

**Western Australian Certificate of Education**

**Semester 2 Examination, 2022**

**Question/Answer Booklet**

**EXAM SOLUTIONS**

Please place you student identification label in this box (if required)

**HEALTH**

**STUDIES**

## Year 12 ATAR: Units 1 & 2

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Student Number: | In figures |  |  |  |  |  |  |  |  |  |  |  |
|  | In words |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |

## Time allowed for this paper

Reading time before commencing work: ten minutes

Working time: three hours

## Materials required/recommended for this paper

***To be provided by the supervisor***

This Question/Answer Booklet

Multiple Choice Answer Sheet

***To be provided by the candidate***

Standard items: pens (blue/black preferred), pencils (including coloured), sharpener, eraser, correction fluid/tape, ruler, highlighters

Special item: nil

**Important note to candidates**

No other items may be taken into the examination room. It is **your** responsibility to ensure that you do not have any unauthorised material. If you have any unauthorised material with you, hand it to the supervisor **before** reading any further.

## Structure of this Paper

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Section | Number of questions available | Number of questions to be answered | Suggested working time (minutes) | Marks available | Percentage of examination |
| Section One:  Multiple Choice | 20 | 20 | 30 | 20 | 20 |
| Section Two:  Short answer | 8 | 8 | 90 | 53 | 50 |
| Section Three:  Extended answer | 4 | 2 | 60 | 30 | 30 |
|  |  |  |  | **Total** | 100 |

## Instructions to candidates

1. The rules for the conduct of the Western Australian external examinations are detailed in the *Year 12 Information Handbook 2022: Part II*. Sitting this examination implies that you agree to abide by these rules.
2. Answer the questions according to the following instructions.   
     
   Section One: Answer all questions on the separate Multiple-choice answer sheet provided. For each question, shade the box to indicate your answer. Use only a blue or black pen to shade the boxes. Do not use erasable or gel pens. If you make a mistake, place a cross through that square, then shade your new answer. Do not erase or use correction fluid/tape. Marks will not be deducted for incorrect answers. No marks will be given if more than one answer is completed for any question.

Section Two: Write your answers in this Question/Answer booklet. Wherever possible, confine your answers in this Question/Answer booklet.

**Section Three contains four questions. Only answer two.**

1. You must be careful to confine your answers to the specific questions asked and to follow any instructions that are specific to a particular question.
2. Supplementary pages for planning/continuing your answers to questions are provided at the end of this Question/Answer booklet. If you use these pages to continue an answer, indicate at the original answer where the answer is continued, i.e. give the page number.

## Section One: Multiple-choice 20% (20 marks)

This section has **twenty (20)** questions. Answer **all** questions on the separate Multiple-choice Answer Sheet provided.

For each question shade the box to indicate your answer. Use only a blue or black pen to shade the boxes. If you make a mistake, place a cross through that square. Do not erase or use correction fluid. Shade your new answer.

Marks will not be deducted for incorrect answers.

No marks will be given if more than one answer is completed for any question.

Suggested working time: 30 minutes.

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

## END OF SECTION ONE

## Section Two: Short answer 50% (53 marks)

This section contains **seven** questions. You must answer **all** questions. Write your answers in the spaces provided.

Supplementary pages for the use of planning/continuing your answer to a question have been provided at the end of this Question/Answer booklet. If you use these pages to continue an answer, indicate at the original answer where the answer is continued, i.e. give the page number.

Suggested working time: 90 minutes.

Question 21 (8 marks)

Australia is playing a key role supporting Indo-Pacific partner countries to address education system disruptions during the COVID-19 pandemic and partnered to invest in health and recovery from the pandemic.

1. Explain how Australia’s aid for education and health helped Indo-Pacific partner countries. (4 marks)

|  |  |
| --- | --- |
| **Description** | **Mark** |
| Explanation how Australia’s Aid to Indo-Pacific countries in **education** during the COVID pandemic addressed disruptions | 2 |
| Limited explanation | 1 |
| **Subtotal** | **2** |
| Explanation how Australia’s Aid to Indo-Pacific countries in **health** during the COVID -19 pandemic assisted recovery from pandemic | **2** |
| Limited explanation | **1** |
| **Subtotal** | **2** |
| **Total** | **4** |
| Answers for **education** could include:  Supporting learning continuity during COVID-19, safely reopening schools and identifying innovative learning approaches that are a good fit for local contexts;  Supporting teacher training, curriculum reform and improved learning assessment, technical education, skills development and training aligned with labour market needs;  Constructing and improving education infrastructure in disadvantaged regions; investing in innovative approaches and analytics together with the private sector and civil society to improve access, reach and the quality of education; and  Strengthening the management and accountability of education policies and systems, to ensure the sustainability of our investments | |
| Answers for **health assistance** could include:  Provide safe and effective COVID-19 vaccines and support to health security in the Pacific and Southeast Asia  Advance progress towards universal health coverage through equitable access to quality essential health services  Assist countries to ensure essential disease and immunisation programs are sustainably financed and managed  Invest in improved access to clean water, sanitation, hygiene and nutrition  Expand access to quality family planning services, continue our support to partners on non-communicable disease (NCD) prevention and control. | |
| Accept other reasonable answers | |

1. Describe two (2) important roles of the World Health Organisation (WHO) in leading the world in the global COVID-19 pandemic. (4 marks)

|  |  |
| --- | --- |
| **Description For each of two (2) important roles of the WHO (2 x 2 marks)** | **Mark** |
| Chooses and fully describes an important role of the WHO in the COVID-19 pandemic | 2 |
| Limited description of a role of WHO in COVID-19 pandemic | 1 |
| **Subtotal** | **2** |
| **Total** | **4** |
| Answers must choose two of the following roles and correctly apply the role to the leadership of the WHO in the COVID-19 pandemic   1. provide leadership 2. shape the research agenda 3. set norms and standards 4. articulate ethical and evidence-based policy options 5. provide technical support 6. monitor the health situation and assessing health trends   **Provide leadership** As global health organisation the WHO can lead a coordinated approach to the control and ultimately prevention of a pandemic. This includes developing partnerships with private companies or governments to provide proved therapeutics to countries that can’t afford them and engaging in joint action within and between countries and at a global level to prepare for a potential pandemic and to lead action during a pandemic.  **Shape the research agenda**. Provide financial support and direction for research focusing on the control and prevention of the pandemic. This includes the initiation and support of research including prevention strategies, therapeutic medicines or vaccinations, to lead a safe and effective response to a pandemic. The WHO also plays an important role in translating and disseminating knowledge.  **Setting norms and standards** The WHO plays a role in establishing agreed global norms and standards relating to the responses to pandemics to ensure all countries adopt proven public health strategies. An important part of this is monitoring and evaluating procedures, policies and impact on norms. This involves recommending therapeutics or approval of different vaccines based on research and expert evaluation.  **Articulate ethical and evidence-based policy options** The WHO plays a role in discussing ethical responses to pandemics. For example, the issue of quarantine has been discussed as an infringement of individual human rights; however to ensure the safety of the public, in the event of a pandemic, quarantine is considered an important strategy. Policy options should be evidence based meaning they are informed by scientific, peer reviewed studies but advice can be quickly out of date with the rapidly changing nature of a pandemic and may be different in different locations depending on the severity.  **Provide technical support** The WHO supports governments and organisations through the provision of expert knowledge and advice. WHO has published more than 100 documents about COVID-19. Of these, more than half are detailed technical guidance, on how to find and test cases, how to provide safe and appropriate care for people depending on the severity of their illness, how to trace and quarantine contacts, how to prevent transmission from one person to another, how to protect health care workers, and how to help communities to respond appropriately.  **Monitor the health situation and assessing** health trends. One of WHO’s most vital roles is to gather data and research from around the world, evaluate it, and then advise countries on how to respond. This may include collecting data about the number of infections, number of deaths, proportion of recoveries, demographics of people infected etc. This data helps countries monitor what is happening during the pandemic and helps understand the health issue. | |
| Accept other relevant answers for the six mentioned roles of the WHO. | |

