Health Studies Year 12

Characteristics and needs of specific populations

*A specific population is a group of people that share similar characteristics and needs*

**Characteristics** are features or qualities that cause groups to be characterised.

Eg. Education, gender, height/weight.

**Needs** are things that the population needs in terms of prevention, health care and support.

Eg. Education, health care, access.
Access and Equity Issues of Specific Populations

**Access and equity** – Everyone should be able to access all services if they are in need, and there should be equitable opportunities and standards of living for all.

To achieve equity, resources need to be allocated unequally, since some people need more than others.

Factors That Create Health Inequities (GUAARDDOGGSSH)

- **G**eographic location

- **U**nemployment

- **A**ccess to health care

- **A**ccess to and level of education

- **R**acism

- **D**iscrimination

- **D**islocation of land

- **O**ccupation

- **G**overnment policy

- **G**ender

- **S**ocial isolation

- **S**ocioeconomic status

- **H**ealth literacy

Qualitative and Quantitative Measures for Detecting Health Inequities and/or Injustices
- Epidemiological data

- Social determinants of health

Impact of Determinants on Health Inequities

**SOCIAL:** (FUSSWASTESC)

- Food
- Unemployment

- Social gradient

- Social exclusion

- Work

- Addiction

- Stress

- Transport

- Early life

- Social support

- Culture

**SOCIOECONOMIC:** (FAHEEMIF)
- Family

- Access to services

- Housing/neighbourhood

- Education

- Employment

- Migration/refugee status

- Income

- Food security

**ENVIRONMENTAL**
- Features of the natural and built environment

- Geographical location

**BIOMEDICAL**
- Birthweight

- Bodyweight

Global and Local Barriers to Addressing Social Determinants of Health (PDFDA)

**Poverty:**The state of being extremely poor. People’s basic needs for food, clothing and shelter are not being met. It is a deprivation of basic human needs which depends not only on income but also on access to services. The poverty line in the world’s poorest countries is approximately $2 a day.

*How does poverty impact the social determinants/prevent them from being addressed?*- Food, unemployment, stress, etc.

**Disease outbreak:**The occurrence of cases of disease in excess of what would normally be expected in a particular community. An epidemic occurs when an infectious disease spreads rapidly to many people.

*How does disease outbreak impact the social determinants/prevent them from being addressed?*

- Unemployment, stress, social gradient etc.

**Famine:**A famine is a widespread scarcity of food caused by several factors including crop failure and population imbalance.

*How does famine impact the social determinants/prevent them from being addressed?*

- Food, unemployment, stress, early life etc.

**Drought:**A drought is a period of below average precipitation in a given region, resulting in prolonged shortages of water supply.

*How does drought impact the social determinants/prevent them from being addressed?*

- Food, unemployment, early life, stress etc.

**Availability of clean drinking water:**

Approximately half of the developing world lack clean drinking water and have no access to any type of improved drinking source of water. This leads to the spread of diseases in a population.

*How does availability of clean drinking water impact the social determinants/prevent them from being addressed?*

- Unemployment, early life, stress etc.

Socio-ecological Model

*The socio-ecological model is a conceptual model that outlines how the health status and behaviour of an individual is influenced by their personal attitudes and actions, personal relationships, and community and society factors.*

**Individual:** Refers to the personal choices of an individual; including their attitudes, values, beliefs, skills, abilities and decision making. The individual level acknowledges the impact of different personal factors on health.

**Interpersonal:** Explores how close social relationships (partners, friends, family) can impact health behaviours.

**Organisational:** This level aims to explain how an individual lives, works and learns within organisations. Rules, policies and expectations of these organisations will have an impact on the health of the individual; as well as the interactions that occur within the organisations.

**Community:** Examines the community norms that cross organisations within a community. Individuals within a community have their own cultural or social norms which get brought into the community and can affect health behaviours.

**Societal:** Focuses on the larger societal factors that influence health behaviour. Includes bigger policies or issues than can affect health behaviour.

