The total number of candidates who sat this year’s external assessment was 939; a slight increase from 2006. This report comprises specific comments from individual Marking Examiners. The Marking Examiners acknowledge this exam was very fair with questions enabling candidates to fully demonstrate their knowledge and understanding although the timing of Section E was an issue. Many of the questions in this examination were very similar to a previous examination, although did not appear to greatly impact on the standard of answers. 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, particularly now that they have many of the facts on their notes pages. 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. Disappointingly, approximately 5 candidates failed to write anything for Section C hence ensuring a failing grade on the examination.

(ii) Read each question carefully in order to write completely relevant answers rather than everything and anything about a general topic. This has been was particularly relevant since the introduction of the notes sheet.

(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’

(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 section.

(viii) Candidates are allowed to take calculators into the exam. This may be useful for Section E - Criterion 7 - Use mathematical ideas and techniques.

(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 what exactly is being asked of you and do just that.

(xi) Candidates are reminded that using tippex 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. This is important in all sections.
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 a ‘prepared’ answer which did not answer the question asked. Poor spelling, incorrect grammar and lack of punctuation continued to be a problem. Some candidates continue to use an emotional style of writing in their answers.

**Section A**

The most commonly answered question was 2 followed by 1 and 3 with 4 by far the least commonly answered.

- Candidates often had 1 very well answered question, but the second answer let them down.
- A large number of candidates had not answered all aspects of an attempted question, e.g. community and individual strategies.
- There was a lot of obvious copying from notes sheets. This led to lots of information based on the topic area but not addressing the question.

**Question 1**

This question was generally well answered.

*Better answers:*

- The best answers clearly took the theory on environment and health and linked correctly to examples.
- Better answers gave and explained a definition of health

*Poor answers:*

- A lot of generalisations especially to do with socio-cultural environment.
- Examples not specific – some included statements but without examples.
- Not a lot of answers included a definition of health.
- Only focussed on one area of the environment.
- No examples.
Question 2

This question was generally not well answered.

**Better answers:**

- Correctly identified the importance and moved quickly to discuss the impact of the environment on risk taking.

**Poor answers:**

- Did not answer question; commonly defined risk taking then went on to the environment OR gave much detail on why adolescents take risks (reasons) and not why it is important.
- Pre-prepared type answers - some answers focused on positive and negative risks and positive and negative outcomes without answering question.
- Very few answered why risk taking is important – only gave reasons.
- Second part of question not answered well – a lot of people said environment would have a huge impact/major influence but that was the extent of the answer.
- A lot of candidates made little or no attempt to address the second dot point (the environment in which the risk takes place), and with the first dot point many spoke in general about why adolescents risk take and didn't explain why this was important. Too many answers focussed on positive and negative risk taking - suggested prepared answers.

Question 3

In general, answers to this question lacked depth.

**Better answers:**

- Identified effects relating to a specific drug.
- Had obviously read the demands of the entire questions and could move through the points that needed covering in a well documented and seamless fashion. Good choice of two drugs rather than two random drugs that they simply 'knew' about.

**Poor answers:**

- Gave a general set of combined effects of drug use.
- ‘Story’ became more important than the critical information; too focused on story without details – some very sad stories!
- Did not clearly understand differences between physical effects and side effects.
- Difficulty talking about the interaction of two drugs.
- Physical effects too general – a lot did not show understanding, but just wrote down all effects they could think of, but some were not relevant to the type of drug mentioned.
A lot of candidates focused on alcohol and tobacco – but did not show understanding of the effects other than the obvious ones.

**Question 4**

*Better answers:*

- Broad range of strategies in both community and individual.
- Could apply these strategies in to real life scenarios.

*Poor answers:*

- Very few answers looked at reducing pressure and stress.
- Only focussed on one aspect of sex (did not recognise a continuum).
- Only provided one strategy (or only mentioned individual strategies).
- Some focused on prevention related to using alcohol/drugs at party – mainly community strategies but did not look at individual strategies.

