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| NCEA Level 3 Planning Framework 2020  **AS91462 (Health 3.2)** Analyse an international health issue  *and*  **AS91465 (Health 3.5)** Evaluate models for health promotion  *No changes from 2020* – this planning framework (re)considers the work we did around the SDH-DoH |  |

This document is to support teachers of health education to make planning decisions about teaching units leading to assessment by the externally assessed **Level 3 Achievement Standards**. **This file is formatted as an A3 landscape page.** Please note that this is NOT a planned unit, but a **guide to support teachers** to plan programmes that meet the unique needs of their learners. The framework leaves open the opportunity for teacher to add locally relevant and topical material to the learning programme

NZHEA provides **practice exams** for teachers (who are association members) who wish to make use of them. These documents (prepared examination scripts based on the exam formats from the previous year, assessment schedules and resource booklets – where applicable) become available during term 1 of the school year. Notification of these is via the NZHEA Facebook page and our newsletters. Teachers are also encouraged to develop their own practice exams to help prepare students for the end of year examinations.

The Assessment Specifications for 2021 state the following (link to <https://www.nzqa.govt.nz/ncea/subjects/assessment-specifications/> for original and full text)

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| **AS91462 (Health 3.2) Analyse an international health issue** | **AS91465 (Health 3.5) Evaluate models for health promotion** |
| Candidates will be expected to apply knowledge and understanding from their learning to scenarios and / or stimulus material provided in a separate resource booklet in the examination.  Candidates will be required to analyse resources through:   * identifying relevant health determinants * provide implications for individuals, others and society * provide strategies that bring about more equitable outcomes (see enz.govt.nz). *[No further clarity on this from 2020]*   Candidates should be familiar with health issues related to poverty. These will be derived from:   * disease * life expectancy * sexual and reproductive health.   Candidates are required to use specific and relevant research evidence to support their analysis. Refer to Explanatory Note 4 of the standard.  Candidates are required to use the resources provided to support their analysis with evidence.  Assessment will be based on the quality of content, rather than the length of the response.  Candidates' responses should provide evidence of their own thinking. | A resource booklet will be provided.  Candidates will need to be familiar with various health promotion models and supporting documents, including the Treaty of Waitangi. Refer to Explanatory Note 3 of the standard.  Assessment will be based on the quality of the response, rather than its length.  Candidates' responses should provide evidence of their own thinking. |
| **Extra notes:**  The 2020 examination focused on period poverty in India. As anticipated, sexual and reproductive health as a topic choice presented a complex array of considerations that (a) maintain a focus on the poverty aspects of the issue, and (b) avoid getting lost in the cultural attitudes and values and associated policies (or lack of these). |  |
| **It was noted that many schools chose to look at child poverty in NZ for AS91461 (3.1 NZ health issue) which provided the opportunity for teaching and learning about poverty that could then be applied to AS91462 (internal health issue) albeit with a different focus.**  **Also, the *Child and Wellbeing Strategy* is still one of four documents that form the foundation for the HPE Scholarship report so this 3.1/3.2 learning may also provide ideas for a 2021 Scholarship topic.** |  |

Planning framework for:

**AS91462 (Health 3.2) Analyse an international health issue - topics for 2020 are issues related to poverty derived from: disease; life expectancy; or sexual and reproductive health.**

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| **Using this planning framework** | | |
| **As a planning framework this is NOT a developed unit plan. The purpose of the following information is to provide teachers with a series of prompts and ideas to initiate planning discussions.**   * Make use of department or regional cluster meetings develop this into a unit plan reflecting learning needs, local knowledge, and specific interests of students. * Locate and share resources to use as evidence or to support the learning – most teachers find this is a really useful way to develop their programme, especially when topics change and there are so many online information resources to choose from.   **Note:** As with all learning leading to assessment at Level 3, **there is wide scope for what could be covered for this and other Level 3 standards**. Unlike the L1&2 planning frameworks which contain some specific detail, this framework is just that – a framework. Teachers working with their students will need to make a number of decisions leading to detailed planning, notably, choosing **which topic listed in the Assessment Specifications will be the focus for the learning** AND in most cases, a particular focus within this (a named disease or group of diseases e.g. communicable childhood diseases; OR which aspect(s) of sexual and reproductive health) and then **which region or countries the learning will focus on**. At that time, more detailed planning can occur. | | |
| **Resources – Curriculum teaching resources** | **Resources related to health and poverty** | **Topic specific resources** |
| The Level 3 ESA Learning Workbook provides a framework of ideas for learning about the health impacts of poverty (in general), and other international health issues. <https://esa.co.nz/products/level-3-health-education-learning-workbook?variant=912876103>  There is an old resource *“A guide for teachers with teaching and learning programmes at NZC Level 7 (NCEA Level 2) and NZC Level 8 (NCEA Level 3)”* produced in 2013 – after the alignment of the standards which may provide ideas for planning Level 3 units - *ask us for this as it is not online!* | These are extensive – see notes following. | See notes following. |
| **Explanatory notes** | | |
| EN2 **Analyse** involves applying a critical perspective to an international health issue through:   * explaining the nature of the international health issue and its implications on the well-being of people and society * explaining how the major determinants of health influence the issue * recommending strategies to bring about more equitable outcomes in relation to the health issue.   The analysis is supported by evidence.  **Analyse, in depth**, involves recommending strategies for addressing the health issue that take account of:   * the influence of the major determinants of health on the issue * the impact of the major determinants of health on well-being.   The in-depth analysis is supported by detailed evidence.  **Analyse, perceptively**, involves recommending strategies based on a coherent explanation that connects the international health issue and the influence of the determinants of health on the issue to the underlying health concepts (hauora, socio-ecological perspective, health promotion, and attitudes and values).  The perceptive analysis is supported by the coherent and consistent use of evidence. | EN3 An international health issue is one currently affecting the well-being of significant numbers of people in a country (or countries) other than, or as well as, New Zealand, and which is a matter of public concern.  EN5 Supported by evidence refers to the use of specific and relevant details to support an analysis. Supporting evidence may include examples, quotations and/or data from credible and current sources such as government ministry websites, recognised nongovernment organisations (NGOs), research journals, and other publications. Generally, current research means data or theories published within the last five years. | |