Question 22 (5 marks)

On 25 September 2015, the United Nations General Assembly formally adopted the universal, integrated and transformative 2030 Agenda for Sustainable Development, along with a set of 17 Sustainable Development Goals (SDG) and 169 associated targets.

Outline **progress** towards achieving **five (5)** SDGs studied in this course.

|  |  |
| --- | --- |
| **Description** | **Mark** |
| Description of progress of each of **five** SDGs. No mark for just identifying and describing the SDG. | |
| Fully describes progress of each SDG from the list below | 1 |
| **Total** | **5** |
| 1. end hunger, achieve food security and improved nutrition and promote sustainable agriculture (Goal 2) 2. ensure healthy lives and promote well-being for all at all ages (Goal 3) 3. ensure inclusive and equitable quality education and promote lifelong learning opportunities for all( Goal 4) 4. achieve gender equality and empower all women and girls (Goal 5) 5. ensure availability and sustainable management of water and sanitation for all (Goal 6)   **Goal 2:** Despite earlier extended progress, the number of people suffering from hunger has been on the rise since 2014. An estimated 821 million people were undernourished in 2017, the same number as in 2010. The proportion of children under five years suffering chronic malnutrition has decreased. Food insecurity is increasing with aid to agriculture decreasing. Some countries have experienced sharp increases in food prices because of ongoing conflict, extreme weather conditions and macro-economic difficulties. The global pandemic is an additional threat to food systems.  **Goal 3:** Major progress has been made to improve millions of people's health. Maternal and child mortality rates have been reduced, life expectancy increased globally, and the fight against some infectious diseases has made steady progress. However, at least half the world’s populations, many of whom suffer financial hardship, are still without access to essential health services.  **Goal 4:** Very low proficiency rates in reading and mathematics signal a global learning crisis, and one-third of the world’s children are being left behind; progress has stalled in reaching out-of-school children, too many schools in sub-Saharan Africa lack the basic elements of good quality education. Southeast Asia is home to nearly half of the global illiterate population and equitable quality education is too slow. Over 200 million children will still be out of school in 2030. COVID-19 has exacerbated these inequalities across and within countries.  **Goal 5**: The world is a better place for women today than it was in the past. Fewer girls are forced into early marriage, more women serve in parliament and leadership positions, and laws are being reformed to advance gender equality. Despite these gains, discriminatory laws and social norms remain pervasive, along with harmful practices and other forms of violence against women and girls. COVID-19 has placed additional burden on women, for example, increased domestic violence, home schooling responsibilities, more unpaid work, women account for 70% of front-line health care workers.  **Goal 6:** Freshwater is a precious resource, yet water is under threat like other natural resources. Billions of people, mostly in rural areas still lack these basic water and sanitation services. In response, donors increased their aid commitments to the water sector between 2016 and 2017 but countries experience a funding gap of 61% for achieving water and sanitation targets. Water scarcity could displace 700 million people by 2030. | |
| Accept other relevant answers. When discussing **progress towards the SDG** students may include progress to 2019 or they may refer to impacts to the progress because of the current global pandemic as articulated in the SDG website | |

Question 23 (6 marks)

In December 2019, 47 people including many Australian tourists were injured or killed in an unexpected volcanic eruption on White Island/Whakaari, just off the coast in New Zealand.

Survivors were rescued by inflatable boats in the area and helicopters flown to the crater by those who saw the eruption on the mainland. They were treated in four specialist burns units in NZ and 13 evacuated to Australia in specially equipped defence force airplanes.

Increased volcanic activity in the weeks before resulted in an increased alert level of “moderate to heightened volcanic risk with potential for eruption hazards to occur”.

Recently an Auckland judge dismissed charges against one crown agency, agreeing the agency could not be held accountable under New Zealand's work health and safety legislation, with charges against other agencies to go to trial next year.

Explain the impact this may have had on personal, social and cultural identity of the affected Australians.

|  |  |
| --- | --- |
| **Description** | **Mark** |
| For each of **personal, social and cultural identities.** | |
| Accurate explanation including the positives and negatives of the impact of the natural disaster on each of personal, social and cultural identities | 2 |
| Limited description of the effect of the natural disaster on each of personal social and cultural | 1 |
| **Subtotal** | **2** |
| **Total** | **6** |
| Answers must correctly identity personal, social and cultural identities when describing the impact the natural disaster and could include;  **Personal Identity**  Unexpected deaths of many young fit and active people who were on the Island during the eruption has robbed them of many years of potential life, with survivors being connected through friendship or family making the losses harder and affect self and personal identity.  Many survivors had severe injuries which involved amputation and severe burns and still wear compression garments on faces and exposed limbs after three years of rehabilitation. They will face permanent changes in personal identity because of their experiences, but also feel bonded with those who went through the eruptions with them.  Heroic efforts to rescue survivors at great personal risk by rescuers with skills and access to helicopters that could land on the Island and rescue survivors, or boats occurred before formal rescue efforts could be organised, which saved many lives.  **Social Identity**: relates to how we identify ourselves in relation to others according to what we have in common, include social contacts or family.  Families were devastated with the eruption occurring in another country with little information or being unable to contact missing family members and were uncertain if their relatives or friends survived. Communication is important to inform and support and build social networks  Some family or friends travelled to NZ to help in finding their missing relatives, be with them in hospital while they recovered or bring their bodies home. They were supported in their grief and assisted in travel and community groups to help build a social connection to assist with grief and recovery.  Natural disasters can bring communities together with the Australia public supporting quick action to offer disaster relief and assistance. NZ hospitals overwhelmed treating survivors all over the country in specialist burns units and Australians airlifted in specialist aircraft for burns treatments back in Australia where they would also be close to family and friends assisting recovery.  **Cultural Identity**: is related to nationality, ethnicity, religion, social class, generation, locality or any kind of social group that has its own distinct culture.  Feeling connected by strong relationship with NZ being two similar nations with a common history, meant trust that all rescue efforts would be employed, injured or deceased loved ones would be looked after with the highest care and families assisted in all ways to travel and with collective mourning of both nations.  Cooperation occurred easily between countries with co-ordinated airlifts of Australian survivors within days. Australia is known for its expertise in treating burns and in the defence force being able to evacuate expertly and quickly so survivors could be treated with the highest expertise in Australia and taking burden off NZ which had all it’s burns units full with survivors from countries other than Australia.  NZ Māori Cultural groups give traditional blessings to settle the spirit and of sorrow to behaviourally and physiologically assist in coping with loss felt by survivors, friends and families that visited the country or stie of the natural disaster.  NZ accident compensation scheme covers costs of injuries or compensation for deaths that occurred. Court cases and Inquiries are being held to find if there was fault in assessment of the volcano risk to remain open for a tourist attraction and investigate whether the injuries or deaths were preventable or unfortunate timing.  Accept other relevant answers that address each of personal, social or cultural identities impacted by the natural disaster. | |