**Section B**

The most popular question was Question 8 followed by Question 7. Questions 5 and 6 were answered in almost equal proportion. In general, candidates disadvantaged themselves by not answering or addressing all the dot points.

**Question 5**

Candidates wrote detailed answers on the development of health care highlighting the three stages but failed to talk about the present day delivery of health care, the practitioners involved and the health budget and funding. This cost a number of candidate’s valuable marks. The history component was done really well, but key groups in general were missing, and division of funding was sometimes incorrect. For A+s in this section the examiners were looking for statistical funding details as % or $ value.

**Question 6**

Question 6 asked the candidates to look at technology and justify their worth. Most answers identified concerns from advantages and disadvantages, and the cost of technology on the budget and the need for trained personnel. A number of candidates did not address whether ‘medical technology was worth it?’ Abortion pill, cosmetic surgery, IVF and stem cell research were the popular examples. Unfortunately, this question was fairly poorly answered, with a lot of opinion and very little discussion about all 5 areas. Sometimes candidates defined ethics, client rights, etc, but failed to give relevant examples.
Question 7

This question called for the candidates to evaluate what is currently being done to tackle the problem of obesity, physical activity and smoking. The average candidate did not extend their list of major illnesses beyond CVD and Cancer which was disappointing and when asked to look at programmes they simply made a list without explaining how they helped reduce the rate of morbidity and mortality. The focus of discussion was mainly on activities for children and not the wider community. The better answers looked at the issues from the individual as well as the community perspective. Better candidates were able to link the risk factors with the 7 National Health Priority Areas. Quit Tas was the most commonly used example. The very best answers gave statistical data on the success before and after such programmes were introduced. The better answers divided programmes into primary/secondary/tertiary, local/state/federal or individual/community. Tax on tobacco and graphic pics/ads for smoking were some of the other more common examples. Although candidates were asked to list the illnesses, very few did.

Question 8

This question on inequalities was the most popular choice with Indigenous, Non English speaking and Rural groups the main examples used. Once again these answers were well prepared, reflecting on the theory behind inequalities. Better answers included the health issues arising eg Depression, diabetes, CVD, accidents accompanied with statistical data and lifestyle choices contributing to their health. Most candidates named three groups. Very few highlighted health problems and how they were hidden – although the answers that did were excellent. Statistics that were often used failed to make a point as relevant to the question or compared, for example, the indigenous population to the rest of Australia.

Section C

The approximate numbers of candidates who chose each question are as follows:
Question 9 – 155; Question 10 – 113 and Question 11 – 660. It was pleasing to see that the majority of candidates only answered one of the questions.

Question 9

This was a reasonably complex question with several facets – profile, prevention, cure, management as applied to the how successful the changes have been in improving individual and community health outcomes. Most answers were of quite a good standard although several candidates misinterpreted the notion of MODERN medicine instead giving paragraphs of information about the development of the health care system since settlement. Common issues included: obesity, depression, cancers – particularly breast, lung and cervical and CVD.
The following points should be noted:

- Candidates MUST answer the question asked – that is ‘how successful …’;
- There was often too much detail given about the illness, risk factors and the history of health care in Australia;
- The best answers referred to all four parts of the question but particularly focussed on how successful the change have been;
- Issues such as homelessness are NOT health issues but a societal issue and needed to be very closely linked to be of use;
- Some candidates stated blatantly incorrect facts such as ‘50% of Australians are obese’;

The following were NOT asked – discuss a high and low profile issue, what is a contemporary health issue? or is prevention really better than cure?. Candidates were also NOT asked to state what they think ‘we need to do ….’.

The best way to answer this question seemed to be to use two appropriate issues which had relevant advances and changes and discuss how these had been helpful in improving individual and community health outcomes. Unfortunately, some candidates chose issues which had experienced little or no change in profile, prevention, cure or management and hence these of no real use in answering this question.

Question 10

Many candidates found this question quite difficult and gave very brief responses (which were generally unable to communicate enough understanding to gain a C rating) or did not answer the question. This question was primarily about health care costs in relation to prevention and cure/treatment. The biggest error was in candidates spending too long detailing the change in the health care system since settlement without relating this information to prevention, cure or cost. Unfortunately, outlining a health issue and its prevention without a clear and comprehensive link to the question was not satisfactory. It was also important for candidates to remember that cost is not just $!

