members) increase the risk for negative behaviour occurring.

Eg; who you live with and who you spend your time with.

Strategies; promote healthy relationships, faster problem solving and strong social networks

**Organisational:**

How an individual lives, works and learns within their organisations. The rules, policies and expectations of these organisations will have an impact on the health of individuals and their families.

Eg; schools, churches, workplaces

Strategies; bullying or harassment policies. Ergonomically designed furniture.

**Community:**

Community norms. Individuals within a community bring cultural, social and their community norms with them to interpersonal and organisational settings.

Eg; Drink driving, binge drinking

Strategies; catering for varying cultures. Creating organisational (eg; school) cultures that foster positive behaviour.

**Societal:**

Focuses on the societal factors that influence health behaviour. Society in this context is much larger than specific culture or community.

Eg; Cultural norms. Economic and social policies.

Strategies; Regulations on health behaviour. Restrictions on young people’s access to negative health choices (alcohol, drugs.)

**Social Justice Principles in health**

The rights of all people in our world are considered in a fair and equitable manner. Social justice is about promoting a more socially inclusive society for all people most likely to be marginalised or in vulnerable situations.

Eg; Indigenous Australians, elderly, people living with disability.

**Access and Equity:**

Access refers to ensuring appropriate access to healthcare, education and information and education is a high priority for specific populations.

The 5 A’s of access;

Availability; are services there when needed?

Affordability; are costs of the program within reach of everyone?

Accessibility; can services be reached and used? Is there adequate transportation?

Acceptability; do services reflect family, community and cultural values?

Adaptability; can services be modified to meet needs? Eg; special needs

Eg; having wheelchair access at doctor’s offices so that PLWD are able to visit the doctor safely.

Equity refers to ensuring that resources to support people are allocated in accordance with their needs.

Eg; having free healthcare clinics for those low socioeconomic populations

**Diversity:**

Diversity recognises that in society there are a broad range of groups and populations. Social justice principles reinforce the importance of access to services of all groups and that the rights of all groups are recognised. Ensuring information and healthcare are relevant and appropriate for all people.

Eg; having healthcare professionals available in many dialects to reduce the language barriers in health.

**Supportive Environments:**

These include environments in which people live and work and how they protect people from threats to health and encourage healthy behaviour

The four key public health strategies;

* Strengthening advocacy
* Enabling communities
* Building alliances
* Mediating between conflicting interests in society

Eg; providing free English classes to non-English speaking migrants improves their opportunities to improve health literacy skills and understand health promotion messages.

**Purpose and characteristics of the five levels of need within Maslow’s Hierarchy of Needs**

To prioritise the most important of human needs and working towards the higher levels by successfully achieving the lower. It works on a system of motivation.

Level 1: Physiological Needs

The most basic of Maslow’s needs, the needs required to sustain life.

Eg; Air, food, drink, shelter, warmth, sleep, sex

Level 2: Safety Needs

Safety and security are sought after once physiological needs are met. Level is to ensure individuals are free of threat to emotional and physical harm.

Eg; protection, law, order, security, stability, limits

Level 3: Social Needs

Social needs are those related to interaction with others.

Eg; family, affection, relationships, work group

Level 4: Esteem Needs

After a person feels that they “belong” the urge to attain a degree of importance emerges.

Eg; achievement, status, reputation, responsibility

Level 5: Self-Actualisation

Only a small percentage of the population reaches this level of complete satisfaction in their lives.

Eg; personal growth, fulfillment

**Steps in the PABCAR public health decision making model**

An important component of public health is decision-making, which includes deciding what needs to change and what needs to be done to facilitate change. When planning an action, a useful framework to follow is the PABCAR model. PABCAR represents a public health decision-making model which can be used by public health to justify and/or advocate for interventions, as well as guide decision making about advocacy campaigns.

**Identification of the problem:**

This part of the process involves clearly identifying the problem, determining its significance and subsequent research into the problem, including how it affects the community, the factors which contribute to it, and the community perception of it.

* Identify the problem
* Determine the significance of the problem
* Who is the target group?
* Use epidemiology
* What is the cost to the community?
* What are the community perceptions?

**Amenability to change:**

Involves investigating other communities where similar problems have occurred and solutions found, then addressing whether

or not the solution to the problem was successful. If there is little evidence that the problem can be overcome, the options are

to stop, or to undertake further research to uncover alternate ways to address the problem.

* Is it likely that the problem can be changed?
* No? – discontinue
* Unknown? – pilot (continue/discontinue – further research for alternatives)
* Yes? – develop interventions (policy, education, environmental) investigate other communities with similar issues (comparative needs.)

**Benefits and costs of implementing interventions:**

Benefits could include improvements to the social and/or physical environment; an increase in healthier behaviour

Development of community empowerment or positive impacts to health status. This may result in things such as increased life expectancy, reduced incidence and prevalence of disease and reductions in mortality.

Costs could include social and ethical impacts on the community as well as the direct financial costs of implementing the intervention.

