Meanings of Health and Physical Activity

PRELIMINARY PDHPE

• Aphrodite Cox • Wayne Cox •
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Introduction

What the book includes

This book provides questions and answers for each dot point in the syllabus for the following topics in the Year 11 PDHPE course:

- Better Health for Individuals
- The Body in Motion
- First Aid
- Fitness Choices

Format of the book

The book has been formatted in the following way:

1. Main topic statement.

1.1 Syllabus requirement.

Note that the numbering of these statements is the authors’ choice and has been used to make referencing questions and answers clearer. The individual requirements are not numbered in the syllabus, they are simply bulleted – hence our use of ‘dot points’ when we refer to them.

1.1.1 First question for this syllabus requirement.
1.1.2 Second question for this syllabus requirement.

The number of lines provided for each answer gives an indication of how many marks the question might be worth in an examination. As a rough rule, every two lines of answer might be worth 1 mark.

How to use this book

Completing all questions will provide you with a summary of all the work you need to know from the syllabus.

You may have done work in addition to this with your teacher as extension work. Obviously this is not covered, but you may need to know this additional work for your school exams.

When working through the questions, write the answers you have to look up in a different colour to those you know without having to research the work. This will provide you with a quick reference for work needing further revision.
Verbs to Watch

account, account for
State reasons for, report on, give an account of, narrate a series of events or transactions.

analyse
Identify components and the relationships among them, draw out and relate implications.

apply
Use, utilise, employ in a particular situation.

appreciate
Make a judgement about the value of something.

assess
Make a judgement of value, quality, outcomes, results or size.

calculate
Determine from given facts, figures or information.

clarify
Make clear or plain.

classify
Arrange into classes, groups or categories.

compare
Show how things are similar or different.

construct
Make, build, put together items or arguments.

contrast
Show how things are different or opposite.

critically (analyse/evaluate)
Add a degree or level of accuracy, depth, knowledge and understanding, logic, questioning, reflection and quality to an analysis or evaluation.

deduce
Draw conclusions.

define
State the meaning of and identify essential qualities.

demonstrate
Show by example.

describe
Provide characteristics and features.

discuss
Identify issues and provide points for and against.

distinguish
Recognise or note/indicate as being distinct or different from, note difference between things.

evaluate
Make a judgement based on criteria.

examine
Inquire into.

explain
Relate cause and effect, make the relationship between things evident, provide why and/or how.

extract
Choose relevant and/or appropriate details.

extrapolate
Infer from what is known.

identify
Recognise and name.

interpret
Draw meaning from.

investigate
Plan, inquire into and draw conclusions about.

justify
Support an argument or conclusion.

outline
Sketch in general terms; indicate the main features.

predict
Suggest what may happen based on available data.

propose
Put forward a point of view, idea, argument or suggestion for consideration or action.

recall
Present remembered ideas, facts or experiences.

recommend
Provide reasons in favour.

recount
Retell a series of events.

summarise
Express concisely the relevant details.

synthesize
Put together various elements to make a whole.
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Answers to Fitness Choices: 263
DOT POINT
Better Health for Individuals
1. What does health mean to individuals?

1.1 Investigate the varying meanings and degrees of health, by analysing health dimensions and guidelines for being healthy.

1.1.1 In the table below compile a list of terms or phrases that would indicate either healthy or unhealthy.

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1.1.2 ‘Health is a state of physical, mental and social well-being. It involves more than just the absence of disease or infirmity.’ World Health Assembly, 1948.

Outline in what ways health is more than just absence of disease.

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1.1.3 WHO definition of health: ‘Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity’.

(a) Explain how this definition incorporates a holistic approach to health.

(b) Outline the limitations, plus propose some changes to the WHO definition in order to improve it.

1.1.4 Explain each of the dimensions of health and provide examples of good health to illustrate each area.

(a) Physical health.

(b) Social health.
1.1.5 Complete the diagram below by identifying the skills or attributes that need to be considered in each area of health.
1.1.6 ‘Exercise and activity are natural antidepressants and a great way to reduce stress after a long and difficult day.’

Examine this quote in terms of the positive and negative effects of physical health on mental health.

1.1.7 ‘Social support is one of most important factors in predicting the physical health and wellbeing of everyone.’ Corey M Clark, Rochester Institute of Technology.

Outline how social support is essential in maintaining good health – particularly for adolescents and the aged.
1.1.8 Referring to the dynamic nature of health, and the dimensions of health, explain why health may be viewed as a continuum.

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1.1.10 Individual health is dependent upon many environmental factors. Provide examples to illustrate how each of the environments stated below may alter overall health.

Physical environment

Sociocultural environment

Socioeconomic environment

Sociopolitical environment

Heredity
1.2 Examine the perceptions individuals and groups have of health and determine the degree to which these are socially constructed.

1.2.1 Explain how social constructs affect individuals’ health and physical activity levels.

1.2.2 Marilyn Monroe’s ‘perfect’ natural hourglass body was perfect for the 1950s where womanly curves made for the desirable body image of the fashion era. Her body ideal would today be considered too heavy for today’s icons of beauty.

Explain how healthy body images of both men and women have changed over time.
1.2.3 Referring to the photographs below outline how the meanings of health as it relates to skin colour have changed over the years. Propose reasons for these changes in perception.
Mental illness throughout history.

Witchcraft and demonic possession were common explanations for mental illness. Colonists declared these lunatics possessed by the devil, and usually they were removed from society and locked away. Although the colonial era’s methods of handling the mentally ill and medical procedures could be considered barbaric by present-day standards, the vast majority of people were content because the lunatics were no longer visible in society.

In the 1800s, nervous diseases became fashionable and affictions of the rich and well off.

Walter J Freeman developed the transorbital lobotomy. This new medical procedure could be performed quickly and required limited after-care for the patient.

Along with the common use of lobotomy procedures in asylums, electroconvulsive shock treatment continued to be a dominant practice.

Psychotropic medication was pioneered in the 1950s. In 1954 the medical community introduced an antipsychotic drug called Thorazine for the treatment of the mentally ill. In rapid succession, other psychotropic medications became available, making it possible to cut substantially the length of time patients stayed in mental institutions. This breakthrough led to a significant decline in asylum populations, and the gradual discontinuation of less humane treatments and procedures.

Explain how the perceptions of mental illness have altered over history. Use examples of the treatment of mental illness to illustrate your answer.
1.2.5 In relation to ethnicity, socioeconomic status and geographical location discuss how different cultures have differing beliefs and meanings of health.
1.2.6 Explain how the quest for world acceptance and modernisation or Westernisation has contributed to China’s obesity crisis.

<table>
<thead>
<tr>
<th>The increasing ‘Westernisation’ of China’s diet, coupled with a generation of spoiled only children, is producing a marked increase in clinically overweight citizens.</th>
</tr>
</thead>
<tbody>
<tr>
<td>BBC News Home.</td>
</tr>
</tbody>
</table>
1.2.7 Observe each of the images below and suggest reasons that may have contributed to the situation in terms of an individual or victim blaming approach and a sociocultural/environmental approach.

(a) ![Image](image_url)

<table>
<thead>
<tr>
<th>Victim blaming</th>
<th>Sociocultural/environmental</th>
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<tbody>
<tr>
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### Dot Point Preliminary PDHPE

**Victim blaming** | **Sociocultural/environmental**

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</table>
Read the case study below. Explain why this sociocultural view of the issue at Thornton Public School was successful in producing positive health outcomes.

**Girls and sport at Thornton Public School – a case study**

**Problem**

When staff, students and parents researched the use of playground space they found that the active play spaces were dominated by groups of boys.

**Proposed actions**

A playground timetable was developed to allow girls specific access to active play areas such as the basketball courts, playing fields and climbing equipment to encourage more physical activity.

Playground game skills such as handball, bat and ball skills, and soccer were taught to assist girls to participate in playground activities.

Issues of bullying and harassment were dealt with in PDHPE lessons.

Classroom discussions were initiated about playground use and associated gender issues to allow students to talk about their experiences.

A peer support program was implemented with a focus on cooperative group skills and gender issues around being a boy or being a girl.

An alternative sport program providing students with a wide variety of choice such as bike safety and archery was introduced.

**Outcomes**

An increase in girls’ participation in physical activities with girls’ teams being entered in interschools knockout days in cricket and soccer.

Strong support by girls for the sport program offering a wide variety of physical activities.
1.2.9  Briefly explain why individuals place different meanings on health and how this may affect attitudes and health behaviours.

1.3   Examine current health trends of young people and identify the protective and risk behaviours associated with these.

1.3.1  Explain the protective behaviours, skills and knowledge required to maintain health in terms of the poor health choices confronting Australia’s youth today.

<table>
<thead>
<tr>
<th>Youth health issues</th>
<th>Protective behaviours required to maintain health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overconsumption of alcohol or binge drinking and under-age alcohol consumption</td>
<td></td>
</tr>
<tr>
<td>Unprotected sexual activity</td>
<td></td>
</tr>
<tr>
<td>Increased risk-taking whilst driving (speeding, alcohol consumption, overcrowding)</td>
<td></td>
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</tbody>
</table>
1.3.2 Using the information from the AIHW tables explain the reasons behind the gender and age differences in physical activity for youth in Australia.