Some good information included:

- A discussion of increased cost to the community via medicare $;
- A current health care system focus;
- Increased cost of running the pharmaceutical benefits scheme;
- Cost of resources, support people, medical professionals and need to use resources more effectively;
- Discussion of invasive, costly, sometimes unsuccessful treatments for cancer, CVD’s, obesity to both individual and community;
- Many diseases are not curable so there is an ongoing cost of control and management (e.g. HIV, diabetes;
- Individual cost can be counted in $, loss of productivity, emotional and social cost;
- Cost of private health care is constantly increasing and not accessible to all;
• Lifestyle changes are sometimes not seen as being available to those of very low SES;
• Sometimes lifestyle changes can increase individual $ in pocket, e.g. giving up smoking, alcohol, fast food, or be very low cost changes such as walking or relaxing;
• Often rehabilitation and recovery after surgery is as expensive as the surgery itself;
• Success of otherwise of health promotion and primary prevention is difficult to measure, benefits may take time to become evident;
• It may be expensive to implement preventative measure initially but still less expensive than cure/treatment/management in the long run;

Best answers included some data about thing such as: number of Australians affected by CVD, cancer or diabetes annually or government $ spent on cure versus prevention.

Common issues discussed included skin cancer, breast cancer, lung cancer and smoking, type 2 diabetes, cardiovascular disease and obesity.

**Question 11**

The format of the question clearly set out the two main areas which needed to be answered:

- How the media, medical profession and others raise the profile of health issue.
- Whether health issues can ever be considered to be resolved.

Candidates were then expected to support this theory with specific examples of ways the profiles of current health issues have been raised.

**Better answers:**

- showed a good understanding of the theory on how the media, medical profession and other groups raise the profile of health issues and then supported this with appropriate examples (from current health issues) for each point;
- showed a good understanding of the theory on how health issues are resolved and discussed whether health issues can ever be considered resolved;
- included other groups who have raised the profile of health issues such as: governments, educational settings / departments, religious groups / churches, support / lobby groups, interested family and friends;
- gave appropriate examples from health issues such as:
  - How high profile people or groups have raised the profile of certain issues.
  - How specific organisations/foundations/groups have raised the profile of certain issues.
  - The impact of medical technologies e.g. vaccinations in raising the profile of issues.
  - Specific education / awareness campaigns.
  - Legislation developed; and
- identified current/topical issues as examples such as the Cervical cancer vaccine – Gardasil or the drug ‘ICE’ epidemic and it's implication for the Australian health care system, it's approach to policies and drug education (re ‘ICE’).
**Common errors:**

- not answering the question, instead spent time discussing ‘what is a health issue’, ‘how health issues arise’ and ‘what determines high and low profile issues’;
- no specific examples of ways the profile of certain issues have been raised;
- failing to mention groups other than the media and medical profession;
- selecting issues to use as examples and then saying the media, medical profession and other groups were doing nothing to raise their profile. (It was therefore a waste of time to include such issues);
- examples of health issues that also have an environmental application were not linked to the health side of that issue. For example, Pulp Mill, Global warming needed to be linked to issues such as skin cancer and lung cancer;
- writing a whole extended answer without referring to a single issue;
- a lot of prepared answers that were not made directly relevant to the question being answered; and
- candidates need to spell the issue they are discussing correctly, they choose the issue and have an info sheet so they should spell the issue correctly. Some errors included: Cicix Cancer, Xeoplants and Sun Cancer.

**Section D**

Question 13 was by far the most popular question followed by questions 15, 14 and then 12.

