The total number of candidates who sat this year’s external assessment was 982; a slight increase from 2011. This report comprises specific comments from individual Marking Examiners.

The Marking Examiners acknowledge this exam was generally fair with questions enabling candidates to fully demonstrate their knowledge and understanding although there were some specific concerns about the narrowness of a couple of questions as well as concerns about how some of the data might have been interpreted.

Although the standard of answers varied it should be noted that formal writing skills continue to be important with higher ratings generally awarded to formally written, concise answers that directly answered the question being asked as well as the criterion being assessed. Candidates cannot afford to ‘pad out’ answers and expect to gain high ratings. Examiners were keen to see candidates demonstrating an ability to apply their knowledge to directly answer the question asked.

There is a need to remind candidates of a number of important points:

(i) **Allocate time very carefully** – follow the suggestions on the paper. Candidates must clearly differentiate between the requirements of 15 minute and 30 minute questions.

(ii) **Read each question carefully in order to write completely relevant answers rather than everything and anything about a general topic.** Candidates must ensure that they address the particular criterion being assessed.

(iii) **Provide accurate, up-to-date, specific information rather than broad generalisations.** Phrases such as ‘and so on’ and ‘etc.’ should not appear and do not convince the examiner that you know more than you have written.

(iv) **Avoid** writing sexist or racist remarks or making value judgements, which are completely inappropriate and waste valuable time that should be used for writing specific content and theory. Candidates should also not use personal pronouns such as ‘I, you, we’ unless their personal opinion is sought.

(v) **Do not** regurgitate information prepared for different questions, the answer written must be directly relevant to the question posed and the criterion assessed.

(vi) **Choose examples** carefully to make sure they are appropriate to the nature of the questions asked.

(vii) Ensure that **something relevant**, even if it is minimal, is written for each criterion.

(viii) **Candidates are allowed to take calculators into the exam and are encouraged to do so.** They should also bring a ruler to assist in accuracy with data.

(ix) Writing out the question from the examination paper at the start of the answer is an unnecessary waste of time.

(x) ‘Detail’ means more than list/mention… Whereas ‘list’ means don’t write a couple of paragraphs. Read exactly what is being asked of you and do just that.

(xi) **Candidates are reminded that using tippex, red pen and highlighters is a waste of time.** Candidates must also not write notes to the examiner nor write their name.

(xii) Candidates are reminded that they must label questions clearly and ensure that they answer in the correct booklet. This is important in all sections.
(xiii) Candidates are also reminded to start a new booklet for each section.
(xiv) Candidates should put each question on a new page – this assists with the clarity of information. Candidates should also try to paragraph their work. Paragraph answers should have a line space between the paragraphs.

The most common problem was the inability of candidates to concisely answer the question asked. Instead they gave answers which included everything they knew about the topic or wrote a ‘street’ answer which lacked the degree of sophistication expected in a pre-tertiary subject. Poor spelling, incorrect grammar and lack of punctuation continued to be a problem and often made it difficult for examiners to ‘sift’ through the answer for the relevant content. Some candidates used an emotional style of writing in their answers which is not appropriate.

**Question 1**

This first part of the data was fairly straightforward although some candidates were confused with how to read the bar graph. Unless requested, candidates were not required to provide supporting data; however, a number of candidates did not have data in (c) (i) that was close enough to the actual figures so lost easy marks. Despite being given the 60+ figure of 2% a number of candidates put 1% in their answers, again losing easy marks.

Part (f) saw many candidates come unstuck. This question was not totally clear in its requirements and a number of candidates thought they needed to bring in outside reasons for the results. Some candidates mixed up treatment with drug use although in (f) some flexibility was allowed. Many candidates did not get full marks in (f) because they did not provide supporting data as requested. When comparing males with females it was important that the totals added up to 100%.

**Suggested Solutions:**

(a) Cannabis - 50% in 10-19 year age group
(b) Approximately 32-33%
(c) (i)

<table>
<thead>
<tr>
<th>Age Gp</th>
<th>10-19</th>
<th>20-29</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
<th>60+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>50%</td>
<td>30%</td>
<td>17-18%</td>
<td>12%</td>
<td>7%</td>
<td>2%</td>
</tr>
<tr>
<td>treatment rate</td>
<td>+/- 2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

(ii) Cannabis treatment rates decrease as age increases from 50% in 10-19 age groups through to 2% in the 60+ age group. An overall decrease of 48%.

(d) Alcohol treatment rates increase as age increases from 33% in 10-19 year group to 85% in 60+ group, an overall increase of 52%.

(e) Benzodiazepines 51% F 47% M
(f) Graph 2 suggests that:
• Suggests that males may be much bigger users of alcohol, cannabis and heroin than women as over twice the number of males seek treatment for these issues which account for 80% of drugs of concern.

  From the 80% of those seeking treatment…

<table>
<thead>
<tr>
<th></th>
<th>F</th>
<th>M</th>
<th>diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>31%</td>
<td>69%</td>
<td>38%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>29%</td>
<td>71%</td>
<td>42%</td>
</tr>
<tr>
<td>Heroin</td>
<td>35%</td>
<td>65%</td>
<td>30%</td>
</tr>
</tbody>
</table>

• Overall males seek treatment more often than females (68% compared to 32%)
• The only category where women seek treatment more than men is with the use benzodiazepines. (55-48 = 6-7% difference)

Question 2

This question was very poorly answered. Rather than outline one community strategy a number of candidates gave very brief details of several. Very few candidates linked the strategy to the components of health or the theory of risk taking or harm minimisation. Better answers were able to clearly state ‘how’ the strategy actually worked and included detail for example – harm minimisation strategy encourages you to tell a parent where you are going, pre-organise a safe lift home, have a sober friend to look out for you, education about factors causing binge drinking, strategies to avoid peer pressure, the message of ‘my life my choices’, developing excuses to say ‘no’ and practising them assertively and confidently.