**How exercise levels are defined in national health surveys**

Exercise levels reported in ABS National Health Surveys are based on frequency, intensity (i.e. walking, moderate exercise and vigorous exercise) and duration of exercise (for recreation, sport or fitness) in the two weeks prior to the interview. From these components, an exercise score was derived using factors to represent the intensity of the exercise. Scores were grouped into the following four categories:

Sedentary – Less than 100 minutes (includes no exercise/sitting in one place for extended periods of time)

Low – 100 minutes to less than 1600 minutes

Moderate – 1600-3200 minutes, or more than 3200 minutes but less than 2 hours of vigorous exercise

High – More than 3200 minutes and 2 hours or more vigorous exercise

*Source: ABS 2006*

<table>
<thead>
<tr>
<th>Exercise level</th>
<th>15-17 years</th>
<th>18-19 years</th>
<th>20-24 years</th>
<th>15-24 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>Moderate to high</td>
<td>54.3</td>
<td>34.1</td>
<td>47.3</td>
<td>28.1</td>
</tr>
<tr>
<td>Low</td>
<td>26.7</td>
<td>36.1</td>
<td>25.1</td>
<td>37.4</td>
</tr>
<tr>
<td>Sedentary</td>
<td>18.9</td>
<td>29.8</td>
<td>27.5</td>
<td>34.5</td>
</tr>
</tbody>
</table>
1.3.3 Examine the graphs below and propose actions that would deal with reasons for not being active for young people.

![Bar graph showing reasons for not being physically active.]

Reasons for not being physically active
(SA Dept of Human Services – Physical activity survey, 1998)

![Bar graph showing factors to encourage physical activity.]

Factors to encourage physical activity
(SA Dept of Human Services – Physical activity survey, 1998)
1.3.4 Compare the National Physical Activity Guidelines for adults with Australia’s Physical Activity recommendations for 12-18 year olds.

1.3.5 Explain the link between diets high in saturated fat, atherosclerosis and cardiovascular disease.
1.3.6 A century ago, fibre in the diet was thought to be harmful to the body. It was believed to interfere with the absorption of essential nutrients from food and also increase bacteria in the bowel. Today however, the Australian Dietary Guidelines recommend that we eat more breads and cereals (preferably wholegrain) and fruit and vegetables. CSIRO, 2007.

Explain the importance of including dietary fibre or roughage in a diet.

1.3.7 Evaluate the effectiveness of using body mass index (BMI) as compared to waist/hip ratio comparison in determining obesity and risk of cardiovascular disease.
1.3.8 Explain how media influences have contributed to the increase in disordered or extreme eating in males, resulting in muscle dysmorphia or what is commonly known as the Adonis complex.

1.3.9 ‘The tide has turned for men, guys are now meant to look like waifs or weight-lifters.’

Analyse this statement with reference to the changing ideals of male body image.
1.3.10 Over the last 20 years, rates of obesity in children have risen greatly in many countries around the world, leading some researchers to speak of an ‘international epidemic of childhood obesity.’

Outline some of the major social, emotional and physical problems that these children will experience as they age.
1.3.11 Analyse the table below and suggest reasons for differences in patterns of drug use for the two years identified.

**Summary of lifetime drug use among Australian young people from national surveys**

<table>
<thead>
<tr>
<th>Survey</th>
<th>Year</th>
<th>Sample</th>
<th>Amphetamines</th>
<th>Cannabis</th>
<th>Ecstasy</th>
<th>Opiates</th>
<th>Any illicit substance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian secondary school students</td>
<td>2002</td>
<td>School students aged 12-17</td>
<td>7</td>
<td>25</td>
<td>5</td>
<td>3</td>
<td>27</td>
</tr>
<tr>
<td>Australian secondary school students</td>
<td>2001</td>
<td>Young people aged 12-19</td>
<td>8</td>
<td>34</td>
<td>7</td>
<td>1</td>
<td>38</td>
</tr>
</tbody>
</table>
1.3.12 Analyse the graph below then outline reasons for the difference between non-indigenous and indigenous male smokers.

![Graph showing the percentage of non-indigenous and indigenous male smokers by age group.](image)

- Non-indigenous
- Indigenous
1.3.13 Account for the differences in the levels of tobacco use between males and females as reported in Tobacco Use, *Volume 233, Issues in Society, 2006.*

‘Daily smoking rates for Australians aged 14 years and over have declined by 40% between 1985 and 2004. In 1985, 29% of Australians aged 14 years and over smoked daily, while in 2004, this proportion had dropped to 17%. Rates for males have declined a little more sharply than for females, dropping by 43% between 1985 and 2004, compared with a 38% decline for females.’

‘Males were more likely to smoke than females in every age group, except at ages 14-19 years. Some 10% of males aged 14-19 years were daily smokers, compared with 12% of females aged 14-19 years.’

1.3.14 According to the National Institute on Drug Abuse (Risk and protective factors in drug abuse prevention, 2002), parental role models and family have a significant influence in providing protective factors in drug abuse. Outline the significance of family, in particular parents in providing such protection.
1.3.15  Outline the importance of peer influence in the initiation of drug use amongst adolescents.

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1.3.16  In 2008, the NSW and Federal governments proposed an increased tax on ‘alcopops’ or ready
to drink (RTD) alcoholic beverages. Examine how this was an attempt to tackle adolescent
drug use and propose some consequences of such a tax.

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1.3.17 Outline the reasons why individuals engage in drug use and propose realistic alternatives for adolescents.
1.3.18 Referring to the extract and graph below, briefly outline why there has been an increase in the sexual activity of adolescents over the past 50 years.

**Aussies start earlier than their parents did**

The Australian Study of Health and Relationships – Australia’s first large-scale national survey of sexual behaviour and attitudes – found that Australians are having sex at a younger age and with more partners.

The University of Sydney and the University of New South Wales reported that more than three-quarters of those surveyed believed that sex before marriage was acceptable.
1.3.19 Examine the barriers to sexual safety experienced by youth today.

The Australian Secondary Students survey in 2002 reported that over 50% of contraceptive pill users did not use a condom during sexual intercourse. Explain reasons for this unsafe choice.
1.3.21 As a youth growing up in the 21st century, describe methods designed to improve sexual safety.

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1.3.22 Sexually transmitted infections (STIs) are on the increase, particularly among adolescents. Suggest reasons for this trend.

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2. What influences the health of individuals?

2.1 Investigate and analyse how an individual’s health can be determined by a range of factors in various combinations.

2.1.1 Discuss the relationship between the individual factors of knowledge, skills and attitudes and their effect on health.

2.1.2 Outline genetic predisposing factors that negatively affect individual health.
2.1.3 Explain the ‘protective’ nature of a strong family unit in terms of influencing the health of individuals.

2.1.4 Outline both the protective and risk influence that peers may have on the health of individuals.

2.1.5 Describe the skills required by individuals to resist the negative influence of peer groups.
2.1.6 Research has shown a strong correlation between watching TV and maladaptive behaviours. It is without doubt one of the strongest influences on individuals and by the age of 18, the average Australian will have watched over 20 000 hours of programs and 350 000 advertisements.

Discuss how media may negatively influence health in terms of nutrition, body image, alcohol and violent behaviour.
2.1.7 Discuss the positive health influences derived from religious involvements and beliefs.

2.1.8 List negative influences on individual health as a consequence of cultural differences.
2.1.9 Recent studies reveal Aboriginal life expectancy was 59.6 years at birth; however Canada’s indigenous community had the highest life expectancy of 72.9 years, followed by New Zealand’s Maori at 72.1 and the United States at 70.6.

Discuss reasons why indigenous Australians suffer such poor health in comparison to non-indigenous Australians.
2.1.10 Referring to the table, outline reasons for the differences in life expectancy at birth in NSW across different socioeconomic groupings.

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</thead>
<tbody>
<tr>
<td>Lowest socioeconomic</td>
<td>Males</td>
<td>74.9</td>
<td>74.9</td>
<td>75.0</td>
<td>75.7</td>
<td>75.6</td>
<td>76.3</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>81.1</td>
<td>81.1</td>
<td>81.3</td>
<td>82.0</td>
<td>81.3</td>
<td>81.7</td>
</tr>
<tr>
<td>4th quintile</td>
<td>Males</td>
<td>75.1</td>
<td>75.1</td>
<td>75.4</td>
<td>75.5</td>
<td>76.2</td>
<td>76.4</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>80.8</td>
<td>81.3</td>
<td>81.2</td>
<td>82.1</td>
<td>82.2</td>
<td>82.6</td>
</tr>
<tr>
<td>3rd quintile</td>
<td>Males</td>
<td>74.3</td>
<td>74.9</td>
<td>75.2</td>
<td>75.9</td>
<td>76.5</td>
<td>76.9</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>80.9</td>
<td>81.2</td>
<td>81.4</td>
<td>82.3</td>
<td>82.7</td>
<td>82.3</td>
</tr>
<tr>
<td>2nd quintile</td>
<td>Males</td>
<td>75.7</td>
<td>75.8</td>
<td>76.6</td>
<td>76.5</td>
<td>76.4</td>
<td>77.3</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>81.3</td>
<td>81.9</td>
<td>81.9</td>
<td>82.4</td>
<td>82.5</td>
<td>82.4</td>
</tr>
<tr>
<td>Highest socioeconomic</td>
<td>Males</td>
<td>78.0</td>
<td>78.3</td>
<td>78.7</td>
<td>79.2</td>
<td>79.2</td>
<td>79.6</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>82.7</td>
<td>82.7</td>
<td>83.0</td>
<td>83.4</td>
<td>84.1</td>
<td>84.3</td>
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<tr>
<td>NSW</td>
<td>Males</td>
<td>75.6</td>
<td>75.8</td>
<td>76.2</td>
<td>76.6</td>
<td>76.8</td>
<td>77.3</td>
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<tr>
<td></td>
<td>Females</td>
<td>81.4</td>
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<td>81.8</td>
<td>82.4</td>
<td>82.6</td>
<td>82.7</td>
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2.1.11 Discuss the relationship between levels of educational attainment and the health of individuals.