An assessment must be made to determine whether the benefits outweigh the costs of any intervention.

* What would be the benefits to the community of successfully addressing the problem?
* Access costs: social impact, ethics, economic efficacy
* Do the benefits outweigh the costs? No – discontinue

**Acceptability of proposed measures:**

In many public health decisions there will be those opposed to the implementation of an intervention. The PABCAR model requires the public health advocate to consider the position of these groups or individuals. Groups could include the target group, the community, politicians, and industry representatives. The public health advocate needs to form their arguments based on evidence and research within the target group (local community.)

* High levels of acceptance? – implement
* Low levels of acceptance? – advocate to specific groups

**Recommended actions and monitoring:**

If there is a significant level of acceptance of the proposal, then the appropriate authorities should be issued with the task of implementing the intervention. If there is not a high level of acceptance, advocacy should be conducted to increase this. Advocacy should be directed at those who oppose to the intervention as well as those already in acceptance. Recommendations should also be made regarding evaluation and monitoring of the intervention. Timelines should be recommended, and the relevant authorities will be required to ensure adherence to timelines and monitoring guidelines.

* Implement desired actions
* Monitor progress and success

**Roles of the World Health Organisation (WHO)**

The primary role is to direct and co-ordinate international health within the United Nations system. The role of the world health organisation is to promote health for all, eradicate poverty, ensure essential medicines are accessible and coordinate specific disease programs.

**Provide leadership:**

Provide leadership on matters critical to health and engaging in partnerships where joint action is needed. WHO works with countries in need of better leadership to support improvement of health. Close partnerships with UN agencies, donors, foundations, academia, non-governmental organisations and the private sector.

**Shape the research agenda:**

Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge. Identifying gaps, needs and priorities in research sector. Research disseminated in multiple languages, adapted for multiple level of health literacy to ensure sustainable development of valuable knowledge.

**Set norms and standards:**

Setting norms and standards and promoting and monitoring their implementation. Intended to improve the quality, analysis and use of country and regional health information for better measurement and accountability for health. This information is vital for monitoring and evaluating the progress towards universal health coverage.

**Articulate ethical and evidence-based policy options:**

Policy options should address evidence of scientific, economic, social and political forces that impact health. Laws and policies that are brought in to reduce and prevent the occurrence of transnational threats.

**Provide technical support:**

Providing technical support, catalysing change, building sustainable institutional capacity and furnishing appropriate technical assistance. WHO provides technical assistance to developing countries in four major areas;

* Agricultural production
* Basic resource surveys and administrative services
* Health services
* Education

Help countries develop informed approaches to addressing the health implications of trade issues at the national, sub-regional and regional levels.

**Monitor the health situation and assessing health trends:**

Collecting information vital in maintaining a record and tracking progress within a given population. For monitoring and evaluation of progress towards universal health coverage and achieving the health-related Sustainable Development Goals.

**Purpose and functions of Australia’s Aid program**

To promote Australia’s national interests by contributing to sustainable economic growth and poverty reduction. They will pursue this purpose by focusing on two development outcomes; supporting private sector development and strengthening human development. The governments aid program will promote prosperity, reduce poverty and enhance stability with a strengthened focus on the Indo-Pacific region.

Infrastructure, trade facilitation and international competitiveness: means Australia is supporting improved infrastructure to ensure the right conditions for sustainable economic growth and to enhance trade and investment opportunities across the region.

Agriculture, fisheries and water: aims to increase contributions to national economic output, increase outcomes of poor people and enhance food, nutrition and water security.

Effective governance: policies, institutions and functioning economies: supporting the building of governments that have a direct role to play in promoting stability, inclusive economic growth and poverty reduction and in strengthening gender equality and women’s empowerment.

Education and health: critical to improve livelihoods, enabling poor people to participate in the economy and lifting living standards.

Building resilience: humanitarian assistance, disaster risk reduction and social protection: helps build the resilience of countries and communities.

Gender equality and empowering all women and girls: contribute to the growth, development, stability and security of all females.

**Purpose of, and progress towards, the following 5 United Nations Sustainable Development Goals**

The sustainable development goals aim to end extreme poverty, fight inequality and injustice and tackle climate change. These goals will frame the agendas and policies from 2015 until 2030.

**End hunger, achieve food security and improved nutrition and promote sustainable agriculture (Goal 2)**

Purpose; Aims to end all forms of hunger and malnutrition, making sure all people – especially children and the most vulnerable – have access to nutritious food all year round. This goal works to remove hunger from society and have sustainable food sources all over the world.

Progress;

**Ensure healthy lives and promote well-being for all at all ages (Goal 3)**

Purpose; to promote physical and mental health and wellbeing and extend life expectancy by addressing the major causes of morbidity and mortality in both developed and developing countries. This goal works to reduce global mortality rates and end the epidemics of common diseases such as HIV, AIDS, tuberculosis.

