**2016 WACE Exam**

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**Migration/refugee status:**

* **There may be barriers (e.g., language, cultural beliefs, etc) that impact on the individual’s ability to access necessary healthcare. If these needs aren’t met then health inequities can develop.**
* **The group may not be aware of the healthcare services present and thus won’t access them.**

**Income**

* **Income affects the health services that an individual can afford and access.**
* **Less income restricts healthcare options, contributing to health inequities due to large waiting lists, etc.**

**Education:**

* **Access to education improves health literacy, helping the individual make informed decisions and locate and access required and appropriate healthcare.**
* **Those who are uneducated are disadvantaged as they are less likely to have adequate access to healthcare, contributing to health inequities.**

**Housing/neighbourhood:**

* **Individuals who don’t have access to adequate housing are more susceptible to poor health, contributing to health inequities.**

**Employment**

* **Certain jobs may pose increased risk of health conditions, contributing to health inequities e.g., labourer may have increased risk of musculoskeletal conditions.**
* **Being employed can have mental health benefits due to increased self-esteem, mental stimulation, etc, reducing health inequities.**
* **Certain jobs may increase stress and psychological issues, contributing to health inequities.**
* **Being in a rural areas may make finding or remaining in employment difficult, increasing stress and contributing to health inequities.**

**Food security:**

* **Lack of access to sufficient nutritional food can have many implications on the individual’s health status.**
* **Developing a range of diet-related health conditions can have a large impact on health, contributing to health inequities.**

**Family:**

* **Individuals may be more susceptible to particular health conditions due to hereditary links.**
* **A family’s beliefs, values and attitudes towards healthcare can impact on an individual’s health behaviour and this can in turn contribute to health inequities.**

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**Social gradient:**

* **PLWD may be subject to averse socioeconomic circumstances, putting them lower on the social gradient and thus at risk of poorer health.**

**Unemployment:**

* **Living with a disability may impact on a person’s ability to find employment, thus contributing to unemployment. This can affect their economic security and ability to afford goods and services that support good health. Being unemployed also restricts opportunities for social interaction.**

**Early life:**

* **PLWD who don’t receive adequate prenatal and early childhood care and access to health services may suffer from health inequities e.g., effects on their cognitive and/or physical development.**

**Work:**

* **Living with a disability may restrict 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.**

**Addiction:**

* **PLWD generally have poorer mental health, and addiction may be the result of inefficient coping mechanisms. Addiction may be exacerbated by the existence of other determinants e.g., social exclusion, unemployment, etc.**

**Stress:**

* **PLWD may experience harmful levels of stress. This can be worsened by discrimination which can negatively impact health, increasing stress and anxiety and risk of mental health problems.**

**~~Food~~**

**Transport:**

* **PLWD may not have access to independent transport which can impact on their ability to be involved in community activities and their levels of physical activity. Public transport for PLWD may not adequately meet their needs and may impact on their ability to access healthcare services.**

**Social exclusion:**

* **Living with a disability can result in limited opportunities to participate/engage in community activities. Furthermore, it may result in discrimination and exclusion from social interactions. Social interactions are an important protective factor for positive mental health.**

**Social support:**

* **Living with a disability may limit social support which has a protective effect on health. Without sufficient social support, individuals may be more prone to depression and lower health outcomes.**

**Culture:**

* **PLWD may have difficulties identifying and accessing relevant healthcare. There may also be language barriers or other cultural traditions and habits that perpetuate health inequities.**

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**Access and equity: Resources are allocated according to the needs of individuals and populations with the overarching goal of equal health outcomes.**

**Access and equity can improve the health of PLWD by:**

* **Specifically allocating resources based on the needs of PLWD.**
* **Ensuring that access is equal regardless of the nature of the disability.**
* **By ensuring that PLWD have the opportunity to be actively involved in planning and decision-making about their health.**

**Diversity: Respecting and accounting for the differences that may exist between individuals and people groups e.g., race, ethnicity, gender and socioeconomic status.**

**Diversity can improve the health of PLWD by:**

* **Ensuring that the differences between the types of disability are accounted for.**
* **Using personalised and meaningful approaches to acknowledge the range of disability.**

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

**Supportive environments can improve the health of PLWD by:**

* **Providing opportunities for healthy choices and behaviour by making community facilities easily accessible (e.g., ramps, railings, etc) to encourage participation in community activities and opportunities for physical activity.**
* **Providing opportunities for PLWD to be involved in healthcare services.**

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**~~Migration/refugee status~~**

**Income:**

* **Being unemployed means Rueben would be living in or near poverty. Low income puts him at risk of poor health due to being unable to afford goods and services necessary for good health, compromising his physical and mental health status.**

**Neighbourhood/housing:**

* **Rueben doesn’t have access to safe or secure housing, increasing risk of poor health. Sleeping rough can be dangerous and crime may be an issue.**

**Education:**

* **It may be difficult for Rueben to access education whilst he’s homeless. Most educational facilities require permanent accommodation and access to a phone/email, and courses often cost money. Low levels of education are also linked with low levels of health literacy, decreasing his health status due to being unable to make informed decisions and access relevant healthcare when required.**

**Employment:**

* **It may be difficult for Rueben to find employment due to having limited resources (no bank account, unable to dress properly, etc) and not having an address, which are all often required to work. Unemployment can lead to poorer health outcomes e.g., mental health problems and stress.**

