

# Vulnerable Populations of Women

## LEARNING OUTCOMES

On completion of this chapter, the learner will be able to:

1. Explain risk factors that contribute to vulnerability in women.
2. Analyze vulnerability from an individual and aggregate perspective.
3. Explain concepts that form the conceptual basis of vulnerable populations.
4. Discuss factors that contribute to health disparities in vulnerable populations.
5. Describe specific vulnerable populations of women and the significant characteristics of their health disparities.
6. Analyze how knowledge of health literacy, social justice, cultural competence, and resilience can be applied to promote well-being and positive quality of life outcomes in vulnerable populations of women.

## Introduction

Over the last century, progress in public health, medicine, and technology has led to major advances in the prevention, diagnosis, and treatment of diseases in women. Consequently, countless women are enjoying longer and healthier lives, as well as improved quality of life. Despite these strides, however, significant disparity continues to exist in women's health and health care. Numerous individual and societal factors tend to place women at greater risk for health problems and increase their vulnerability to disease, injury, and psychological trauma. While women, on

the whole, can be considered vulnerable, there are many subgroups of women who have greater than average risk for developing health problems and thus comprise vulnerable populations. This chapter will explore the meaning of vulnerability and what it means to be a vulnerable population. In doing so, a theoretical perspective of vulnerability in women as well as vulnerable populations of women will be provided. This chapter will also present a discussion of concepts particularly essential for the promotion of well-being and positive quality of life outcomes of vulnerable populations of women.

## Vulnerability From Individual and Aggregate Perspectives

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### *Vulnerability*

In general, vulnerability means *susceptibility*. The specific implication of vulnerability in health care is *to be at risk for health problems*. People who are vulnerable are more likely to develop health problems. Certain community and corresponding individual factors are risk factors associated with the development of poor physical, psychological, or social health. Risk factors are attributes, characteristics, behaviors, or exposures that are associated with or lead to increases in the probability of occurrence of health-related outcomes (Aday, 2001).

Women can be at risk for poor physical, psychological, or social health. Some women who are not members of culturally defined populations frequently designated as being vulnerable might be vulnerable only in certain contexts. For example, emergency room nurses are vulnerable to violence. Hospital employees and visitors are vulnerable to infections. Teachers in preschool and daycare are vulnerable to a multitude of communicable diseases because of their daily contact with young children.

There is an unfortunate propensity in society to judge some vulnerable women as being at fault for their own vulnerability. For example, rape victims have often been blamed for enticing their attackers. Although people should be more cautious about personal protection in societies in which dangers exist in many contexts, this concept is quite different from blaming the victim. When a victim is blamed for his or her vulnerability, the onus of accountability is removed from the criminal and placed on the victim, which is an injustice. In the final analysis, criminals and predators need to be held accountable for criminal behavior. Victims need to be reassured that an assault is not their fault because they were simply in the wrong place at the wrong time.

### *Vulnerable Populations*

Vulnerable populations are groups who are especially sensitive to risk factors and generally possess multiple cumulative risk factors. Vulnerable populations have a greater likelihood of developing health problems as a result of exposure to risk, or have poorer outcomes from these health problems than the rest of the population (Pacquiao, 2008). Vulnerable populations have a greater-than-average risk of developing health problems by virtue of their marginalized sociocultural status, their limited access to economic resources, or their personal characteristics such as age and gender (Aday, 2001). To illustrate this, members of ethnic minority groups have traditionally been marginalized even when they are highly educated and earning good salaries. Immigrants and the poor (including the working poor) have limited access to healthcare because of the way health insurance is obtained in the United States. Women, children, and the elderly are vulnerable to a host of healthcare problems—notably violence, but also specific health problems associated with development or aging. Developmental examples might include poor influenza outcomes for children and the elderly, psychological issues of puberty and menopause, osteoporosis and fractures, as well as Alzheimer's disease among older women.