Progress;

**Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all (Goal 4)**

Purpose; addresses the need for all girls and boys to have equal access to high quality education at all levels from pre-primary, through to tertiary and to develop the vocational skills needed for employment. This goal targets education at all ages, that is affordable and accessible to everyone from early childhood development to adult training and skill building for the workforce.

Progress;

**Achieve gender equality and empower all women and girls (Goal 5)**

Purpose; seeks to end discrimination and violence against women and girls by addressing the barriers that exist to achieving full gender equality. Gender equality is not only a social issue but also an economic issue. The goal targets harmful and unsafe practices towards women and girls (genital mutilation, sexual exploitation etc) and end all forms of violence and unjust behaviour towards females.

Progress;

**Ensure availability and sustainable management of water and sanitation for all (Goal 6)**

Purpose; ensuring that all people are able to enjoy clean water and adequate sanitation. The goals aim to achieve adequate sanitation rights for all people and better access and availability of clean drinking water globally to stop the spread of water borne diseases and dehydration.

Progress;

**Definition of health promotion advocacy and when it is best used**

Health promotion advocacy is a political process by an individual or group which aims to influence decisions within political, economic, and social systems and institutions. Advocacy strategies are best used when you want to promote public health needs. Advocacy provides the opportunity to overcome barriers that restrict public health. Aids in increasing funding for health prevention and promotion.

**Strategies for health promotion advocacy**

**Lobbying:**

The act of attempting to influence decisions made by officials in a government, most often legislators (those who create and change legislation, laws and policies.) lobbying involves giving views and information to influential parties to sway them towards the change you want. (Similar to influencing policy.)

**Raising awareness:**

Refers to people’s knowledge or perception of a situation. This can include education, increasing health literacy, impacting and changing beliefs, values and attitudes. Involves disseminating information to engage the public in discussion – which raises awareness. Using contemporary technology is vital to raising awareness – social media, advertising and online spaces. Use a multifaceted approach; websites, fact sheets, statistics and data – then promoting them via Facebook, Instagram and Twitter using hashtags.

**Creating debate:**

Formal discussion on a popular topic held in a public meeting, parliament or broadcast via the media. Resolution is usually found through a judge or audience vote. Debate can be held over a period of time. The best example of this is through the media where news producers broadcast views over a period of time (for example; during an election.) Some debates do not end with a resolution, rather raise awareness, educate and allow audiences to choose a standpoint.

**Developing partnerships:**

It is important to make contact with companies, agencies and organisations that already exist – and share similar views on the cause and support the advocacy goals. By forming a partnership with other likeminded people the advocacy effort will be stronger and more effective.

**Building capacity:**

An approach to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over. Building capacity by;

* Health infrastructure or service development
* Program maintenance and sustainability
* Problem solving capability of organisations and communities

**Mobilising groups:**

People uniting to make a difference. Mobilising means organising and encouraging people to act in a certain way in order to bring them to consensus about a particular need. Community leaders mobilise their local community to lobby to change attitudes, to change policies, to change legislation, and sometimes to change votes. There is power in numbers.

**Framing Issues:**

How to couch an issue so it gains traction politically and with the media. Framing refers to presenting an idea using techniques to achieve a desired response. People react differently to an idea or information based on how its worded – the aim is to gain positive emotional response – to make people act.

**Using Champions:**

Champions means identifying leaders who will have followers and thus some political sway. Champions are often not afraid to stand up and be heard. Once we have clearly defined our issue and mobilised support it can be helpful to appoint a champion. The champion chosen should have the desired influence, credibility or commitment, and knowledge of the issue.

**Influencing policy:**

Health promotors influencing policy makers and encouraging them to create policies and laws that are healthy. Policies should; protect, encourage healthy behaviours, outlaw unhealthy products or services, regulates the sale of or access to unhealthy products and services. (Similar to lobbying.)

**Actions and Strategies;**

**Purpose of a needs assessment**

A needs assessment is the first step in planning any health initiative. Identify and analyse the priority health problem and nature of the target group. Allows health promoters to determine resource allocation in order to improve health and reduce inequalities.

**Types of need**

Perceptions form from person to person so it is important for health practitioners to consider different types of need when determining priority health problems.

**Comparative:**

A comparative need us derived from examining the services provided in one area to one population and using this information as the basis to determine the sort of services required in another area with a similar population. Comparative need is where they are individuals with similar characteristics to those receiving/needing help.

**Felt:**

Felt needs are what communities say or feel they require. Common methods of assessing felt needs are household opinion surveys, phone ins, public meetings and calling for submissions from those in the community. Felt needs are those perceived by the individual.

**Expressed:**

Expressed need refers to what has been demanded by a community. They can be assumed that they’re needed, given observations about a community’s use of facilities and services. Expressed needs are felt needs turned into action, Eg; help seeking.

**Normative:**

Refers to need based on research that defines many people within the population. Normative need is defined by experts and you could look at what the research shows are effective strategies. Eg; the Australian government recommends all children aged 12-15 months to be vaccinated against measles.

**Steps in a needs assessment**

**Identifying health issues**

* What is the specific population?
* How is this population different from others?
* Who are we going to include?
* What resources are needed to conduct the needs assessment?