2.1.12 Explain how the environmental factors of geographical location, access to health services and access to technology are all linked and directly affect individual health.
2.1.13 Overall, indigenous Australians experience lower levels of access to health services than the general population, attributed to factors such as proximity, availability and cultural appropriateness of health services, transport availability, health insurance and health services affordability and proficiency in English.

Outline approaches the government has attempted to tackle the problem of health access.

2.2 Assess the degrees of control individuals have over their own health.

2.2.1 Identify the modifiable and non-modifiable health determinants.

<table>
<thead>
<tr>
<th>Modifiable health determinants</th>
<th>Non-modifiable health determinants</th>
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<tbody>
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<td></td>
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</table>
2.2.2 Discuss how the determinants of health change in influence through different life stages.

2.3 Investigate how the determinants of health and their interrelationships explain the inequalities experienced by individuals in terms of health.

2.3.1 Explain ‘social construct’ in terms of health.
2.3.2 Briefly outline the socioeconomic and sociocultural factors that influence health.

2.3.3 Analyse the reasons why the government and health authorities need to recognise the importance of social determinants on the health status of an individual. (Include education, socioeconomic status, employment, ethnicity, gender and geographic location in your answer.)
3. What strategies help to promote the health of individuals.

3.1 Investigate and describe health promotion strategies and roles and responsibilities of individuals, groups and governments.

3.1.1 Outline the main aims of health promotion.

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3.1.2 Explain what ‘empowerment of the individual’ means and how it relates to health promotion.

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3.1.3 The local community can no longer take a ‘passive role’ in health care. Compare and contrast how the community sector’s role has changed in recent times.

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3.1.4 Explain the importance of non-government organisations in health promotion.

3.1.5 Outline the roles and functions of the World Health Organisation (WHO) in terms of health promotion and prevention.

3.2 Investigate the effectiveness of health promotion strategies relevant to young people.

3.2.1 Using relevant examples outline the concept behind the ‘lifestyle/behavioural’ approach to health promotion.

3.2.2 ‘Zero tolerance is an archaic term – we now need to focus on harm minimisation’.

Examine this statement and justify the harm minimisation approach to drug use in the 21st century.
3.2.3 Discuss the strategies employed using the ‘preventive medical approach’ to health promotion.

3.2.4 Outline examples of primary, secondary and tertiary prevention in health promotion strategies.

<table>
<thead>
<tr>
<th>Primary prevention</th>
<th>Secondary prevention</th>
<th>Tertiary prevention</th>
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3.2.5 Discuss the effectiveness of public health approaches in health promotion.
3.2.6  Outline the main features and aims of the ‘Health Promoting Schools’ framework.

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3.3  Research the significance and features of the Ottawa Charter for Health Promotion.

3.3.1  Briefly outline the historical background of the Ottawa Charter and outline the designated prerequisites for health improvement.
3.3.2 Apply each of the five action areas of the Ottawa Charter to health promotion strategies targeting reducing road and traffic-related injuries.

(a) Developing personal skills.

Describe how modifying personal behaviours and accessing information can help reduce the prevalence of road injury.

(b) Creating supportive environments.

Describe how identifying personal support networks in workplaces, schools and where we live can reduce prevalence of road injury.

(c) Strengthening community action.

Describe community-based support networks that can reduce the prevalence of road injury.
(d) **Reorienting health services.**

Describe the ways money and resources used on curative services can be redirected to prevention and promotion to reduce the prevalence of road injury.

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(e) **Building a public health policy.**

Describe the legislation the government has implemented to reduce the prevalence of road injury.

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3.4 **Identify social justice strategies that promote the health of individuals.**

3.4.1 Outline the fundamental principles of social justice and the importance of their application to health.

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Better Health for Individuals 48 Dot Point Preliminary PDHPE
3.4.2 Explain how the recognition of ‘diversity’ in health promotion is essential in delivering meaningful and effective health information.

3.4.3 Explain how the Medicare system is an attempt to tackle social justice principles in delivering basic health cover.

3.4.4 Supportive environments are essential for effective health promotion and include physical, political, economic and social domains. Outline a strategy which endeavours to deal with these environments in delivering equity in health.
1.1.1 Healthy | Unhealthy  
--- | ---  
Sound, wholesome, hale, robust, well, hardy, vigorous, sound, fit, strong, active, flourishing, blooming, sturdy, hearty, beneficial, nourishing, good for you, nutritious, salutary, hygienic, healthful, salubrious. | Unwholesome, contaminated, corrupted, demoralising, detrimental, noxious, unsanitary, sickly, unwell, poorly, weak, delicate, crook, ailing, frail, feeble, invalid, unsound, infirm, bad, negative, corrupt, degrading, undesirable.  

1.1.2 Early definitions of health revolved around whether a person was either ill or well; health was an absence of disease. Today’s definition includes more than this. One’s health is now evaluated along a continuum of several components: social, mental, physical and spiritual health are all considered important. The health of an individual fluctuates between poor and good health across all components. This represents a more holistic approach to health, a focus on the whole person. Health is now defined as a state of complete physical, mental, and social wellbeing and not merely the absence of disease.  

1.1.3 (a) The WHO definition is an attempt to recognise that components of health are all important and they are not interdependent of one another. Physical health may affect mental health. Mental health may affect physical health and so on. This definition recognises the importance of the whole person when considering health. It allows individuals to plan a more balanced approach to achieving and maintaining good health.  
(b) The WHO definition infers that, to be healthy, one must be in prime health in all dimensions, physical, mental and social. This is almost unattainable and excludes many individuals who may not be able to achieve complete physical health due to disability or other health problem. Another limitation of this definition is that it ignores the dynamic nature of health. A person may achieve health at one moment and then find oneself in an unhealthy situation the next. Therefore some recognition of these two areas would produce a definition more fitting to today’s society.  

1.1.4 (a) Physical health refers to bodily health, and is the result of regular exercise, proper diet and nutrition, and proper rest for physical recovery. It involves ‘efficient’ functioning and regulation of the body, our level of fitness, nutritional status, degree of energy, body weight and resistance to disease.  
(b) Social health refers to relationships on all levels and interactions with other people. Aspects of good social health include effective communication of thoughts, feelings, and emotions plus the ability to establish and maintain quality relationships whilst maintaining individuality and personal values.  
(c) Mental/emotional health refers to our feelings and emotions. It impacts on how we manage our surroundings and make choices in our lives. Mental health has to do with many aspects of our lives including how we feel about ourselves, how we feel about others and how we are able to meet the demands of life. A large part includes self-esteem and self-concept and our ability to express our emotions. Mental/emotional health has a large impact on all other components of health.  
(d) Spiritual health refers to the meaning and direction in our lives. It involves the development of positive morals, ethics and values. Being healthy spiritually helps us to demonstrate love, hope and a sense of caring for yourself and others. Attributes of spiritual health can include sharing and caring, forgiveness, faith, hope, integrity, honesty, citizenship, respect for and appreciation of nature, and the ability to value life, demonstrate kindness, recognise one’s individuality and self-worth as well as showing a sense of purpose or direction in activities.  

1.1.5 | Physical  
---  
Fitness and physical health.  
Healthy weight range (hip/waist).  
Disease resistance.  
Ample energy supplies for activity.  

| Emotional  
---  
Excellent self-concept and self-esteem.  
Good social skills.  
Collaborative skills.  
Ability to be oneself.  
Sense of humour.  
Adaptive to change and challenge.  

| Spiritual  
---  
Awareness and understanding of self.  
Setting realistic/attainable goals.  
Values development.  
Appreciation of others and environment.  
Purpose/meaning/connectedness.  

| Social  
---  
Relationship/communication skills:  
- Active listening.  
- Negotiation skills.  
- Authenticity.  
- Openness.  
- Conflict resolution.  
- Assertiveness.
1.1.6 The physical state of the body can have an incredibly large impact on mental state. A person who is not in good physical condition has a tendency to feel more self-conscious and be less self-confident. Thus poor physical health can impact negatively on a person’s mental health. Exercise, especially after a long and difficult day, is a great way to try and improve mood, improve confidence and avoid depression. Studies are now being undertaken to further the understanding of how exercising and improving an individual’s physical health can positively influence mental health. As well as exercise being a natural antidepressant, there are many other reasons why being more fit can actually improve a person’s outlook. Exercise is a great way to reduce stress after a long and difficult day and it helps get the body into better physical condition which can make a person look and feel more attractive. Exercise will also help to reduce the chance of developing diseases, such as heart problems, some cancers and diabetes, which would have a negative impact on an individual’s mental health.