Vulnerability is both an individual and group concept. To be a member of a vulnerable population does not necessarily mean a woman is, in fact, vulnerable. Moreover, many individuals within a vulnerable population would resist the notion that they are vulnerable, because they prefer to focus on their strengths rather than their weaknesses. These individuals might argue that *vulnerable population* is just another label that healthcare professionals use to promote a system of health care that they, the consumers of care, consider patronizing. Thus, it is important to distinguish between a state of vulnerability at any given point in time and a labeling process that further marginalizes groups of

people at risk for certain health conditions. Nonetheless, the notion of a vulnerable population is a public health concept that refers to vulnerability by virtue of status, that is, some groups are at risk at any given point in time relative to other individuals or groups.

From a public health standpoint, the group concept is dominant. Consideration of aggregates helps healthcare providers increase their awareness of the health disparities and increased risk for health problems of a particular vulnerable group at any given time relative to other individuals or groups. It is critical to understand that persons who are members of a vulnerable group might not view themselves as vulnerable and may likely resent labels that imply they are not autonomous. Thus, healthcare providers should be careful to avoid labeling or stereotyping that could further marginalize the vulnerable.

### *Conceptual Basis of Vulnerable Populations*

Numerous important concepts form the basis of vulnerable populations. These key concepts include risk, social status, social capital, human capital, access to care, cost of care, and quality of care. They influence vulnerability and are essential for understanding vulnerability as well as the nature of health care for vulnerable populations. These concepts and how they are linked to vulnerability provide a framework for describing women as a vulnerable population.

### **RISK**

Risk is an essential underlying concept for understanding vulnerable populations. Any person can be at risk statistically by way of having the potential for certain illnesses based on genetic predisposition (Scanlon & Lee, 2007). All persons are potentially at risk for poor physical, psychological, and social health. Anyone can be vulnerable at any

particular moment as a result of circumstances in their lives or response to illness or events. People may be more or less vulnerable to poor health at different times in their lives, and there is likelihood that some individuals and groups may be more at risk than others at any given point in time (Aday, 2001).

Women who are in poor physical health, such as those having a debilitating chronic illness, may be at higher risk for poor psychological health (such as depression). Furthermore, they may be at higher risk of poor social health, such as having few supportive social contacts. Risk is cumulative. Thus persons who are in poor health and have little material (economic) and nonmaterial (psychological or social) resources to assist them in coping with illness are at greater risk for harm or neglect (Aday, 2001).

### **SOCIAL STATUS**

Social status is linked with the standings that persons occupy in society that are related to age, sex, race or ethnicity, and the opportunities and rewards, such as prestige and power, they have as a result (Aday, 2001). Social status can influence vulnerability. The pervasiveness of certain diseases and the need to depend on others for help because of poor health differ throughout the life cycle. Socially defined roles that typify females at different stages of the life cycle can lead to differential exposures to health risks. For example, the dependency of infants and elderly on others, the risk-taking behaviors of adolescents, and occupation-related exposures among women in the workforce presents varying degrees of risk for illnesses or injury (Aday, 2001). Women tend to have a higher incidence of many types of illnesses as compared to men. Such disparity is frequently attributed to women's differing health needs, stress related to the complex deferential and demanding roles women play in society, and the social acceptability of women to admit their vulnerability (Aday, 2001). In addition,

racial and ethnic minorities frequently have poorer health and fewer material and nonmaterial assets to meet their needs. These disparities are likely related to historical and contemporary patterns of discrimination with associated residential or occupational segregation, limited economical or educational opportunities, and disproportionate exposure to environmental risks in mainly minority neighborhoods (Aday, 2001). Consequently, women with a combination of statuses, such as being poor, elderly, and a member of a racial or ethnic minority, are in an extremely vulnerable position due to the high risk of having poor health and few material and nonmaterial resources (Aday, 2001).