**Analysis of the problem**

* Describe the characteristics and needs of the population
* Compile qualitative and quantitative health status data
* Identify and assess risk and protective factors

**Prioritising Issues**

* Prioritise the health conditions, issues and risk factors in order of impact
* Using interventions, strategies or actions to achieve this

**Setting Goals**

* Specific
* Measurable
* Attainable
* Realistic
* Time-bound

**Determining Strategies**

Use PABCAR to decide on a course of action

* Identification of the problem
* Amenability to change
* Benefits and costs of implementing interventions
* Acceptability of proposed measures
* Recommended actions and monitoring

**Developing Action Plans**

* What needs to be done in order to apply your strategies?
* Develop a plan and timeline of what must be done and who can do it

**Evaluate Outcomes**

* Goals achieved?
* Measure data/compare previous data
* Determine how well/how much was achieved
* What can be learnt or done better for next time?

**Enabling, mediating, and advocating strategies in the *Ottawa Charter* to reduce inequities of specific groups**

Enabling:

Give an individual or group the means or opportunities to do something. To empower…

Mediating:

Through mediating strategies positive change in public health is brought about by reconciling the inequities that exist within society. Reducing inequity requires a co-ordinated approach by health and economic sectors and government. Connects communities and groups with government and non-government organisations.

Advocating:

To speak on behalf of another person to plead for a case or an idea. Reduce inequity through advocacy on behalf of the underprivileged and under-represented.

**Actions to address health inequity**

**Improving access to healthcare:**

Involves ensuring all individuals (regardless of age, gender, socioeconomic status etc) know where to access healthcare and the means to access healthcare when it is required. This leads to improved health outcomes for all individuals.

Strategies; mobile doctors and dentists services, free healthcare for low socioeconomic populations, build more healthcare centres in remote areas.

**Improving health literacy:**

Health literacy is the ability to locate, access, understand, evaluate and communicate information in order to promote, maintain and improve. It enables people to successfully identify and access services required and practice selfcare and disease management.

Strategies; empowering populations though education, ensuring health information is available in multiple languages, simplify information.

**Ottawa Charter action areas:**

* Building healthy public policy
* Creating supportive environments
* Develop personal skills
* Strengthen community action
* Reorienting health services

Strategies; depend on action area.

**Actions to achieve social and health equity in the Rio Declaration on Social Determinants of Health**

To adopt better governance for health and development:

* Transparent and inclusive decision-making processes that give voice to all groups and sectors involved
* Develop policies that perform effectively and reach clear and measurable outcomes
* Develop policies that build accountability and are fair in both policy development processes and results
* “Health in all policies” approach, where policy makers work together for health gains

To promote participation in policy-making and implementation:

* Promote and enhance inclusive and transparent decision-making
* Empower the role of communities in decision making
* Promote inclusive and transparent government approaches
* Promote the full and effective participation of developed and developing countries in the formulation and implementation of policies and measures to address social determinants of health at an international level.

To further reorient the health sector towards reducing health inequities:

* Acknowledging that accessibility, availability, affordability, acceptability and quality of health care and public health services are essential to the enjoyment of the highest attainable standard of health.
* One of the fundamental rights of every human being
* The health sector should firmly act to reduce inequities and focus on specific populations and their healthcare needs

To strengthen global governance and collaboration

* Support national governments, international organisations, non-governmental entities and others to reduce health inequities and strive to ensure that efforts to advance international development goals and objectives to improve health equity are mutually supportive
* Support the leading role of the world health organisation in global health governance, and in promoting alignment in policies, plans and activities on social determinants of health

To monitor progress and increase accountability

* Acknowledging that monitoring of trends in health inequities and of impacts of actions to tackle them is critical to achieving meaningful progress
* Accountability mechanisms to guide policy making in all sectors are essential, taking into account different national contexts.

**Principles of the National Strategic Framework for Chronic Conditions**

**Equity:**

All Australians receive safe, high quality healthcare irrespective of background or personal circumstance.

**Collaboration and Partnerships:**

Identify linkages and act upon opportunities to co-operate and partner responsibly to achieve greater impacts that can occur in isolation.

**Access:**

High standard, appropriate support and services are available, accessible, equitable and affordable for all Australians.

**Evidence-Based:**

Rigorous, relevant and current evidence informs best practice and strengthens the knowledge base to effectively prevent and manage chronic conditions.

**Person Centred Approaches:**

The health system is shaped to recognise and value the needs of individuals, their carers and their families, to provide holistic care and support.

**Sustainability:**

Strategic planning and responsible management of resources delivers long-term improved health outcomes.

**Accountability and Transparency:**

Decisions and responsibilities are clear and accountable, and achieve best value with public resources.

**Shared Responsibility:**

All parties understand, accept and fulfil their roles and responsibilities to ensure enhanced health outcomes for all Australians.