Question 24 (12 marks)

Chronic disease is one of the main factors behind the gap in life expectancy between Aboriginal and Torres Strait Islander (ATSI) people and non-Indigenous Australians.

* 1. Explain why a focus on prevention for a chronic condition such as cardiovascular disease is an important objective to improve health of ATSI peoples. (2 marks)

|  |  |
| --- | --- |
| **Description** | **Mark** |
| Well-developed explanation that focuses on at least two of the following for prevention of conditions such as heart disease. | 2 |
| Less well-developed explanation. | 1 |
| **Total** | **2** |
| Any two of the following sample answers Focusing on prevention for chronic conditions such as cardiovascular disease.:  **Health promotion** goes beyond the treatment and cure of illness to address the root causes of ill health. For ATSI people, this means empowering people to make decisions that prevent ill health before it occurs, including through access to information that heart attacks can be reduced through early detection, lifestyle changes and opportunities for making healthy choices.  **Early intervention** with screening and recognising chronic kidney disease, diabetes and heart disease are often associated with each other and share risk factors. Reducing smoking and controlling weight with a healthy nutritious diet and increasing physical activity are important protective factors in these chronic diseases.  For ATSI people health promotion activities must also understand **the social and emotional wellbeing and be trauma aware.** Approaches must harness the protective aspects of culture, while addressing the physical, emotional and spiritual aspects of harm. | |
| Accept other relevant answers that do not repeat the same information. | |

* 1. Other than access, equity and sustainability, identify and outline five (5) guiding principles that enable the successful prevention and management of chronic conditions for a target population of ATSI people. (5 marks)

|  |  |
| --- | --- |
| **Description** | **Mark** |
| For each of the **five** **(5)** principles of National Strategic Framework for Chronic Conditions (NSFCC) | |
| Outline of correct principle applied to prevention and management of chronic conditions for ATSI people. No marks if not identifies correctly. | 1 |
| **Total** | **5** |
| Only accept the following principles of NSFCC applied to prevention and management of chronic health conditions in ATSI people:   * collaboration and partnerships: ATSI peoples must lead partnerships with mainstream health services to make the health system accountable and responsive to the diverse needs of Aboriginal and Torres Strait Islander people across their regions and communities and include disability and workforce support, mental health and aged care services. * evidence-based: a culturally informed evidence base requires ATSI access to, and control over, ATSI data. This includes ensuring that the community can benefit from research and data by building local capacity to generate, store and share locally relevant knowledge base to effectively prevent and manage chronic conditions. * **person-centred approaches**: understanding and respecting the specific factors that relate to history, culture, equality and must also be culturally and linguistically accessible for ATSI populations. This includes delivering materials and programs in language to enable self-management and informed decision-making. To maximise effectiveness and reach, use a variety of mediums, to target specific groups and sub-groups. * **accountability and transparency**: large amounts of money are being allocated by the States and Federal governments for systemic changes needed to improve health outcomes for ATSI people. Financial accountability to achieve best value with public resources is necessary along with how well it the health plan is progressing towards intended outcomes. This includes through annual reporting against key performance indicators. * **Shared responsibility:** Many peak ATSI bodies also represent interests across broader sectors that have strong intersections with the health system, including disability and aged care, workforce, research, mental health, and social and emotional wellbeing. | |
| Do not accept equity, access or sustainability principles of the NSFCC or generic explanation of the principle. | |

* 1. In the East Kimberly area of Western Australia, Indigenous organisations trying to achieve better health outcomes for all, have identified determinants of health as important.

Outline the impact of **five (5)** socio-economic determinants of health to reduce health inequities. (5 marks)

|  |  |
| --- | --- |
| **Description** | **Mark** |
| For each of the **five** **(5)** socio-economic determinants that account for a significant amount of the health gap between ATSI and non-Indigenous Australasians. | |
| Outline of socio-economic determinant that accounts for health gap between ATSI and non-indigenous people | 1 |
| **Total** | **5** |
| **Only accept five (5)** of the following socio-economic determinants   * **Education**: difficult to access education if living in remote locations and local schools often are limited in educational level offered and in attracting experienced teachers. Low levels of health literacy are linked to low levels of education. Not having the necessary skills or level of education is also a barrier to achieving employment. Many Indigenous families need support to motivate students to stay in school. Offering incentives through mentors, sport or scholarships to board in build up areas are showing success. * **Employment:** to get work with fewer opportunities depending on location and level of education achieved. A good-paying job makes it easier for workers to live in healthier neighbourhoods, provide quality education for their children, secure childcare services, and buy more nutritious food—all of which **affect** **health**. Good jobs also tend to provide good benefits. * **Income: N**ot having a job would mean living on or below the poverty line and associated with poor health outcomes. Income also has an impact on other lifestyle needs that can affect health, like housing and food security. * **Family:** Having no family or poor family support occurs with many Indigenous students resulting less value on education and occurs families don’t stand beside their children and provide encouragement or social or economic support. Families with drug and alcohol problems affects mental health and wellbeing and can occur through generations. Connection to social networks is a protective factor for resilience and good health * **Housing/neighbourhood:** no access to secure and/or safe housing or overcrowding in houses, can increase risk of poor health. Unsafe structures or transportable buildings, hostels, camps are more exposed to the health risks. For example, lack of facilities for cooking, cleaning or no power is highly detrimental to health. With lack of support, unreliable food, possible problems with sanitation. * **Access to services: may** have access to some basic services but these may not include essential health, medicines, trained health professional, maternity or dental services necessary for good health. Would be unlikely to access preventive services, such as immunisation, which reduce the likelihood of disease and illness. * **Food security:** A nutritious and plentiful food supply is necessary for good health. Poor diet is a risk factor for chronic disease and illness and may compromise Reuben’s immune system, leaving him at risk of infection. | |
| Do not accept ‘migration/refugee status’ which does not apply in this scenario. | |

Question 25 (7 marks)

Recent research on sports-betting motivations, attitudes and behaviours of young men under 25 who watch or play sports, suggests that sports betting has become normalised among this population of young men, facilitated by the growing accessibility of gambling and new technologies. One quarter of bettors reported being under 18 when they first placed a bet on sports.