### **SOCIAL CAPITAL**

Social capital is related to the quantity and quality of interpersonal ties among people. Members of social networks gain social capital in the form of social support and related feelings of belonging, psychological well-being, and self esteem. Social support is valuable to people in that it provides resources that enable them to achieve goals as well as helps them in coping with and minimizing the effects of negative life events or adversity on their physical and mental health. People who are members of supportive social networks experience enhanced physical, psychological, and social well-being (Aday, 2001). Communities are sources that both generate social capital and provide social capital to individuals and community members. Individuals with weak community integration or connection are most likely to have the least social capital or fewest social ties to count on. Women who likely have low social capital include those who are not married or in an otherwise committed intimate relationship, live alone, head single-parent households, have weak or nonexistent social networks of family or friends, and do not belong to any voluntary organizations such as churches or volunteer interest groups (Aday, 2001).

### **HUMAN CAPITAL**

Human capital is the investment in skills and capabilities of individuals that enables them to act in a new way or improve their contributions to society. Human capital is frequently reflected by the quality of schools, housing, jobs, and income in the community. Thus, communities with poor schools, substandard housing, and high rates of unemployment likely have diminished levels of investment in the human capital or potential for productivity of the people who live there (Aday, 2001). Disparities in education and income, as well as sustained economic deprivations over the life course, are associated with wide disparities in health. Inadequate and unsafe housing can increase exposure to health risks. Consequently, women who are poorly educated, unemployed, and poorly housed are likely to lack the resources essential for coping with illness or other personal or economic adversities (Aday, 2001).

### **ACCESS TO CARE**

Access to care refers to the ability of people to find, obtain, and pay for health care. Issues associated with access to care frequently center on being able to access healthcare providers and institutions that will impart healthcare services, as well as managing financial barriers and inadequate or lack of health insurance to pay for services (Aday, 2001). Vulnerable populations are often confronted with barriers to access of care. Women, especially those who are elderly, immigrants, of lower socioeconomic means, or of racial and ethnic minorities, frequently encounter such barriers. Women in these groups commonly lack health insurance or may be challenged with language barriers, discrimination, poor health literacy, or isolation.

### **COST OF CARE**

Costs of care can be either direct or indirect. Direct costs are the dollars spent by healthcare facilities

to provide care, whereas indirect costs are losses resulting from decreased patient productivity, such as absenteeism from work. Frequently, the out-of-pocket costs or cash outlays of individuals or their families are significant components of the financial burden of health care. The bulk of resources consumed in caring for vulnerable populations of women involve costs associated with treatment and loss of human productive potential (Aday, 2001).

### QUALITY OF CARE

Quality of care refers to the relative inadequacy or superiority of services. Issues associated with quality of care involve characteristics of providers and institutions delivering services, treatment protocols or standards recommended or used by care providers, and the actual health consequences or outcomes of the care delivery process for patients. The effectiveness of care for many vulnerable populations of women is greatly affected by accessibility, adequacy, and acceptability. In essence, this means that outcomes of care for vulnerable populations of women are greatly influenced by what type of care they are able to get, whether the care is enough and appropriate for their needs, and whether they are willing to follow the plan recommended for treatment (Aday, 2001).

### *Health Disparities and Vulnerable Populations*

A major characteristic of vulnerable populations is their increased risk for adverse health outcomes because of marginalization due to personal attributes, sociocultural status, or limited economic resources. Vulnerable populations commonly are affected by health disparities, which are significant differences in overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates. Factors such as poverty; racial, ethnic, and gender inequalities; and access to health care contribute to health disparities.

Trends over the last five decades (the lifetime of the baby boomers) show marked changes in the demographics of the population and families, and these changes in turn have affected health disparities by way of dramatically shifting social status and social capital. A larger portion of the population is comprised of racial and ethnic minorities. The elderly population has risen from 35.5 million in 2002 to 43.1 million in 2012. It is estimated that by 2030, the elderly population will rise to 72.1 million, and 92 million by 2060 (U.S. Department of Health and Human Services, Administration for Community Living, 2015). Presently, more men and women are delaying marriage, with many choosing to live together first. Divorce rates are higher, with a concurrent increase in single-parent families. An increase in out-of-wedlock births has occurred as well as a sharp increase in maternal employment (Hofferth, 2003).