**Access to services:**

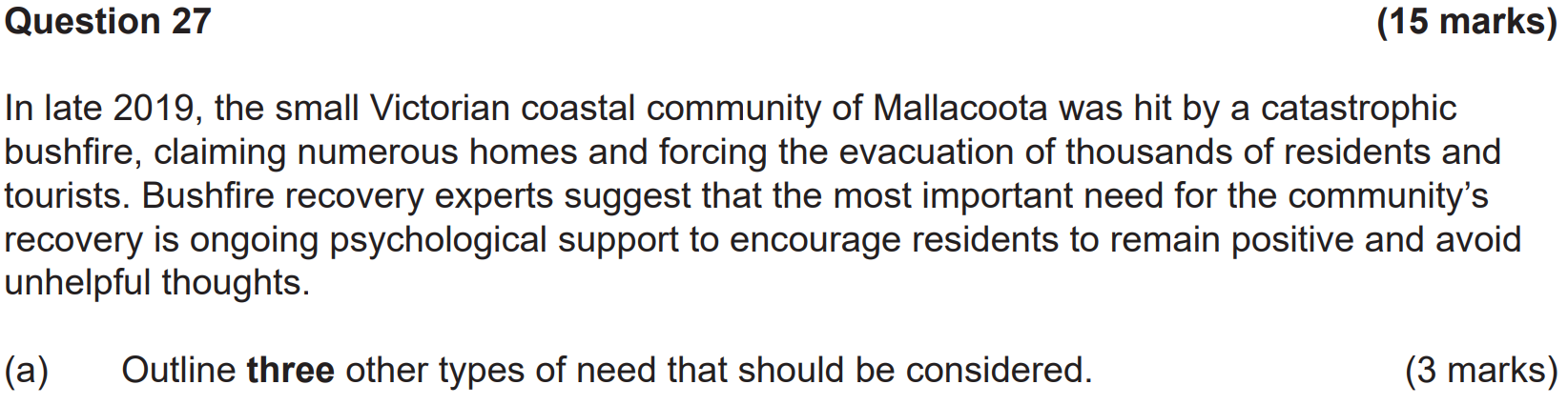
* **Rueben may have limited access to health services that are essential for good health. He would be unlikely to engage in preventive services e.g., immunisations which reduce the likelihood of disease and illness.**

**Food security:**

* **Rueben may have limited access to healthy, fresh food. A nutritious and plentiful food supply is necessary for good health. Poor diet is a risk factor for chronic illness and disease, increasing Rueben’s risk of infection.**

**Family**

* **Having no social support from his family, Rueben doesn’t have any social or economic support from them, which is critical for good health. This may affect his mental wellbeing, as social networks are a protective factor for good health.**

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1. **Identifying health issues:**

**This stage involves collecting information surrounding the key issues facing the community. This stage should explore which members of the community should be involved in the process. The types of need that demand action will be researched. Health issues may be determined by accessing local data and by talking to people.**

1. **Analysing health issues:**

**This stage involves an in-depth analysis of the characteristics of the population, how it differs from other populations and gathering relevant data. This may include health status data, access to services, availability of services, etc. Local data may be compared to state and national data to determine the extent of the problem.**

1. **Prioritising health issues:**

**Key health issues should be considered and prioritised. Prioritisation may be based on relative importance, amenability to change and available resources. Input from the community members should be considered at this stage.**

1. **Setting goals:**

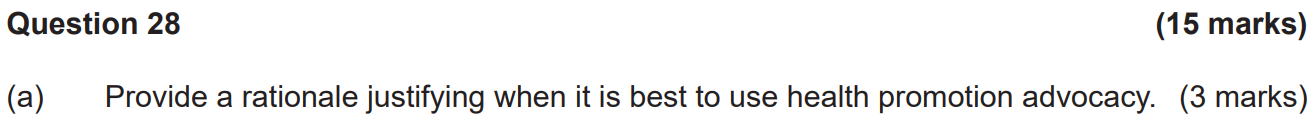
**Once the most significant health issues are determined the needs assessment team needs to set SMART goals for the best possible outcomes for the community.**

1. **Determining strategies:**

**This stage involves using an effective decision-making model to determine the best course of action. Research could be done into other fire-affected communities and what worked effectively for them.**

1. **Developing action plans:**

**Once the most effective strategies have been determined, the needs assessment team needs to develop an action plan to them into place. This involves producing a detailed plan of what needs to be done by who and when. Adhering to a timeline will allow the plan to be most effective in achieving the best outcomes for the community.**

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**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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**Individual: At this level, an individual’s characteristics, traits and identity influence health behaviour. These characteristics include factors e.g., knowledge, attitudes, self-efficacy, socioeconomic status, age, gender, ethnicity, etc. Prevention strategies should take into account these factors.**

**Example: Refugees may require free or subsidised healthcare to remove barriers to accessing healthcare e.g., poor/limited access to healthcare services and cost.**

**Interpersonal: At this level, the impact of support networks can influence health decisions and behaviour. Support networks include family, friends, co-workers and other connections. Prevention strategies can utilise these networks to broaden the reach of health messages.**

**Example: Refugee support groups can be used to promote healthy messages and increase health literacy.**

**Organisational: At this level, organisations in which an individual participates in can support positive health decisions and behaviour such as by implementing policy to enable or restrict health behaviour, making healthy choices easier. This can include schools, workplaces, etc.**

**Example: Workplaces can provide counselling services to reduce the impact of trauma.**

**Community: At this level, social networks and the broader aspects of the community including the built environment can influence health decisions and behaviour. Prevention strategies should have an impact on building and promoting services that support health.**

**Example: Establishing community connections/social groups for refugees where health priorities can be identified and addressed with appropriate support from community healthcare providers.**

**Societal: At this level, local, state and national policies and regulations impact health decisions and behaviour. Health policies will either have a direct or indirect impact on health. Prevention strategies should aim to support the health status of refugees and remove barriers that may result in health problems.**

**Example: Policies that provide free or ongoing health checks for refugees can allow an individual to remain in contact with the healthcare system.**