70% were at risk, or already experiencing, gambling harm. Of these, 15% were over the threshold for 'problem gambling' as measured by the ‘Problem Gambling Severity Index’ (PGSI), a tool for estimating a person's risk of gambling problems and, consequently, harm.

Other than to influence and change policy, outline giving examples of seven (7) strategies for health promotion advocacy that may support a raising awareness campaign to decrease sports betting behaviour, particularly in this population group.

|  |  |
| --- | --- |
| **Description** | **Mark** |
| Correct outline with example of one strategy of health promotion advocacy | 1 |
| **Total** | **7** |
| Only the following seven strategies are correct:   * **Lobbying:**  Includes attempts to persuade members of the public to take action to persuade operators to make changes, such as sporting organisations to phase out sponsorship arrangements with betting operators. Meet with National Sporting bodies, produce media campaigns, writing to newspapers to raise awareness. * **Creating debate:** Creating an opportunity for those with differing views to discuss issues. For example to organise meeting between sporting organisations and groups that deal with harms from problem gambling and research showing young males, attracted to watching sports are increasingly at risk. * **Developing partnerships**: Build relationships between sporting organisations and groups also working towards the same goals of reducing harmful gambling behaviour. For example developing partnerships with leagues, teams, players associations, colleges and high schools to provide problem gambling prevention and education programs, particularly for youth and developing partnerships with sports betting operators and vendors on responsible gambling. * **Building capacity:** Capacity building taps into existing abilities of individuals, communities, organisations or systems to increase involvement, decision-making and ownership of issues. For example, educating sporting organisations and committees on the risks of promoting sports betting and normalising effect of sports betting leading to harmful gambling and addictive behaviour, encouraged by 24-hour online access, widespread promotion of athletes and sports betting branding highly recognisable to children and encouraging changes. * **Mobilising groups:** Encouraging communities or groups to become involved and gaining support of those with influence. For example creating social media or action groups to gain support for limiting advertisements or widespread betting options designed to be appealing for young men. * **Framing issues:** Presenting the issue in a way to get the response wanted from decision makers, community, politicians and media. For example approach sporting bodies with information on how sports betting agencies are using tactics to appeal to young people and children. Highlight the risks as a means of getting the sporting bodies to find healthier sponsorship options. * **Using champions:** Using a well-known sporting personality to raise awareness and promote change. Athletes are already used in gambling promotions to foster positive attitudes towards gambling and would need a top level highly respected player to speak out about ending betting advertisements during sporting events to push back on other messages.   For example limiting sports bet marketing when people under 18 are watching, introduce targeted protection messages and ban gambling promotions and inducements targeted primarily to young men. | |
| Accept other relevant answers. | |

Question 26 (7 marks)

1. Apply your knowledge of social and cultural norms related to alcohol use in Australia and explain how these norms could encourage, support or reinforce risky drinking behaviour in young people. (3 marks)

|  |  |
| --- | --- |
| **Description** | **Mark** |
| Well-developed explanation of how social and cultural norms relate to alcohol use in young Australians. | 3 |
| Description of how social and cultural norms relate to alcohol use in young Australians. | 2 |
| General outline of how social and cultural norms relate to alcohol use in young Australians. | 1 |
| **Total** | **3** |
| Answers may include but not limited to;  Young people seeing alcohol used in almost all social situations, from relaxing in day to day lives to celebrating success or after sporting events and is a well-accepted Australian norm, develop positive beliefs about drinking from peers attending parties or in environments where alcohol use is socially acceptable and encouraged.  Media exposure helps influence social norms about alcohol through advertising, product placements, and stories in a wide range of sources, including movies, television, social media, and other forms of entertainment. Although alcohol sales and marketing are highly regulated, young people are exposed to a wide variety of alcohol and liquor advertisements.  With low cost, sweet, fruity, flavoured alcoholic beverages colourfully packaged with lower alcohol content, the alcohol industry has engaged in targeted marketing efforts toward youth in general, and especially young women.  Binge drinking, drink driving, and unsafe sex can all result from engaging in risky drinking and in Australia, alcohol is the most used drug and contributes to all the leading causes of death for young people. | |
| Accept other relevant answers. | |

1. In this course, ‘Principles,’ ‘Frameworks,’ ‘Models’ and ‘Theories’ are studied to understand and respond to health problems.

State the purpose of the following. (4 marks)

|  |  |
| --- | --- |
| **Description** | **Mark** |
| Correct definition of the purpose of each | 1 |
| **Total** | **4** |
| **Needs Assessment**: a process used by health professionals to identify and analyse community needs that involves understanding the community,determining and analysing priority health problems and using this information to plan appropriate health promotion actions.  **Socio-ecological model of health:** a model which recognises links between multiple factors or determinants that influence health behaviour.  **PABCAR:** Identifying problems, assessing benefits and costs and acceptability of Implementing an intervention, then recommending and monitoring actions.  **Maslow’s hierarchy of needs:** are a motivational theory in psychology that chart comprising a five-tier model of human needs, important to achieve complete development and self-actualisation. | |
| Accept similar answers for each. | |

Question 27 (8 marks)

Papua New Guinea (PNG) is the world’s third largest Island country, located close to the north of Australia. It has a developing economy, with nearly 40% of the population living a self-sustainable natural lifestyle with no access to global capital with diverse languages and limited education.

Study the following data, which shows a selection of recent health-related statistics for Australia and PNG and answer the questions that follow.

|  |  |  |
| --- | --- | --- |
| Health Related Statistics | Australia | Papua New Guinea |
| Life Expectancy at birth (male/female) in years | 81 / 85 | 63/ 66 |
| Infant mortality  (deaths per 1000 live births) | 3.1 | 37 |
| Population (million) | 25 | 9 |
| GNI\* | 69,730 | 3700 |
| Current expenditures on health per capita\*\* (% GNI) | 7926 (11%) | 89 (2.4%) |

\*GNI: gross national income, in Australian dollars, divided by the midyear population.

\*\* Total expenditure on health in Australian dollars per capita, refers to per head or for each individual person.