1.1.7 Social support is crucial for adolescents as they are often exposed to situations, which may impact on their health if they do not get adequate social attention from others. For example, they may be involved in situations that make them feel overwhelmed or awkward. The adolescent is still developing and could easily experience emotional strain if no support is immediately available. Anxiety and depression are two main psychological disorders that are often seen among adolescents.

For adolescents, family support is the most important element in their lives. As part of their growth experience, adolescents usually expect a lot from their parents. Inadequate parental support is likely to increase the chance of depression in adolescents who get into unfortunate situations. Beside family support, peer support is also a very important factor for adolescents. Peer support can be an alternative source of social support if adolescents receive inadequate attention from their parents. Receiving social support is essential for adolescents to become successful and achieve a satisfactory level at school.

As we get older, our physical component of health decreases and social support resources may also decrease. Older adults usually face significant changes when they reach their retirement ages. If their career is over, they need to establish a new focus. Retired workers have several choices to make: fully retire from the work force, continue working part-time and collect some money, or focus primarily on non-paying jobs or volunteer activities. Volunteering is a big factor in providing social support for older adults as it helps provide companionship and interaction with more people in the community. This may become necessary if older adults lose some social support from their family members. This group of people needs to keep busy by connecting with other people as often as needed to maintain overall mental and physical health and wellbeing. Social support is the key to determining life satisfaction among older adults. As expected, older adults who elect not to do any work during their retirement, can experience a lower level of life satisfaction. Their body functions may deteriorate more quickly than other older adults who keep themselves busy.

1.1.8 Health may be viewed as a continuum because each dimension of health can vary across a range. Health is always in a state of flux and all of the dimensions closely interact and influence each other. In addition, what is healthy to one may not be for another, so viewing health across the continuum allows us to compare individual health across time as well as larger groups. It also allows individuals to realise that one’s health may be up then down. Learning to cope and adjust to changes is another important part of remaining healthy.

1.1.9 Health is referred to as being ‘relative’ as it is seen in respect to each individual situation.

The first photograph may be deemed to portray an unhealthy boy, but if the circumstances meant no food or clothing or shelter, then at this point in time, he may be relatively healthy, at least to other children in his country.

The second photo reveals a person with a physical disability who thus may be considered as in a lower position of health. Howe ver, as we get older, our physical component of health decreases and social support resources may also decrease. Older adults usually expect a lot from their parents. Inadequate parental support is likely to increase the chance of depression in older adults who get into unfortunate situations. Beside family support, peer support is also a very important factor for older adults. Peer support can be an alternative source of social support if adolescents receive inadequate attention from their parents. Receiving social support is essential for adolescents to become successful and achieve a satisfactory level at school.

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1.1.10 Physical environment – The physical environment has a direct effect on an individual’s health. Examples of harmful effects are: increased skin damage through exposure to harmful UV rays (increased by ozone depletion); effects of pollutants, e.g. increased concentrations of sulfur dioxide causing respiratory problems such as asthma; increased industrial and transport noise; increased radiation and chemical pollutants linked with increased cancer and death rates in some locations. Positive influences include water treatment plants, fluoridation, and regular waste disposal.

Sociocultural environment – Ethnicity may affect health as migrants may experience, through isolation and language difficulties, loss of support and lower self-esteem. Gender is significant, as life expectancy is greater in females; whereas males have increased cardiovascular disease and are higher risk takers. Male youth culture has a high suicide rate as well as higher violence and injury rates.

Socioeconomic environment – Access to health care and services has a significant bearing on an individual’s health. Adequate and safe housing, nutritious food, health education and knowledge all cost money and people with low incomes tend to have higher rates of smoking and disease, lower self-esteem, higher unemployment and lower levels of education – all of which are detrimental to health status.
Sociopolitical environment – Closely related to socioeconomic issues. Health infrastructure and maintenance is the responsibility of governments, which are often driven with an agenda to remain in power. These have a direct influence on critical areas of health such as availability of hospital beds, emergency care and ambulances.

Heredity – There is a large number of genetically transmitted conditions which affect health. These range from short-sightedness to Down syndrome and cystic fibrosis. The genetic blueprint can predispose individuals to poor health. Asthma, diabetes and some cancers are passed through genetic links and directly affect health.

1.2.1 Social constructs – peoples’ views based on their social circumstances (e.g. age, culture, geography, gender) and the ways this affects their interpretation of and interaction with their environment. Social constructs are in place in all areas of life; they provide guidelines on acceptable behaviour or rules for engaging in health services or activities.

Social constructs affect health directly, in particular they help to determine an individual’s nutrition, drug use and activity levels. For example:

- Nutrition – the availability of various types of food, effects of advertising, whether the family eats together at a table or in front of the television.
- Drug use – smoking or other drug use may be to obtain peer acceptance or stress reduction.
- Activity levels – exercise may be a part of everyday work or family lifestyle or it may be difficult due to time constraints, safety issues and geographic location.

1.2.2 Appearance and being healthy are very much socially defined, so over the past 100 years, healthy body image (particularly the female image) has changed with social changes. In the 1920s, the Victorian hourglass gave way to the thin flapper who bound her breasts to achieve a washboard profile. But by the 1950s, a thin woman with a large bust line was considered most attractive. The voluptuous (size 16) Marilyn Monroe set a new standard for women. However, today in our modern Western society, ‘thin is in’ and artificial means such as liposuction are often used to lessen the appearance of hips, buttocks and fat in general.

Throughout history, tanning has changed in popularity and in meaning. The class system in Victorian societies created social distinctions between those of tanned complexion and those without: a distinction based solely on skin colour. Those with tanned skin were often grouped together as lower class because of the association between tanned skin and labour-intensive jobs which involved long hours spent in the sun. Tans tended to be labour tans, rather than the leisure tans of today. Women would even use whitening agents on their skin, as in the first picture, creating a pale complexion to indicate they were of higher social status.

After Coco Chanel accidentally got sunburnt on the French Riviera, tanned skin became a trend, partly because of her status in the fashion industry. This transformed the perception of tanned skin and it became accepted as a sign that the person was fashionable and healthy, with a luxurious lifestyle. The second shot epitomises how, for many years, tanned skin was seen as a reflection of overall health and wellbeing, typical of the bronzed Aussie iconic image.

We have gone full circle in many ways. Today pale skin is generally perceived as healthy skin and is increasingly accepted in the fashion industry, as is the wearing of sun-protective clothing and lotions. This has largely come about because of a growing awareness that exposure to ultraviolet light causes skin cancer. The third photograph shows a child at the beach, covered up to prevent skin overexposure as recommended by organisations such as the Cancer Council. Promotions by such organisations attempt to reduce our high incidence of skin cancer, but many of today’s youth still see a tan as sexually appealing.

1.2.4 Early treatment of mental illness was by the church as it offered shelter to the poor and destitute. From the 16th century, insanity was viewed as a disturbance of reason and the mad were considered nothing more than beasts and treated accordingly. People were locked away or provided labour for demeaning jobs. Medical intervention such as bloodletting, scarring, and leeching were common to attempt to ‘drain the madness’.

Mental hospitals became increasingly overcrowded so radical treatments such as electroconvulsive therapy were used and the surgical technique of lobotomy was developed. This reflected the idea that mental patients had a brain function disorder that could be ‘cured’ through surgery. For a while, lobotomy was heralded as a miracle cure.

Today, psychoanalysis and the use of antidepressants are more frequently used reflecting a more humane and preventive culture in treatment of the mentally ill. The change stems from the development of a wider variety of suitable drugs and the realisation of the numbers of people, across age groups and gender, who need help for some degree of mental illness.

1.2.5 Different cultures have varying beliefs of health determined by ethnicity, socioeconomic status and geographical location. Impacts from these beliefs may promote a positive image of health or be more of a barrier. A cultural or ethnic barrier includes the exclusion of females from physical activity especially for certain groups, and especially for those of non-English speaking backgrounds. Some groups consider sport as unimportant, or may be unaware of opportunities due to language barriers. Family responsibilities may restrict participation in sport and gender role stereotypes may have an influence, especially for girls. Ethnicity and race effects on health can be clearly seen through world life expectancy tables. Positive cultural influences also occur and these promote activity and leisure pursuits, e.g. the Australian beach scene. Indigenous Australians tend to have a more holistic view of health.
Geographical location has a great impact on health and has a direct relationship with life expectancy and wellbeing. As access to health care is more urban centred, rural dwellers tend to have a decreased overall health, have increased rates of mental illness and have relatively high rates of injury and suicide.

Members of lower socioeconomic groups have poorer health with greater rates of disease and lower life expectancies. They also have lower education resulting in poorer health literacy and health skills.

1.2.6 China already has an estimated 70 million overweight people and one in ten Chinese adults and one in five urban schoolchildren are now officially overweight.

Many have attributed the obesity problem in China to the economic reforms introduced 20 years ago. These have led to radical changes in the diet of the Chinese, once reliant on healthy fish, rice and vegetables, and now including more meat and dairy products as well as Western-style fast food with its higher fat and sugar content. In the quest for modernisation and Westernisation, many people have moved from rural agricultural centres to urban industrialised centres, with resulting changes not only in diet but also in levels of physical activity.