Vulnerable populations characteristically reflect health disparities associated with age, gender, race, ethnic minority, socioeconomic status and societal trends. The following discussion describes vulnerable populations of women that have been adapted from the vulnerable populations identified by Aday (2001). Significant characteristics of their health disparities are presented.

### HIGH-RISK MOTHERS

This population reflects the currently high rates of teenage pregnancy and poor prenatal care, leading to birth-weight problems and infant mortality. Affected groups include very young women, African-American women, and poorly educated women, all of whom are less likely than middle-class white women to receive adequate prenatal care due to limited access to services. Although in a downward trend, the U.S. teen pregnancy and birth, sexually transmitted disease, and abortion rates are substantially higher than those of other Western industrialized countries (Centers for Disease Control and Prevention [CDC], 2011a).

Factors that increase the risk for teen pregnancy include growing up in poverty, having parents with low levels of education, growing up in a single-parent family, and having low attachment to and performance in school (CDC, 2014a).

### **CHRONICALLY ILL AND DISABLED WOMEN**

Women who are chronically ill or disabled not only experience higher death rates as a result of heart disease, cancer, and stroke, but are also subject to prevalent chronic conditions such as hypertension, arthritis, and asthma. The debilitating effects of such chronic diseases lead to lost income resulting from limitations in activities of daily living. African-Americans are more likely to experience ill effects and to die from chronic diseases. About 27 million women in this country have disabilities and more than 50% of women over the age of 65 are living with a disability (CDC, 2014d).

### **WOMEN LIVING WITH HIV/AIDS**

In the past decade or so, advances in tracing and treating AIDS have resulted in declines in deaths and increases in the number of people living with HIV/AIDS. This increase is also due in part to changes in transmission patterns from largely male homosexual or bisexual contact to transmission through heterosexual contact and sharing needles among intravenous drug users. Although more men than women become infected with HIV each year, it is estimated that if the current rate of new HIV infection continues worldwide, women with HIV may soon outnumber men with HIV. Women account for 23% of all people in the United States living with HIV. Women of color are disproportionately affected by HIV as compared to women of other races and ethnicities. In 2010, 64% of the total number of new HIV infections in women occurred in African-American women, 18% in white women, and 15% in Hispanic women (CDC, 2015).

### **MENTALLY ILL AND DISABLED WOMEN**

Mental illness affects women differently than men. Some disorders occur more commonly in women as well as present with different symptoms. Numerous biological differences associated with hormones and brain structure affect mental health risks, rates of disorders, and the course of disorders. Also influential in risk and prevalence are numerous environmental and psychosocial factors, such as likelihood of women seeking treatment, likelihood of diagnosis bias, social status, and experience of abuse. Certain social and protective factors can also affect mental health, such as the effects of race, ethnicity, culture, and level of resilience (Office of the Surgeon General, 2005). Severe emotional disorders can seriously interfere with a woman's ability to function in the primary activities of daily living and interpersonal relationships, resulting in the need for prolonged mental health care.

Mental disorders that commonly affect women include anxiety disorders, attention deficit hyperactivity disorders, borderline personality disorder, postpartum depression, and schizophrenia. Women also have high incidence of unipolar and bipolar depression as well as eating disorders (CDC, 2013a; National Institute of Mental Health, 2015). Depression is twice as likely to occur in women as compared to men, and the prevalence is higher among Caucasian and Hispanic women as compared to African-American women. Early puberty is a high-risk period for specific mental disorders prevalent in adolescents, such as eating disorders.