**Consumer Health;**

**Healthcare system reforms**

Is a means of achieving a fairer healthcare system for all through the provision of subsidised products and services. Healthcare reform is a general phrase often used to describe changes to the structure and delivery of healthcare. Reforms can occur at a federal, state or local level. It is in response to escalating healthcare costs.

**Private health insurance rebate:**

Most Australians with private health insurance currently receive a rebate from the Australian Government to help cover the costs of their premiums. The private health rebate is income tested. The rebate applies to hospital, general treatment and ambulance policies. The government has the rebate to encourage people to take out private health insurance. Most people are eligible for a rebate on their insurance costs. If someone is not covered by a private health insurance policy and they earn above a certain income threshold, they may have to pay the Medicare Levy Surcharge when they lodge their tax return.

**Public Screening and/or vaccination programs:**

Public Screening:

Population screening refers to a test that is offered to all individuals in a target group, usually defined by age, as part of an organised program. Screening involves simple tests to look for particular changes, or early signs of a disease, before a disease has developed or in its early stages before any symptoms develop. No screening test is 100% accurate and the body changes over time, which is why it is important to be screened at regular intervals. The Australian Government has three national population based screening programs;

* BreastScreen Australia
* National Bowel Cancer Screening Program
* National Cervical Screening Program

Vaccination Programs:

The ‘Immunise Australia’ program funds the purchase of vaccinations to protect millions of Australians from vaccine preventable diseases. The program implements the ‘National Immunisation Program Schedule’ which currently includes vaccines against a total of 16 diseases. These include routine childhood vaccinations against disease that were once widely fatal such as;

* Measles
* Diphtheria
* Whooping cough

As well as more recently developed vaccines such as;

* HPV
* Meningococcal C vaccine

**Pharmaceutical Benefit Scheme (PBS):**

The pharmaceutical benefit scheme provides timely, reliable and affordable access to necessary medicines for Australians. The PBS is part of the Australian Government’s broader national medicines policy. The PBS schedule lists all of the medicines available to be dispensed to patients at the Government subsidised price. The scheme is available to all Australian residents who hold a Medicare card, as well as overseas visitors from countries in which Australia has a Reciprocal Health Care Agreement.

**Relationship between health literacy and health status**

As one increases/decreases the other increases/decreases.

Eg; if you have a competent level of health literacy your self efficacy and disease management skills are higher therefore you are more likely to make better health choices as opposed to someone with an incompetent health literacy level.

**Comparison of health indicators between Australia and developing countries**

Developed countries have lower mortality and morbidity rates, while developing countries have higher. This is due to a number of factors such as lack of resources, education, health care professionals, stable economy etc. to reduce the barrier these countries need both financial and healthcare aid.

**Life Expectancy:**

An indicator of how long a person can expect to live on average given prevailing mortality rates in their population.

**Mortality:**

Refers to death; the numbers of people dying in a populations (typically per 1000 live births.)

* Crude death rate (number of deaths over a year)
* Age specific mortality rates
* Infant mortality
* Cause specific death rates
* Maternal mortality

**Morbidity:**

Usually reported as a rate or ratio, and refers to the total number of people in a population who are diseased, disabled or unhealthy. Incidence and prevalence of disease also fall under morbidity.

**Objectives that support the vision of the National Strategic Framework for Chronic Conditions:**

**Focus on prevention for a healthy Australia:**

Prevention is key to improving the health of all Australians, reducing health related expenditure and ensuring a sustainable health system. There is significant potential to target common preventable risk factors and determinants of health as an effective approach to reducing the burden associated with chronic conditions.

* Promote health and reduce risk (empowering people to take control of health and control risk factors)
* Responsible partnerships promote health and reduce risk factors for chronic conditions (comprehensive approach to prevention – health in all policies approach)
* Critical life stages (targeted prevention at transitions positions in the life cycle that are age and circumstance appropriate – maternal, children, young adult, working adult, retirement etc)
* Timely and appropriate detection and intervention (involves identifying and planning action for people with or at risk of chronic conditions – reduce costs, effectively manage improving quality of life and life expectancy)

The goal will hopefully reduce the overall rate of chronic conditions in Australia, and with the help of timely interventions prevent or treat diseases in the early stages.

**Promote efficient, effective and appropriate care to support people with chronic conditions to optimise quality of life:**

Support with navigating health systems, tertiary prevention, coordinated health systems. All Australians are entitled to efficient, effective and appropriate quality health care. Without effective support people with multimorbidities often experience poor health and reduced quality of life.

* Active engagement (families and individuals are central to the care and management process.)
* Supportive systems and continuity of care (coordinated, consistent holistic care from systems that work together to individual needs.)
* Accessible health services (equitable access to quality healthcare.)

The goal of this objective is to improve the care given to people with chronic conditions to reduce the premature mortality rates and especially reduce the rates of co-morbidities so that the risk of death is significantly reduced.