1. Using the above information, describe three (3) reasons that could explain the difference in life expectancy and infant mortality between Australia and Papua New Guinea. (6 marks)

|  |  |
| --- | --- |
| **Description** | **Mark** |
| **For each of three (3) reasons (3 x 2 marks)** |  |
| Description of reasons that could explain the differences in life expectancy and infant mortality between Australia and PNG using data from the table. | 2 |
| Outline of reasons that could explain the differences in life expectancy and infant mortality between Australia and PNG | 1 |
| **Total** | **6** |
| Answers could include:  Life expectancy for both males and females are almost 20 years higher for Australians, than for PNG. Higher rate of population living in extreme poverty in PNG with an average GNI of $2660 and a subsistence lifestyle, could mean shortages of food, inadequate shelter, clean drinking water and sanitation, leading to increased chances of deaths from diarrhoea type illnesses or infections. Little or no access to preventive screening tests, such as syphilis or treatable chronic conditions also decreases life expectancy compared to Australia.  PNG has an infant mortality rate ten times worse than Australia (37 deaths per 1000 births compared to 3). Poorer access to health care and skilled birth attendants in PNG compared to Australia can increase both maternal and infant mortality with a higher rate of preventable or treatable conditions such as haemorrhages or infections or asphyxiations in babies causing deaths.  Cost is a significant issue and not only does PNG have a much higher gross national income per capita than Indonesia, Australia spends 15% of their GNI on health compared to 2.4% PNG. That is only $64 per person per year compared to $7900 in Australia. Transport and payments for services and supplies that should be free are another cost and sick people and for pregnant women report waiting ling hours only to be sent home and told to return the next day further increasing travel costs.  Lower access to and level of education in PNG and low pay means shortages of health care staff trained and available for a large percentage of population that lives out of built-up areas. For the general PNG population a lack of knowledge about risks such as smoking or being able to recognise and provide self-care for disease symptoms increases mortality and decreases life expectancy compared to Australia.  Many Health care facilities lack basics such as running water and electricity to ensure safe sanitary conditions for giving birth and don’t have refrigerators for vaccines or adequate stock of drugs for common conditions like intravenous fluid to stabilise drops in blood pressure or have patients dying waiting for staff to arrive. Poorly trained health professions that can’t use essential medicines or stop haemorrhages. | |
| Accept other relevant answers. | |

1. Outline two (2) important global or local barriers to improving the health and increasing life expectancy of people in PNG. (2 marks)

|  |  |
| --- | --- |
| **Description** | **Mark** |
| **For each of two (2) global or local barrier** | |
| Outline of reasons that could explain the differences in life expectancy and infant mortality between Australia and PNG. | 1 |
| **Total** | **2** |
| Answers could include **two (2)** out of the following **three (3)** only:  **Poverty** is a major cause of disadvantage and poor health. It can prevent people from accessing health services and from the government of providing free basic health care of trained health care professionals. And results in a lower life expectancy and higher infant mortality in PNG compared to Australia.  **Disease outbreaks** demand higher health care and people who are vulnerable to respiratory infection, lack basic medicines such as antibiotics, or care to prevent or treat, such as those in PNG are at a greater risk of dying and of getting multiple illnesses.  **Availability of clean drinking water** and water borne diseases can increase the risk of disease outbreaks suck as diarrhoea which has a high death rate in PNG especially among young children under 5 years. PNG is country with the least access to safe drinking water in the world. (In a country of around 9 million people, has 6000 diarrheal deaths per year. This would correspond to 16,600 diarrheal deaths in Australia per year.) | |
| Accept other relevant answers for ‘poverty,’ ‘disease outbreaks,’ or ‘availability of clean drinking water’ | |

**END OF SECTION TWO**

## Section Three: Extended answer 30% (30 marks)

This section contains **four** questions. You must answer **two** of these questions. Write your answers in the spaces provided. If you answer more than two questions, cross out the answer you don’t want marked, otherwise only the first two answers will be marked.

Supplementary pages for the use of planning/continuing your answer to a question have been provided at the end of this Question/Answer booklet. If you use these pages to continue an answer, indicate at the original answer where the answer is continued, i.e. give the page number.

Suggested working time: 60 minutes.

Question 28 (15 marks)

Health status is a generic term referring to the **health**, good or poor of a person, group or population in a particular area, especially when compared to other areas or with national data.

Differences in health status between communities/specific populations can be explained by the impact of social determinants that create health inequities.

1. Describe the impact of ‘the social gradient’ in improving life expectancy and positive disease outcomes in improving health status. (3 marks)

|  |  |
| --- | --- |
| **Description** Choose **three (3)** out of the following four types of need | **Mark** |
| Explain impact of social gradient in improving life expectancy and improving health status | 3 |
| Describe impact of social gradient in improving life expectancy and improving health status | 2 |
| Outline impact of social gradient in improving life expectancy and improving health status | 1 |
| **Total** | **3** |
| Answers for **the social gradient** could include:   * the social gradient refers to the position on a continuum according to socioeconomic circumstances/characteristics. Generally, life expectancy is shorter and diseases are more common in populations who are disadvantaged both socially and economically, and therefore low on the social gradient * this disadvantage can take many forms, from being poorly educated, having no or insecure employment, living in a poor or unsafe neighbourhood and/or having poor housing conditions. It is not uncommon for people suffering disadvantage to have multiple factors which contribute to disadvantage, making them susceptible to additional stressors for extended periods of time. Such stress can contribute to preventable and/or chronic conditions and premature morbidity and mortality * the effects of being low on the social gradient accumulate throughout life and over time contribute to poor health outcomes, thus impacting rates of premature morbidity and mortality. | |
| Accept other relevant points | |

Social determinants of health are key aspects of peoples living and working circumstances and their lifestyles, that are recognised as important in changing health status.

1. Describe the impact of six (6) other social determinants of health influence on health inequities. (12 marks)

|  |  |
| --- | --- |
| **Description** | **Mark** |
| **Describe six (6)** social determinants. (6 x 2 marks each). | |
| Well-developed description of a social determinant’s influence of health inequities | 2 |
| Outline of a social determinant’s influence of health inequities | 1 |
| **Subtotal** | **2** |
| **Total** | **12** |
| Answers from the following social determinants:  **Transport**  good transport infrastructure and systems are necessary for good health in many ways. For example, efficient transport systems can connect people with essential services, as well as provide an active means for people to get around. Being able to walk and cycle, can achieve benefits of regular physical activity and protection against heart disease and a reduction in sedentary lifestyles, health conditions such as obesity and Type 2 Diabetes. This can have an impact on rates of premature illness (morbidity) and overall life expectancy  • road infrastructure is essential for creating safer conditions on roads and may decrease the likelihood of premature injury and death from vehicle crashes or incidents involving pedestrians.  **Stress**  Stressful circumstances making people feel worried anxious and unable to cope are damaging to health and can lead to mental health problems and premature death, Long periods of anxiety and insecurity and lack of supportive friendships are damaging. Stress causes a hormone and nervous system response to prepare us to deal with an immediate physical threat which affects both the cardiovascular and immune systems and can lead to a wide range of poor health including infections, diabetes high blood pressure, heart attack, stroke or depression. Increasing physical activity and activities that can calm the biological response and increase control over situations at work, school and home help to reduce stress.  **Early life**  A good start in life supporting mothers and young children improves early child development, education and has a lifelong effect. This includes pregnancy, smoking or misuse of alcohol leading to problems in foetal development. Risks to a developing child are higher in lower socio-economic circumstances and can best be reduced with improved preventative health and nutrition care before and after birth, in clinics and in schools improving education levels of parents and children.  **Social exclusion**  can result from discrimination, poverty, unemployment, disabled, in ethnic groups or in homeless people. The greater length of time living in disadvantaged situations, the more likely suffering from a range of health problems particularly cardiovascular disease. Poverty and social exclusion increase risks of divorce, separation, disability, illness and addiction. Public health policies should remove barriers to health care, social services and affordable housing.  **Work**  People who have more control over their workplace have better health. Without satisfying meaningful work opportunities economic security and health might be affected. Some work environments may be related to increased back pain, sickness absence or other illnesses, Improved work conditions lead to improved productivity and opportunity to create a healthier, happier workplace.  **Unemployment**  Affects economic security and ability to afford goods and services that support good health. Not having a job also impacts on opportunities for social interactions. Unemployment puts health at risk, especially in areas with widespread unemployment. Job insecurities mental health, particularly anxiety and depression, self-reported ill health, and risk factors for heart disease.  **Social support**  Friendships, good social relations and strong supportive networks improve health at home, school and community. Belonging to social networks help people feel loved, cared for esteemed and valued and has a protective factor on health. Bad close relationships can lead to poor physical and mental health.  **Addiction**  May be the result of poor coping mechanisms and made worse by the existence of other determinants such as social exclusion and unemployment. Drug use is both a response to social breakdown and an important factor in increasing health inequities and a risk factor in many chronic health conditions and deaths linked to accidents, violence, poisoning injury and suicide.  **Food**  A good diet and adequate nutritious food are central to good health and well-being. A lack of food can cause malnutrition and deficiency diseases. Excess intake of food contributes to cardiovascular disease, diabetes, cancer, degenerative eye diseases, obesity, and dental caries. Dietary goals to prevent chronic diseases are to eat more fresh fruit and vegetable, and less processed, high sugar foods.  **Culture**  Language barriers or other cultural traditions and habits decreasing health literacy may perpetuate inequities. **Culture** influences **health beliefs and**  comprehension, treatment methods, and diagnostic claims of an individual. Family members’ opinions weigh into the final decision of the decision-maker. Stigmatizing diseases and illnesses- for example, some cultures believe that seeing a psychiatrist means the patient is “crazy.” | |
| No marks for just identifying a step in the needs assessment process and answers relevant must apply to a community recovering from bushfire scenario. | |