In addition to this, government rules have banned families from producing more than one child in an attempt to control China’s population and as a result have created a nation of one-child families. This has led to doting parents and grandparents overfeeding these precious only children. Many parents in China believe this is not a problem, as fatter children look more Western and thus more acceptable. However, Western-style living is bringing an increase in incidence of the diseases of affluence, such as obesity and heart disease, to the country. Heart attacks, previously almost unheard of, are now affecting those in their 30s and 40s.

1.2.7 (a)

<table>
<thead>
<tr>
<th>Victim blaming</th>
<th>Sociocultural/environmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too lazy to get a job.</td>
<td>Unable to secure job due to poor skills.</td>
</tr>
<tr>
<td>Uses all his pension money and money he gathers from passers-by on alcohol.</td>
<td>Non-completion of education as family could not afford to send him to school.</td>
</tr>
<tr>
<td>Would rather live off the street than have to conform to living in designated shelters and housing commission developments. ‘Probably has more money than us!’ ‘Bum’.</td>
<td>Supported single mother with small jobs.</td>
</tr>
<tr>
<td></td>
<td>Government housing not available to single men.</td>
</tr>
<tr>
<td></td>
<td>Preference to families.</td>
</tr>
<tr>
<td></td>
<td>Homeless shelters only temporary and do not allow long-term users.</td>
</tr>
<tr>
<td></td>
<td>Lost contact with family when left home at 14.</td>
</tr>
</tbody>
</table>

1.2.7 (b)

<table>
<thead>
<tr>
<th>Victim blaming</th>
<th>Sociocultural/environmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Just stop eating!</td>
<td>Has developed obesity due to poor cooking skills from parents, who work long hours and for little income. This results in the convenience of fast food.</td>
</tr>
<tr>
<td>Probably sits and plays computer games all day.</td>
<td>Has limited skills in recognising good food and when to stop eating due to limited education.</td>
</tr>
<tr>
<td>Probably would rather eat junk food than healthy food.</td>
<td>Has only limited fresh food outlets close to home and several fast food chains closer.</td>
</tr>
<tr>
<td>Parents are to blame for feeding him so much.</td>
<td>Is limited in skills to be able to increase activity – poor hand-eye skills and movement ability.</td>
</tr>
<tr>
<td>He has gotten to a stage where he can’t help himself.</td>
<td></td>
</tr>
</tbody>
</table>

1.2.8 By viewing this issue as multifaceted and based on a social/cultural cause, the staff were able to gain considerable success. Previously the girls did not engage in activity due to boys’ domination of the areas. Releasing areas to girls enabled equity, improving their access and allowing them to be free from ridicule, or harassment – a basic human right. This was reinforced by tackling issues of bullying and harassment in PDHPE classes. With this was coupled the development of game skills. This ensured increased proficiency in activities, leading to increased enjoyment and then to increased participation in activities. The peer support program enhanced feelings of empowerment and therefore improved participation levels in the program. In addition, the alternative program catered for diversity of choice and allowed some girls to increase involvement in non-traditional forms of physical activity.

1.2.9 Personal views and meanings on health can vary greatly as they are a product of many influences including, age, gender, expectations, financial status, and motivation and even perceived barriers such as time. They are very much based around sociocultural influences, so views will differ with variations in background and past experiences. Different meanings will affect health attitudes and behaviours. For example:

- The view that good health means not being ill, will do little to motivate a person to gain fitness or to reduce problem drinking, as they will see themselves as being healthy (not ill) and may not realise that these activities will have effects later in life.

- A person with the attitude that health is purely physical may not understand the need for skills to cope with stress and therefore will do little to develop these behaviours.
1.3.1

<table>
<thead>
<tr>
<th>Youth health issues</th>
<th>Protective behaviours required to maintain health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overconsumption of alcohol or binge drinking and under-age alcohol consumption</td>
<td>Factors include knowledge of consequences of binge drinking, personal resilience and communication skills that may reduce impact of peer pressure, role models that model responsible drinking behaviours – these include family.</td>
</tr>
<tr>
<td>Unprotected sexual activity</td>
<td>Personal and family expectations, individual knowledge of contraception, communication skills within relationships and skills and knowledge of consequences of alcohol and substance use (25% of unprotected sexual activity is linked to alcohol or substance use).</td>
</tr>
<tr>
<td>Increased risk–taking whilst driving (speeding, alcohol consumption, overcrowding)</td>
<td>Knowledge and skills to resist drinking and driving. Provisions for alternative transport – planning, resilience skills allow protection from peer pressure. Personal limits or goals regarding social behaviours.</td>
</tr>
</tbody>
</table>

1.3.2

Males demonstrate considerably higher levels of exercise in the most vigorous category as compared to females of each of the age specifications. The age trend reflects that males reduce their high level involvement as they get older but females maintain their involvement.

Males' greater involvement may be attributed to social constructs such as expectations of sporting involvement, the ‘rough and tumble’ type socialisation placed on males and even expectations of individuals, parents and schools. Playgrounds are dominated by male activity and schools often do not cater for female involvement on the same level. Males also tend to decrease their involvement in high levels of exercise due to the transition from school and planned sports to decreased time due to external and social commitments. These include employment and study and impinge on the available time. Females maintain their levels of activity (although they are still lower than males) and in some cases actually increase their involvement. This may be attributed to management of weight and improved health becoming more of a focus later.

1.3.3

Reasons of poor self-image (40%) and inadequate time (18%) are cited by many students as reasons for not being physically active. These can be dealt with by providing activity through the school system in a participatory and non-threatening way, and by providing adequate and accurate training and grading of players to reduce stress and feelings of inadequacy. This would also deal with the excuse of no partners to assist as in the school system this would be minimised. Individuals also responded that they would increase their involvement if there was an improvement in the environment that would make it more conducive to exercising (e.g. safer environments for walking, cycling – 25% ND 15%). Therefore an increase in funding and infrastructure to allow this to happen would directly influence involvement and subsequently improve health.

1.3.4

The National Physical Activity Guidelines for adults recommend 30 minutes of activity either through an accumulation of smaller bouts of exercise or in one session. Activity needs to be moderate and be regular with most days being catered for.

The recommendations for adolescents (12-18 year olds) raise this to 60 minutes of vigorous work, made up from a variety of activities if possible, and also attempting to improve and enhance skills.

Activity is recommended each day for both age groups with adult emphasis on prevention of heart disease, stroke and high blood pressure and reducing the risk of developing type 2 diabetes and some cancers. Adolescent emphasis is on building and maintaining healthy bones, muscles and joints to reduce the risk of injury.

1.3.5

Atherosclerosis is a disease in which plaque builds up on the inside of the walls of arteries. Although the exact cause of atherosclerosis is not known, many studies indicate that atherosclerosis is a slow developing, complex disease linked with high amounts of certain fats and cholesterol in the blood. With increased amounts of saturated fat in the diet, plaque or fatty deposits can accumulate in blood vessels narrowing blood pathways. Once this commences, the process may accelerate with increased plaque build-up causing atherosclerosis. This is directly linked to heart disease, with the blockages reducing oxygen supply to tissues and vital organs.

1.3.6

Dietary fibre (rougahge) refers to the non-digestible chemical substances found in plant cell walls within the food we eat. Foods high in dietary fibre are fruits, green leafy vegetables, root vegetables, and whole grain cereals and bread. Almost all natural fibre comes from plants and, although it has little nutritional value, it offers other health benefits. By adding bulk to the diet, fibre prevents constipation, minimises intestinal disorders, and may serve as an aid in dieting. The benefits of consuming foods high in fibre include lower levels of blood cholesterol and triglycerides.

1.3.7

The established body mass index (BMI) measure is less effective than the waist/hip ratio as the BMI does not take into account muscle to fat percentage and the distribution of that fat. BMI has been shown to have only minimal links with cardiovascular disease, whereas significant statistical links have been found between cardiovascular disease and waist/hip ratio. The Australian government has recently realised this with a national measure up campaign concentrating on this.

1.3.8

Often referred to as ‘bigruxia’, this relatively new disease is linked to obsession with building muscle size and fitness. The media, men’s magazines and e-advertising prey on men’s insecurities – with broad shoulders, slim waist and washboard abs being areas the media and advertisements are focusing on today. Media fabrication of the so-called perfect body is dangled in front of men and in particular youths of today in magazines such as Men's Health, in movies such as 300 and in advertising of products ranging from jeans to aftershave.
1.3.9 Making up for years of exploitation of women, the male torso has now become the great crossover image of today, appealing to men and women, gays and straights. Men are now sculpted or chiselled mesomorphs with hairless bodies to accentuate definition. The media show a more defined image only attainable by daily gym visits and diets of steamed chicken (Hugh Jackman, Australia). Another image sought after is the ‘Daniel Johnson’ waif or skeletal image. This image is becoming more acceptable through advertising, particularly with high fashion.

1.3.10 Obesity is considered a long-term disease and therefore childhood obesity is of major concern because it can set up an individual for many years of ill health. There are over 30 serious medical concerns related to obesity and these are even more prevalent in individuals with long-term obesity. Obesity takes its toll on the entire body whether the person is eating the wrong kinds of food or overeating in general. Health issues include the higher rates of type 2 diabetes, heart disease, high blood pressure, sleep apnoea, osteoarthritis, gall bladder disease, fatty liver disease, cancer, asthma, chronic headaches, varicose veins and coronary artery disease. In addition, obesity is closely linked to poor self-esteem and depression and may lead to a lifetime of social and emotional distress. There are also clear links between obesity, post-traumatic stress disorder and social phobia.

