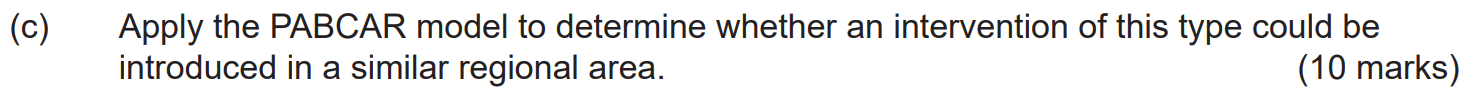
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1. Identification of the problem:

The problem is that socioeconomically disadvantaged groups are suffering from poor health due to alcoholism and gambling. The community is subject to problems associated with alcoholism e.g., violence and foetal alcohol syndrome.

2. Amenability to change:

Research could be undertaken to determine the outcomes of interventions in other communities where the welfare card has been introduced. Data such as hospital admissions and school attendance could also be collected and examined.

3. Benefits and costs of implementing interventions:

A cost-benefit analysis could be undertaken to determine the potential advantages and disadvantages related to the implementation. If the benefits outweigh the costs, then the intervention should be considered.

4. Acceptability of proposed measures:

Consider community attitudes and framing arguments to gain the most support for the intervention. This aims to consider opposition to the intervention and mobilise support. If support isn’t significant then advocacy strategies may be required.

5. Recommended actions and monitoring:

Consider recommended actions for successful implementation of the welfare card and develop strategies to monitor such actions.

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Education:

Access to education improves health literacy and an individual’s ability to locate and access required and appropriate healthcare services. Those who are less educated are disadvantaged as they don’t have the same access to healthcare as those who are educated, and are less able to make informed choices regarding health, contributing to health inequities.

Employment:

Some jobs may lead to increased risk of certain health conditions, and certain areas of employment may cause increased stress and psychological issues, contributing to health inequities. Living in a rural and remote area may limit opportunities to find or remain in employment.

Income:

Income impacts on the health services that an individual can afford and access. Less income restricts healthcare options and this can contribute to health inequities.

Family:

Individuals may be more susceptible to certain health conditions due to hereditary links. Also, a family’s beliefs, values and attitudes regarding healthcare can impact an individual’s health behaviour. This can contribute to health inequities.

Housing/neighbourhood:

Individuals who don’t have access to adequate housing are more susceptible to poor health, contributing to health inequities. Neighbourhood can impact health inequities as an individual’s health can be influenced by the availability of healthcare services.

Migration/refugee status:

There may be barriers (e.g., language, cultural beliefs, values, etc) that impact on migrant/refugee groups’ ability to access necessary healthcare, contributing to health inequities. Also, these groups may not be aware that certain healthcare services are available and hence they’re unlikely to access them.

Food security:

Lack of access to sufficient nutritious foods can have many implications on health. Development of a range of diet-related health conditions has a large impact on health and can result in health inequities.

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Education:

Rueben will likely have difficulties accessing education whilst he’s homeless. Schools and other education institutions often require permanent accommodation and access to a phone/email. Also, many courses cost money. Not having skills or necessary education is also a barrier to finding employment.

Employment:

Rueben will likely have difficulty finding employment. He doesn’t have a fixed address, nor does it seem he has the resources to dress appropriately, access public transport, have a bank account, etc, all of which are necessary for working.

Income:

A low income places him at risk of poor health as he’s unable to afford goods and services that support good health.

Family:

Having no family networks, Rueben doesn’t have any social or economic support, which is critical to good health. This may impact his mental health and wellbeing. Social connections are a protective factor for resilience and good health.

Housing/neighbourhood:

Rueben is unlikely to have access to safe and secure housing, putting him at risk of poor health. Sleeping rough can be dangerous and crime may be an issue in unsafe areas.

Access to services:

Rueben may not have access to essential healthcare services that are necessary for good health. He’s unlikely to access preventive services e.g., immunisations, increasing his risk of illness and disease.

Food security:

Rueben’s access to fresh, healthy food is likely to be limited. A nutritious and plentiful food supply is necessary for good health. Poor diet is a risk factor for chronic illness and disease. His immune system may be compromised, putting him at risk of infection.

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Goal 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture.

* Globally, millions of children are undernourished.
* Rates of hunger are expected to rise in the future.
* The agriculture sector provides key solutions for development and are critical to progress to eradicate/reduce hunger.