Question 29 (15 marks)

* + 1. Define mortality, morbidity, incidence and prevalence of disease and burden of disease. (4 marks)

|  |  |
| --- | --- |
| **Description** | **Mark** |
| Both incidence and prevalence of disease need to be correct for one mark.  Not asking for mortality or morbidity rate, so if time is mentioned answer is incorrect | |
| Mortality: the number of deaths within a particular society | 1 |
| Morbidity: a disease condition or the **morbidity** **of** a disease is how many people have it in a particular population: | 1 |
| Incidence and prevalence of disease: **incidence** refers to the number of **new cases** of an illness, disease, or event occurring during a given period and **prevalence** is the number or proportion of existing cases present in a population at a given time. The prevalence of disease is related to both the incidence of the disease and how long people live after developing it | 1 |
| Burden of disease: Burden of disease analysis is the best measure of the impact of different diseases or injuries on a population. It combines the years of healthy life lost due to living with ill health (non-fatal burden) with the years of life lost due to dying prematurely (fatal burden). Fatal and non-fatal burden combined are referred to as total burden, reported using the disability-adjusted life years (DALYs) measure | 1 |
| **Total** | **4** |

* + 1. Outline two (2) key purposes of epidemiological data. (2 marks)

|  |  |
| --- | --- |
| **Description** | **Mark** |
| For each of **two (2)** key purposes or epidemiological data | |
| Outline of a key purpose of epidemiological data. | 1 |
| **Total** | **2** |
| to identify health inequities and or needs.  to provide a picture of the health status of a population.  to identify areas for action.  to allocate resources to areas where attention is needed to improve health status.  to compare changes in the population over time.  to compare populations and/or countries.  to measure/evaluate the impact of health initiatives | |

Study the infographic to answer questions c and d.

**Burden of disease measured by Disability Adjusted Life Years (DALY) rate per 1000 of population in 2003 and 2018**

Diagram

Description automatically generated with medium confidence

COPD: Chronic Obstructive Pulmonary Disease

* + 1. Describe three (3) leading causes of burden of disease in Australia between 2003 and 2018. (3 marks)

|  |  |
| --- | --- |
| **Description** | **Mark** |
| For each of **three (3)** different points in leading causes of burden of disease (3 x 1 mark) | |
| One mark for each of **three (3)** leading causes of burden of disease in Australia between 2003 and 2018 | 1 |
| **Total** | 3 |
| **Sample answers for Leading causes of Burden of Disease**  **Coronary heart disease** was the leading cause of burden between 2003 and 2018 years, but the total burden rate for coronary heart disease fell markedly between 2003 and 2015 and continued to fall in 2018 showed the largest reduction in total burden over time—from 21 to 10 DALY per 1,000 people.  **Back pain and problems** were the second highest cases of burden of disease in both 2003 and 2018. The total burden of disease from back pain and problems increased from 8.0 to 8.2 DALY per 1000 population during this time.  **Stroke** was the third highest cause of burden of disease in 2003 in Australia. This deceased dramatically to the 11 highest in 2018. The total burden of disease almost halved from 7.4 to 4.2 DALY per 1000 popn.  **Lung cancer** was the fourth highest cause of burden of disease in Australia in 2003 with 6.8 DALY per 1000 of population which decreased to the 8th highest in 2018 with 5.4 DALY per 1000 of popn. Smoking is a large risk factor for lung cancer and the decrease in smoking rates in Australia could be responsible for the successful decrease in burden of disease of lung cancer.  **COPD** was the fifth highest cause of burden of disease in 2003 and this decreased to slightly to sixth highest in 2018 in Australia, with the rate decreasing from 6.5 5.8 DALY per 1000 per popn.  **Dementia** was rated 12 highest cause of burden of disease in 2003 and this increased markedly to the fourth highest in 2018. The rate increased from 4.5 to 6.1 DALY per 1000 population. | |

* + 1. For three (3) health conditions outline possible reasons why changes between 2003 and 2018 occurred. (3 marks)

|  |  |
| --- | --- |
| **Description** | **Mark** |
| One mark for each of **three (3)** outline why the disease has changed between 2003 and 2018 (3 x 1 mark) | **1** |
| **Sample answers for Describing the changing burden of disease between 2003 and 2018**  The rate of burden for **dementia** increased substantially, from 12th highest DALY per age standardised rate to 4th highest. Australia’s population is aging and dementia increases with age but this seems to be a dramatic increase and the results indicate research is needed.  Changes in DALY per 1000 population from **strokes** have decreased dramatically from 3rd highest burden of disease in 2003 to 11th highest. Medications that mitigate key risk factors have undoubtedly reduced mortality rates from strokes, while specialised stroke recovery units have also increased survival rates. In the event of a person suffering a stroke, time elapsed before medical intervention is critical to survivability and recovery and successful awareness of signs and symptoms have helped.  Decreases in DALY per 1000 of population in **lung cancer** from 4th to 8th between 2003 and 2018 is probably from successful early screening programs and awareness and removing of risk factors such as smoking.  **Coronary heart disease** while still the leading cause of burden of disease has halved. This reduction is probably driven by large declines in fatal burden. There has been increase in education and awareness of recognising and preventing risk factors of heart disease and screening programmes.  **Chronic** **obstructive** **pulmonary** **disease**, (**COPD)**, is a group of progressive lung **diseases**. The most common of these diseases are emphysema and chronic bronchitis.  The main cause of **COPD** is smoking and the decrease of COPD between 2003 and 2018, is probably a result of large decreases in smoking in the Australian population. | |
| Accept other relevant answers | |
| **Total** | **3** |