1.3.11 Although the age groups differ slightly we may hypothesise that the youth drug culture has made a significant shift away from cannabis (34% to 25%) but not from synthetic hallucinogenic drugs. In fact, although the use of opiates has increased slightly (from 1% to 3%), this is probably not a significant increase and there has been a decrease in illicit drug use overall (from 38% to 27%). Reasons for this shift may include changed availability and prices of the drugs. In addition, education may have provided information and skills for individuals to make better health choices regarding drug use.

1.3.12 The graph shows a consistently higher percentage of indigenous people are smokers than non-indigenous for all ages. The gap between them is least in younger people (55% compared to 30%) with a sharp jump for those in the 35-44 years age group and older (60% compared to 20%). On average, about 20% more indigenous people are smokers than non-indigenous people. The percentage of smokers, both indigenous and non-indigenous, are decreasing; but the gap between non-indigenous and indigenous smoking rates is increasing.

Indigenous people are also more likely to have lower levels of social and economic resources. It is well established that health can be affected by socioeconomic factors and, on all of these measures, Aboriginal Australians fare badly. They are less likely to have formal qualifications, they are more likely to have lower income levels, and they are more likely to be unemployed. Because of these factors they are more likely to engage in activities such as smoking that are deleterious to health.

1.3.13 Rates of smoking, for both males and females, have decreased over nearly all age groups due to widespread campaigns and education within schools. However, the reduction in males smoking (43%) has been greater than the reduction in females smoking (38%). Generally, males smoke more than females, except in the 14-19 year age bracket (10% males and 14% females).

Reasons for these differences could include:

- Female smokers appear to be less influenced by anti-smoking messages.
- Even more significantly, teenage girls start on the path to smoking because of impossible body standards. Girls see ridiculously thin actresses portraying ‘real life’ and as smoking suppresses the appetite to keep weight off, they view it as a reasonable risk.
- Unreasonable academic demands push teenage girls to relieve stress by smoking – particularly with an increased push for women in more demanding and executive roles.

1.3.14 A strong family unit has strong and positive family bonds, with parental monitoring of children’s activities and their peers, clear rules of conduct that are consistently enforced within the family and parental involvement in the lives of their children. Children are more at risk of drug abuse when the family unit falters. This may happen when the parents abuse substances or suffer from mental illnesses; when parenting is ineffective, especially when their children have difficult temperaments or conduct disorders; when there is a lack of parent-child attachments and nurturing; or when drug-using behaviours seem to be approved of within the family.

1.3.15 Peer influence is one of the strongest predictors of drug use during adolescence. It has been argued that peers initiate youth into drugs, provide drugs, model drug-using behaviours, and shape attitudes about drugs. Studies have shown that 84% of adolescents who tried drugs did so because of peer pressure, with adolescents rating peer pressure as one of the top three reasons for using drugs and alcohol (Dupre, Miller, Gold, Rospenda, 1995). These findings have been replicated by other studies.

1.3.16 The tax on ready to drink beverages was directly aimed at the practice of binge drinking in Australian youth. By increasing the retail price it was meant to reduce the availability of alcoholic, sweet tasting, and therefore highly acceptable, alcoholic drinks. Consequences of this proposal saw the increase in distilled alcohol sales and the consumption of amounts of alcohol that could not be monitored in terms of standard drinks. This led to the failure of the proposal as it was perceived to actually increase binge drinking risks and not really tackle the real reasons behind why youths find it necessary to consume alcohol to get drunk.
1.3.17 Teenagers use drugs for similar reasons to adults – to feel better or different. Reasons given for drug taking may include: to socialise with friends; peer pressure or the need to feel part of a group; for relaxation or fun; boredom; curiosity or experimentation; wanting to take risks; to escape from psychological or physiological pain; or to remove themselves from any contact with others, to ‘veg’ out.

Alternatives to drug taking, for any age group, need to take into account the actual reasons why the drug was taken. Study and stress at school have been mentioned as significant contributors to engaging in drug use. If stress is a contributing factor, then learning techniques of stress reduction could help deal with the problem. Learning to plan workloads, organising time for relaxation, improving diet and exercise may all contribute to stress reduction and diminish the need for drug use.

1.3.18 The graph shows that, in 2002, the percentage of young people (male and female) who had had intercourse increased with age, from about 8% at age 14, to 65% at age 19 years. The information given states that Australians are having sex when younger and with more partners and that most accept sex before marriage.

Most youths nowadays feel less guilty about premarital sex when compared to attitudes 20-30 years previous. This shift in attitude is found particularly in young women and has been due to the availability of birth control; a shift toward satisfying an individual’s needs rather than society’s; and gender equality – young women are growing up feeling equal to their male counterparts. This cultural shift is linked to reduced acceptance by today’s teenagers of the well-known double standard, in which it was considered okay for men, but not women, to have sex outside marriage. Certain sexual activities, such as oral sex, are also becoming more acceptable. In previous generations, oral sex was considered disgusting. Now young people see it as another way of being sexual. This is also part of the general trend of sexual behaviour as being for pleasure rather than being considered as appropriate only in marriage for the purpose of reproduction.

1.3.19 Barriers to sexual safety of youth may include:

- Boys may avoid using condoms because they are afraid of losing an erection if they use one.
- Carrying, buying or suggesting the use of a condom is seen as indicating sexual experience, and this can have a negative impact on chaste reputation, particularly of girls.
- A lack of knowledge about what constitutes a sexually transmitted infection and the long-term outcomes of STIs. Many adolescents are aware that HIV is a sexually transmitted infection, but have difficulty identifying chlamydia and gonorrhoea as STIs that can cause pelvic inflammatory disease (PID) and are unaware of the risks of PID on future fertility.
- Not wanting to hurt the partner’s feelings. Asking someone to use a condom may be seen as implying they have a disease.
- Condoms interrupt the mood, are less intimate and just do not feel as good.
- The attitude of ‘I don’t believe in casual sex, so I don’t need to get condoms.’ Many people are not interested in casual sex. However, despite their personal and moral beliefs, these same people sometimes find themselves having sex they had not planned on, often without protection.
- Lack of knowledge about effective birth control methods and their costs.
- Religious beliefs.
- Feelings of immortality and fearlessness.

1.3.20 Due to misinformation and lack of knowledge many students falsely believe that the contraceptive pill is also a mechanism to avoid STIs. They do not see the need for using an additional method.

Many believe that the spontaneity of sexuality is disturbed by the planning required to purchase and apply condoms.

Statistics reveal that alcohol and drugs have a common link with intercourse and may lead to poorer judgement or higher risk-taking.

1.3.21 The development of technology, such as the contraceptive pill, diaphragms and IUDs, placed a larger responsibility on women. In the 21st century, the responsibility for contraception is seen as less of ‘a female problem’ although this responsibility is still heavily weighted towards women. Today men and women are increasingly seeing the need for collaboration within relationships and, with male pills and longer term methods becoming available, men are accepting more responsibility. Men nowadays are more aware of safe sex issues and the need for consent and this has led to modifications in their behaviour related to this issue.

1.3.22 An increase in the incidence of STIs is related to improved and more accessible birth control methods and a cultural shift to increased acceptance of casual sexual relationships. Also the average age of initial intercourse has dropped and this, coupled with an increase in binge drinking and development of a drug culture, has been associated with a shift towards more unprotected sex. This has occurred despite increased school-based education.

2.1.1 Individual health is heavily dependent on an individual’s knowledge base, skills in applying this knowledge and their attitude towards the importance of this information. The provision of health knowledge allows individual action and ownership of one’s health and allows individuals to choose wisely on a variety of health-related areas. Whether it is as a consumer choosing correct health information relating to nutrition or knowledge on the health factors relating to smoking, a sound and broad knowledge base is a essential protective factor in health. In addition, applying this knowledge is needed and individuals require good skills in areas of decision making, relationships and even performance-based skills. These both tie up with an essential ingredient of attitude which influences both the immediate health concerns as well as future ones. Attitude is a most powerful determinant in an individual’s health as it will allow both knowledge and skills to be used positively to gain improved health.
2.1.2 There is a direct link between genetic traits and disease risk. Cancer and heart disease have established links to genetic material and although these have a high correlation with lifestyle factors, hereditary influences can occur with weaknesses in vessels as with stroke or tissue abnormalities as with some cancers. Respiratory disorders such as asthma and also juvenile or insulin-dependent diabetes also have direct genetic links. Other than direct disease links, genetics will influence health through areas such as skin/hair and eye colour and factors relating to skin cancer.

2.1.3 Family influences on health and health decision making is great. In terms of protective factors, the family may provide social support structures through communication and modelling of health behaviours but also through high expectations of health in terms of nutrition, substance use, relationships and emotional health. These expectations, along with knowledge provide a health framework for individuals to work within. Strong family units also provide greater resources in terms of access to health care and new technologies. Protective influences from the family embrace all dimensions of health. From provision of physical shelter and food to emotional support and often spiritual support, the family is perhaps one of the most protective factors in adolescent health.

2.1.4 Peer influence is often regarded as negative. Although this does occur, both positive and negative influences can arise from peer pressure or support. Negative peer influence can be seen in alcohol and substance abuse where peer or group direction drives negative behaviors. Negative peer influence is often linked with high-risk activities and may involve poor judgement and poor decision making due to pressure applied. However, positive influences from peers may in fact enhance health such as social networks and encouragement to participate in activities. Peers may also provide excellent health role models in terms of nutrition and substance use as well as emotional support in difficult times.