**Mapping out the main ideas for AS91462**

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| **Step ONE: Poverty – develop an understanding of the complexities of poverty and how a combination of social and economic issues lead to inequities, which then result in increased rates of communicable diseases, reduced life expectancy or sexual and reproductive health problems.** | **Think about …. Population(s) for focus** | **STEP 2: Understand poverty in relation to the social determinants of health (SDH)** |
| **Define ‘poverty:**   * In NZ terms …. * In global terms ….   **(Intro/background/local context - *optional*)**  **Which NZ organisations are most interested in issues of poverty for NZers?**   * Why does NZ - a ‘developed’ and relatively wealthy country with a high quality of life - have a child poverty issue? * The current NZ Labour government are aiming to reduce child poverty in NZ – what has happened so far? Which government ministries are involved in this?   **Which are the main international organisations that have something to say about poverty or who work to eliminate poverty?** What is the main mission of each of these organisations?   * From a health perspective? * From an economic development perspective? * From a human rights perspective?   **Think of ….**  **WHO –** see the section on poverty and health<https://www.who.int/hdp/poverty/en/>  **UN and UNESCO –** see the SDGs below  **World Bank** <https://www.worldbank.org/en/topic/poverty/overview>  **Name any key initiatives or strategies these organisations are responsible for, and/or documents produced by these organisations that may be useful for this unit.** | **EN 3**  ‘An international health issue is one currently affecting the well-being of significant numbers of people in a country (or countries) other than, or as well as, New Zealand, and which is a matter of public concern.’  What will help you to decide which country(ies) will be the focus for the students’ learning and investigation?   * The availability of evidence? * ‘Local/regional’ (e.g. Pacific, South East Asia)? * The topic selected by the students (or you as teacher) and where in the world the issues are most prevalent (and therefore data exists? * Access to resources and resource people in your community who have experience of these situations overseas? | ***Note that the WHO are reframing the way they approach the determinants of health, and more importantly, the social determinants of heath (SDGs).*** *We (health education) will start to shift the way we use these concepts (and the language) in the lead up to the revision of the Level 3 Achievement Standards. With the AS91462 2020 assessment focused on poverty related issues, it would seem appropriate to use some of this newer material now.*  **Source this newer material at** [**https://www.who.int/social\_determinants/en/**](https://www.who.int/social_determinants/en/)   |  | | --- | | “The **social determinants of health** (SDH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include **economic policies and systems, development agendas, social norms, social policies and political systems**.” |   **See following questions and framework of activity ideas.** |
| **United Nations Sustainable Development Goals (SDGs)** [**https://sustainabledevelopment.un.org/?menu=1300**](https://sustainabledevelopment.un.org/?menu=1300) | | **Exploratory Q to build understanding about poverty** |
| **Goal #1 is NO poverty.** Find out more about this goal at <https://sustainabledevelopment.un.org/sdg1> | | **SDGs in detail**   * What is the purpose of the SDGs? * Who is responsible for seeing that these goals are met? * What sorts of actions have already taken place? * Which examples might be useful to refer to for learning in this unit?   Linking ideas about poverty with your selected topic(s):   * Explore the UN website on ending poverty – how do ideas on this page relate to the topics for the AS92462 examination? <https://www.un.org/en/sections/issues-depth/poverty/> * Which of the ‘global issues links’ on this page will be useful for these topics e.g. health (disease, sexual health), gender equality (sexual and reproductive health), children (disease, life expectancy), etc   Extra:  **The cycle of poverty**  You may have heard of the ‘cycle of poverty’ or the ‘poverty trap’. Find out what this means and source a diagram/model. Why is it so hard for people living in poverty to break out of this cycle by themselves? Why does it require external intervention (by way of improved policies, systems etc) to help people out of poverty? |

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| **Social determinants of health** | **Teaching and learning activities about the SDHs** |
| |  | | --- | | **These extracts, from different parts of the WHO website, offer two versions of an explanation of the social determinants of health. The second statement is highly relevant for the AS91462 assessment in 2020.**    The social determinants of health (SDH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. **These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems**.  <https://www.who.int/social_determinants/en/>  The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the **distribution of money, power and resources at global, national and local levels**. **The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.**  <https://www.who.int/social_determinants/sdh_definition/en/> |   **Comprehension:**   |  |  | | --- | --- | | **Terms from extract above** | **Comprehension and discussion questions** | | Social | If something is ‘social’ in nature, what does this mean? | | Determinant | What does the term ‘determinant’ mean? | | Economic policies | Give an example or two of ‘economic policy’ (these can be NZ for ease of understanding)?  How is economic policy a ‘force’? | | Economic systems | What is meant by an ‘economic system’? How are economic systems linked with health? Perhaps think about how poverty is linked with health and therefore how economic systems impact health. | | Development agendas | What is meant by ‘developmental agenda here? Give an example of a NZ (or overseas) developmental agenda related to health or reduction in poverty. | | Social norms | *If we think of social norms as cultural attitudes, values and practices*…How are cultural (or subculture) attitudes, values, beliefs and practices in some way a ‘force’ that contributes to people’s health outcomes – their own or others? Use examples to illustrate your ideas. | | Social policies | What sorts of policies are ‘social policies’? Give examples of a wide range of what might be called ‘social policy’ | | Political systems | What is meant by ‘political system’? What different sorts of political systems do you know about (think about what you learned in social studies)? What sort of political system does NZ have? What sorts of political systems are (mostly) associated with countries where there are high levels of poverty and poor health for many people in the population? Why is this – what’s the link between the political system and why many people are poor and unhealthy? | | Distribution of money | Give an example of the way money is distributed **unevenly** which means some people miss out (and live in poverty/have unhealthy lives). Try to give an example for each of  (1) globally, (2) nationally, (3) locally (ie your city/town or your area of the city/community or even your school) | | Distribution of power | What is ‘power’ referring to here? (Think people in decision making positions, people who have control over matters ….)  Same question as above this time focused on the distribution of power. | | Distribution of resources | When it comes to health and reducing poverty, what ‘resources’ are going to be important?  Same question as above this time focused on the distribution of resources. | | Health inequities are the unfair and avoidable differences in health status seen within and between countries | What does ‘equity’ mean and how is it different to equality? Therefore, what is ‘inequity’? Source an online cartoon (there are many variations) that show this difference visually.  How or why are these health inequities ‘unfair’?  How or why are these health inequities ‘avoidable’?  Why do these differences exist within countries (think of NZ for example)?  Why do they exist between countries? | | The determinants of health activity in *Social Issues: Alcohol* (Tasker and Hipkins, 2002) still has application here – with some modifications.  Another activity familiar to many is to use images from James Mollison’s photo-essay books. The images from *‘Where children sleep’* are all online at <https://www.jamesmollison.com/where-children-sleep> - instead of (or as well as) discussing what you know, infer/deduce or assume about the child’s wellbeing, discuss what you know, infer/deduce or assume about conditions in which they were born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of their daily life’.  Another of Mollison’s books called ‘*Playground’* could also be used for this task <https://www.jamesmollison.com/playground-copystand>  The book *‘Material World’* by Peter Menzel also has images of very wealthy to very poor families available online at <http://menzelphoto.com/galleries/material-world/> that could be used the same way.  **With reference to the activity about the SDH key concepts (see above right hand column):**   1. Why focus on **employment conditions** and not simply whether or not people have a job when considering people’s health? 2. With everything we know globally about the importance of have social connections (and not being **socially excluded**) who (what groups or sorts of people) are still excluded from community and social life? Why are some people still being excluded? 3. Why is it important to understand health issues from the perspective of disadvantaged groups when planning new **public health programmes** and support for people? (Think about the people who plan and finance these and the people that the programmes are expected to support.) 4. Why has there been so much focus on **women and gender equity** in recent years – thinking specifically about women’s health? In this context, what is meant by gender equity? 5. Why do you think so much poverty-related research and health promotion (action) is related to **early childhood**? 6. What is globalisation (define it)? How does (or could) the processes of **globalisation** either contribute to poverty or reduce poverty? 7. What is referred to by ‘**health systems**’? How does the quality and availability of health services within these systems relate to people’s health? 8. Why is having health (and other) data (or **measures**) and evidence important when deciding the changes that need to be made to bring about improved health of groups and populations? 9. What is a ‘slum’? How do urban slums come about (link these ideas to understandings of poverty)? Where (what countries) do we think of most slums being? How do you know this? Do you think NZ cities have slums? Why or why not? How or why has **urbanisation** in some countries led to the formation of slums? What do you know about the health of people living in slums?   Thinking about the selected topic (disease, life expectancy or sexual and reproductive health) how could a selection of these listed concepts link with this topic? What’s the evidence for these links? *See table on following page to expand this discussion.*  **Education**  There is no explicit mention of education in here although it is among with the WHOs overall list of the ‘determinants of health’ – where would you include consideration of education in all of this discussion? Why? |