A number of candidates chose individual strategies like skill building or assertiveness training but did not identify a particular community strategy that might develop these skills.

Answers needed to be specifically directed at adolescents, with the issue being targeted clearly indicated. Discussion of the community harm minimisation strategy needed to show how it promoted positive risk taking and/or reduced negative outcomes. Better answers clearly indicated the impact of the risk taking on an individual’s health.

Better answers integrated the following into their response:

• information related to their strategy with strong links to the underlying theory
• Risk taking is exposure to chance of loss, injury or gain.
• Aspects of positive risk taking include being informed, educated, consequences considered, voluntary and conscious decision made and where steps are taken to minimise risk level.
• Adolescent’s frontal lobe (brain) where judgement and decision making occurs is less well developed than the ‘feel good’ (Limbic system) part of the brain therefore many actions are taken because it ‘feels good’ rather than taking into account possible negative outcomes.
• Adolescents will take a physical risk before they take a social risk so peer pressure can have a big influence.
• Community harm minimisation strategies need to take into account these factors to assist adolescents with the transition from childhood through to adulthood.
- Harm minimisation strategies do not eliminate risk altogether but aim to reduce the potential for negative outcomes of that particular risk.
- Effective harm minimisation strategies help adolescents to make positive choices in terms of risk taking. They can build skills, assist with the development of assertiveness to reduce peer pressure and raise awareness. They can include:
  - Awareness campaigns - Slip Slop Slap Seek Slide, Don’t turn a night out into a nightmare, Off your head, don’t share your bed
  - Support Groups - Sporting groups, Beyond Blue, Reach Out, Pulse, Headspace, The Zone, Community Health Centres, Sexual Health Clinics, Family Planning, Outdoor Education, RYDA (Rotary Youth Driving Awareness), SAM – Save a Mate, Red Frogs Chaplaincy program, Youth Arc, IParty, Oasis,
  - Laws – Drinking, smoking, gambling, driving, sex age, Driving laws for L and P platers, minimum school leaving age eg 17
  - Government initiatives - increased taxes on alco-pops and cigarettes, dental vouchers for adolescents up to 18 years, Government benefits such as Abstudy or Austudy to encourage young people to stay at school, Government Drug Harm Minimisation Strategy ie Limit the supply, reduce the demand and minimise the harm
  - Role Models – RAAAD, Jim Stynes
  - Technology - Gardasil – cervical cancer immunisation, road humps and roundabouts to reduce speeding, factor 50 sunscreen and UV protective clothing, improved safety equipment for sporting/challenge activities

Candidates need to understand that their answers must reflect the underlying concepts of health. Answers lacked depth. The section examiners felt it was unfair that Question 3 specifically asked for information on pregnancy but many candidates still chose to answer this question despite having little background information other than ‘general knowledge’. Approximately 60% of candidates answered question 3. Substantial educative information has been provided by the section examiners for this question so that candidates can see the sorts of things that could have been included rather than the very ‘general answers’ that were written.

**Question 3**

Overall, this question was very poorly answered. Too many candidates only had a limited ‘general knowledge’ about the topic and very few made any reference to why the issue might be increasing. There was little detailed understanding of the effects of teenage pregnancy on the internal components of health with superficial statements like 9 months of pain, stretch marks and enlarged stomach given as examples. The allocation of marks did not work well here as the interrelationship between the components (particularly mental, emotional and spiritual health) made it difficult to discuss them separately. With 5 marks allocated for each of these the lack of knowledge very quickly meant a significant reduction in marks.

A simplistic strategy included more sex education in schools and free condoms – again this reflected poor understanding of the topic as these avenues are available currently but we are still seeing an increase in teen pregnancies.
Better answer could have integrated some of the following into their response:

Introduction about the rising number of teen pregnancies.

The number of births to teenage mothers in Australia has jumped after decades of steady decline, with the Australian Bureau of Statistics (ABS) recording a 10% increase nationally between 2007 and 2008. Teenagers are becoming sexually active earlier, putting themselves at risk of sexually transmissible illnesses and unplanned pregnancies. The rate of sexual activity in adolescents and young people is occurring at an increasingly earlier age. The median age of first sexual intercourse is now 16 years for both women and men. Most young people now experience 10 to 20 years of sexual activity before committing to a life partner. This increases exposure to sexually transmissible infections (STIs) and unplanned pregnancy.

Many pregnant teenagers delay testing for pregnancy therefore reduce their options in terms of abortions (medical or surgical). Tasmania’s birth rate among teenagers (27.5 births per 1,000 15–19 year old women) is one of the highest in Australia and second only to Northern Territory. In Burnie, the rate is 48.3 for every 1000. Teenage pregnancy, abortion and birth rates vary between communities. Birth rates are higher in rural and disadvantaged areas, among Aboriginal young women and among young people who are homeless. Variations have been attributed to a number of risk factors including social disadvantage, low educational achievement and aspirations.

Teenage motherhood is associated with an increased risk of poor pregnancy, social, economic and health outcomes. A brief definition of each component gained marks.