**Target priority populations:**

Support with navigating health systems, tertiary prevention, coordinated health systems. Chronic conditions impact all Australians, but some populations are disproportionately affected due to complex interaction between the physical environment, social and cultural determinants and biomedical and behavioural risk factors. Higher prevalence of chronic conditions and a greater burden of disease in target populations, resulting in inequitable health outcomes.

* Aboriginal and Torres Straight Islander health (chronic conditions are the leading cause of the gap between ATSI and non ATSI, culture plays a key role in improvement.)
* Action and Empowerment (priority populations are more likely to experience inequitable access to healthcare, population and community level approaches.)

The goal of this objective is to reduce the rate of chronic conditions and specifically the population differences, by targeting those populations most at risk first and aiming better resources and care towards them.

**Social and Cultural Norms;**

**Conflict between norms of specific groups and majority norms**

Majority norms:

Unwritten rules or standards are followed by more than half the population.

* Australian cultural norms (BBQ’s, beach, bathers)
* Marriage as an option (marriage equality beliefs)
* Alcohol consumption
* Preventable medicines (immunisations)

Specific norms:

Norms that are followed by / unique to people who belong to specific cultural groups.

* Cultural dress
* Marriage practices
* Food (types of food, diet etc) and alcohol consumption

**Relationship between health behaviours and proscriptive, prescriptive and popular norms**

Proscriptive Norms:

Norms that prohibit you from doing something. A behaviour you should not do, and society frowns upon people who do these things.

Eg; drink driving, smoking, rape, underage drinking

Prescriptive Norms:

Norms that prescribe behaviour, so they make you do something. A behaviour you should do and society encourages and enforces these behaviours and actions

Eg; designated drivers (Uber), giving to charity, health eating, study

Popular Norms:

Norms that majority of people are doing. Norms that suggests who is “in” and who isn’t. These norms are generally started by people who are considered popular and hold power. These behaviours are considered fashionable and trendy.

Eg; being thin, being vegan, college education, having social media, wearing makeup

**Beliefs, Attitudes and Values;**

**Influence of cultural traditions and habits on the formation of personal beliefs, attitudes and values towards healthcare**

* Hierarchy: some cultures have a hierarchy system (elders) who make decisions and influence BVA’s towards healthcare. These influences can stem from their own beliefs in cultural traditions.
* Gender: In some cultures, within the family networks the male members influence BVA’s based on their own belief in cultural conditions, and therefore influence their wives and children.
* Mistrust of Western Medicine/belief in traditional medicine and therapies (like bush medicine): due to practicing traditional medicine and not having experience with western medicine or understanding leads to BVA’s formed that lean towards sticking with traditional medicine specific to cultures.
* Belief in causes of illness: some cultures believe in illness and health being gods will, course of life etc, and this will impact a person’s BVA’s towards healthcare.
* Prior experiences: negative/positive experiences- own or others experiences influences BVA’s towards certain types of healthcare.

**Influences of environmental factors on the health behaviour of cultural groups**

Can have positive or negative impacts…

**Geographical Location:**

Impacts the norms and health of cultural groups who live there;

* Urban sprawl
* Facilities available
* Food and exercise options available
* Transport available

**Social Networks:**

Positive and negative norms / behaviours can be promoted within social networks

* Social networks allow people to communicate about useful information
* Health messages are widely distributed
* Large network increases social support and inclusion

**Influence of government policies and regulations on beliefs, values and attitudes**

Policiesand regulations can impact beliefs values and attitudes towards health behaviour. Governments seek to regulate or

influence the behaviour of individuals and organisations through a range of policy tools, including legislation, sanctions,

regulations, taxes and subsidies, the provision of public services and information and guidance material. Health promotion

advertising and advocacy can also influence BVA’s about health behaviour.

**Government policies and regulations that restrict or promote healthy behaviour**

Government policies and regulations can restrict or promote behaviours due to changes to physical (facilities, buildings, signs) or structural (laws, policies etc.) environments. Changes can either enable people to make positive healthier choices (promote) OR control their choices and take away their freedom (restrict.)

Restrict:

* Speed limit
* Smoking in a public area
* Legal drinking age
* Wearing a seatbelt
* No hat, No play policy
* Northbridge curfew
* Drink driving
* Secondary supply laws
* 1m around cyclists
* Licence to drive a car

Promote:

* Plain packaging on cigarettes
* Traffic light system in canteens
* Bike helmets
* Sugar tax
* Speeding
* Alco-pop tax
* Cigarette tax
* Health star ratings
* Nutrition label
* Not advertising cigarettes

**Self-Management Skills;**

**Skills that support positive health behaviours**

**Assertiveness:**

A style of communication that enables people to clearly state their feelings, needs and wants, without dominating or acting

aggressively. Being assertive is essential to good health and wellbeing, not being assertive can lead to feelings of stress, anxiety

or resentment. Assertion is empowering in that it maintains the right to refuse, the right to request and the right to correct a

wrong.

Being Assertive:

Being assertive is about taking control, having confidence and feeling positive. You are being assertive when you articulate your

thinking, decisions and emotions and arguments in a manner that observes others’ dignity and rights, as well as maintaining

your own. Assertiveness creates an environment of constructiveness and with a focus on solutions. Being assertive can also

include requesting others to change their behaviours.