2.1.5 Necessary skills in resisting negative peer influence include resiliency, assertiveness and communication skills. These combined often provide a framework for individuals to resist peers without confrontation. Having planned health goals and expectations communicated to others may alleviate unnecessary pressure, plus provide a guideline for individuals to meet. Skills in weighing up risk and consequence are essential and allow individuals to objectively deal with situations.

2.1.6 Much research has revealed a positive correlation between TV violence and aggressive behaviours in children. These influences directly affect health in terms of dealing with conflicts, mental health, and socialisation. In addition, images projected on media including TV are often unrealistic and have negative effects on body image and personal perceptions. Music videos, reality television and other programs portray both men and women unrealistically as compared to the general public. They are ‘model’ like and may lead to negative health behaviours such as restricted diets or excessive exercise.

Nutritional information from media is often focused on quick delivery of food that is nutritionally questionable. Fast food and foods high in fat or sugar grab much of the media spotlight and negatively affect adolescence in terms of food choice. Alcohol representation on media is often as a social lubricant or associated with sporting excellence as with motor racing or some team sports and as a result may provide confusing or conflicting information. The portrayal of alcohol being necessary for enjoyment also has a negative influence as adolescents may regard this as a formula to adhere to.

2.1.7 Several studies have shown that the practice of religious activity improves health and increases longevity but on a more simple level, religious involvement can provide direction and emotional support as well as social networking and a forum to express views and ideas. Involvement in religious ceremonies such as marriage ceremonies may provide opportunity to reflect on important issues. Research also suggests that those involved in religion had significantly less smoking and alcohol use and more preventive care visits, influenza immunisations, vegetable intake, satisfaction with care, and social support.

2.1.8

<table>
<thead>
<tr>
<th>Negative influences</th>
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</thead>
<tbody>
<tr>
<td>Social exclusion leading to decreased educational opportunities and subsequent financial reward.</td>
</tr>
<tr>
<td>Difficulty accessing health services due to poor language skills.</td>
</tr>
<tr>
<td>Decreases health due to altering of diet.</td>
</tr>
<tr>
<td>Decreased social network may lead to isolation and poor mental health.</td>
</tr>
<tr>
<td>Differences in some behavioural expectations such as body language and gestures may lead to misunderstandings.</td>
</tr>
</tbody>
</table>

2.1.9 Aboriginal and Torres Strait Islanders have lower life expectancy rates than the non-indigenous Australians. Indigenous males live 18.7 years less than non-indigenous males whilst females live 18.2 years less than the non-indigenous females. Infant mortality is also four times the national average. Indigenous people experience higher morbidity rates for CVD, cancer, motor vehicle accident (MVA), homicide, suicide, respiratory diseases, and nutritional diseases such as diabetes. There are numerous factors that have influenced these trends including: lower levels of education, higher levels of unemployment lower socioeconomic status (SES), greater levels of drug taking (smoking and drinking), poor diets (high in saturated fats and lacking in nutrients), greater exposure to violence, geographic isolation. Mental health issues also are prevalent with a sense of loss of culture and marginalisation of the community; indigenous people suffer feelings of isolation and are vulnerable to many health concerns. On top of this, indigenous people in remote communities have little access to adequate health care.
2.1.10 Life expectancy across different socioeconomic levels reveals a rise in longevity as a consequence of wealth. Approximately 3 years is gained in both males and females when comparing the two extreme quintiles. This is due to higher socioeconomic individuals being able to access higher education, providing higher levels of knowledge and increased access to a whole range of health care. In addition wealth provides increased opportunity to provide healthy options in terms of food and housing as well as opportunities for leisure and rest.

2.1.11 The level of completed education has some correlation with income and prospective earnings and therefore is directly related to an individual’s ability to access health care, both preventive such as in gym programs or treatments such as with pharmaceuticals and medical care such as physiotherapy. Higher levels of education also correlate with higher skills and knowledge and an ability to utilise this information in positive health behaviours. Skills and knowledge such as with food preparation or as simple as health food purchases is linked with higher educational achievement. Lower educational levels are associated with increased health risk behaviours such as smoking resulting in poorer health.

2.1.12 Due to Australia’s vastness, geographical location directly influences health access and health technology availability and as a result has profound impact on the health of individuals. Urban dwellers have numerous access opportunities to health, either through public or private institutions which offer a wide range of services. Remote and rural dwellers do not have this same opportunity and are often isolated in terms of health. Access may even be on a visiting basis as with remote areas of Australia and The Royal Flying Doctor Service. Or it may be that population does not require large services so travel to bigger centres are required for everything from emergency to chronic care. With this isolation, availability to technology is further limited due to financial constraints and ‘population to service’ type quotas. Access to health care in terms of mental health is far more difficult in remote areas as are all specialist and surgical type care.

2.1.13 Recent developments in government action include a $1.6 billion National Partnership Agreement on Closing the Gap on Indigenous Health outcomes that includes measures to tackle chronic disease factors through adult health checks; improving chronic disease management and follow-up care; improving access to medicines; workforce expansion and support; other initiatives relate to smoking and maternal and child health services. The Closing the Gap initiative deals with access to care and points towards more regional specialist care services with circumstances that surround them. Their health is determined by the social, physical and political environments of the moment and an individual’s interaction with them.

<table>
<thead>
<tr>
<th>Modifiable health determinants</th>
<th>Non-modifiable health determinants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance use – tobacco/alcohol/illicit drug use.</td>
<td></td>
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<tr>
<td>Physical inactivity/overweight and obesity.</td>
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<tr>
<td>Unsafe sexual activity.</td>
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<tr>
<td>High cholesterol and blood pressure.</td>
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<tr>
<td>Stress levels.</td>
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<td>Abnormal blood lipids.</td>
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<tr>
<td>Unhealthy diets.</td>
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<td>Diabetes.</td>
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<td>Health knowledge and skills.</td>
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<td>Health attitudes and motivation.</td>
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<td>Advancing age.</td>
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<td>Gender.</td>
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<tr>
<td>Ethnicity.</td>
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<tr>
<td>Hereditary or family history.</td>
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<tr>
<td>Environmental factors.</td>
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2.2.2 Health determinants alter their level of influence on individuals over time. For example, socioeconomically disadvantaged children suffer lower levels of education, higher obesity rates and poorer fitness levels. This then leads to higher unemployment rates later in life, reduced health literacy and an inability to adequately access the health support they require. Poor circumstances during pregnancy can lead to less than optimal foetal development via a chain that may include deficiencies in nutrition during pregnancy, maternal stress, a greater likelihood of maternal smoking and misuse of drugs and alcohol, insufficient exercise and inadequate prenatal care. Poor foetal development is a risk for health in later life. Determinants such as social influences like peer influence alters over time as seen with pressure to conform during adolescents but as people move into adulthood the diminished influence of peers is marked. Access to health care through geographic location is a significant factor in remote areas with elderly or new born babies as chronic care or specialist and emergency treatment facilities may be at too greater distance and therefore create further problems.

2.3.1 Social construct in terms of health is the recognition that an individual’s health status is directly influenced by the social circumstances that surround them. Their health is determined by the social, physical and political environments of the moment and an individual’s interaction with them.
Socioeconomic factors are major determinants of health and wellbeing. People with a more favourable socioeconomic position have better health compared to those who are less well off. For example, social disadvantage can affect a person’s education, which may lead to poorly paid work and poor housing leading to poor health. Sociocultural risk factors may include family and peer influences, demographic factors, and economic and availability factors. These factors are crucial in providing protective factors guarding against poor health choices.

The government and health authorities have to recognise the importance of social determinants as they play an integral part in an individual’s health status. Social determinants reflect the situation in which an individual has been placed through no choice of their own; however, if willing to challenge these inequities, health status can be greatly improved.

Education levels of many Australians are considerably limited, which means that many lifestyle choices may be made without sound knowledge of the consequences, for example, choosing foods that are high in saturated fats, which can ultimately lead to high cholesterol and possibly CVD.

Socioeconomic status can also impact upon an individual’s health status as it may be difficult or impossible to afford private medical insurance therefore services such as diagnostic and ancillary treatments are out of reach for many. Statistics show that people from lower SES are more likely to engage in risk-taking behaviours such as drug abuse, namely smoking and drinking.

An individual’s occupation can negatively impact upon their health as many blue collar workers are exposed to carcinogens (chemicals such as asbestos) and heavy machinery that can cause potentially fatal injuries. Some individuals such as office workers having sedentary occupations which can lead to obesity, high blood pressure, which are causal factors for CVD and diabetes.

Unemployment and low-income employment have been shown to have a negative effect on the psychological and physical welfare of the individual and family unit. Lack of disposable income can mean inadequate provision of basic needs, including food, clothing and accommodation. Mental health issues associated with unemployment include lack of self-esteem, depression, and a higher prevalence of suicide.

Ethnicity affects health status of the individual, as the longer the residency the greater the impact of the Australian culture on their lifestyle choices. This can be seen by changes in diet, for example, fast foods that are high in saturated fats and processed sugars leading to higher rates of CVD and colorectal cancer and sun exposure leading to skin cancer.