Physical
- Higher complications due to biological immaturity.
- Pregnant women may also have Chlamydia and can pass it on to their babies, who can then develop infections of the eye, nose, throat, or lungs.
- Poor sexual health results in high rates of infertility (1 in 6 couples) in Australia.
- Premature births are common in teenage girls.
- One-third of teens do not receive prenatal care. This results in health issues in the child and the mother.
- Nutritional deficiencies are common in pregnant teens. They have improper eating habits like dieting, snacking, eating fast foods or skipping meals etc. This affects the growth and development of the mother and the child.
- According to WHO, the risk of death following pregnancy is larger in teens (15-19 years old) than in women (20-24 years old).
- Rate of caesarians amongst teens is higher than the general population.

Social
- Biggest factor is that it interrupts education. This is well recognised as a major long term issue which can impact on health in terms of low skill, less employment opportunities, poorly paid or insecure jobs, poverty cycle meaning less access to healthy food, private health, more risky behaviours such as smoking, drugs, binge drinking and unprotected sex. This will lead to long term lower health outcomes and a
possible reliance on Centrelink benefits which can put them under great financial and emotional pressure.

- Low income often means living in poor housing and being unable to afford adequate health care or even basic necessities.
- Teenage mothers may also experience alienation from their peers and family. In addition, a pregnancy can place a great deal of strain on young relationships. Consequently, 60% of young mothers do not have a male partner when their baby is born. Loneliness and financial dependence can make teenage mothers vulnerable to becoming involved in unhealthy relationships (e.g., domestic violence situation).
- Disconnectedness from friends.

**Emotional**

- There is also still a stigma in society attached to being a teenage mother. This stigma can affect the way a teenage mother feels about her parenting abilities, motherhood in general and even herself as a person. Negative attitudes towards young mothers can erode their self-esteem and feelings of self-worth.
- Sense of sorrow or happiness depending on how the individual feels about the pregnancy.
- If a decision for abortion is taken then long term emotional issues may remain if there is a lack of counselling.
- Discrimination in terms of employment opportunities or societal expectations can be felt as a sense of bullying – along with that comes all the same emotions – worthlessness, powerless.
- For a time there may be a feeling of ‘being noticed’, ‘loved’.

**Mental**

- Depression.
- Teenage mothers have a higher risk of postnatal depression than older women. This is most likely due to a number of factors including a lack of support, isolation from peers and/or family, financial pressures and societal attitudes.

**Spiritual**

- If the individual is part of a religion where pre-marital sex is against the values of that religion then there may be a loss of belonging, sense of self.
- For some, pregnancy provides a sense of purpose and a reason for being.

Any strategy to reduce the number of unwanted pregnancies needs to reduce the negative impact of the risk factors associated with teen pregnancy which include:

- Family situations with regular conflict between members, violence and sexual abuse in childhood and unstable housing arrangements.
- Poor school performance and attendance often associated with low socio-economic background.
- Absent father.
- Low self-esteem.
- In a relationship with an older partner.
- Aboriginal or Torres Strait Islander.
- Living in rural and remote areas.
Strategies

Research suggests that knowledge about reproductive matters (i.e. sex education) and access to contraception, including emergency contraception are vital in preventing teenage pregnancies. Teenage girls often use contraception sporadically. While this can be due to a lack of understanding about the chances of pregnancy, it is also due to a lack of skills to successfully negotiate safe sex, particularly with a new and/or older partner.

As evidenced by the risk factors for teenage pregnancy it is clear that much broader issues than just sex education and contraception are required to prevent teenage pregnancies. Protection from violence and abuse, family support, affordable housing, improved school retention, building self-esteem and better educational and vocational opportunities, addressing social isolation and exclusion, increasing health literacy by giving all people access to comprehensive information and education about relationships and sexual health including pregnancy options such as abortion and adoption, improving unsafe and impoverished environments and promoting safer sexual practices are all required. It is also important to recognise situations where unsafe sex was more likely to occur.

Supporting teenage mothers is critical, particularly when it comes to helping them complete their education. There has been a change in funding to teenage mums. The Federal Government is trialling a pilot program in 10 selected areas across the country in an effort to get teenage mothers either back to school or in to the workforce. At present, any unemployed mother on a parenting payment must look for work or enrol in an education course by the time their child turns six. From January 1, teenage mothers in Burnie must attend a regular skills and education course organised by Centrelink once their child is one year old. Failure to do so would result in suspension of a $641 fortnightly allowance. Burnie was one of the areas selected for the trial because of its high rate of teenage parents, unemployment and jobless families with young children.

Support Groups or Programs
- The Tasmanian Making Choices Program
- Tasmanian Sexual Health Reference Group
- Sexuality Education Interagency Group
- The better coordination of services and the promotion sexual health and wellbeing in the North West of Tasmania is a strategy currently under development.
- Family Planning Tasmania, Department of Education, Department of Health and Human Services
- Sexual Health Service
- Youth Health Team
- The Link Youth Health Service
- Headspace

Question 4

This should have been a good question and while overall there were higher marks given, candidates fell into the trap of not answering the question i.e. a 1948 WHO definition of
Health does not really constitute a current definition. Having said this any definition was accepted as long as it contained reference to physical, social, emotional, mental and spiritual (holistic) components where the individual, genetics and community (environment) influenced the dynamic balance of health. Most candidates recognised that the definition had changed to include a more holistic approach to health since the days of ‘absence of disease’. Some mentioned the move from ‘Old Public Health’ through to the ‘New Social Model of Health’ (although this is not part of the current course).