* + 1. Outline **three (3)** reasons why improving health indicators is a challenging prospect for governments. (3 marks)

|  |  |
| --- | --- |
| **Description** | **Mark** |
| For each of **three (3)** reasons (3 x 1 mark) | |
| Outline a reason why improving health indicators is challenging for governments | 1 |
| **Total** | **3** |
| * improving health indicators takes time – is a long-term proposition and it may be difficult to see improvements in the short-term (and within the election cycle) * improving health indicators can be very costly and require substantial financial commitment/resources * as health indicators are linked to health inequity, addressing the social determinants of health is critical, which is a challenge for governments to coordinate * poverty is major issue in impoverished/under-developed nations and is a very difficult issue to address without the necessary resources such as workforce and vital infrastructure * in some nations, health indicators are extreme and changes may be difficult to achieve due to extraneous factors such as poverty and limited resources and cultural factors | |

Question 30 (15 marks)

In April 2022 the Solomon Islands signed a security pact with China that Australia regards as a security concern. In late May the newly appointed Australian Minister of Defence, Penny Wong, immediately visited Fiji and other South Pacific nations trying to match China’s diplomatic advance, repair relations and encourage partnerships with Australia.

* 1. Describe **four (4)** communication and collaboration skills Ms Wong could use to manage the situation. (8 marks)

|  |  |
| --- | --- |
| **Description** | **Mark** |
| **Four (4)** skills for two marks out of the following list mediation, negotiation, compromise, managing conflict, leadership, facilitation (4 x 2 marks). | |
| Describe how the skill could be used to manage | **2** |
| Outline how the skill could be used | **1** |
| **Total** | **8** |
| Answers could include:  **Mediation** is a process by which a neutral third party called a mediator helps people in conflict negotiate a mutually acceptable agreement. The parties to the **mediation** control the outcome. A mediator facilitates communication, promotes understanding, assists the parties to identify their needs and interests, and uses creative problem solving.  This could happen with an independent mediator like the United Nations, or an independent country agreed to by both Island nations and Australia, bringing them together to facilitating communication about the Australian government was concerns with Chinese influence in the Pacific, and the Island nations problems and needs so both can solve problems to come to agreement.  **Negotiation.** A negotiation is a strategic discussion that resolves an issue in a way that both parties find acceptable. Each party tries to persuade the other to agree with his or her point of view. all involved parties try to avoid arguing but agree to reach some form of compromise.  Participants learn as much as possible about the other party's position before a negotiation begins, including what the strengths and weaknesses of that position are, how to prepare to defend their positions, and any counter-arguments the other party will likely make.  Negotiations involve some give and take and the South Pacific nations now have a stronger negotiating position with China wanting to make deals with them, giving them money or building infrastructure in return for China holding security positions on their Islands. Because Australia doesn’t want that the Islands have a position they can come out on top in the negotiation.  **Compromise** is a settlement of a dispute by concessions on both sides with the terms of such a settlement something midway between two or more different sides or to settle a dispute by making concessions. Some South pacific countries feel China has overreached in pursuing a regional security and economic pact with Pacific nations but feel ignored by Australia. Australia has to compromise recognising the region determines its own security needs but offer their cooperation and deals to Island nations to make them a better choice to assist than China.  **Managing conflict** is the practice of being able to identify and handle **conflicts** sensibly, fairly, and efficiently. Since conflictsoften arise between different countries**in** a it is important that we understand conflicts and know how to resolve them.  Australia’s previous government was accused of an over aggressive approach to China and ignoring problems and needs of its South Pacific neighbours despite have treaties between the countries. Ms Wong, Minister of Defence with ability to influence Australian decisions has been making large efforts in visiting many South Pacific countries to listen and mange conflict that has arisen.  **Leadership has different types depending on the situation** to motivate and be able to encourage others to work toward a common goal. This ability to motivate has largely been a result of solid **communication** skills.  Penny Wong holding one of the highest positions in the Australian government is showing leadership visiting many of the nations communicating, listening and showing respect to motivate them to coordinate their security and aid needs with Australia and reject the major influence building contracts offered by China.  **Facilitation** A facilitator plans, guides and manages a group event to meet its goals. To facilitate effectively, you must be objective and focus on the ways that groups work together to perform tasks, make decisions and solve problems.  Penny Wong is acting as a facilitator for different groups in the Island nations that have different ideas about whether China or Australia are the best countries to partner with to have their security and other service and aid needs met.  Ms Wong’s important visits aim to renew and strengthen Australia‘s deep ties to the Pacific nations reminding them Australia will take responsibility for security concerns and cooperate in a range of issues including disaster mitigation, agriculture and fisheries and health. | |
| Accept other relevant responses except arbitration | |

* 1. Discuss three (3) ways the Australian Governments could seek to regulate or influence the behaviour of South Pacific nations. (3 marks)

|  |  |
| --- | --- |
| **Description** | **Mark** |
| **One (1)** mark for each of **three (3**) | 1 |
| **Total** | **3** |
| * Through a range of policy tools, including legislation, sanctions, regulations, taxes and subsidies, the provision of public services and information and guidance material.   **Putting pressure on all the countries of the region, that have similar rules and norms,** emphasising historical connection to Australia. In this context, Australia is stepping up our work with partners to shape the region's order.  **Security cooperation** with Pacific countries covers defence, law enforcement, transnational crime, climate and disaster resilience, border management and human security.  Australia has provided financial, technical and legal support to Pacific island states to establish their **maritime zones**, negotiate shared boundaries and submit extended continental shelf claims.  **Policies** inform how we address long-standing and emerging health priorities including: funding for hospitals, training facilities and instructors for health professionals and health products and help in dealing with known chronic health problems int eh South Pacific nations.  Australia to offer **scholarships** to awardees from the Pacific countries to undertake studies in environment related issues including fisheries, marine science, climate change and environmental management. | |
| Accept other reasonable answers | |