**Another overview of planning for 3.2 *International Health issue.* Please adapt and add to – the mini investigations are suggestions only to give plenty of coverage and practice for extracting information about the ways the DoH (or SDH) have contributed to poverty and therefore the health situation, and strategies for more equitable outcomes from resource materials.**

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| **The issue for the 3.2 exam is POVERTY**  Ensure students have a good grounding in the ways **poverty impacts health** (and wellbeing) in ANY situation. They also need to understand the concept of **inequity** as part of this.  This requires understanding of the **social determinants of health** (that’s the umbrella understanding – see previous notes and YouTube videos). However there’s NO expectation that student will engage with this bigger picture understanding this year and previous DoH understandings will suffice. To all intents and purposes, developing an understanding of poverty will develop understanding of the SDH anyway, even if the previous DoH language is used. *If students have moved to using SDH terms, note the obvious in brackets if words like ‘economic’, ‘political’ a, ‘cultural’ and social environment determinants are not self-evident.*  The expectation is ONLY that student will have an understanding of **the Determinants of Health** much as we’ve used in the past. That is how these determinants work in combination (and it’s the combination that are critical to understanding the complexity of the way poverty impacts health):   * **Economic factors** – such as the distribution of money * **Political factors** – like the MANY policy level decisions that happen in countries that either support or more’s the point DON’T support people living in poverty * **Cultural factors** – the attitudes and values inherent in policy decisions, or the dominant values and beliefs of society that resist change * **Social environment factors** – how psychologically stressful work and living environments are, whether people are in/excluded in communities and societies (included in local decision making, included in education etc, opportunities early in life to ‘get a good start’, how much control people have over their own lives or if they are in effect enslaved etc.) * **(Physical) environmental factors** may be a consideration when things like water shortage, crop failure nd other pollution reduce life expectancy or increase the likelihood/cause disease(and it’s often a lack of financial resource and political will to clean up such environments).   *See the previously supplied NZHEA resources about the SDH/DoH and the 3.2 planning framework.* | **Poverty and life expectancy**  How does poverty impact life expectancy? Find examples with good data to illustrate all of this ….  ***Direct impact e.g.*** Limited access to   * healthy food (food security) * health care across the life span (and poorer health overall means more susceptibility to all disease) * poor work and living conditions (air, land and water pollution, dangerous work conditions, poorly located housing open to environmental problems etc) * What else?   ***And indirectly? E.g.***   * Limited education to have employment and other choices in life and to have knowledge of ways to access support and live healthier lives (but ensure that this is NOT seen as the fault of people living in poverty – it’s about what Education can provide people with) * What else? | **Mini investigation 1.**  Take a developed country where there are high levels of social and economic inequity - with easily accessed population data (countries with indigenous populations indicate added concerns and consideration e.g. USA, Australia – even NZ)  What are the causes/ factors contributing to the patterns of life expectancy between rich and poor? What can be done about it? | **Mini investigation 2.**  Look across rich/developed and poorer/developing-underdeveloped countries and look at the life expectancy between these countries.  What are the causes/ factors contributing to the patterns of life expectancy between rich and poor? What can be done about it? | *Just a note about these* ***‘mini-investigations’*** *– it is anticipated 2-3 lessons may be spent on one main one to establish key ideas and then just 1-2 periods on the others as additional illustrations. Keep to the main points of needing to show how the DoH/SDH are implicated in the situation and what can be done about it – don’t get lost in extraneous detail (you won’t have time!).* | **STRATEGIES for more equitable outcomes.**  Illustrate these with actual examples found for the investigations. E.g by linking to actions being taken towards meeting targets in the SDGs.  What actions or approaches (strategies) are needed to:  **Redistribute money and resources to provide health services (and healthy food and living conditions, etc)**  Aid packages, international agencies intervening …. More a short term fix and dependent on ongoing funding. What about long term sustainability – think of the political will to prioritise funding in a way that supports the health of populations e.g. free health care for all, prioritising health of people over other costly ventures that don’t benefit people (international pressure from agencies World Bank(?) etc to reduce government corruption).  **Redistribute money and resources to provide a minimum wage so that people are meaningfully employed, have income and increase their quality of life/reduce poverty.** Improve infrastructure so communities have the ability to increase productivity and support them with international aid to do so.  **Change laws and policy –** or better implementation and monitoring if they already exist.Requires advocacy, people being able to vote for better representation in local and national government, international support (and documentation) for poor/ unfair/ unjust health-related practices.  **Disrupt and change cultural attitudes, values and practices** (the hard one). EDUCATION.  Working at the coal face with the people whose behaviour needs to change e.g. men’s attitudes to women – target groups. Build capacity at local level to ‘spread the word’ – local activists, lobby and action groups.  **For SexReproHealth**  Control of/access to resources - women having access to their own income – their own ability to work - and choice over how income is spent, access to education and greater employability, and learning there are alternatives/challenging harmful cultural and religious practices (for both men and women), leadership and governance that prioritises women’s reproductive health, etc. |
| **Poverty and disease**  How does poverty impact people’s susceptibility to disease? Find examples with good data to illustrate this.  Suggest looking up ‘diseases of poverty’ – select a variety of diseases and across different countries e.g. malaria is an obvious one then perhaps one communicable disease and one non-communicable disease to draw attention to the ways poverty impacts people’s health. | **Mini investigation 1.**  Malaria – given malaria can be easy to control why is it still a major health problem in poor countries around the world? | **Mini investigation 2.**  Communicable disease - how living in poverty (usually overcrowded, unsanitary etc) is disastrous for spreading communicable diseases. | **Mini investigation 3.**  Non-communicable disease - how poor quality of life makes people susceptible to preventable health conditions and disease. |
| **Poverty and sexual and reproductive health (SRH)**  This is the most complex of the issues  *See also the references provided by Jackie Edmond from FP after our 23 July Zoom PLD session.*  Her diagram showing the intersection of poverty and sexual and reproductive health and gender equality is REALLY useful, that is:  Early marriage, gender based violence, son preference, access to contraception, safe motherhood (maternity, safe abortion) *up against* control/access to resources (income), access to education, ability to work, leadership and governance – all of which indicate the strategies for change. | **Mini investigation 1.**  How is early (underage, illegal age, arranged and child) marriage linked with poverty and then how does this impact sexual and reproductive health of young girls? Check out the UNICEF website for this data. | **Mini investigation 2.**  How is access to contraception an issue of poverty? What is the impact on the reproductive and sexual health of women who are unable to access contraception and plan families?  AND/OR How is access to safe maternity services (pre and post-natal care) an issue of poverty?  AND/OR How is access to safe abortion) an issue of poverty? | **Mini investigation 3.**  How ***is or can*** violence toward women be linked with poverty (noting this is not only an issue for women living in poverty. Several Pacific studies on this – research data over the past decade has shown Pacific women are subject to the most violence of any population of women in the in the world.) |
| Think also about what is in COMMON across these three examples of the way poverty impacts health – especially **the cause** (the recurrent ways economic, political, cultural and social environment factors operate), and then **the effect** these factors have on health. | Don’t be unduly hung up on which country – choose examples that illustrate the point well. In the examination students will have to interpret unfamiliar text so the POINT is to give them plenty of opportunity to look at a range of materials and draw out understanding of how the SDH/DoH have impacted the issue AND strategies for reducing poverty and the health issue that results.  That said, it might be useful to spend a short amount of time when you select an item, to consider WHY poverty is an issue in *this* country – think about the political structure (e.g. dictatorship, democracy, or a monarchy). If a democracy is it right wing – favouring economic policy, or left wing – favouring social policy? Is it an under-developed, developing or developed country (what used to be called 3rd world or 1st world etc) and therefore is the population living in poverty almost all people or just some people? What natural or other resources does the country have? How corrupt is the leadership and government of the country? | | |

As you and your students populate a framework like this, consider sharing it around the teachers in your network, and keep adding to it.