The depth of answers in the four reasons for health differences also varied widely. A number of candidates went with disadvantaged groups within a community and the reasons for this. Very few answers showed how health outcomes differed eg increased levels of national health priority areas.

Better answers integrated the following into their response:

Health is a dynamic balance between an individual’s physical, social, emotional, mental and spiritual components. These components are influenced by genetics, lifestyle choices and the physical, social/cultural, political and economic environment in which the individual lives. It is about the ability to get through the day, have choices and to be able to contribute positively to a community.

The World Health Organisation describes the basic requirements for achieving health as being peace, shelter, food, income, education, sustainable resources, stable eco-system and social justice and equity. Above all, poverty is the biggest deterrent to achieving good health.

This definition has changed considerably from health being a ‘lack of illness or disease’. It is far more holistic and recognises that health is much more than the physical (how our body functions). Social (how an individual fits into society and relates to others) and emotional/social/spiritual (how an individual feels including having a sense of belonging and purpose) health aspects are also considered very important in the overall assessment of health. It recognises that the individual (through lifestyle choices such as safe sex practices, drug use, smoking, binge drinking, safe driving, following the laws of the community and the environment through genetics (inherited factors), physical (everything in air, land and sea), social/cultural (values, attitudes and support groups of the community) political and economic (laws, policies, money in the community, employment opportunities) all influence the balance of health.

Reasons why individuals in the same community may have very different health status may include: (Reason for disadvantage should be explained, impact on health noted and group identified) – good answers backed up with statistics to reinforce the disadvantage. Some reference to low socio-economic status should be mentioned as ‘poverty’ is the biggest deterrent to achieving good health.

- Low socio-economic status (SES) – tend to have poorer levels of health and experience higher levels of morbidity and mortality in almost every disease category. Low SES groups are less likely to use preventative health services and are more likely to engage in higher risk taking behaviours.
• **Cost of and access to health care** - transport, isolation, disability, old age. People living in rural and remote area or those of lower SES tend to have less access to health care and services due to the regionalisation of health services. People who live in rural and remote areas or low SES are also more likely to delay medical treatment due to the distance, length of travel and cost of medical services. Specialists not covered by Medicare such as physiotherapists and dentists means low SES will often miss out on health treatments.

• **Lack of information** - a person’s education level generally determines their level of income, socio-economic status and health. Poor levels of education may inhibit a person’s ability to locate, interpret and evaluate health information. Therefore, these groups are more likely to have high levels of preventable illness and a poorer quality of life. Cost and availability of internet and other information services may be difficult for many including the aged who may be surviving on a pension and also have more limited experience with the internet and other communication sources.

• **Fear and ignorance, language barriers** – Aged with technology, refugees.

• **Discrimination** – disabled, can result in reduced access to services, poor mental health and low recognition of health issues amongst local communities.

• **Government policies** - rising food and living costs, petrol costs and the cost of child care have directly affected poorer communities. Rural and remote communities are particularly affected by the rising cost of petrol due to the long distances they have to travel to access health and other services as well as paying higher prices for food and services. Stolen generation plus forced adoptions also had a big and long term social and mental health impact.

• **Occupation** – manual or labour intensive – higher rates of accidents for males who are more likely to work in high risk occupations, such as those involving transport, mining, machinery, heavy lifting and exposure to the sun. People in rural and remote communities (particularly farmers) and people of low SES are more likely to be in an occupation that carries an element of risk to their health. The impact of drought on farmers in rural communities has become increasingly evident with a rise in anxiety, depression and suicide in these farming communities.

• **Living conditions** – homeless.

• **Access to health care** – specialist services not provided by Medicare,

• **Gender** - males, particularly those in rural and remote areas, are more likely to work in high risk occupations. They are also less likely to seek medical assistance. Males are generally in the high risk categories in the leading causes of illness and death and have a lower life expectancy than females.

### Question 5

Overall most candidates did well in the first part of this question from (a) to (d) and were able to get to a C standard from these alone.

Part (e) of the question was more difficult.
It is important for candidates to give supporting data when it is specified and leave it out when it is not required. Many candidates unnecessarily wrote a lot of supporting data when it was not required.

Suggested Solutions:

(a) (i) Hospitals  (ii) State and Local Government

(b) (i) 43.2  (ii) 26.2

(c) hospitals, community health and capital

(d) (i) 47.5 in 2000-01 (2001-02 was also accepted)
(ii) 45 in 2000-01

(e) (i) Variations on the following were accepted as long as the candidate stated their prediction and used the data to support their position. ‘Explain your answer’ required that candidates base their prediction on data from the preceding years.

In the 6 year period from the 2000-01 financial year to the 2006-07 financial year, Australian government funding decreased approximately 7% (about 1.2% per year) from 45% to 38%. In the same period, State/territory Government funding increased by 6% from 47% to 53%, or about 1% per year.

These trends reversed in the financial years from 2006-07 to 2009-10 with the Australian government increasing by 4% from 38-42% (about 1.3% per year) and the S/T Government decreasing 5% from 53-48% (about 1.6% per year)

Based on these past trends, the financial years from 2009-10 to 2014-15 a 5 year prediction could reasonably expect to see an increase in Australian government funding to continue for at least 3 more years by about 1% per year to about 45% (as this was the previous highest) in 2012-13 and then to remain steady till about 2014-15 as it did in the 1999-2002 period.