An individual’s gender can have an impact upon an individual’s life expectancy, obesity, disease and injury. Males are more likely to take risks, work in hazardous occupations, and ignore health problems leading to greater morbidity and premature mortality. Age directly impacts on the individual’s health status. As the individual becomes older they are more likely to develop chronic degenerative diseases such as CVD, cancer and diabetes.

Geographic location directly affects an individual’s ability to access health services and information. For example, those in remote areas of Australia are often less healthy. If the government and health officials work together they can tackle these social determinants by focusing on preventive and promotional initiatives focusing on these inequities.

The main aims of health promotion are to enable people to have increased control over their own health and to steer people towards optimum health in all domains, thereby preventing illness or injury.

Empowerment of the individual means giving the individual the authority to make decisions based on knowledge without relying on others. When relating this to health promotion it means that the individuals make sound decisions about their health based on currently available health information.

The role the community played in health care was very much a passive role prior to the establishment of the NPHA. This meant that they provided a limited amount of health services and were reactive to health problems in the local community. There was little or no consultation between members in the community regarding community concerns. The community’s role has now changed in a number of important ways. There is far greater consultation between all community members, and the focus of health care has been towards proactive preventive health-care measures. This has been particularly evident in areas where certain health issues have been identified as problematic within the local community.

Non-government organisations in health such as the NSW State Cancer Council play a vital role in health delivery. Specified health services and extensive research are the main areas these organisations focus on. Also, they provide exposure to enhance community awareness such as Diabetes Week and up-to-date data collection and analysis.

The WHO provides expertise, advice and policy recommendations to countries regarding health issues. It supports health promotion initiatives and providing guidelines and recommendations on the delivery of health programs to enhance health in countries of need such as water and food. WHO also provides feedback and suggestions for current programs and develops worldwide strategies on global health issues.

The lifestyle approach is a behavioural approach to health in which risk factors are identified and targeted in order to promote change in behaviour and subsequent health.
3.2.2 Drug and alcohol counsellors work from the principle of harm minimisation which accepts that drug use will continue to be part of society, that eradication of drug use is impossible and continued attempts at eradication may well result in increasing harm to society. These attitudes led to the idea that zero tolerance was not an acceptable approach. The primary aim of harm minimisation is to help people survive their drug use with minimal damage to themselves and others. Advocates of harm minimisation do not take a position on whether drug use is intrinsically a good or bad thing; they seek neither to punish nor cure the drug user. This approach accepts that people make choices whether to use drugs or not, and that some will choose to use them, while others will not. The focus remains on preventing harm while a person uses the drug, not on whether they made the right choice.

3.2.3 Based around medical treatment and intervention this model of health promotion is directly focused on health professionals providing medical care and expertise to treat health problems. Recognition of risk factors allows medical practitioners to identify these early and limit potential harm. Preventive medical approaches utilise three stages of health care and promotion: primary, secondary and tertiary preventive strategies.

3.2.4

<table>
<thead>
<tr>
<th>Primary prevention</th>
<th>Secondary prevention</th>
<th>Tertiary prevention</th>
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<tr>
<td>Primary prevention measures fall into two categories.</td>
<td>Secondary prevention concentrates on higher risk groups. An example of secondary prevention is blood pressure screening to identify people with hypertension (high blood pressure). Other diseases in which secondary prevention plays an important role are diabetes, glaucoma, breast cancer (screening over 50 years of age), and cancer of the cervix (regular pap smears). State and local health departments, voluntary health agencies, hospitals, medical clinics, schools, and physicians often conduct screenings for these conditions during which people with no signs or symptoms are tested to uncover these diseases in their earliest stages.</td>
<td>Tertiary prevention programs aim to improve the quality of life for people with various diseases by limiting complications and disabilities, reducing the severity and progression of disease, and providing rehabilitation. Tertiary prevention efforts have demonstrated that it is possible to slow the natural course of some progressive diseases and prevent or delay many of the complications associated with chronic diseases such as arthritis, asthma, heart disease and diabetes.</td>
</tr>
<tr>
<td>1. The first category includes actions to protect against disease and disability, such as getting immunisations, ensuring the supply of safe drinking water, applying dental sealants to prevent tooth decay, and guarding against accidents. Examples of primary prevention of accidents include government and state requirements for workplace safety to prevent industrial injuries and equipping automobiles with airbags and anti-lock brakes. Limiting exposure to sunlight, using sunscreen, and wearing protective clothing are examples of primary prevention measures to reduce the risk of developing skin cancer.</td>
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<td>2. Examples of health education programs aimed at wellness include stress management, parenting classes, preparation for retirement from the work force, and cooking classes.</td>
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3.2.5 Public health promotion tends to be successful as it is multifaceted. It involves social, cultural, environmental and personal lifestyle aspects and utilises expertise from a range of areas including planners, teachers, political experts as well as medical practitioners. The Health Promoting Schools campaign is an example which demonstrates the partnership required between groups to achieve a positive outcome. School members, teachers, and health services all contribute to the program.

3.2.6 The Health Promoting Schools framework focuses on a relationship between the educative level of promotion as well as the environmental, school and community levels. Its effectiveness is increased with established links with local community. The framework encourages school communities to take action for their own health and wellbeing, with better health leading to better learning.

Examples of this campaign include healthy canteen policies, breakfast clubs, ‘Tooty Fruity Veggie breaks’ at school, Crunch and Sip campaigns, Walk safe to school days, Walking Bus initiatives, Sun Smart policies and practices, Active School Kids projects and healthy fundraising.

The framework provides a six-step formula for a whole school health promotion strategy and emphasises a ‘shared’ vision with all school representatives. A Health Promoting School positively promotes and supports healthy practices. It regards the health of its students and those in the school community as a high priority. This is reflected through the curriculum, school environment and links with the local community.
3.3.1 The first International Conference on Health Promotion met in Ottawa in November 1986 and set down action to achieve health for all by 2000 and beyond.

This conference was primarily a response to growing expectations for a new public health movement around the world and discussions focused on the needs in industrialised countries to help with achieving equitable health.

The Charter stated that improvement in health requires a secure foundation in these basic prerequisites:

- peace
- shelter
- education
- food
- income
- a stable ecosystem
- sustainable resources
- social justice and equity.

3.3.2 (a) Developing personal skills: Strategies include mandatory learner driving instruction over a minimum number of hours in a variety of driving environments. Advanced driving skills courses are also recommended. Individuals must learn to recognise signs of fatigue whilst driving and be able to defleet peer pressure to speed or drive unsafely. Avoiding alcohol whilst driving and preparing travel arrangements ahead of time with a designated driver are also emphasised.

(b) Creating supportive environments: Supportive environments for road trauma include physical environmental improvements such as dual lane expressways and speeding restrictions. Supportive environments can also include rest stops placed to encourage short trips and prevent driver fatigue and community strategies such as driver reviver areas. Another example includes school communities placing visible signage to reduce speeding and create awareness around school zones.

(c) Strengthening community action: Examples of this in road trauma areas are community supported driver reviver stations as seen with Lions Club initiatives. Other community examples include safe local pedestrian and cycle ways and driver simulator areas to increase experience for young drivers in a safe environment.

(d) Reorienting health services: Preventive measures are evident in all areas of the Charter’s principles. Strategies to help prevent accidents include alerting drivers by providing information and warnings of weather, traffic and road conditions. Defensive driving courses are also recommended as a preventive measure.

(e) Building a public health policy: Legislation to reduce road trauma involves many aspects such as speed limits, drivers’ licences, number of passengers, mobile phone use, car engine size restrictions and car safety features such as stability control. To make legislation effective involves the cooperation of drivers to obey the road rules and be considerate of other drivers.

3.4.1 The fundamental principles include equity, diversity and supportive environments. Equity involves ensuring all health resources and funding are distributed equally. Diversity involves eliminating discrimination from cultural, economic and individual aspects. Supportive environments involve physical, administrative and emotional support to help ensure all community members achieve good health.

3.4.2 Recognition of diversity existing within a community enables health strategies to be formulated to suit the different groups. Examples include provision of language-sensitive health material in areas such as sexual health, immunisation and indigenous nutrition.

3.4.3 Medicare is an attempt to provide increased equality to Australians in terms of health access and availability. Classified as a universal insurance scheme it relies on funds from taxation of individuals depending on their income. This means that higher income earners pay more than low income earners. It provides medical insurance for health care in hospital and outpatient services as well as some specialised services.

3.4.4 Supportive environments, like health itself, are generated from a range of areas or dimensions. Physical, emotional, financial, organisational and political support are often necessary when attempting to achieve optimum health for individuals that suffer inequities. Low socioeconomic status leads to restrictions on available resources for health such as daily commodities of nutrition and sanitation and is also linked to lower levels of individual self-esteem and satisfaction which then lead to poorer mental and emotional health.

Politically, infrastructures to support health include provision of transport networks, adequate housing and community structures with medical care within an appropriate distance. These decisions need much planning to avoid congestion or isolation. Provision of employment is crucial in health and supportive environments may be created by stimulating the economy and planning for future growth.

Improving environments that are conducive to either walking or cycling is an example of a supportive environment. Allowing safe and convenient access to employment or leisure whilst increasing activity is an aim to reduce health problems and promote exercise. These strategies are evident in many local communities and are successful in tackling some inequities for individuals.