- Candidates should not waste time using highlighters or red pen. Answers should not be in pencil.
- It appeared that a number of candidates may not have used their time well in previous sections as several obviously ran out of time. A number even wrote this message on the exam paper – candidates are not allowed to write notes to the marking examiners.
- Many candidates are still not using a new page for each question. While this is not a big issue it is still important for candidates to develop the skills of exam protocol. Maybe this is something that needs reinforcing back in schools.
- Despite candidates having 18 minutes to complete each answer (compared to the previous 12 minutes) there did not appear to be an increase in either depth or length of responses. Many answers were not 18 minutes worth of information.
- It was clear that many candidates took their answers word for word from their ‘information sheet’ and did not apply the information to the question.
- Some (quite a few) appeared to struggle with what the question was actually asking. Primary Health Care responses appeared in all four answers and often candidates wrote about it in each of their two answers. Candidates were generally not penalised for this as long as they could clearly related their information back to the question.
- A number of candidates did not number their questions and it was not immediately obvious, at times, which question to which they were responding.
- Candidates need to be aware that markers gave equal weight to each dot point. Many candidates gained high marks for one dot point but then left little time for the second and consequently ended up with an overall lower mark.
Health is a constantly changing concept and it was clear that a number of candidates were working with ‘old’ information including statistics from as far back as 1988. Many are still using ‘third world’ rather than ‘less developed’. The best answers used up to date examples to reinforce the theory.

DEBT was spelt DEPT in many cases. Not a major problem but just stood out.

**Question 12**

- This was an interesting slant on a profile question and it was surprising that more candidates did not answer this one as the dot points clearly indicated the sort of information that was required.
- Overall this question was quite well answered.
- Some interesting responses were made with some candidates actually writing a report to the WHO. Others wrote as if they were in the country as an aid worker.
- Others confused the question and wrote a report about Primary Health Care.
- A big percentage of candidates failed to include realistic and relevant statistics to back up their information.
- A number of candidates used a comparison table with an MDC but instead of using statistics used terms like low, high. It was important that candidates related the table back to the question.

**Better answers:**

- Included relevant statistics woven into their report relating to each of the dot points:
  - LE, IMR U5MR, HIV/AIDS, GNI, Death rates for various diseases like malaria or malnutrition, contraception rates, medical personnel per head of population, total fertility rate, % urban/rural, % under15/over 65 years;
  - Identified a specific country or data to back up their responses;
  - Gave an overall picture of the country including reasons why they were suffering eg ongoing effects of post independence, war, debt, natural disasters as well as clear information regarding each of the specified dot points;
  - Included how the country(ies) was/were fairing in relation to achieving the Millennium Goals;
  - Discussed the influence of Poverty (education, water, food, health care, housing, work, role and status of women), environment, water/sanitation, overcrowding/population/living conditions, malnutrition/famine, communicable/nutritional diseases, debt, infrastructure/housing, basic health care, HIV/AIDS, lack of education, wars, droughts, floods, lack of access to essential medicine, obesity, cigarettes land mines, dumping – smoking – lung cancer, exploitation, lack of infrastructure, housing or shelter, orphaned children, limited access to health clinics/medical professionals, loss of income opportunities eg tourism;
  - Covered the link between illness and productivity (and therefore ability to produce goods for export and income).
Question 13

- This was by far the most popular question and it was very clear that many had prepared answers for this as a number of answers were identical.
- Many responses were heavily weighted to the first dot point but did not allow enough time for the second and consequently ended up lowering their overall mark.
- While many candidates were able to explain the historical causes of poverty a number did not mention that the flow on effect of it all was that the Governments were unable to commit enough money to health and education – the basic necessities that would help them get out of the poverty cycle.
- A pattern amongst some answers – war/government/natural disasters were the only mention of the historical causes of poverty – NO colonisation/trade/debt.
- The 8 factors of Primary Health Care were generally well covered but the question asked for candidates to evaluate how a PHC could improve outcomes. Merely listing the components was not enough and did not show understanding about why they were so important.
- Candidates scored better marks if they wrote how the elements of a primary health care system improved the health of the people eg immunisation programs help decrease the number of deaths in babies and young children from diseases like tetanus, polio, diphtheria, TB, measles; providing safe water and sanitation helps reduce the number of people suffering from diarrhoea, worms, and bacterial infections which will in turn improve the health of all…
- Candidates who were able to back up their statements regarding the relevance of PHC with statistics gained higher marks.