Likewise a decrease in State/territory Government funding by up to 1.6% (based on 5% over a 3-year drop) per year for 3 years to about 43% in 2012-13 and then remain at about this level for another two years. This would result in a higher amount of funding by the Australian government by the year 2012-13.

(e) (ii) Data from the 2006-07 financial year to 2009-10 financial year shows a decrease in funding to public hospitals from State/territory governments from 54% to 48% a decline of 6% in 3 years or 2% per year. Whereas in the same period the Australian government funding increased from 38% to 42% an increase of 4% in 3 years or 1.3% per year.

This trend could be expected to continue as given only this amount of data over the next 5 year period. In which case State/territory government funding would decline to approximately 39% and Australian government funding would increase to approximately 47%.
Question 6

Overall this question was not well answered. The lack of structure to this question made for some confusion. Candidates were required to explain how the presence or absence of health resources in a community affect the health of individuals. ‘Include examples in your answer’ was almost invariably interpreted as examples of health resources and candidates mostly neglected to provide examples of ways in which an individual’s health may be affected. This resulted in what amounted to a Criterion 2 answer instead of a Criterion 1 answer.

Many candidates took the opportunity to provide lengthy scripted answers relating to Medicare, PBS, various aspects of the Australian Health Care system, social justice principles, rural and remote health including Indigenous health and so on but paid scant attention to the fact that the question was assessing Criterion 1 and so failed to relate the resources to an individual’s physical, social, emotional and spiritual health.

It was noted that some candidates used the time to discuss references to Old Public Health and Bio-medical models of health and this seemed rather inappropriate.

Better answers integrated the following into their response:

- the school doctor is an example of a health resource within the community. An individual can go to them free of charge and get assistance like regular check-ups for their physical health when they are feeling unwell, or to find ways to improve their physical health e.g. in relation to avoiding viruses and flu, or STI’s like Chlamydia. They can also talk over problems they are having and get referrals if needed
- the school counsellor or psychologist is a health resource in the community and an individual may get assistance with emotional issues if they are experiencing a relationship problem or not coping with the workload or have social issues related to their family background
- sporting clubs are a health resource as involvement in training and practice of a sport improves physical health and general fitness as well as provides social connections and a sense of belonging for an individual. Improvement in both these aspects of health also builds confidence and self-esteem.
- Medicare as a health resource ensures that an individual need not go without seeing a GP when they are sick even if they are on a low income, this provides a sense of security to a person a safety net, whereby they are not isolated from services that are needed.

The absence of a health resource in a community may affect individuals in a variety of ways:

- If a person lives in a remote region they may not have access to gyms, sporting clubs, well developed areas designed for exercise like walking tracks, outdoor gyms and so on. This can impact on their physical health because it may be difficult to exercise for 30 minutes a day. This may also deprive them of social contact that people experience
by using such facilities, they have a chance to maintain social health when they exercise.

- In a remote region a person may not visit a GP or a health centre often and therefore don’t frequently hear the messages provided by health promotion campaigns about alcohol, work safety, smoking, being overweight or obese etc.

Some candidates found the more ‘open ended’ nature of the this question quite challenging compared to the previous structured questions.

**Question 7**

Over 90% of candidates answered this question.

This was a well-structured question with clear guidelines. This was very helpful to candidates as an introduction was not an essential feature to their answer nor was it necessary to include any information other than what was required by the question. However, many candidates filled their answer with much of this e.g. a description of the National Health Priority Area, risk factors, naming all the NHPA’s, the history of the NHPA’s and so on. No marks were given for this.

Some candidates did not use community preventative strategies but provided a range of preventative strategies that an individual may use. Marks were not given for this.

Some candidates spent more time on this first dot point which was worth 12 marks and spent little time on the second dot point which was worth 18 marks.

Overall candidates’ knowledge of curative and treatment strategies was sometimes inaccurate and less detailed than their knowledge on community preventative strategies.

Some candidates mistakenly used tobacco or alcohol as an NHPA.

**Better answers integrated the following into their response:**

- Examples of good answers were a direct approach, naming the 2 NHPA’s up for discussion and then providing examples for each dot point with detailed explanations.

- Many candidates were able to detail information of campaigns such as ‘Measure Up’, ‘Swap it Don’t Stop it’, ‘Go for 2+ 5’, ‘Find 30’ and relate these to Cardiovascular Disease, Cancer, Obesity and Diabetes.

- Candidates who covered Mental Health, Accidents and Injury found it more difficult to name community campaigns and describe them as effectively as candidates that chose the other NHPA’s.

- Candidates that addressed Asthma generally provided strong answers with lots of detail about campaigns.

- Some examples from this answer:
Heart Foundation, tick of approval. This relates to being able to select food that is good for the heart and reduce risk of CVD. It makes choosing food in the supermarket, regulating your diet, reducing fat intake and keeping your heart healthy an easier task.

‘Slip, Slop, Slap’ message and its use in primary schools, of using sunscreen, using a hat and sunglasses and the schools providing outside shaded areas for children to play. Distribution of free sunscreen at events such as sporting matched, music festivals and on beaches.

Anti-smoking campaigns and smoking legislation was commonly used for Cancer, CVD and Asthma.

Asthma Friendly programs help create safer environments through an holistic approach to support and care.

**Question 8**

Very few candidates chose this question but generally those who did were able to get a reasonable base mark as part (a) required a simple list of stakeholders for 6 marks.