### **WOMEN WHO ARE ALCOHOL AND SUBSTANCE ABUSERS**

Substances that are abused include a wide array of drugs and chemicals, alcohol, and tobacco. Intoxication results in chronic disease, accidents, and, in some cases, criminal activity. Smoking has been linked to chronic diseases such as cancer, heart disease, and

lung disease. Although late teen and young adult males are more likely to smoke, drink, and take drugs (CDC, 2011), the use of illicit drugs, tobacco, and alcohol, including riskier practices of binge drinking, is quite prevalent among women during their childbearing years. Substance use, abuse, and dependence among women is associated with poorer health, increased stress, psychiatric comorbidity, and increased prevalence of intimate partner violence (Simmons, Havens, Whiting, Holz, & Bada, 2009). Research findings suggest that approximately 6 out of 10 women, 18 to 44 years of age use alcohol and slightly less than one-third of women who drink in this age group binge drink (4 or more drinks within a 2-hour period) (Sidhu & Floyd, 2002). Approximately 7.6% of women who are pregnant use alcohol (CDC, 2014b). Substance use and abuse during pregnancy may result in premature birth, miscarriage, low birth weight, fetal alcohol syndrome, and places the child at risk for a variety of physical, behavioral, and cognitive problems.

### **WOMEN EXHIBITING SUICIDE- OR HOMICIDE-PRONE BEHAVIOR**

Rates of suicide and homicide differ by age, sex, and race. Although men are four times more likely to die from suicide, women are three times more likely to report attempting suicide (CDC, 2010). Suicide rates are highest for women between the ages of 45 to 54, with poisoning as the most common method (CDC, 2012a). A substantial number of homicides in the United States are committed by intimate partners of the victims. Among women who are victims of homicide, 1 in 3 is a homicide perpetrated by an intimate partner (Paulozzi, Saltzman, Thompson, & Holmgreen, 2001).

### **WOMEN IN ABUSIVE FAMILIES**

Children, the elderly, and spouses (overwhelmingly women) are likely targets of violence within the family. Although older children are more likely to be injured, young female children

older than 3 years of age are consistently at risk for sexual abuse. Each year, women experience approximately 4.8 million intimate partner-related physical assaults and rapes, almost twice as many as experienced by men. About 70% of deaths resulting from intimate partner violence are women and 30% are men. These numbers underestimate the problem, since many acts of intimate partner violence are unreported (CDC, 2012b).

### **HOMELESS WOMEN**

It was estimated that on any given night in 2014, 578,000 persons were homeless and nearly 70% were living in emergency shelters or transitional housing, while 31% were living unsheltered. Homelessness has a severe impact on the lives of people. People who are homeless suffer disproportionately high rates of other chronic diseases and communicable infections, have poorer mental health than average, are more likely to engage in substance abuse, and are frequently the victims of violence. The mortality rate of homeless people is 4 to 9 times higher than that of people who are not homeless (CDC, 2014c).

Women who are homeless are likely victims of domestic violence. In addition to the previously discussed health problems of the homeless, many homeless women have experienced severe physical or sexual assault perpetrated by an intimate partner. Domestic violence increases the likelihood for women to become homeless because victims of domestic violence often lack support networks and financial resources due to isolation by their abusers. Furthermore, homeless women who are victims of domestic violence frequently suffer from anxiety, panic disorder, major depression, and substance abuse (National Alliance to End Homelessness [NAEH], 2015).

### **IMMIGRANT AND REFUGEE WOMEN**

Following the 1965 Immigration Act and its emphasis on family unification, women have

immigrated to the United States in large numbers. Of the overall 41.3 million foreign-born immigrants in this country, 51%, or 21.2 million, immigrants are female. Globally, 48% of the immigrant population is female, making the United States the world's top destination for female immigrants (Ruiz, Zong, & Batalova, 2015).