Better Answers:

The greatest contributing factor to the high rates of morbidity and mortality in the developing world is POVERTY which has generally arisen through a combination of the following factors:

- The effects of colonisation
- High debt level meaning less funds available for health expenditure
- Inequitable trade
- Corrupt or incompetent Governments
- Natural disasters such as drought, floods and earthquakes
- War and other conflicts

Almost one billion people are trapped in the cycle of poverty which has meant less education, water, appropriate sanitation, food, health care, suitable housing, employment, and the overuse and destruction of the environment. This in turn has lead to malnutrition, disease and despair that reduces energy, work capacity and a community’s ability to plan for the future. As a result of these and other issues, many countries are locked in a cycle of poverty causing much illness and high death rates.

Declaration of Alma Ata – Primary Health Care Model – Health for All
A focus on **Primary Health Care** is one of the major steps that has been employed to improve the health status of the world’s poorest people. PHC aims to assist a community in developing strategies both short and long term to improve and sustain the health of all its members.

Primary health care system is a cheap and effective way of dealing with health issues that are faced by the populations of Less Developed Countries.

PHC includes:

- Education concerning health problems and methods of preventing and controlling;
- Promotion of food supply and proper nutrition;
- Adequate supply of safe water and basic sanitation;
- Use of oral rehydration therapy;
- Promoting the importance of breast feeding;
- Maternal and child health care, including family planning;
- Immunisation against the major infectious diseases;
- Child growth monitoring;
- Prevention and control of locally endemic diseases including HIV/AIDS;
- Appropriate treatment of common diseases and injuries;
- Provision of essential drugs;
- Education for all especially improving opportunities for girls; and
- Trained medical personnel particular in rural areas where access to health facilities is limited.

As well as these health sector factors it also includes:

- Aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing public works, communications.

**Question 14**

Again this answer required two parts. There were a number of very good answers that clearly outlined the various types of aid and gave strong specific examples about why they may be inefficient. It was clear that some candidates were very well prepared for an answer like this. Others merely gave a definition but failed to identify inefficiencies or changes to improve the delivery of aid.

**Better Answers included:**

- Mention that overseas aid has made a significant contribution to the health and well being of the world’s poor and a child born today in a developing country can expect to live 16 years longer than a child born 35 years ago. IMR has halved since 1960 but there are still many inefficiencies.
• Description of multi lateral, bi lateral and NGO aid while others described tied aid, emergency/humanitarian aid, developmental aid.
• Examples of inefficiencies including the dumping of inappropriate aid such as cigarettes, baby formula, out of date drugs, pesticides, pushbikes, asbestos in Thailand, fish in Victoria River that ruined the original ecosystem, clothing into places where they produce their own, cheap food that meant that local producers lost revenue, ‘bandaid’ solutions, tied aid that often benefited the donor country more than the receiver, administrative costs of aid agencies, bi lateral aid mostly directed to building bridges, road and infrastructure that was largely in the cities whereas the greater need for aid is in rural areas, corrupt governments using aid for weapons and luxurious lifestyle, NGO aid heavily reliant on donations therefore even though effective in working where there is the greatest need, their funds are limited.

• **Changes** - The key points of effective aid for long term development with an explanation why they were so important ie
  - It must be the right type of aid that reaches the poor/focus on women/water and sanitation/basic health programs and primary education/focus on health/effective community involvement and participation.
  - As of 2006 many countries have agreed to only give ‘un tied’ aid so that all countries (including LDC’s) can tender for projects within various countries.
  - Donor countries should meet the agreed level of 0.7% of their budget for aid.
  - Wiping debt or low/no interest loans.
  - Aid linked to the achievement of the Millennium goals with a Primary Health Care focus.
  - Many used the statement ‘feed a man a fish and you feed him for a day, teach a man to fish and you feed him for life’ to develop their ideas about the need for sustainability with aid.
  - Good governance, assisting with peace keeping, land mine reduction, assisting to improve technical understand to help build expertise and institutions needed for economic stability and growth.