* 1. Define the term ‘environmental determinants of health’ and provide three examples of how these determinants might affect health inequities for countries Australia give aid to. (4 marks)

|  |  |
| --- | --- |
| **Description** | **Mark** |
| Definition of ‘environmental determinants’ of health | 1 |
| For each example of how ‘environmental determinants’ of health might affect inequities in countries Australia givens aid to. (3 x 1 mark) | 1 |
| **Total** | **4** |
| Sample definition:  Environmental determinants include the physical, chemical and biological factors external to the individual, as well as all the other factors impacting behaviours to prevent diseases and create healthy environments. Most commonly these refer to features of the natural and built environment and geographical location.  Examples could include but are not limited to:  **lack of adequate shelter**: many in the populations live a subsistence lifestyle and houses have unsafe structures or transportable buildings; hostels; camps,  are more exposed to the health risks associated with sleeping rough. For example, need hot water, refrigeration, and facilities for cooking and washing clothing and no power sources which is highly detrimental to health.  • **exposure to hot humid conditions**–are more at risk of developing respiratory disease or infection and don’t have access to health services, medicines or transport to get assistance when problems occur.  **• crime and violence** – many homeless people tend to reside in geographical locations that commonly experience high levels of crime and violence. This can impact an individual’s mental health through ongoing psychological stress  **• built environment** –Overcrowding or lack of hygiene and resource management, with no waste or rubbish disposal or sewage can result in poor water and sanitation quality which can cause illness.  \***poverty** -often causes people to put relatively more pressure on the environment which results in larger families (due to high death rates and insecurity), improper human waste disposal leading to unhealthy living conditions, more pressure on fragile land to meet their needs, overexploitation of natural resources and more deforestation.  \***extreme weather events** like floods, cyclones or can destroy environments used for growing food or work, or houses and causing populations to become homeless reduce food security and have no incomes causing health problems and psychological stress. | |
| Accept other relevant answers | |

Question 31 (15 marks)

1. Identify and describe five (5) levels of Maslow’s hierarchy of needs that clarify the effects school shutdowns may have had on students in COVID-19 lockdowns.   
    (10 marks)

|  |  |
| --- | --- |
| **Description** | **Mark** |
| For each ofthe **five (5)** levels (5 x 2 marks). No marks for just identifying the *Maslow’s Hierarchy* level. | |
| well-developed description of each level in *Maslow’s hierarchy of needs* with examples connected to school lockdowns | 2 |
| limited explanation of *each level in Maslow’s Hierarchy of needs* | 1 |
| **Subtotal** | **2** |
| **Total** | **10** |
| **Physiological:**  food, water, shelter sleep and clothing which is mainly the responsibility of the parent/guardian, but some school provided breakfast of a meal that many families relied on to feed their children, which would be gone. Some families were put out of work by lockdowns, but government provided income for those with part- or full-time employment, so this level of Maslow’s hierarchy should have been met in school shutdowns.  **Safety:** Personal security, employment, resources, health, property. This is a big one for all of us. First there is the worry about being safe from catching or getting serious infection with COVID-19. Then because of this upheaval in daily lives, we may feel worried, stressed, or even fearful about what will happen. Online learning can occur but has mixed results with unsuitable online platforms, keeping students motivated to present lessons. Ways of coping at home is accept what you can control. For example, write letters to a local retirement home, walk around the block, clean out closets, learn how to cook, write a story about their experience, sing and dance, play an instrument inwriting what they did in writing or in video with the class.  **Love and belonging**: Friendship, family, sense of belonging. Students will miss the comradery and friendship of being with other people their age. Those social connections are important and if deprived lead to loneliness or antisocial behaviour. Ways to enhance healthy social communication for students during this time is to encourage a virtual learning community. Keeping a physical exercise plan with a few others to motive each other. Teacher can connect with them individually to find out how they are doing and if they need any support and advise them how to access support. Many young people who reported their education was impacted also reported high psychological distress and it’s important to focus on benefits of school apart from education  **Esteem:** desire for reputation or acceptance from others. Students may define themselves by the things that they do in the school setting—they are actors in a play, they are the goalie in lacrosse, they are the straight A student, they are the class clown. Students are missing a piece of their identified self when the common structures where they practice their craft are uprooted. If deprived, can lead to feelings of inferiority; if pathological, can lead to depression. It is important to think about how we can recreate some of those experiences, even if they are in a much smaller form. For students whose esteem needs are met by purely academic pursuits, how are we making sure that they can stay on track for their exams or important tests? Are there online resources or tutoring that can help them continue their rigorous studies? Can you collaborate across disciplines to get ideas from each other?  **Self-actualisation**  This will be a challenge for all and an opportunity to reach full personal potential in self actualisation. This doesn’t distort our perception as do other needs; when self-actualized, we more accurately perceive what exists. If deprived, can cause feelings on lack of meaning in life, boredom or alienation. Individuals who are motivated to pursue this goal seek and understand how their needs, relationships, and sense of self are expressed through their behaviour. To give and receive love and community with your students, co-workers, and school is the highest calling. Educators are lifelong learners. . | |

1. Explain why Maslow's hierarchy of needs is an important theory to understand motivation. (2 marks)

|  |  |
| --- | --- |
| **Description** | **Mark** |
| Well-developed explanation | 2 |
| Limited explanation | 1 |
| **Total** | **2** |
| The basis of Maslow's theory is that we are motivated by our needs as human beings. Additionally, if some of our most important needs are unmet, we may be unable to progress and meet our other needs.  This can help explain why we might feel "stuck" or unmotivated. It's possible that our most critical needs aren't being met, preventing us from being the best version of ourselves possible. Changing this requires looking at what we need, then finding a way to get it. | |
| Accept other relevant answers | |

1. Discuss why it is difficult to meet psychological and self fulfilment needs as described in Maslow’s hierarchy of needs. (3 marks)

|  |  |
| --- | --- |
| **Description** | **Mark** |
| Well-developed discussion showing good understanding of Maslow’s Hierarchy that includes multiple reasons of the difficulty of students achieving lower order needs to access higher order needs. Uses correct terminology and referring to three or more levels in the hierarchy. | 3 |
| Discussion demonstrating understanding of Maslow’s Hierarchy and outline some reasons for difficulties of students. One or two levels of the hierarchy using mostly correct terminology. | 2 |
| Discussion demonstrates limited understanding. May include one or two reasons, terminology may be inaccurate or not included. | 1 |
| **Total** | **3** |
| The basis of Maslow's theory is that we are motivated by our needs as human beings and according to the theory each prior stage must be satisfied before moving on to the next, with the goal being to achieve self-actualisation.  Reasons why it is difficult to achieve higher order. Complex or growth needs of psychological or self-esteem and self-actualisation needs that are not being meet when lower order needs such as safety or love and belonging are difficult to achieve if students are not able to attend schools or when fears caused by COVID-19 are high.  Safety and security needs are lower order and with fears for safety from COVID – 19, having to be protected by wearing masks or not attending school increases feelings of worry, stress and fear of the future, social stability and alienation of friends. This can limit needs being met and being able to move on to high levels of need such as love and belongs of self-esteem  Physiological needs are the bottom tier of Maslow’s hierarchy and important to school aged children because they usually rely on adults to get these needs met. Some rely on schools for food and children generally have higher physical need scores than the other age groups.  There is research that shows the esteem need was highest among the adolescent group with a desire for reputation or acceptance from others, that is defined by what they do in a school setting. Not being able to attend school can lead to feelings of inferiority or if pathological, could lead to depression | |
| Accept other relevant answers | |

**END OF QUESTIONS**