*Revising the way we use* **The Determinants of Health** & **The Social Determinants of Health** in HEALTH EDUCATION (Nov 2020)

**Preamble:** After a range of discussions and professional learning and development across 2020 we are proposing the following revisions to the way we use terminology and apply meanings associated with The Determinants of Health (DoH) and The Social Determinants of Health (SDH) in health education. The reason for this is to better align our teaching and learning programmes with the latest DoH and SDH literature produced by the World Health Organisation. Our resourcing to date is based on materials from the late 1990s and is long overdue for revision.

**Overall:**

* We wantto minimise impact on teaching and learning programmes, so the proposed changes around the ongoing use of the DoH are relatively minor.
* The adoption of the umbrella understanding of the SDH is only recommended for topics where these more complex ideas are warranted.

**The Determinants of Health (DoH)**

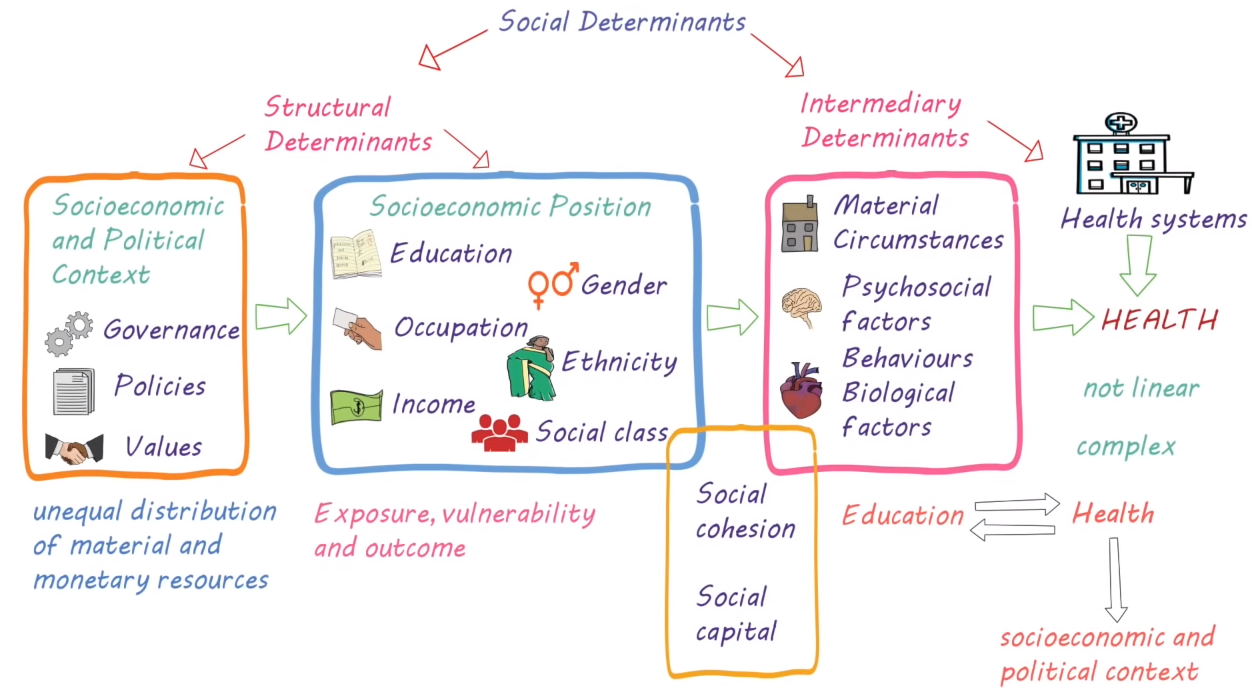
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| **Recommendation:** | That we retain the use of the term DoH for health-related topics when **a general description ONLY of DoH ideas is all that is needed.** This would typically be in situations where students are using the HPE socio-ecological perspective to explore a health issue and require an evidence base for the ‘societal’ level of influences on health and actions to promote health. | **Changes to make:**   * The previous list of 10 ‘social determinants’ (from the WHO *The Social Determinants of Health: Solid Facts*, 1998) needs to be removed from our resourcing and reframed (see left). That list is: unemployment, social exclusion, social support, prenatal and early childhood, access to healthy food, access to transport, social gradient, stress, work conditions and addiction. * The way we have previously used the term ‘social determinants’ needs revising to focus specifically on ‘**social environment determinants’** so as not to confuse it with the overarching term the Social Determinants of Health   **Cautions:**  **Don’t force the DoH to fit every health education topic.**  The HPE socio-ecological perspective is a very useful concept for exploring many health education issues. Only add the DoH/SDH where the evidence shows there are social and economic inequities impacting population health which need to be addressed. *For example, unless a focus on resilience includes consideration of the way poverty is a risk factor, then avoid adding undue complexity to understanding risk factors by layering in DoH understandings as well. The SEP is the suggested model for organising ideas in this context.*  The very nature of the DoH (and SDH) **focuses attention on disease** - that is, health issues of a biomedical nature. Although the term ‘wellbeing’ is being increasingly used when DoH and SDH matters are being reported, the evidence base is still strongly around the prevalence of disease and disorders (and considerations of wellbeing are in response to these conditions). *For example, application of DoH & SDH ideas are highly relevant for sexual and reproductive health but may become less relevant when exploring sexuality and gender diversity wellbeing issues (and where the SEP works best).* |
| **Political determinants** | The way local, national and international laws and policies impact the health of populations.  *These factors often go hand in hand with economic factors and reflect particular values and beliefs of those in power who make policy decisions on behalf of communities or populations.* |
| **Economic determinants** | The distribution of money and resources across a population, and whether or not people live in poverty with little access to employment, health and other services, safe housing, healthy food, education, etc.    *These factors often go hand in hand with political factors and reflect particular values and beliefs of those in power who make resourcing decisions on behalf of communities or populations.* |
| **Cultural determinants** | The range of social norms, values and beliefs held by society or subgroups within society.  *‘Culture’ here does not only mean ethnic culture but could also be national culture, generational culture, subgroup or interest group culture. It is noted that the term ‘culture’ can be problematic and the term ‘social norms’ might be more useful to use in some cases.* |
| **Social environment\* determinants** | These are the many situational or context specific factors that feature in people’s interactions with each other. Some of the ideas previously associated with what we called the social determinants still apply. The social environment determinants give focus to the quality and availability of social support factors (which can be named and framed in different ways) *e.g. social capital, social cohesion, social in/exclusion, early childhood factors, psychosocial factors like workplace or neighbourhood stress, social support. Do not be limited by this list.*  Social determinants are inevitably underpinned by a combination of political, economic and/or cultural determinants.  **The introduction of the word ‘environment’** here is deliberate to separate it from the umbrella term ‘The Social Determinants of Health’, and to draw attention to the social environment in which people live and work. ‘Social’ makes it to do with people as distinct from the physical environment below. |
| **Physical (environment) determinants** | People’s access to clean air and water; arable land, unpolluted soil and environmental conditions for growing food; access to safe outdoor recreational areas. |
| *Personal determinants*  *Lifestyle/behavioural determinants* | * *Unchangeable factors like age, sex, genetics* * *Choices people make about their diet, alcohol or other drug use, exercise, etc*   *For health education purposes we tend to reframe these ideas within a SEP understanding.* |

**The Social Determinants of Health**

**Recommendation:**

That we introduce the use of the term SDH for health-related topics **ONLY** when **the health issue being studied is the result of social and economic inequity, that is, the unequal distribution of money, power and resources.** In other words, when the issue is clearly linked to **poverty** and the simpler descriptive accounts of the DoH do not explain the complexity of the topic or situation.