In the United States, immigrant women are more likely to be older, and widowed, divorced, or separated than immigrant men. Immigrant women are more likely to be unemployed and live in poverty than native born women. Moreover, immigrant women are less likely to have health insurance than immigrant men and native born women (Ruiz et al., 2015). Immigrant women are among the most vulnerable and exploited people in American society. They are largely voiceless, isolated, and afraid. Frequently immigrant women do not know their rights, and are vulnerable to abuse, exploitation, sexual harassment, and sexual violence (Southern Poverty Law Center, 2011).

Health care for women who are immigrants, refugees, and temporary residents is complicated by diversity of languages, health practices, food choices, culturally based definitions of health, and previous experiences with American bureaucracies. Some immigrants may have infectious diseases of personal or public health significance; others often have untreated chronic conditions such as vitamin deficiencies, diabetes, or hypertension. Many immigrants and refugees arrive with both infectious and chronic conditions. Healthcare providers are often unfamiliar with screening recommendations and diseases endemic to the immigrants' countries of origin and are unprepared to deal with language, social, and cultural barriers encountered in caring for the new arrivals. Furthermore, immigrants and refugees frequently experience demands imposed by their new environment that compete with their perception of need for health care, and subsequently create additional health challenges (CDC, 2013b).

## **LESBIAN, BISEXUAL, AND TRANSGENDER WOMEN**

Although a widely diverse community, lesbian, bisexual, and transgender (LBT) women are a vulnerable and historically underserved population who frequently lack access to needed health care and social services. They frequently experience barriers to care and services such as lack of health insurance coverage, low income, lack of access to culturally competent health and social service providers, and cultural beliefs about health care and health providers that decrease utilization of available services (Berberet, 2005).

LBT women are at higher risk for diseases and conditions such as heart disease, cancer, depression, and HIV infection and tend to have higher incidence of smoking, obesity, and stress. LBT women are less likely than heterosexual women to seek medical care and routine health screenings such as mammography and Pap tests due to fear of discrimination or previous negative experiences with healthcare professionals. LBT women are apt to have a higher tendency toward alcohol and drug abuse than heterosexual women. Moreover, many healthcare providers may be uninformed regarding specific health issues of LBT women, and often will not inquire about sexual orientation when taking personal health histories. Many LBT women fear sexual orientation bias among healthcare providers and this fear serves as a significant barrier to care, even among women who have adequate financial resources or health insurance coverage (Berberet, 2005; Cochran, 2012; Dutton, Koenig, & Fennie, 2008).

## **INCARCERATED WOMEN**

More than one million women are under criminal justice supervision. Over 200,000 women are incarcerated in prisons and jails in the United States, a number that has grown 800% over the last three decades. Approximately two-thirds of incarcerated women are there for non-violent crimes,



many for drug-related crimes. African-American women represent 32.6% of incarcerated women and Hispanic women 16%. Nearly two-thirds of incarcerated women are mothers, with close to 77% having been the primary caregivers for their children prior to incarceration (Women's Prison Association, 2009).

Incarcerated women are more likely to be of low socioeconomic status and have low levels of education. A substantial number of incarcerated women have history of alcohol and substance abuse and have been victims of physical and sexual abuse. Incarcerated women are more likely to suffer mental illness and have HIV infection (Sentencing Project, 2007). They also are more likely to suffer from poor nutrition, and have elevated risk of reproductive health problems, including high-risk pregnancies and sexually transmitted diseases. In addition to experiencing numerous health disparities, incarcerated women are often underserved in receiving adequate health care (Clark, et al., 2006).

### *Key Factors That Influence the Care of Vulnerable Women*

The care of vulnerable women can be influenced by any number of factors that can increase or diminish access to care, quality of care, and cost of care, as well as affect individual and social resources for coping with vulnerability. The following discussion explores selected factors associated with health vulnerability that are fundamental to establishing a theoretical perspective of care for vulnerable women. Health literacy, social justice, cultural competence, and resilience are highlighted as essential areas in which intervention can promote well-being and positive quality of life outcomes in vulnerable women.