Social Justice Principles in Health

*The rights of all people in our world should be considered in a fair and equitable manner.*

Social justice is about promoting a more socially inclusive society for all people. It targets the marginalised and disadvantaged groups of people in the world .
**Access and Equity** – Access refers to greater equality of access to services and equity means that groups with different socioeconomic status should not experience health inequities. Everyone should be entitled to the same opportunities, in regards to their health especially.

*5 As of access*

*-* ***A****ffordability – Costs of the program are within reach of everyone?*

*-* ***A****ccessibility – Can services be reached and used? Transport options?*

*-* ***A****cceptability – Do the services reflect family, community and cultural values?*

*-* ***A****vailability – Are services there when they are needed?*

*-* ***A****doptability – Can services be modified to meet needs?*

Equity refers to the provision of services based on need. Those with a higher need should be given more support.

**Diversity** – Refers to the differences that exist between individuals and groups. Health programs and services should recognise the diversity that exists between people of different cultural backgrounds, religions, genders, ages and geographical locations.

**Supportive environments** – Equity must be a basic priority in creating supportive environments for health. Public action for supportive environments must recognise the interdependence of all living beings and manage all natural resources.

Purpose and Characteristics of the Five Levels of Need Within Maslow’s Hierarchy of Needs

**Acronym:** SPF, EARRS, BLARWooF, SPOLLSS, PASSFWDS

**Purpose:** The purpose of Maslow’s hierarchy of needs is to gain an understanding of what motivates people. When one person achieves one level of needs, they become motivated to achieve the next. There are 5 needs levels; physiological, safety, belongingness and love, esteem and self actualization. In order to move up to the next level of needs, the previous level must be achieved.

**Biological and physiological needs:** This level involves the most basic of Maslow’s needs. The needs that are required to sustain life.
**A**ir, **S**helter, **S**leep, **F**ood, **W**armth, **D**rink, **S**ex

**Safety needs:** Safety and security needs must be met in order to be free from the threat of physical and emotional harm.
**P**rotection, **O**rder, **L**aw, **L**imits, **S**ecurity, **S**tability

**Belongingness and Love needs:** Needs related to interaction with others. **A**ffection, **R**elationships, **W**ork, **F**amily

**Esteem needs:** Involves the urge to attain a degree of importance. Can be internal or external motivators.

**A**chievement, **R**eputation, **R**esponsibility, **S**tatus

**Self-actualisation:**

**P**ersonal growth and **F**ulfilment

## 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 is a public health decision making model to guide decision making and is the first step in any health promotion initiative/advocacy campaign.

**Identification of the problem:** Involves clearly identifying the target group, problem, determining its significance (epidemiology). Includes how it affects the community, the factors which contribute to it and community perception of it.

**Amenability to change:** *Is it likely that the problem can be changed?*This step involves investigating other communities where similar problems have occurred, and solutions found, then addressing whether or not the solution to the problem was successful and therefore if there is a possibility for change.
**Benefits and costs of implementing interventions**

BENEFITS:*What would be the benefits to the community of successfully addressing the problem?*Benefits could include improvements to the environment, healthier behaviour, community empowerment or positive impacts to health status. These may result in things such as increased life expectancy, reduced incidence and prevalence of disease and reductions in mortality.

COSTS:*Will the benefits outweigh the costs of any intervention?*

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

**Acceptability of proposed measures:** *Assessment of the acceptability of intervening to the target group, community, politicians, industry.* There may be opposition from particular groups to implement any proposed interventions. Close contact with the community is essential at this time, as it provides a mechanism for them to contribute their responses to any proposed interventions.

**Recommended actions and monitoring:** *What actions are recommended as part of a comprehensive intervention?*

If there is a significant level of acceptance, 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 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 monitor guidelines.

## Role and Functions of the World Health Organisation

*The World Health Organisation (WHO) is a specialized agency of the United Nations that is concerned with international public health*.

Their primary role is to direct and coordinate international health within the UN’s system. The role of the World Health Organisation is to promote health for all, eliminate poverty, ensure essential medicines are accessible and coordinate specific disease programs.

WHO’s main objective is the attainment by all people of the highest possible level of health.