**Stress Management:**

Skills seek to identify and manage stressors and apply techniques and strategies to cope with stressful situations. For example;

* Exercise and diet (reduce anxiety and release endorphins)
* Talking to others (psychologists, family, friends)
* Goal setting (achievable goals)
* Relaxation (meditation and mindfulness)
* Accessing support networks and resources
* Time management

Managing Stress:

Stress management includes avoiding unnecessary stress by taking control. If dealing with a stressful situation changing the

situation by altering/avoiding the stressor or changing your reaction (accepting/ adapting the stressor.) stress management can mean better time management can mean better time management, including learning how to say no – knowing your own limits and sticking to them. Stress management means devising and using healthy ways to cope with stress and framing problems, looking at the big picture, adjusting standards and focusing on the positive. Also include relaxation time to destress and engage in activities that aren’t stressful; desensitising.

**Resilience:**

The ability to bounce back. It is a protective skill and can be used to combat stress. A resilient person can face considerable

hardship or difficulty. If you have resilience you are more likely to;

* Suffer less from harmful consequences of stress
* Communicate well with others
* Have a higher self-worth and belief
* Solve problems
* Achieve personal goals
* Less risk of having issues with substance use

Being Resilient:

Awareness; resilient people are aware of the situation, their own emotional reactions and the behaviour of those around them.

having a sense of emotional intelligence. Understanding that setbacks are a part of life and that life is full of challenges. Being

able to ask for help and have an internal sense of control of your emotions. Resilient people have strong problem solving skills,

having strong social connections when dealing with a problem and identifying as a survivor, not a victim, to achieve the most

optimistic mindset.

**Impact of culture on health decision making**

**Organ and tissue donation (transplants):**

* Hierarchy; some cultures have a hierarchy system (elders on top) who make decisions. Therefore the elders will decide if the process is necessary.
* Gender; in some culture, within the family networks, the male members make decisions for the women in their family. During organ donations, women typically don’t have a say in what happens after their death and their husbands or fathers will make the decision for them.
* Belief in causes of illness/death; some culture believe that illness and death are gods will, course of life etc, so their death happened for a reason. These cultures will see organ donation as an unlawful practice and against the wishes of god, therefore will refuse.
* Level of understanding/mistrust of western medicine; some cultures still practice traditional medicine and their belief in that may impact their decisions about organ donation.

**Blood transfusions:**

* Hierarchy; some cultures have a hierarchy system (elders on top) who make decisions. Therefore the elders will decide if the process is necessary.
* Gender; in some cultures, within the family networks, the males make the decisions for the women in their family. Therefore in medical emergencies, men will decide whether their wives or daughters receive a transfusion, and the women have no say in their own health.
* Belief in causes of illness/death; some culture believe that illness and death are gods will, course of life etc, so their death happened for a reason. These cultures will see blood transfusions as an unlawful practice and against the wishes of god, therefore will refuse. Eg; Jehovah’s Witness don’t believe in any blood transfusions or swapping of blood.
* Level of understanding/mistrust of western medicine; some cultures still practice traditional medicine and their belief in that may impact their decisions about blood transfusions.

**Childbirth:**

* Hierarchy; some cultures have a hierarchy system (elders on top) who make decisions. Therefore the elders will decide if the process is necessary.
* Gender; in some cultures, within the family networks, the males make the decisions for the females in their families. During childbirth, the husband may make decisions on the level of intervention and pain relief allowed, as well as who is allowed in the room during the birth.
* Belief in causes of illness/death; some cultures believe that everything is part of gods will/ course of life, so during childbirth any complications (miscarriage, caesarean) will be seen as part of gods will and believed to be what must be done.
* Level of understanding/mistrust of western medicine; not taking any pain relief during childbirth as it is seen as unnatural.
* During childbirth culture can impact decisions such as pain relief, who is present, where the birth takes place, placenta, circumcision.

**Impact of world events on personal, social and cultural identity of population groups**

Personal identity:

The distinct characteristics of an individual regarded as a separate or individual entity (meaning you can lose your personal

identity when you conform to a group.) The concept you develop of yourself that evolves over the course of your life. Could be

due to factors such as race, homeland, hobbies, career, beliefs etc.

Social identity:

The identification of individuals as members of a group. The characteristics they hold because they belong to that group. A sense

of knowing who you are based on what groups you belong with and fit into, and is an important source of your pride and self-

esteem. This could be your family, friends, social class, football team etc.

Cultural identity:

Belonging to a particular ethnic or cultural group. Aspects of the individual that are held due to culture. Is part of a persons self-

conception and self-perception, and is related to nationality, ethnicity, religion, social class, generation and locality.

**Displacements from traditional homelands:**

The temporary removal from place of residence (house, region, land, country.) internally displaced people are moved off their

land within their own country (eg; due to war or flood.) Refugees have moved off their land either voluntarily or forcibly to

another country. This impacts their sense of belonging and they lose themselves as they adjust to a new life and new home.