Goal 3: Ensure healthy lives and promote wellbeing for all at all ages.

* The infant mortality rate is unacceptably high, particularly in developing nations.
* Children born into poverty are more likely to die or suffer from poor health than children from wealthier families.
* Children of educated mothers are more likely to survive than children of uneducated mothers.
* Vaccinations are essential but aren’t routine for many of the world’s children.

Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.

* Many children in developing nations don’t have access to basic schooling and remain uneducated.
* Many children lack basic literacy skills.
* There’s a large difference in health status between those who are educated and those who are uneducated.

Goal 5: Achieve gender equality and empower all women and girls.

* Gender inequality stagnates the progress and economic growth of the nation.
* Gender inequality means some girls don’t receive adequate healthcare or education.
* Gender inequality means girls don’t participate fully in the workplace due to limited opportunities in the labour market and this inhibits economic growth.
* Women are subject to physical and/or sexual violence.

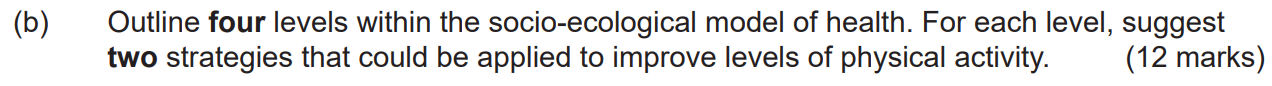
Goal 6: Ensure availability and sustainable management of water and sanitation for all.

* Dirty, contaminated water remains the leading cause for the death of children under the age of 5.
* Poor water quality is linked to infectious diseases due to poor hygiene.
* Managing water sustainably means better management of food production (and improved food security) and a positive impact on biodiversity.

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It’s a conceptual model that outlines how the health status of an individual is not only influenced by their attitudes and behaviour but also by their relationships, community and society.



Individual: At this level, an individual’s characteristics, traits and identity influence their health behaviour. This level includes personal factors/choices that affect physical activity levels e.g., attitudes, knowledge, motivation, perceived barriers, motivation, etc.

Strategy: Education

Interpersonal: This level relates to the impact of interpersonal relationships and norms on health behaviour and how they influence physical activity participation.

Strategy: Parent education.

Organisational: This level relates to the impact of organisations/institutions on health behaviour and how policies and practices influence physical activity levels.

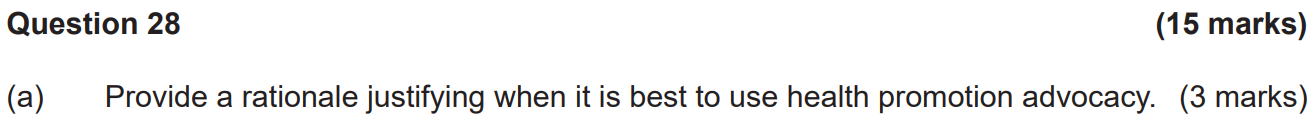
Strategy: Workplace programs.

Community: This level relates to the broader community context within which people reside and how communities influence physical activity participation.

Strategy: Community education.

Societal: This level relates to the broader social and political environment that creates a climate in which physical activity is seen to be valuable and is encouraged through policy that supports access and equity for all.

Strategy: Subsidies for disadvantaged groups.



When there’s a need to:

* Raise awareness about a particular issue.
* Increase the health status and quality of life of a population.
* Influence or change policy/target policy makers to enact change.
* Challenge norms, stereotypes and stigmas.

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Building capacity: The development and strengthening of human and institutional resources.

Example: Educate students about healthy eating and exercise so that they’re better equipped to make healthy choices when ordering from the canteen.

Using champions: Utilising high profile/influential personalities and celebrities to promote awareness of a particular issue and to promote change.

Example: Use high profile personalities who value healthy eating and the associated benefits to be guest speakers at school assemblies.

Framing issues: Presenting an issue in a particular way that’s likely to generate agreement/support from others.

Example: Approaching the school board with statistics and data on how unhealthy eating and physical inactivity are contributing to poor health in young people.

Lobbying: Attempting to influence decisions made by politicians, legislators, business or regulatory agencies to create or change legislation.

Example: Meet with the school board to speak about improving nutrition and/or physical activity opportunities in the school.