WHO’s **core functions** include: PASSMP

- **P**roviding leadership on global health matters

- **A**rticulating evidence-based policy options

- **S**haping the health research agenda

- **S**etting norms and standards

- **M**onitoring and assessing health trends

- **P**roviding technical support to countries

Purpose and Functions of Australia’s Aid Program

*The Australian Government’s aid program promotes prosperity, reduces poverty and enhances stability with a focus on our region, the Indo-pacific, and our closest neighbours.* *(Papua New Guinea and Indonesia)*

The purpose of the aid program is to promote Australia’s national interests by contributing to sustainable economic growth and poverty reduction. The Australian aid program pursues this purpose by focusing on two **development outcomes**:

**Supporting private sector development** and **strengthening human development**

The **priority areas** of Australia’s aid program are: IAGERG

- Infrastructure, trade facilitation and international competitiveness

- Agriculture, fisheries and water

- Effective governance: policies, institutions and functioning economies

- Education and health

- Building resilience: humanitarian assistance, disaster risk reduction and social protection

- Gender equality and empowering women and girls

The United Nations

The United Nations (UN) is an international organisation. It was established in October 1945 to help prevent conflict between a total of 193 nations.

The purpose of the United Nations is to bring all nations of the world together to work for peace and development, based on the principles of justice, human dignity and the wellbeing of all people. The organisation aims to help nations work together to improve the lives of poor people, to overcome world hunger, disease and illiteracy, and to encourage respect for each other’s rights and freedoms. On September 25th 2015, the UN developed a set of goals with specific targets to be achieved over the next 15 years.

Purpose of, and Progress Toward, the Five Sustainable Development Goals (SDGs)

*The sustainable development goals were developed to help improve the lives of people around the world. The goals aim to end poverty, promote prosperity and well-being for all, protect the environment and address climate change.*

**Goal 2 – Zero Hunger.** The goal is **to end hunger, achieve food security and improved nutrition and promote sustainable agriculture.**

TARGETS:
- By 2030, end hunger and ensure access by all people to safe, nutritious and sufficient food all year round. INDICATOR: Prevalence of undernourishment.

 - By 2030, end all forms of malnutrition. INDICATOR: Prevalence of malnutrition among children under 5 years of age, by type.

- By 2030, double agricultural productivity. INDICATOR: Proportion of agricultural area under productive and sustainable agriculture.

PROGRESS: Prevalence of hunger decreased from 15% to 11%

**Goal 3 – Good health and wellbeing.** The goal is **to ensure healthy lives and promote wellbeing for all at all ages.**

TARGETS:
- By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births. INDICATOR: Maternal mortality ratio.

- By 2030, end preventable deaths of newborns and children under 5 years of age. INDICATOR: Under five mortality rate.

- By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases. INDICATOR: tuberculosis incidence per 1000 population.

PROGRESS: Maternal mortality has declined by 37%

**Goal 4 – Quality education.** The goal is **to ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.**

TARGETS:

- By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education. INDICATOR: Proportion of children and young people achieving education

- By 2030, ensure that all girls and boys have access to quality early childhood development so that they are ready for primary education. INDICATOR: Participation rate in organised learning.

- By 2030, ensure equal access for all women and men to affordable and quality technical, vocational and tertiary education, including university. INDICATOR: Participation rate of youth and adults in formal and non formal education

PROGRESS: Completion rates for primary and secondary schooling have steadily increased

**Goal 5 – Gender equality.** The goal is **to achieve gender equality and empower all women and girls.**

TARGETS:

- By 2030, end all forms of discrimination against all women and girls everywhere. INDICATOR: If legal frameworks are in place to promote equality and non discrimination.

- By 2030, eliminate all forms of violence against all women and girls. INDICATOR: Proportion of women and girls aged 15 years and older subjected to sexual violence

- By 2030, adopt and strengthen for the promotion of gender equality and the empowerment of women

**Goal 6 – Clean water and sanitation.** The goal is **to ensure availability and sustainable management of water and sanitation for all.**

TARGETS:

- By 2030, achieve universal and equitable access to safe and affordable drinking water for all. INDICATOR: proportion of population using safely managed drinking water services.