We don’t expect students (even at year 13) to understand all of the diagram below. However, to explain health issues related to poverty requires some understanding of the complex interactions between the many contributing factors. In this case students will need a reasonable understanding of (some aspects of) structural and intermediary determinants and how, in combination, these contribute to poor health for people who live in poverty.



**Source:** Let’s Learn Public Health: Social Determinants of Health - an introduction <https://www.youtube.com/watch?v=8PH4JYfF4Ns>

**Step 3: TOPIC SELECTION**

Once the overall topic is selected from disease, life expectancy, or sexual AND reproductive health (make sure both aspects are covered), teachers and students will still need to refine the focus within these – especially for disease and sexual and reproductive health. Once that decision is made information can be collected about the topic specific aspects of the investigation. **S**elect a focus for which and **adequate amount of recent data can be located AND a topic that has clear and obvious social and economic factors ie poverty as a central feature of the issue.** Some of these ideas suggested below may be more useful for class investigation and discussion only and not the main focus for assessment.

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| **Disease** | **Life expectancy** | **Sexual AND reproductive health** |
| **Will you focus on:**   * **Communicable or non –communicable diseases?** * **A specific named disease or a group of diseases?** * **Diseases that kill the most people, or ones that are debilitating and lead to loss of productivity, or diseases that a mostly thought to be controlled in many countries but outbreaks then impact poorer communities/countries** (e.g. measles would seem to be an obvious choice with recent data from NZ, the Pacific and other countries.) * **Children or adults?** * **Which region of the world?**   If thinking about **recycling previous disease-based topics like diabetes or nutritional issues (in the Pacific), or HIV,** make sure the emphasis and the evidence shifts to the poverty related causes of these.  Check – are they diseases that are caused by the effects of people living in poverty – as shown by evidence?  **(Intro idea only) Briefly consider the relationship of disease and poverty in NZ.**  e.g (preventable) communicable diseases in childhood – see Child Poverty Action Group (CPAG <https://www.cpag.org.nz/> ) - the 4 page pdf A New Zealand where Children can flourish is a useful start <https://www.cpag.org.nz/assets/170512%20CPAG%20Reducing%20the%20health%20risks%20for%20children%20backgrounder_v2.pdf> | **This topic probably(?) doesn’t warrant refining as it ‘is’ the topic.**  **Head for some key sources such as**  **United Nations**  <https://www.un.org/en/un75/inequality-bridging-divide>  and the UN Development Programme  <http://hdr.undp.org/en/content/human-development-index-hdi>  **Global burden of disease** <http://www.healthdata.org/gbd>  There are a number of reports here that have direct relevance for the all of listed topics - there are several on fertility and mortality related topics as well as diseases <http://www.healthdata.org/gbd/gbd-2017-resources>  **World Bank** - Life expectancy at birth <https://data.worldbank.org/indicator/SP.DYN.LE00.IN>  Make sure there’s an obvious ‘health’ focus to all of this and how poverty reduces life expectancy because of poorer states of health. | Note that ‘sexual and reproductive health’ is a specific consideration in the health literature – if selecting this topic make sure the learning links to these established meanings. See example following.  **Family planning or planned parenthood, birth control/contraception - [Extract] Health Poverty Action** <https://www.healthpovertyaction.org/how-poverty-is-created/women-girls/sexual-reproductive-health/>  *Sexual and reproductive health can be a sensitive topic. In many places around the world it is taboo to speak openly about sex. This can make it difficult to access information and services around sexual and reproductive health, especially in places where religious or cultural beliefs restrict access to contraception or abortion. Good sexual and reproductive health means having a safe and fulfilling sex life, with the freedom to decide whether or not you want to reproduce, and at what time in your life. Access to clear advice and information on sexual health is crucial, as is being able to choose from a range of contraceptive options, without facing any stigma or discrimination. It is also important to have access to maternal health services during pregnancy and childbirth, to ensure a safe pregnancy for both mother and child.*  **Other issues – insufficient in isolation for assessment purposes but may be of added interest**  **Teenage (and older) mothers** who develop an **o**bstetric fistula after giving birth - a medical condition in which a hole develops in the birth canal as a result of childbirth – not only, but especially among very young mothers. This hole can be between the vagina and rectum, ureter, or bladder (which can usually be repaired by surgery – which costs). It can result in incontinence of urine or faeces. There’s a lot of information online and some video documentary about this (related to Asian and African countries) and it has been a high profile topic in recent years.  **Exploitation of children and adolescents:** cheap surrogacy (‘rent a womb’), sex trade and implications of this for sexual and reproductive health, very) young teenage (virgin) brides and consequences for sexual health  If STIs are being considered – make sure there are strong links to poverty related causes and if the STI(s) considered do not have reproductive implications make sure that appears elsewhere in the learning and recommend the assessment focuses clearly on sexual AND reproductive health issues. |
| **Resource ideas** | **Resource ideas** | **Resource ideas** |
| The **WHO** website and the regional aspects of this are a useful place to start before heading to other region or topic specific websites for information.  An easy-read account of the links between poverty and disease is at <https://www.healthpovertyaction.org/news-events/key-facts-poverty-and-poor-health/>  [Extract] ***Which infectious diseases are the main killers worldwide?*** *HIV, diarrhoea, tuberculosis and malaria, as well as communicable respiratory diseases such as pneumonia kill the most people. Diarrhoea, pneumonia and malaria account for nearly half of all child deaths globally.*  ***Which are the most deadly non-communicable illnesses worldwide?*** *The biggest non-communicable killers are maternal and newborn deaths and deaths related to poor nutrition, cardiovascular disease and non-communicable respiratory diseases.*  **UNAIDs website is the initial go-to site for international data about HIV.** Link to other sites from there.  There’s an open access academic journal called ‘Diseases of Poverty” – probably a bit hefty for secondary school but at least known it exists. <https://idpjournal.biomedcentral.com/articles> | **There’s plenty of material online to map out the health related details of this issue e.g.**  **WHO**  <https://www.who.int/gho/mortality_burden_disease/life_tables/situation_trends_text/en/> (includes country profiles)  And various articles e.g. <https://www.who.int/news-room/detail/04-04-2019-uneven-access-to-health-services-drives-life-expectancy-gaps-who>  Life expectancy and poverty, Vladimir Canudas-Romo Yhe Lancet, 2018  <https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(18)30327-9/fulltext>  Our world in data <https://ourworldindata.org/grapher/poverty-vs-life-expectancy> | **WHO has material on a lot of this** <https://www.who.int/gender-equity-rights/knowledge/poverty-gender-in-health-programmes-sexual-reproductive-health/en/>  There are various planned parenthood organisations e.g. **International Planned Parenthood Federation**  <https://www.ippf.org/news/announcements/sexual-and-reproductive-health-and-rights-are-crucial-ending-poverty>  **An online search brings up plenty of data and information. Maintain a focus on exmaples with a clear link to poverty, and not only cultural/political gender issues.** |