**Question 15**

This question also had two parts. Many candidates focussed heavily on Primary Health Care in either/both dot points but did not give specific or other examples particularly about what is being done in various countries.

*Better Answers Included:*

• Some of the factors that contribute to the high rates of morbidity and mortality in LDC’s including: poverty, ongoing effects of war eg landmines, corrupt governments, natural disasters, communicable diseases eg HIV/AIDS, malaria, worms, nutritional diseases.
• The major cause of death and illness in LDC’s tend to be infectious diseases; however, more recently lifestyle diseases such as cancer, cardiovascular disease and diabetes, accidents and injuries have become more prevalent.
• Statistics to reinforce the rates of morbidity and mortality.
• Many used ‘Almost one billion people are trapped in the cycle of poverty which has meant less education, water, appropriate sanitation, food, health care, suitable housing, employment, and the overuse and destruction of the environment. This in turn has lead to malnutrition, disease and despair that reduces energy, work capacity and a community’s ability to plan for the future.’
• What is being done? (with specific examples of effective programs in various countries) – Primary Health Care –Health for All, Millennium Goals, G8 Summit, ongoing foreign aid both humanitarian and developmental, wiping of debt for some countries, immunisation programs, Make Poverty History awareness campaigns; child sponsorship eg World Vision, land mine eradication
• What needs to be done?
  o ensure that aid is ongoing and appropriate;
  o continue working towards the achievement of the Millenium Goals with particular emphasis on Africa;
  o ongoing Preventative Health Care Measures for communicable diseases such as immunisations, malaria nets, HIV awareness, improved access to safe water and sanitation, improved food and nutrition, maternal and child health, essential drugs eg retroviral, health education; improving the status of women; particular emphasis on culturally appropriate development where the local community has a strong input into what is needed;
  o further eradication of foreign debt;
  o micro loans to allow small businesses to be set up;
  o breaking down the trade barriers and making rules fairer to LDC’s;
  o affordable health care and access to essential medicine;
  o ongoing landmine eradication;
  o empowerment/ownership, education, sustainability, stability (political), constructive (not destructive) aid;
  o sponsorships;
  o wealthy countries committing to 0.7% of budget for aid;
  o Reduction/elimination of trade sanctions;
  o developing a sustainable economy – ie not reliant on one or two areas eg tourism, agriculture;
  o improved technology/communication – eg earthquake warning;
  o compulsory free school meals which balance a child’s diet will reduce underweight and malnutrition children;
  o stopping discrimination of minorities;
  o protection of the planet by reducing pollution, planting more trees;
  o awareness campaigns for eg warning about the dangers of smoking; and
  o diverting military spending into health and education.
Section E

On the whole, candidates coped admirably with this section with only a few candidates failing to make any attempt and relatively few failing to complete all three questions. Many candidates achieved ‘A’ ratings as the questions did not call for higher order mathematical skills or data analysis. If candidates find that they do not enough time to do all questions, which sometimes happens in the last section, they are advised to spend the least time on the one worth the least points. A useful strategy is to do some of the first question to get the idea of what the graphs/tables are about, and then go onto questions 17 and 18 as they will score more points.

Candidates should take care not to:

- make ambiguous statements which can confuse markers - ‘Country C is a developing country’ ‘Country C is not a developing country’ (in context meant it should be developing but isn’t);
- generalise without including the stats - ‘... a closer to average IMR’ and ‘... a more realistic HIV/AIDS figure’ (what would those figures be?); or
- confuse IMR with IMF (several candidates did this)

Question 16

Expected response:

(a) False Country C and D have the same Gross Domestic Product (GDP) of $1000US in 2001.
(b) True Graph 2 clearly shows that the life expectancy (LE) in country C is declining from approximately 51 years in 2000 to 48 in 2004.
(c) False Country C has the highest HIV/AIDS rate of 4.9% while country E has a rate of 3.7%.
(d) True or False – depended on candidate’s interpretation of the question and explanation of their answer because countries C and D had the equal lowest GDP in 2001.
(e) True Country A has a LE of 80 years in 2002 whereas country B has a LE of 79 years.
(f) False Table 4 shows that country E has higher literacy rates – 83 for males and 63 for females.
(g) True Graph 1 shows that Country A had a per capita GDP of $27000US which was higher than Country B with $25,000US.
(h) False Table 3 shows country E has a higher 2004 death rate of 24 whereas country C’s rate was 17.
(i) True Table 2 clearly shows that in 2004 country C has the second highest infant mortality rate (IMR) with 101.0 whereas country E’s IMR was 139.0
(j) False Table 4 shows country E has a rate of 55 which is higher than Country C’s rate of 36.

(1/2 point each = 5 points)
Candidates needed to answer True or False and provide the relevant data. Better answers included the number of table or graph where data came from. The sample answer gives absolutely every bit of information. It is important to write the data in full, using percentages, per 1000 etc. It is equally important to write the indicator in full. Many candidates referred to LE, IMR, or even DOI(??), without demonstrating any understanding of the abbreviations. This was the easiest question in this section and candidates appeared to spend much longer on this question than either of the following questions which were weighted much more heavily. **Put in stats before info about whether it was in graph 1 or table 2 etc.** Some candidates also converted years of decline, or literacy rates into a percentage - this didn't score any more points, and may have wasted time. Quite a few candidates added male and female literacy rates coming up with 140 which makes no sense. Remember the correct number of zeros - there's a big difference between a GDP per capita of $2,600 and $26,000 in the given examples.

**Question 17**

Candidates could have selected either country C, D or E as the best example of an LDC. The most popular choice was Country C. Better answers provided accurate statistics on 4 indicators, described the relevance of the indicator and also outlined changes in the data over the 5 year period, 2000 – 2004, (where it was available.) The correct unit of measurement for each indicator was used (where given) and linkages made between the data, for instance low levels of safe water and sanitation were linked to the high death rate and infant mortality.

**Question 18**

Candidates could have selected either country A or B as the best example of an MDC. As for question 17 the better answers included much more detail than a list of indicators and a number representing that indicator.

Both questions 17 and 18 contained two dot points and the first dot point was given a heavier weighting than the second. To make reference to, and explain 4 indicators many candidates entwined discussion of why each indicator was suitable to use to assess the level of development. It was, therefore, difficult to mark these questions with the expectation that each dot point would be addressed separately.

**Summary Section E comments:**

Examiners recognised the difficulty candidates faced with the time allocated for each question. For instance, to adequately complete the requirements for Question 16 took much longer than the assigned 5 minutes. Examiners also took into account the ambiguous phrasing of the last two questions and the inconsistencies on the data sheet; however, these oversights did not detract from candidates being able to demonstrate their ability to meet the requirements of Criteria 7.
Overall, this section provided all candidates with ample opportunities to demonstrate their ability to use mathematical ideas and techniques, and most candidates did that quite successfully. In questions 17 and 18, candidates got maximum marks from naming 4 indicators and matching statistics, AS WELL AS some info. in the second part of questions eg ’...high literacy rates equates to a stronger work force and a more positive future economy’ or ‘access to safe water and sanitation means less disease and sickness’ not from simply quoting all the statistics for the chosen country. That only addressed the first part of the question.

There is a difference between saying why you chose the indicators, which candidates were asked to do, and providing reasons for the trends which candidates were advised was not necessary. Examples of saying why you chose the indicators are:

- IMR is a good indicator of level of maternal and child health care which is important for children's growth and development.
- a high GDP indicates high employment levels which provides family income to pay for goods and services.

Statements such as: ‘There are not enough Doctors and midwives: progress mustn't be being made in the right areas; the country must be living in danger (at war); HIV/AIDS will stay a problem because they are unable to buy contraception; Country E has a high birth rate of 24 per 1,000 so this indicates unwanted pregnancy’ are examples of reasons for the trend and were not assessable under this criterion.

Many candidates made comparisons between countries in an attempt to show that the chosen country was an LDC or an MDC. This was not asked for, and wasted time.