- By 2030, achieve access to adequate and equitable sanitation and hygiene for all. INDICATOR: proportion of the population using safely managed sanitation services

- By 2030, improve water quality. INDICATOR: Proportion of wastewater safely treated.

## Definition of Health Promotion Advocacy and When it is Best Used

*A political process by an individual or group which aims to influence decisions and improve health outcomes. Advocacy provides the opportunity to overcome barriers that restrict public health.*

**Benefits:** Produces positive changes to legislation/policies, promotes wellness and resilience, raises awareness and empowers public health professionals

Strategies for Health Promotion Advocacy
**Using champions:** Identifying leaders who will have followers and thus some political sway. Champions are often not afraid to stand up and be heard. The champion chosen should have the desired influence, credibility or commitment and knowledge of the issue.

**Mobilising groups:** People uniting to make a difference. Organising and encouraging people to act in a certain way.

**Influencing policy:** Health promoters influencing policy makers and encouraging them to create policies and laws that are healthy.

**Lobbying:** The act of attempting to influence decisions in a government. Giving views and information to influential parties to sway them towards change.

**Framing issues:** How an issue is presented so it gains traction politically and in the media. Using techniques to achieve a desired response – to make people act.

**Raising awareness:** Refers to increasing people’s knowledge or perception of a situation/issue.

**Developing partnerships:** Making contact with companies, agencies and organisations that already exist and share similar views on the cause/support the advocacy goals.

**Creating debate:** Formal discussion on a particular topic. Debates raise awareness and educate and can lead to change.

**Building capacity:** The development of sustainable skills to improve health.

Types of Needs

*It is important to consider different types of needs when determining priority health problems.*

There are four types of needs:

**Felt needs:** What communities say or feel that they need. They are perceived by an individual and are therefore personal.
Methods of assessing felt needs: Household opinion surveys, phone ins, meetings or conservations.

**Expressed needs:** Refer to what a community demands. For example, communities demanding or acting to achieve something. Eg. long waiting lists or high demand for a new service.

**Comparative needs:** Comparing different services with the same services in different populations in order to determine the service/level of service required in other areas with similar populations.

**Normative needs:** Based on research that defines people within the population. For example, data showing an issue will therefore indicate a normative need.

Purpose of a Needs Assessment

*A needs assessment is the first step in planning any health promotion initiative. It is a systematic approach for reviewing the health issues facing a community. It is the process of identifying and analyzing the priority health problem and nature of the target group.*

A needs assessment allows health promoters to determine resource allocation in order to improve health and reduce inequalities.

Steps of a Needs Assessment

**Step 1 – Identifying health issues**

- What specific population?

- How is it different from others?

- Who are we going to include?

- What resources are needed?

- What are the risks?

**Step 2 – Analysis of the problem**

- Describe the characteristics and needs of the population

- Compile quantitative and qualitative health status data

- Identify and assess risks and protective factors

**Step 3 – Prioritising issues**

- Prioritise the health conditions, issues and risk factors in order of impact

- Using interventions, strategies or actions to achieve this

**Step 4 – Setting goals**

- Using the acronym SMART when setting goals (Specific, Measurable, Attainable, Realistic, Time bound)

**Step 5 – Determining strategies**

- Using a decision making model such as PABCAR to decide on a course of action

- Research strategies used in previous work and decide if they could be applied

- Ask community members what they think will work and then determine strategies

**Step 6 – Developing action plans**

- What needs to be done in order to apply your strategies?

- Write a list of step by step actions

- Develop a plan and a timetable of what must be done and who can do it

**Step 7 – Evaluate outcomes**

- Goals achieved?

- Measure data/compare previous data

- Determine how well/how much was achieved

- What can be learnt or done better next time?