**Overall expectations for AS91462 (adapted from the Level 3 LWB)**

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| **Sentence starters to help organise material collected form your investigation** | As a range of health topic material is analysed, record sentence and paragraph length ideas in response to these sentence starters. Incorporate ideas from the introductory learning about poverty and the social determinants of health to show how these ideas apply to the topic. Provide reference’s for all of the evidence used (although citing these in the examination is only needed in very basic terms e.g. the name of an organisation). |
| * My selected health issue is… * The links between this health issue and poverty are …. * Evidence to support this is… |  |
| **Determinants/factors contributing to the health issue** |  |
| * A social determinant of health that contributes to the health issue is… * The way this SDH contributes to the health issue is … *(use relevant aspects of the language of the determinants of health here)* * An example to support this is… |  |
| * A social determinant of health that contributes to the health issue is… * The way this SDH contributes to the health issue is … An example to support this is… |  |
| * A social determinant of health that contributes to the health issue is… * The way this SDH contributes to the health issue is … * An example to support this is… |  |
| * Overall and in combination, the social determinants of health responsible for these health inequities have resulted in unfair and avoidable differences in health status because ….. |  |
| **Implications for well-being of people and society** |  |
| * In the short-term, the individual well-being of people (and their relationships with others) is affected because... * This could lead to the long-term personal/interpersonal effects of… * An example to support this is... |  |
| * In the short-term, the well-being of communities (and countries where relevant) is affected because… * This could lead to the long-term effects for all of society of… * An example to support this is… |  |
| **Strategies to address the factors and create equitable health outcomes** |  |
| * A strategy that could be used to address the first determinant is… * This should address the determinant and its health and wellbeing implications and lead to equitable health outcomes because… * For example, this strategy is used/has been recommended by… |  |
| * A strategy that could be used to address the second determinant is… * This should address the determinant and its health and wellbeing implications and lead to equitable health outcomes because… * For example, this strategy is used/has been recommended by… |  |
| * A strategy that could be used to address the third determinant is… * This should address the determinant and its health and wellbeing implications and lead to equitable health outcomes because… * For example, this strategy is used/has been recommended by… |  |
| * These strategies work in combination to promote healthier outcomes by… |  |

Planning framework for:

**AS91465 (Health 3.5) Evaluate models for health promotion**

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| **Using this planning framework** | | |
| **As a planning framework this is NOT a developed unit plan. The purpose of the following information is to provide teachers with a series of prompts and ideas to initiate planning discussions.**   * Make use of department or regional cluster meetings develop this into a unit plan reflecting learning needs, local knowledge, and specific interests of students. * Locate and share resources to use as evidence or to support the learning.   Note: AS91465 is by far the least popular of all the health education standards. It requires good literacy skills but the learning for it can be quite a structured and be framed around a known series of activities - see past exams for examples. Basically, achievement of the standard requires brief knowledge of a range of health promotion models and practice applying the principles of each of these to know health promotion campaigns, and responding to a series of questions indicated by the requirements listed in the ENs. | | |
| **Resources – Curriculum specific resources** | **Resources related to health promotion models** | **Ideas for health promotion topic specific resources** |
| The Level 3 ESA Learning Workbook provides a framework of ideas for learning about the models <https://esa.co.nz/products/level-3-health-education-learning-workbook?variant=912876103>  There is an old resource *“A guide for teachers with teaching and learning programmes at NZC Level 7 (NCEA Level 2) and NZC Level 8 (NCEA Level 3)”* produced in 2013 – after the alignment of the standards which may provide ideas for planning Level 3 units - *ask us for this as it is not online!* | See notes following. | See notes following. |
| **Explanatory notes** | |  |
| EN2 **Evaluate** involves considering the implications for people’s well-being of models of health promotion by:   * comparing and contrasting models for health promotion * explaining advantages and disadvantages of models for health promotion * drawing conclusions about the effectiveness of the models.   **Evaluate, in depth**, involves:   * exploring links between models for health promotion and their use for improving people’s well-being in given situation(s) * drawing reasoned conclusions about the effectiveness of the models.   **Evaluate, perceptively**, involves:   * showing insight about how the models for health promotion relate to the underlying health concepts (hauora, socio-ecological perspective, health promotion, and attitudes and values) * drawing conclusions informed by the relationship of the models to these concepts. | | EN3 Models for health promotion that use Health Education concepts and terms may include behavioural change, self-empowerment and collective action models, supported by documents such as the Ottawa Charter, the Bangkok Charter and Te Tiriti o Waitangi. For information on the Health Education models of health promotion, see *Making Meaning: Making a Difference,* Learning Media, Ministry of Education, 2004, pp.14-15 <http://www.tki.org.nz/r/health/cia/make_meaning/index_e.php> ). |

Resource page – models for health promotion

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| **The Ottawa Charter** <https://www.who.int/healthpromotion/conferences/previous/ottawa/en/>  The Ottawa Charter for Health Promotion (WHO, 1986) provided much of the impetus for the change to using a socio-ecological approach for health education and health promotion. This charter recognised that major health gains were linked not so much to advances in medical knowledge as to increases in wages and living standards and to public health initiatives accompanied by policy changes at government and community levels.  The Ottawa Charter identifies nine broad prerequisites for health: peace, education, food, shelter, income, a stable ecosystem, sustainable resources, social justice, and equity.  It advocates "a socio-ecological approach to improve health in which people and their environments are considered to be inextricably linked".  In relation to health promotion, the Ottawa Charter determined that five key strategies were needed to enhance public health:   * creation of supportive environments * development of personal skills * strengthening of community action * building of healthy public policies * reorientation of health services. | | **Bangkok Charter** <https://www.who.int/healthpromotion/conferences/6gchp/bangkok_charter/en/>  **Required actions**  To make further advances in implementing these strategies, all sectors and settings must act to:   * advocate for health based on human rights and solidarity * invest in sustainable policies, actions and infrastructure to address the determinants of health * build capacity for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy * regulate and legislate to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people * partner and build alliances with public, private, nongovernmental and international organizations and civil society to create sustainable actions. |
| **Behavioural change model**  The behavioural change model came into use before the other two approaches. Many early New Zealand health campaigns were based on this model, and it is still widely used, in conjunction with other models, as part of comprehensive health campaigns.  The behavioural change model is a preventive approach and focuses on lifestyle behaviours that impact on health. It seeks to persuade individuals to adopt healthy lifestyle behaviours, to use preventive health services, and to take responsibility for their own health. It promotes a 'medicalised' view of health that may be characterised by a tendency to 'blame the victim'. The behavioural change model is based on the belief that providing people with information will change their beliefs, attitudes, and behaviours. This model has been shown to be ineffective in many cases because it ignores the factors in the social environment that affect health, including social, economic, cultural, and political factors. | **Self-empowerment model**  This approach (also known as the self-actualisation model) seeks to develop the individual's ability to control their own health status as far as possible within their environment. The model focuses on enhancing an individual's sense of personal identity and self-worth and on the development of 'life skills', including decision-making and problem-solving skills, so that the individual will be willing and able to take control of their own life. People are encouraged to engage in critical thinking and critical action at an individual level. This model, while often successful for individuals, is not targeted at population groups and is unlikely to affect social norms. | **Collective action model**  This is a socio-ecological approach that takes account of the interrelationship between the individual and the environment. It is based on the view that health is determined largely by factors that operate outside the control of individuals.  This model encompasses ideas of community empowerment, which requires people individually and collectively to acquire the knowledge, understanding, skills, and commitment to improve the societal structures that have such a powerful influence on people's health status. It engages people in critical thinking in order to improve their understanding of the factors affecting individual and community well-being. It also engages them in critical action that can contribute to positive change at a collective level.  Given the importance of determinants of health, the use of a collective action model is more likely to achieve healthy outcomes, both for individuals and for groups within society. |
| Models of health promotion from the 2004 Ministry of Education resource ***Curriculum in action Making Meaning Making a Difference*** <https://health.tki.org.nz/Key-collections/Curriculum-in-action/Making-Meaning/Socio-ecological-perspective/Defining-health-promotion/Models-of-health-promotion> |
| **Behavioural change model**   * Focuses on health professionals' perceptions of health needs – suggests that 'experts' know best. * Transmits knowledge – increases people's knowledge of the factors that improve and enhance health. * Educates 'about' health. * Uses health campaigns. * Uses the transmission approach to teaching – the learners are largely passive. * Often reflects 'healthism'\*. * May have a 'moralistic' tone. * Emphasises disease and other medical problems so tends to be negative and deficit-focused. * Focuses on risks rather than on protective or preventive factors and takes a 'band-aid' approach. * Tends not to reflect the socio-ecological perspective. * Does not take into account determinants of health or consider who is responsible for health. * May imply 'victim blaming'. | **Self-empowerment model**   * Develops a sense of identity. * Promotes reflection in relation to others and society. * Encourages people to reflect and change their views. * Clarifies values. * Helps people to know where, when, why, and how to seek help. * Encourages independence. * Uses critical thinking and critical action in relation to oneself. * Uses the action competence process for the individual, recognising determinants that may be beyond their control. * Fosters resilience and empowerment at a personal level. * Enhances self-awareness. * Focuses largely on the individual. * Gives opportunities to celebrate individuality. | **Collective action model**   * Encourages democratic processes and participation 'by all for all'. * Takes a student-centred/constructivist approach to teaching and learning. * Takes determinants of health into consideration. * Emphasises empowerment for all participants. * Educates 'for' health. * Uses a social action or action competence process to work with others. * Uses a whole community/school development approach. * Views teachers and students as social agents. * Uses critical thinking and critical action in relation to the individual, others, and society. * Takes a holistic approach – inclusive of hauora. * Is based on authentic needs. * Fosters resilience at wider community and societal levels – not just at an individual level. |