The clear dot points and marks allocated for each made it relatively easy for some candidates to answer this question if they covered all dot points adequately.

Part (b) was often not very well addressed as candidates failed to separate out interest and level of influence of a stakeholder for 12 marks. Some candidates discussed the interest of young people or parents in the issue but were unable to explain their level of influence if any, in relation to the issue.

Better answers discussed the interest and influence of the manufacturers of the products who use the power of marketing for example. Some discussed the interest and influence of health professionals in reducing the impact of the issue and influencing government policy.

Some interesting health issue statements were provided in part (c) but mostly candidates just repeated the information given in the question about tremors, heart risk etc.

Part (d) was not well completed overall especially in addressing the dot points as separate aspects. It seemed that many ran out of time to give this important section of the question due thought. Some missed it altogether. Some explained about what might be in a generic campaign but did not give any detail about the campaign itself.

**Question 9**

Few candidates provided a comparison of the averages for Group A and Group B.

A number simply repeated the figures for each country and compared these figures when candidates were required to calculate the average rather than list of the figures directly from the table.
Some candidates made generalisations why GNI should not be used as a sole indicator and did not use the information provided in the table to support their answer.

A few candidates made conclusions from Table 2 and not Graph 4 for question e. Most made the generalisation that as health expenditure increased so did LE; however, this was out of 4 marks so more information was required. This was generally answered poorly.

Some candidates were confused and thought the graph was showing how much the USA was spending on health.

Suggested solutions:

(a) China and Vietnam
(b) U5MR of most concern in China
(c) (i) Group A average per capita health spending (US$) at 393.6
    Group B average per capita health spending (US$) at 65.3
    (full marks for exact figures)
    • Group A per capita spending approx. 6 times higher than Group B
    or
    • Group A per capita spending (US$)328.3 higher than Group B on average

(ii) The above difference in health spending is reflected in 2 other indicators, for example:
    • Group A on average have higher capita spending, lower rates of U5MR and higher LE with data to support this.
    • Group B on average have lower capita spending, higher rates of U5MR and lower LE with data to support this.
    or other indicators but not primary school enrolment ratio female (%) as this does not reflect the same differences as indicated in c (i).

(d) Some countries have performed better in some Health Indicators despite having a lower GNI per capita with data to illustrate this.
    e.g. Chile $11 300 GNI per capita has a lower school enrolment ratio female (%) than Sri Lanka who have a lower GNI per capita at $3730 but have 100% school enrolment ratio for females. (A variety of comparisons with supporting data from the table were accepted here)

(e) Conclusions drawn from Graph 4 could include:
    • A majority of countries spend 0 US$ on health expenditure per capita
    • LE varies considerably for those who spend 0 US$ on health expenditure per capita
    • A number of countries spend 0 - $500 US$ on health expenditure per capita
    • Only a few countries spend over US$ 2000 on health expenditure per capita
    • 75yrs+ link between LE and spending approaches a linear relationship; however, this link does not apply for younger age groups.
    • The majority of the countries have a health expenditure between $0 US - $600 US and LE can range between 40 and 75 years.
Question 10

A range of issues were addressed.

Many candidates provided an outline of the issue but did not include the required profile. Better answers provided statistics.

A number of candidates used the same answer for the preventative approach as well as the strategy for their chosen issue, which was not acceptable for full marks. Some candidates possibly did not understand what the word strategy meant.

Some candidates made false statements, for example ‘women had to walk hundreds of miles every day to fetch water’ or discussed an immunisation against Malaria when there is actually NO effective immunisation against it. Candidates need to use appropriate/correct information to support their answers.

Overall (a) and (b) were answered generally well with (c) either left or answered poorly. This may have been due to running out of time.

Better answers integrated the following into their response:

(a) A Health issue and brief outline of its profile could include:
- Any major cause of morbidity or mortality (HIV/AIDs was particularly popular)
- Poverty
- War/conflict
- Global warming
- A PHC component (lack of safe water)
- Foreign Aid
- Key health indicator
- Gender Equality
- Obstetric Fistula
- Low status of women
- Child Labour

Or other suggested Investigative study topics

The profile could include data to support the significance of the issue eg extent of morbidity/mortality rates, whether the issue is targeted by a Millenium Development Goal (MDG) or the World Health Organisation (WHO) and/or a discussion of the level of profile ie. degree of importance.

(b) One Preventative approach could include:
- Any Primary Health Care (PHC) component
- Any MDG
- Foreign aid
- Micro-finance
(c) One strategy to reduce morbidity and mortality could include:-

- Employ better use of foreign aid
- Preventative approaches eg mosquito nets
- Initiatives eg ‘Dig pits not graves’, ‘Braids not Aids’
- Fistula hospitals/ trained birth attendants
- MDG
- Lifestraw that filters water
- PHC
- Birthing kits
- Wash program (UNICEF)
- Nothing but Nets project - mosquito nets
- Oral rehydration therapy
- New Rice for Africa (NERICA)-prevents malnutrition
- H4+ - HIV/AIDS

(Candidates cannot use the example they gave for B in C again)

Question 11

About 70% of the candidates chose to answer this question.

Some candidates discussed the same topic to answer this question as they did in question 10.

Some candidates started off answering the question really well; however, possibly due to time management issues, did not answer all parts.

The major cause of morbidity and mortality was discussed poorly by a lot of candidates. Many did not expand or give examples of a cause of illness or death and they then struggled to make the MDG’s and PHC fit into the given cause. Some candidates referred to MDG’s incorrectly and mixed them up with PHC indicating inadequate knowledge.