Enabling, Mediating and Advocating Strategies in the OTTAWA Charter to Reduce Health Inequities

**Enabling** involves forming partnerships with individuals or groups to empower them. It aims to reduce differences in health status and ensure equal opportunities and equitable distribution of resources.
Eg**.** Education, programs and groups, improving access

**Mediating** is to act between parties in order to come to an agreement and work past existing differences.
Eg**.** Meetings, setting goals, timelines for actions, establishing leaders

**Advocating** is to speak on behalf of another person, or to plead/argue for a cause or in favour of something. Usually involves reducing inequity through advocacy on behalf of those who are underprivileged.
Eg**.** Writing to government, funding, media campaigns, influencing policies

Actions to address health inequities

**Improving access to health care:** More health care provided, longer opening hours, accessibility, affordability, culturally appropriate, diversity

**Improving health literacy:** Education (schools, adults), printed info, lower level of health literacy required in information, media

**OTTAWA Charter action areas**

Actions to Achieve Social and Health Equity in the Rio Declaration on Social Determinants of Health

APRSM

**- To adopt better governance for health and development.**

**- To promote participation in policy making and implementation.**

**- To further reorient the health sector towards reducing health inequities.**

**- To strengthen global governance and collaboration.**

**- To monitor progress and increase accountability.**

Health Care Reform

*Improving access to health care*
Improved access to healthcare is a key action to address health inequity. Healthcare reform is one means of achieving a fairer healthcare system for all through the provision of subsidized products and services

**Pharmaceutical Benefit Scheme (PBS)**Today, the PBs provides timely, reliable and affordable access to necessary medicines for Australians.
WHO IS ELEDGIBLE:
- All Australian residents who hold a current Medicare card

- Overseas visitors from countries with which Australia has a Reciprocal Health Care Agreement (RHCA)

SAFETY NET
After reaching the Safety Net threshold, general patients pay for further PBS prescriptions at the concessional co-payment rate and concession card holders are dispensed PBS prescriptions at no further charge for the remainder of that calendar year

**Private Health Insurance Rebate**Most Australians with private health insurance currently receive a rebate from the government to help cover the cost of their premiums. The private health insurance rebate is income tested; there are different rebate amounts and Medicare Levy Surcharge levels. The rebate applies to hospital, general treatment and ambulance policies.

- The Australian government provides the Private Health Insurance Rebate to encourage people to take out and maintain private health insurance. Most people are eligible for a rebate on their insurance costs

- If someone is not covered by a private hospital 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**

A test that is offered to all individuals in a target group, usually defined by age, as part of an organised program. The tests look for changes or early signs of a disease, before any symptoms have developed. There are 3 national population based screening programs in Australia:

BREASTSCREEN AUSTRALIA- 50-74, free mammogram every 2 years

NATIONAL BOWEL CANCER SCREENING PROGRAM- 50-74, free, simple at home test

NATIONAL CERVICAL SCREENING PROGRAM

- 18-69 who have been sexually active (Pap tests)

**Vaccination program**

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 (NIP) Schedule, which currently includes vaccines against a total of 16 diseases. These include routine childhood vaccinations against diseases that were once widely fatal, such as:
- Measles

- Diphtheria

- Whooping cough
As well as more recently developed vaccines such as:
- Human Papillomavirus (HPV)

- Meningococcal C

Relationship Between Health Literacy and Health Status

Limited levels of health literacy are associated with poorer health. High levels of health literacy usually mean a higher health status, since the person is able to access, read, comprehend information and engage in self care and disease management and navigate health systems. They will therefore be more likely to take action to improve their health.

## Comparison of Health Indicators Between Australia and Developing Countries

**Life expectancy:** The length of time a person is expected to live in a population at a certain time, taking into account other health factors

**Mortality:** The rate of death in a population at a certain time

**Morbidity:** The rate of disease in a population at a certain time

National Health Priority Areas (NHPAs)

*National health priority areas are diseases and conditions that Australian governments have chosen for focused attention because they contribute significantly to the burden of disease in the Australian community.*

**What are they and when were they added?**

Cancer control (1996) 2010: 3110 deaths in Aus. 2010-11: 880 432 cancer hospitalisations. Growing rates of new cases

Cardiovascular health (1996) 2007-8: 1/6 Australians diagnosed. 1/3 deaths as a result in 2009.