~~Influencing policy~~: Acting with the aim of generating policy change.

Example: Join a committee for influencing policy change regarding food in the canteen and physical activity guidelines.

~~Mobilising groups~~: Getting a group or community involved and gaining their support to increase the ability to influence decision-making.

Example: Use social media to gain support from more people e.g., Facebook, Twitter, etc.

Raising awareness: Increasing/improving people’s knowledge and understanding of an issue or situation.

Example: Displaying posters that inform people of the effects of inadequate levels of nutrition and physical activity.

Creating debate: Generating a formal discussion between 2 parties with differing viewpoints on a particular issue.

Example: Organise a meeting between representatives from the student group wanting change and representatives from the canteen.

Developing partnerships: Building relationships between different organisations or groups/stakeholders working collaboratively towards achieving goals or outcomes.

Example: School canteen managers can develop relationships with new food suppliers to change canteen menu items.

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Stress: PLWD may experience harmful levels of stress. This could be made worse by discrimination which can have negative impacts on health by increasing stress and anxiety, increasing risk of mental health problems.

Social exclusion: Living with a disability may limit opportunities to engage in community activities. Furthermore, it may result in discrimination and contribute to social exclusion. Social connections are a protective factor for good health.

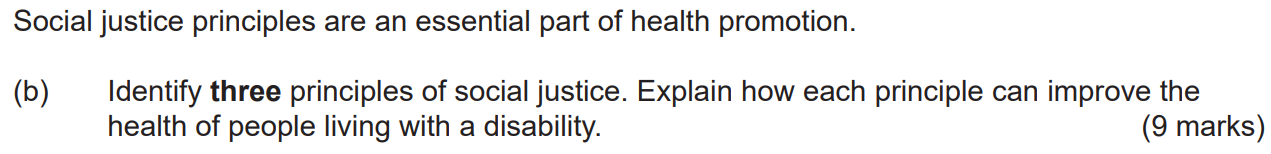
Work: Living with a disability may impact a person’s ability to work or to work in an occupation of choice. Without satisfying, meaningful work opportunities, a person’s mental health and economic security may be affected.

Unemployment: Living with a disability may cause difficulties in finding employment, contributing to unemployment. This affects their economic security and ability to afford goods and services that support good health. Also, unemployment may limit opportunities for social interaction.

Social support: Living with a disability may limit opportunities for social interaction which has a protective effect on health. Without sufficient social support, individuals may be more prone to depression and poorer health outcomes.

Transport: PLWD may not have access to independent transport which can impact their ability to be involved in community activities. They may be unable to cycle, walk or use active transport, all of which are recommended means of ensuring sufficient levels of physical activity are achieved. Public transport options for PLWD may not adequately meet their needs, and it may limit their ability to access healthcare.

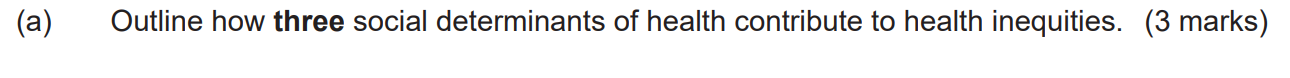
Social gradient: PLWD may be subject to adverse social and economic circumstances, putting them lower on the social gradient and increasing risk of poorer health and/or reduced life expectancy.



Access and equity: Ensuring resources are allocated based on the needs of individuals and people groups with he overarching goal of equal health outcomes.

Diversity: Respecting and accounting for the differences between individuals and populations e.g., race, ethnicity, gender, socioeconomic status, etc.

Supportive environments: Environments where people live, work and play that protect people from threats to health and increase people’s ability to make health-promoting choices.



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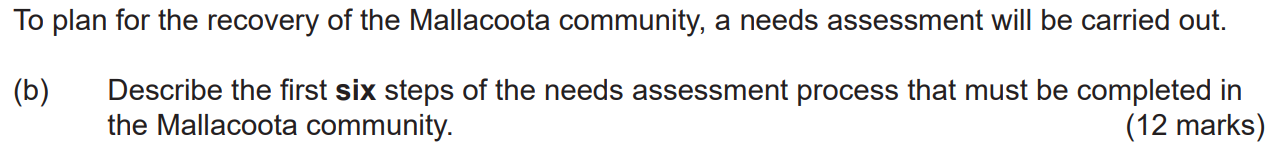
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