Candidates mostly explained how the issue affects the individual rather than the community.

Many candidates had prepared info and went into a lot of detail about what the PHC and MDG’s were, but failed to relate it well to their cause of morbidity or mortality.

Many candidates explained emergency aid, bi-lateral and multilateral aid without actually suggesting another way that foreign aid could be administered. Again this suggests a prepared answer. Better answers gave examples of how aid currently or previously impacted on their issue chosen.

This question required the candidates to have thorough knowledge of several concepts, therefore many of the answers were not well covered and this was reflected in the marks.

Better answers integrated the following into their response:
(a) **One LDC (1/2 mark)** and **identify one** major cause of its morbidity and mortality (1/2 mark) could include:

   - Communicable diseases
   - Nutritional deficiencies
   - HIV/Aids
   - Neonatal infections
   - Poverty
   - Conflict/war
   - Debt
   - Lack of primary education
   - Poor maternal health

(b) Possible impacts of the major cause could include:

   - Higher rates of morbidity and mortality
   - Loss of income/workplace opportunities
   - Homeless/orphaned children – children as family carers
   - Poverty/lack of employment perpetuates cycle of poverty
   - Impact on components of health

(c) Any **2 MDG’s** which were correctly linked to the chosen cause were accepted. The best answers included a discussion on what the MDGs aimed to achieve in LDC’s and what progress is being made. Data was used to support the answer. (It was an advantage to the candidate if they could name the goals properly)

(d) Any **2** components of PHC which apply to the chosen cause were accepted.

   - PHC includes: Maternal and Child Health, Health education, Community development, Essential drugs, Curative care, Food and Nutrition and Access to safe water and sanitation.
   - Candidates needed to know the components of PHC and **apply** it to the major cause.

(e) Foreign aid can be administered in several other ways including through Non-government organisations, Multilateral aid, emergency/humanitarian aid, developmental assistance, microfinance/microcredit e.g. KIVA.org (small personal loans to individuals in LDC’s). The very best answers tied this to their chosen cause.

**Question 12**

The remaining 30% of the candidates answered this question. Candidates who answered this question tended to manage to do a better job than those that answered Question 11.

Most candidates were able to identify 5 indicators although some confused health issues with health indicators.

Some candidates started off answering the question really well; however, possibly due to not having enough time, did not answer all parts.
Once again many candidates used the same issue as they used to answer Question 10.

Candidates who answered this question found it difficult in how to go about answering parts (a) and (b). Some better answers combined parts (a) and (b). They also included why health indicators are used, a description of the indicator and provided comparisons for an LDC/MDC for each indicator provided.

Many candidates struggled to explain how the indicators indicate poor health - many just gave a definition of the indicator and some statistics to compare the countries.

Candidates tended to struggle to identify one working example for each indicator. Numerous times this question was not answered.

There were some good examples of non-government organisations and programs, but candidates forgot to say how they improve health outcomes in LDC’s. Some candidates just listed the non-government organisation rather than providing two specific examples.

Better Answers integrated the following into their response:

(a) 5 Health indicators (any listed for Q9) could include: IMR, U5MR, HDI, % access to safe water, doctors/nurses ratio, population living under US $2 a day, GNI, pop. growth, primary school enrolment ratio, adult literacy rate, HIV/AIDS

Description of how each one indicates poor health examples could include:
- Reasoning behind why the health indicators are used
- Low life expectancy in LDC’s due to less access to health care and higher rates/incidence of communicable and water borne diseases affecting longevity
- Higher percentage of the population with HIV/Aids in LDC’s due to lower use of contraception, especially condoms and less community understanding/education about HIV leading to the reduced ability to work/provide for children which in turn leads to poverty/reduced educational opportunities and employment opportunities.
- Lower access to safe water which leads to increased rates of water borne diseases e.g. malaria/cholera/diarrhoea contributing to ill health and possible lower life expectancy.
- Provided some examples of LDC/MDC rates for indicators.

(b) The components of Primary Health Care are: Maternal and Child Health, Health education, Community development, Essential drugs, Curative care, Food and Nutrition and Access to Safe water and sanitation.
- Candidates needed to know PHC and apply it to indicators using a working example.

(c) 2 specific examples of NGO’s currently operating and how programs improve health outcomes could include:
NGO’s e.g.’s World Vision, Caritas, Water Aid, Oxfam, Care Australia, Medicines Sans Frontieres and outline of how these programs improve health outcomes

Mobile Health Clinics
Ryan’s Well
Play Pump
Marsh Foundation- Bali/Indonesia medical supplies
UMUNTHU Foundation- HIV/AIDs
UNICEF- ‘Wash’ – water, sanitation and hygiene
TYW- Thank you water profit from water bottle sales going to LDCs to build water pumps
Oaktree Foundation-building schools in Papua New Guinea
### HEALTH STUDIES (HLT315108) – 2012

(subject to refinement)