Injury prevention and control (1996) Contributes to burden of disease, (6.5% in 2010). 400 000 p.a. severe injuries. Older = high risk

Mental health (1996) Growing problem

Diabetes Mellitus (1997) 4% of Australians diagnosed. Rates have risen. Indigenous = higher changes

Asthma (1999) Causes poor quality of life. Most common condition for under 14. Contributes to burden of disease

Arthritis and musculoskeletal conditions (2002) 28% of Aus have it. 14% affected by back problems.

Obesity (2008) Rates continuing to rise in Aus. 3/4 adults are obese. 5% more since 1995. ¼ children obese. Major risk factor

Dementia (2012) Not natural. Becoming more prevalent. 2013: 322 000 diagnosed. 1/10 over 65. 3/10 over 85

## \* MHGTBP: (My House Got Towed By Pigs)

- Mistrust in the healthcare system

- Hierarchy

- Gender

- Traditional medicines

- BVAs

- Prior experiences

## \*Influence of Cultural Traditions and Habits on the Formation of BVAs Towards Healthcare

TRADITION**:** is a belief or behaviour passed down within a group or society with symbolic meaning or special significance with origins in the past.

HABIT: is a settled or regular tendency or practice, especially one that is hard to give up.
Culture influences the formation of BVAs
EXTERNALLY: Being influenced by experts and people in authority

INTERNALLY: Come from experience and reflection

**Examples:**- Negative experiences in the past will influence BVAs towards certain types of healthcare

- some cultures have a hierarchy system where males or elders make decisions which will influence the BVAs

 of younger people

Influence of Environmental Factors on the Health Behaviour of Cultural Groups

*Positive or negative impacts*

**Geographical location:** Impacts norms/the health of people who live there. Eg. Urban sprawl, facilities available, food/exercise options available, availability of transport

**Social networks:** Positive and negative norms can be promoted within social networks because they allow people to communicate useful information, health messages are widely distributed, social support and inclusion

Influence of Government Policies and Regulations on Beliefs, Values and Attitudes

**Beliefs:** are an underlying conviction about an issue or concept

**Values:** are something we believe to be worthwhile. They provide a moral basis

**Attitudes:** Feelings and inclinations towards things. Can be positive negative or neutral.

Government policies, legislations and regulations can have an impact no the formation of personal beliefs and attitudes towards health behaviours. Beliefs and attitudes are subject to change regularly as evidence is presented that refutes previously held beliefs.

Governments seek to regulate or influence the behaviour of individuals and organisations through a range of policy tools, including legislation, regulations, taxes and subsidies, Eg. smoking policies

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 enable people to make positive, healthier choices (promoting) OR control their choices, taking away freedom and responsibility

Conflict Between Norms of Specific Groups and Majority Norms
**Majority norms:** Unwritten rules or standards that are followed by more than half (majority) of a population. For example in AUS: beach, BBQs, alcohol

**Specific group norms:** Norms that are followed by/are unique to people who belong to specific groups (cultural), for example, cultural dresses, marriage practices, food, church

Relationship Between Health Behaviours and Proscriptive, Prescriptive and Popular Norms

**Proscriptive norms:** Norms that prohibit people from doing something. They are behaviours that people should **not** perform and are discouraged. Society frowns upon these behaviors and they direct people to avoid or abstain from certain actions. Can be considered formal. **Eg.** Smoking, drink driving

**Prescriptive norms:** Norms that prescribe behaviour and make you do something (what you should do). They are actions that people should take; society favours these behaviours and they are expected. They can be considered informal. **Eg.** Have a designated driver.

**Popular norms:** Standards of behaviour that are typically expected and will differ between cultures and also change over time. Norms made by people who are considered popular or hold power.

Self Management 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. This skill is essential to good health.
- Not being assertive can lead to feelings of stress, anxiety or resentment

**-** Assertion is empowering (right to refuse, request or correct)
- Taking control, confidence, positivity
- Articulating thinking, decisions, emotions and arguments

**Stress management:** Skills seek to identify and manage stressors and apply techniques/strategies to cope with stressful situations. Eg. exercise, talk, goal setting, relaxation

**-** Stress management includes avoiding unnecessary stress, changing the situation or avoiding/accepting stressors

**-** Devising and using healthy ways to cope with stress (focusing on the positive)

**Resilience:** The ability to bounce back. It is a protective skill and can be used to combat stress. A resilient person can face hardship/difficulty

**-** Suffer less from stress, communicate well, have higher self worth/belief, solve problems, achieve personal goals etc.