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| **Te Tiriti o Waitangi principles and health**    **Ministry of Health**  <https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/strengthening-he-korowai-oranga/treaty-waitangi-principles>   * **Partnership** involves working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services. * **Participation** requires Māori to be involved at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services. * **Protection** involves the Government working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.   There are several online articles linking ToW and health and health promotion – most of these are far more detailed than what we would expect senior secondary students to use. This one is more useful for health education purposes and readily accessed:  Berghan, G., Came, H., Coupe, N., Doole, C., Fay, J., McCreanor,  T., & Simpson, T. (2017). ***Tiriti-based health promotion practice.***  Auckland, Aotearoa New Zealand: STIR: Stop Institutional Racism.  Accessed from: <https://trc.org.nz/treaty-waitangi-based-practice-health-promotion> or the pdf is at  <https://trc.org.nz/sites/trc.org.nz/files/ToW%20practice%20in%20HP%20online.pdf>  Use other local resources where these are available. | **Te Pae Mahutonga** by Professor Mason Durie  <https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-pae-mahutonga>  Te Pae Mahutonga diagram.  Te Pae Mahutonga (Southern Cross Star Constellation) brings together elements of modern health promotion. The four central stars of the Southern Cross represent four key tasks of health promotion:   * Mauriora (cultural identity), Waiora (physical environment), Toiora (healthy lifestyles), and Te Oranga (participation in society) * The two pointers represent Ngā Manukura (community leadership) and Te Mana Whakahaere (autonomy).   Further information to explain Te Pae Mahutonga and (and alternative diagrams) can be found at:   * Health Promotion Forum <https://hauora.co.nz/te-pae-mahutonga-mason-durie/> * Community and Public health <https://www.cph.co.nz/about-us/te-pae-mahutonga/> | | **Shanghai declaration on promoting health in the 2030 Agenda for Sustainable Development (2016)** <https://www.who.int/healthpromotion/conferences/9gchp/shanghai-declaration/en/>  Although not specifically named in the AS ENs, also take a brief a look at this document when considering international approaches to health promotion – **this is one place where learning for AS91462 (Health 3.2) links with learning for this standard.**  [Extract] **We commit to**   * apply fully the mechanisms available to government to protect health and promote wellbeing through public policies; * strengthen legislation, regulation, and taxation of unhealthy commodities; * implement fiscal policies as a powerful tool to enable new investments in health and wellbeing - including strong public health systems; * introduce universal health coverage as an efficient way to achieve both health and financial protection; * ensure transparency and social accountability and enable the broad engagement of civil society; * strengthen global governance to better address cross border health issues; * consider the growing importance and value of traditional medicine, which could contribute to improved health outcomes, including those in the SDGs   (and link to the UN Sustainable Development Goals at <https://sustainabledevelopment.un.org/?menu=1300> ) |
| The **Waitangi Tribunal** also produces a number of resources about Te Tiriti o Waitangi for school use. Find the kit of resources at <https://waitangitribunal.govt.nz/publications-and-resources/school-resources/>  See also the *Critical Guide To Maori And Pakeha Histories Of Aotearoa*  - this is a 6 book set of curriculum resources written by Tamsin Hanly and edited and illustrated by Ruth Lemon  These are not health education specific but speak to a wider range of considerations that relate to health and wellbeing <http://cmph.cybersoul.co.nz/> | If time allows, also consider how some Pasifika model of health (and wellbeing), which are also used as models for health promotion, could be applied to health promotion contexts e.g. the Tongan Fonua model and the Samoan Fono Fale model  For an explanation of the model developed by Sione Tu'itahi go to <https://hauora.co.nz/fonua-a-pasifika-model-for-health-promotion/> | The original Fuimaono Karl Pulotu-Endemann explaining the fono fale model is at <https://d3n8a8pro7vhmx.cloudfront.net/actionpoint/pages/437/attachments/original/1534408956/Fonofalemodelexplanation.pdf?1534408956>  Other explanations are available at:  <http://healthhb.co.nz/wp-content/uploads/2014/09/Fonofale-model.pdf> | |
| **Health Promotion Forum**  Contains a lot of information on Māori and Pacific people’s health <https://hauora.co.nz/>  Le Va <https://www.leva.co.nz/>  Is to support Pasifika families and communities to unleash their full potential and have the best possible health and wellbeing outcomes. |

Resource page – health promoting campaigns and agencies/organisations that promote health and wellbeing for specific groups or in relation to specific issues

Don’t be limited by these suggestions, add to this and update this list with any new campaigns in 2020 – but keep it NZ relevant.