#### Criterion 1 – Demonstrate an understanding of health and its influence on individuals

| A+ | A | A- | B+ | B | B- | C+ | C | C- | D+ | D | D- |
|----|---|----|----|---|---|----|---|---|----|---|---|---|
| A student can: demonstrate a comprehensive understanding of health and health related issues, and the influence of health on individuals. | A student can: demonstrate a detailed understanding of health and health related issues, and the influence of health on individuals. | A student can: demonstrate a sound understanding of health and health related issues, and the influence of health on individuals. | A student’s answer is not relevant to the question and may: • read as prepared in response to a different question • lack understanding of what the question is seeking. |
| has answered the questions through sustained discussion of the required numbers of factors, behaviours, skills, strategies or avenues of support. | has answered the questions through a thorough discussion of most of the required number of factors, behaviours, skills, strategies or avenues of support. | has answered the questions through a sound discussion of at least half the required number of factors, behaviours, skills, strategies or avenues of support. | identifies fewer than half of the required number of factors, behaviours, skills, strategies or avenues of support. |
| can recall relevant and detailed information from a wide range of sources and uses information to reach valid, logical and reasoned conclusions | can recall relevant information from a wide range of sources and uses information to reach valid and considered conclusions | can recall information from a limited range of sources and uses information to reach valid conclusions | limited recall of information and conclusions unsubstantiated |
| articulate ideas and issues clearly in writing sustains a logical argument with complex, sophisticated links | articulate ideas and issues clearly in writing constructs logical argument with clear links | articulate ideas and issues in writing attempts to construct a logical argument links may be indirect or not existent | a clear argument is missing or is ill-developed this could result in confusion |

#### Criterion 2 – Analyse factors influencing the health of any population

| A+ | A | A- | B+ | B | B- | C+ | C | C- | D+ | D | D- |
|----|---|----|----|---|---|----|---|---|----|---|---|---|
| A student can: demonstrate a comprehensive understanding of the factors which influence the health of communities and countries around the world. | A student can: demonstrate a detailed understanding of the factors which influence the health of communities and countries around the world. | A student can: demonstrate a sound understanding of the factors which influence the health of communities and countries around the world. | A student’s answer is not relevant to the question and may: • read as prepared in response to a different question • lack understanding of what the question is seeking. |
| can critically analyse these factors and contribute effective suggestions as to how they could be improved or changed | can analyse these factors and contribute realistic suggestions as to how they could be improved or changed | can evaluate these factors and contribute some valid suggestions as to how they could be improved or changed | is unable to discuss the factors in any depth or make reasonable suggestions as to how they could be improved or changed |
| has answered the questions through sustained discussion of the required numbers of factors, behaviours, skills, strategies or avenues of support. | has answered the questions through a thorough discussion of most of the required number of factors, behaviours, skills, strategies or avenues of support. | has answered the questions through a sound discussion of at least half the required number of factors, behaviours, skills, strategies or avenues of support. | identifies fewer than half of the required number of factors, behaviours, skills, strategies or avenues of support. |
| articulate ideas and issues clearly in writing sustains a logical argument with complex, sophisticated links | articulate ideas and issues clearly in writing constructs logical argument with clear links | articulate ideas and issues in writing attempts to construct a logical argument links may be indirect or not existent | a clear argument is missing or is ill-developed this could result in confusion |
| evaluate implications, interpretations or representations of ideas and issues through a cohesive, reasoned and clear argument | justify interpretations or representations of ideas and issues by drawing clear conclusions through observations which are mostly supported by relevant evidence | express (some) reasoned interpretations and representations of ideas and issues which are sometimes supported by relevant evidence | makes little/no attempt at interpretation of ideas and issues makes assertions without relevant links no insights/ conclusions are reached |

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**Tasmanian Qualification Authority – Written Paper Marking Tool**

**HEALTH STUDIES (HLT315108) – 2012**

(subject to refinement)

| A+ | A | A- | B+ | B | B- | C+ | C | C- | D+ | D | D- |
|----|---|----|----|---|---|----|---|---|----|---|---|---|
| A student can: demonstrate a comprehensive understanding of health and health related issues, and the influence of health on individuals. | A student can: demonstrate a detailed understanding of health and health related issues, and the influence of health on individuals. | A student can: demonstrate a sound understanding of health and health related issues, and the influence of health on individuals. | A student’s answer is not relevant to the question and may: • read as prepared in response to a different question • lack understanding of what the question is seeking. |
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**Tasmanian Qualification Authority – Written Paper Marking Tool**

**HEALTH STUDIES (HLT315108) – 2012**

(subject to refinement)

<p>| A+ | A | A- | B+ | B | B- | C+ | C | C- | D+ | D | D- |
|----|---|----|----|---|---|----|---|---|----|---|---|---|
| A student can: demonstrate a comprehensive understanding of the factors which influence the health of communities and countries around the world. | A student can: demonstrate a detailed understanding of the factors which influence the health of communities and countries around the world. | A student can: demonstrate a sound understanding of the factors which influence the health of communities and countries around the world. | A student’s answer is not relevant to the question and may: • read as prepared in response to a different question • lack understanding of what the question is seeking. |
| can critically analyse these factors and contribute effective suggestions as to how they could be improved or changed | can analyse these factors and contribute realistic suggestions as to how they could be improved or changed | can evaluate these factors and contribute some valid suggestions as to how they could be improved or changed | is unable to discuss the factors in any depth or make reasonable suggestions as to how they could be improved or changed |
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| evaluate implications, interpretations or representations of ideas and issues through a cohesive, reasoned and clear argument | justify interpretations or representations of ideas and issues by drawing clear conclusions through observations which are mostly supported by relevant evidence | express (some) reasoned interpretations and representations of ideas and issues which are sometimes supported by relevant evidence | makes little/no attempt at interpretation of ideas and issues makes assertions without relevant links no insights/ conclusions are reached |</p>
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### Award Distribution

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### Student Distribution (SA or better)

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