**-** Resilient people are aware, understand that setbacks are a part of life, are able to ask for help, have an internal locus of control, have strong problem solving skills, strong social connections and identify as survivors rather than victims

\*Impact of Culture on Health Decision Making

**Organ and tissue donation**- Some cultures have specific religious beliefs around death and care of the body after death, Eg. a belief that the body must remain whole or that accepting organs from another will ‘change’ the recipient in a meaningful way.

**-** Some cultures may not believe that the person is dead because for some cultures, the criterion for determining death will not match a Western health professional’s view.

**-** Some cultures see the patient as a spirit personified and removal of any body parts can be seen as a loss of part/all of their soul.

**Childbirth**

- Choice of birth method

- Mother’s pain tolerance regarding medication administrated by a doctor, use of herbal remedy, massage, relaxation, breathing exercises, all to help alleviate pain

- Who is present at the birth in different cultures: nurses, midwives, mother, mother in law, father/husband. Eg. Muslim: father is prohibited from being present – only females are allowed

- How mother reacts to the pain: whether the mum can cry out or not, as some cultures prohibit excessive noise during labour

- Prior experiences with births – whether the mother has given birth before

- Setting for birth: woman’s home or home of relative, regarded the safest birth environment or some cultures view hospital as most appropriate

**Blood transfusion**

- Some cultures believe blood is sacred and contains the soul/spirit of the body therefore by a patient having a blood transfusion, they are essentially receiving someone else’s soul or life force.

- If a person or group within a culture have a bad experience with a transfusion, this experience is likely to be passed down among the same culture and have a negative association with the procedure

- In come cultures, health decision making has to be approved by an elder, or by someone higher up in the hierarchal chain.

- Language barriers can impact on the information being understood (it requires a higher level of health literacy to understand blood transfusion procedures. Lack of knowledge can lead to uninformed decisions

- Culture groups believe that there are no safe laws against where the blood goes or where it comes from

- Procedure is uncommon in some culture groups

- Don’t have access to safe and high quality blood transfusion

Impact of World Events on Personal, Social and Cultural Identity of Populations

**Identity:** Individual characteristics by which a person is recognised or known.

**Personal identity:** Distinct characteristics of an individual regarded as a separate entity – you can lose personal identity when you conform to a group. This may include aspects of your life that you have no control over, such as where you grew up or the colour of your skin, as well as choices you make in life

**Social identity:** The identification of individuals as members of a group. It is a person’s sense of who they are based on their group, and the characteristics they have because they belong to that group

**Cultural identity:** Belonging= to a particular ethnic or cultural group. Aspects of the individual that are held due to their culture and background

*World events impact the development of personal, social and cultural identity of individuals. These events include:*- Displacement from traditional homelands

*-* War

- Violence

- Conflict

- National pride

- Natural disasters

\*Language and Cultural Influences on Relationship Building in Health Settings

Health settings require trusting relationships. It is the responsibility of the health sector to endure effective relationships are built
Relationships can be built if health settings take into account:
- Language barriers

- Background

- Religion

- BVAs

And…

- Allow open communication from both sides

- Incorporate translators

- Include families

- Research into religious rules

Communication and Collaboration Skills in Health Settings

COLLABORATION
**Negotiation:** The process of achieving agreement through discussion, used to resolve disputes. Negotiators bargain for individual or collective advantage.

**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.

**Arbitration:** A dispute resolution procedure where an expert person makes a decision to resolve the dispute.

COMMUNICATION

**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.

**Managing conflict:** Conflict can be dealt with in several basic ways. They are avoidance, accommodation, compromise, competition or collaboration.

**Facilitation:** The act of assisting the progress or improvement of something.

**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.

Health Inquiry

**Planning a health inquiry**

Identification and analysis of a health issue
Development of focus questions to research a health issue

**Use of 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 an appropriate format to suit audience**