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| **Health Promotion Agency or** HPA – there are many HP campaigns supported by HPA – a few are listed below - visit <https://www.hpa.org.nz/our-work/campaigns> for more details.   * #DumbBurn', is a Skin Cancer Prevention Programme targeted to 18 to 24-year-olds in social and workplace settings. In conjunction with SunSmart.org.nz * ‘Let’s play every day’ promotes the importance of active play for children under five by encouraging parents and whānau to play with their children – every day. * A new national Like Minds, Like Mine campaign. ‘Just Ask. Just Listen’ targets family, whānau and friends of people experiencing mental distress. * Depression.org.nz promotes small steps that you can take on the path to recovery from depression and anxiety. It also encourages help seeking by visiting the depression.org.nz website. * Choice Not Chance encourages people to check whether their gambling is just for fun and to seek help if needed. * Say Yeah, Nah contributes to changing New Zealanders’ drinking culture from the current norm of high-risk drinking to one of moderation.      * The Health Star Rating is a trans-Tasman system to provide a quick and easy way to choose healthier packaged foods. | **Are you OK / It’s not OK**  <http://www.areyouok.org.nz/> | **Healthy Food**   * HPA – see left hand column. * See the list on the Community and Public Health website <https://www.cph.co.nz/your-health/nutrition/> * Heart Foundation - Promoting healthy eating and physical activity in schools <https://www.heartfoundation.org.nz/educators/programmes/for-schools> | Also check out the long list of **Ministry of Health actions** at <https://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/new-zealand-health-survey/improving-health-new-zealanders> |
| **Road safety**  Police overview of campagins  [https://www.police.govt.nz/advice/driving-and-road-safety/speed-limits-cameras-and-enforcemental health awarenessment/road-safety-campaigns](https://www.police.govt.nz/advice/driving-and-road-safety/speed-limits-cameras-and-enforcemental%20health%20awarenessment/road-safety-campaigns)  NZTA advertising  <https://www.nzta.govt.nz/safety/our-advertising/>  Includes: Speed, Drink-driving, Drug-affected driving, Young driver, Driver distraction, Seatbelt, and Motorcycling.  Drive <https://drive.govt.nz/> website to help young people become confident, capable drivers  New Zealand’s road safety strategy 2020-2030 <https://www.saferjourneys.govt.nz/> | **Mental health**  Bullying-Free NZ Week 2020 starts on 18 May, ending on 22 May – <https://www.bullyingfree.nz/>  Mental Health Awareness week 2020 is Monday 5 – Sunday 11 October <https://www.mentalhealth.org.nz/home/our-work/category/16/mental-health-awareness-week> | **Sex and gender related**   * Women – International women’s day Sunday 8 March, 2020 (<https://www.internationalwomensday.com/> * White Ribbon (eliminating violence against women) <https://whiteribbon.org.nz/> * Me too <https://metoomvmt.org/> and Time’s up <https://timesupnow.org/> * Men’s health – e.g. Movember <https://nz.movember.com/> * Children – e.g. Healthy kids <https://www.healthykids.org.nz/> * Rainbow communities e.g. <https://www.rainbowauckland.org.nz/> and Rainbow Youth <https://www.ry.org.nz/> |
|  | **Local initiatives**  Local DHBs may have a calendar of locally relevant health promotion events. Check the DHB website for your region  e.g. New campaign launched to reduce teen drinking in Invercargill <https://www.stuff.co.nz/southland-times/118333110/new-campaign-launched-to-reduce-teen-drinking-in-invercargill> | **Disease specific**  **Cancer**  Shave for a cure <https://shaveforacure.co.nz/>  Daffodil Day <https://www.daffodilday.org.nz/>    Heart related  <https://www.heartfoundation.org.nz/>  Vaccination - Communicable diseases <https://www.hpa.org.nz/programme/immunisation>  Asthma |

The focus for the learning is to:

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| 1. **(Briefly) revise and develop students’ understanding of the purpose of health promotion as part of their overall learning in health education**   Use the Making Meaning Making a Difference material at  <https://health.tki.org.nz/Key-collections/Curriculum-in-action/Making-Meaning/Socio-ecological-perspective/Defining-health-promotion> to explain the curriculum purpose and focus of health promotion.  The NZHEA teacher’s resource ***NZHEA position statement and resource on health promotion*** (2017) accessed at <https://healtheducation.org.nz/resources/>. This document provides an overview of health promotion in NZC HPE terms. Use this to summarise what students have already learned about health promotion, particularly all of the actions and strategies.    Key to health education is to **understand health promotion as a process.** It’s about the purposeful and organised/systematic actions people take (based on evidence of what needs to improve) to individually and collectively promote health and wellbeing for self and others, communities and society as a whole. | 1. **Learn some basic ideas about a range of models.**   Notes that for senior secondary health education purposes (for the moment at least) all of the ‘models’ listed in the resources section above are considered to be ‘models’, regardless of whether they are:   * International charters like the Ottawa and Bangkok Charters * Sets of principles like participation, protection and partnership in Te Tiriti o Waitangi * Indigenous and other cultural models like Te Pae Mahutonga, Fono Fale and Fonua – noting that Te Pae Mahutonga *could be* seen and used as an enactment of ToW principles * Understandings developed from academic theory and research such as behaviour change, self-empowerment and collective action.   Note that we will be revisiting this approach and understanding this with the review of standards over the next few years. Any changes that have implications for teaching, learning and assessment will be notified in a timely way and with resourcing to show what’s changing. | 1. **Explore a range of current health promotion campaigns and organisations that have a role in promoting the health and wellbeing of people in NZ.**   As shown in the resource sheet above, there are MANY of these. Be selective.   * Allow some student choice based on interest. * Where possible and relevant, link the selection of these campaigns and organisations with other health education learning and/or whole school or local community actions. * Give some focus to what is new and current. |
| 1. **(Briefly) Develop students’ understanding about what it means to ‘evaluate’ in this context.**   **From the NZHEA Scholarship resource:**  What is a critical evaluation for HPE purposes?   * When you ‘evaluate’ something you are looking to make a judgement about the value, quality or importance of it. ‘Evaluate’ is a verb and therefore it refers to the action of assessing or analysing health-related information from a particular perspective or position based on ethical, social, cultural and political values relevant to the subject matter. * ‘Critically’ is an adverb which modifies the verb to indicate how the action (of evaluating) is to be done or carried out. In this case it means to think seriously or deeply about something – and this requires critical thinking. * A ‘critical evaluation’ then is how you think about the health-related information or topic matter being evaluated relative to those ethical, social, cultural and political values. This is in contrast to an emotional evaluation for example which would be based on your opinions and assumptions, and how you feel about the topic. | 1. **Make connections between the models and a selection of campaigns/work of organisations through questioning, discussion and activities that:**   Evaluate the implications for people’s well-being of using models of models of health promotion by providing students with the opportunity to:   * Compare and contrast the application of different models for health promotion to various campaigns or the health promotion work of organisations * Explain advantages and disadvantages of models for health promotion – this could be in terms of how effective they are known to be (what’s the evidence that the model ‘works’), whether they are culturally responsive, how easy they are to use and implement, etc * Drawing conclusions about the likely effectiveness of the models when applied to a named situation – based on what is known, will the application of the model actually achieve what it aims to? Why or why not? This also includes showing insight about how the models for health promotion relate to the underlying health concepts – as relevant to the situation: * **Hauora** – *are* *all dimensions of health and wellbeing considered or just single dimensions?* * **Socio-ecological perspective** – *e.g.* *is the focus only on* *affected individuals or groups (in isolation), or are there roles and responsibilities for all people regardless of how the issue affects them*? * **Health promotion** - *is there a clear sense of a process to be undertaken, based on evidence about what needs to change, that aims to improve the health and wellbeing of people?* * **Attitudes and values** – *do the actions show respect for a diversity of people (and diversity in every sense), and do the actions reflect the values of social justice – are the actions fair and inclusive?* *Or (for example) are the actions ‘done to’ or ‘done for’ people without engaging them and finding out what is best for people?* * Exploring links between models for health promotion and their use for improving people’s well-being in given situation(s) – in other words, when a model has a set or principles, or action areas, or steps, or (whatever), what is the evidence that these have been applied in actual health promotion campaigns, or in the work health promotion organisations do?   Use past examinations and practice exams as a source of ideas for learning tasks. | 1. **Use past examinations and practice exams to give students experience of the sorts of questions that appear in an examination.**   If the resource booklets for past examinations have had images and text removed for copyright reasons, simply replace this with material that the students have selected and used for their learning. |