**War, violence and conflict:**

War is a state of armed conflict between different nations or states or different groups within a nation or state.

Violence is behaviour involving physical force intended to hurt, damage or kill someone.

Conflict is a serious disagreement or argument.

These three world events can cause loss of homeland and divided culture, social or family groups. This can cause a sense of

Displacement from your home and being unsure of where you belong.

**National Pride:**

The love and devotion people feel towards their country or homeland. Can isolate some cultural groups who aren’t from the

homeland and create severe racial divides. This will impact your sense of belonging in your country, and isolate you in society if

not from the majority culture, and lose your sense of self-worth.

**Natural Disasters:**

The effect of a natural hazard (tornado, flood, hurricane, volcanic eruption, earthquake or landside) that affects the

environment, and leads to financial, environmental and/or human losses. This can cause a serious sense of displacement and

loss of home and security, causing you to question your belonging in society and even your culture, as well as not knowing

yourself in your new life.

**Interpersonal Skills;**

**Language and cultural influences on relationship building in health settings**

Health settings require trusting relationships where both feel valued, understand each other’s needs and cooperate. Language and culture can impede on relationship building. It is the responsibility of the health sector to ensure effective relationships are built.

* Language; different languages in the healthcare setting will impact the relationships formed due to language acting as a barrier to communicating and forming trusting relationships.
* Gender; some cultures believe women should only been seen by female doctors and a male family member must be present. Sometimes the male family member is the one who communicates with the doctor and this will influence the relationship the patient can form with the doctor.
* Hierarchy; similar to gender, sometimes in cultures an elder is in charge of making decisions and this will impact the relationship between healthcare professional and patient, acting as a barrier.
* Dress; it can be hard to examine a female patient when they wear traditional clothing. Health care providers may be limited in the examination process which can impact the health of the patient and have negative impacts on the relationships between patient and doctor.
* Mistrust in western medicine; if a patient or family member do not trust or understand western medicine this will act as a barrier to building trusting relationships between patient and healthcare provider.

**Communication and collaboration skills in health settings**

Collaboration is the act of working jointly and cooperating. Sharing knowledge, learning and building consensus. The main forms

of collaboration are:

* Negotiation
* Mediation
* Arbitration

Collaboration requires communication to drive the process.

Effective communication skills are required when collaborating; active listening, assertiveness and positive body language.

**Mediation:**

A negotiation to resolve differences that is conducted by some impartial party. The act of intervening for the purpose of bringing

about a settlement. The goal is for the distributing parties to resolve the conflict themselves with the support of the mediator.

The mediator does not make decisions, but helps parties come to an equal decision.

**Negotiation:**

The process of achieving agreement through discussion used to resolve disputes. Negotiations bargain for individual or collective advantage.

**Compromise:**

A middle way between two extremes. Finding agreement through communication, a mutual acceptance of terms, often involving variations from an original goal or desire.

**Managing Conflict:**

Conflict can be dealt with in several basic ways. They are avoidance, accommodation, compromise, competition or collaboration. Communication and collaboration skills are used to avoid conflict.

There are four types of conflict;

* Intrapersonal; conflict within the individual (eg; a person who cannot make decisions.)
* Interpersonal; conflict among two or more individuals (eg; an argument between a boyfriend and girlfriend, or child and parent.)
* Intragroup; conflict within a group (eg; between members of the same peer group or team.)
* Intergroup; conflict between two or more groups (eg; between two different youth peer groups, or between students and their school faculty.)

**Arbitration:**

A dispute resolution procedure where an expert person makes a decision to resolve the dispute. Using a third party to resolve a

dispute between two or more parties. The arbitrator makes the decision for the two parties as opposed to the mediator who

just helps support the two parties make their decision.

**Leadership:**

The process of social influence in which one person can enlist the aid and support of others in the accomplishment of a common

task. There are three leadership styles;

* Autocratic: a style of leadership whereby the leader dominates group members, makes decisions then announces them and expects subordinates to comply without question.
* Democratic: a style of leadership whereby the leader makes decisions through consultation, encourages participation and allows decisions to emerge out of group discussion and debate.
* Laissez-Faire: a style of leadership whereby the leader exercises little control over the group, hands over ownership and empowers group members to achieve their goals, by facilitating members to sort out their roles and tackle their work.

**Facilitation:**

The act of assisting the progress or improvement of something, making something easy or easier. Assisting or making easier the

progress or improvements of a goal.

**Health inquiry;**

**Planning a health inquiry**

**Identification of a health issue**

**Development of focus questions to research a health issue**

**Use a range of information to explore a health issue**

**Identification and use of a range of reliable information sources**

**Identification and application of criteria for selecting information sources**

**Interpretation of information**

**Summary of information**

**Identification and analysis of trends and patterns in data**

**Development of argument**

**Development of evidence-based conclusions**

**Presentation of findings in appropriate format to suit audience**