## **LITERACY AND HEALTH LITERACY**

*Literacy.* Literacy has been defined as the use of printed information to maneuver in society, meet one's goals, and develop one's knowledge

and abilities (Kirsch, Jungeblut, Jenkins, & Kolstad, 2002). This definition has been expanded to include comprehension and retention of verbal and gestural information (Doak, Doak, & Root, 2001). The National Adult Literacy Survey (NALS) was conducted in 1992, and again in 2003. The NALS remains the largest study on adult literacy carried out in this country.

The original NALS data suggested that one-fourth to one-third of American adults are functionally illiterate and approximately an equal number have marginal literacy skills that disallow full functioning in society. Essentially, half of the adult population in the United States has poor to nonexistent skills in reading, listening, and computation. Minor proportions of the participants of the NALS survey were learning disabled (5%) and spoke English as a second language, if at all (15%). However, most of the participants were white and born in America. Although education correlated with literacy, adults with a tenth-grade education tended to read at the seventh- to eighth-grade level. Participants receiving Medicaid had an average of a fifth-grade reading level. One-third of the NALS sample demonstrated basic functionality in understanding and using written information. Only 20% of the sample demonstrated a level of proficiency in handling information to perform complex reading and computational tasks (National Center for Education Statistics, 2015).

The NALS was re-administered in 2003 and the results showed a slightly worsening trend. In fact, the NALS data suggested that certain groups fared much worse in their literacy skills than the general population. These groups included the poor, elderly, immigrants, people who did not finish high school (disproportionately represented by Hispanic, African-American, and Asian-Pacific participants), people with physical, mental, or health conditions that disallowed participation in work or school settings, and people with mental health problems (National Center for Education Statistics, 2015).

Participants in the lowest literacy level had difficulty with performing usual tasks of daily living based on printed information and in performing complex tasks that required following directions and computation. Interestingly, members of the group considered having no or minimal functional literacy did not acknowledge themselves as vulnerable, related to their illiteracy.

A meta-analysis of U.S. studies on literacy reviewed literature spanning 1963 through 2004 and, based on a pool of 85 articles, essentially validated the same prevalence rates mentioned earlier. The findings concluded that limited literacy is highly prevalent, negatively affects health, and is consistently associated with education, ethnicity, and age (Paasche-Orlow, Parker, Gazmararian, Neilsen-Bohlman, & Rudd, 2005).

Literacy has been discussed as currency in the United States because those with less literacy are much less likely to meet the needs of daily living and to pursue life goals (Kirsch et al., 2002). From this perspective, illiteracy has the potential to create health risks and exacerbate existing health conditions. Although all humans are vulnerable, certain segments of the community are much more vulnerable to ill health in terms of initial susceptibility and in their responses (Aday, 2001). Illiteracy is related to social status and access to health care. Persons with poor reading skills who are unable to perform basic literacy functions, such as reading a bus schedule or following directions in completing a task generally have low social status outside of their immediate social ties. Low social status is often associated with low-paying jobs that offer no or minimal healthcare insurance. Low status also can affect a provider's perception of the abilities of a patient. Care may be "edited," and based, at times, on misperceptions (Aday, 2001).

Social status has been associated with poor health in that persons with low social status are more likely to use disproportionately more healthcare services, receive substandard care and less information about their illness, and be

presented with fewer options (Duncan, Daly, McDonough, & Williams, 2002). Persons with low literacy have much greater difficulty in accessing human capital, that is, jobs, schools, income, and housing than persons with functional literacy skills (Kirsch et al., 2002). Furthermore, persons who are illiterate tend to lack social capital in that they are more likely to be single or divorced, live in single-parent homes, and be loosely connected to their own communities.

Access to care can be seriously challenged when people have low literacy skills. Accessing care in the United States most often requires complex language skills that are involved with identifying and evaluating possible providers of care, negotiating appropriate entry points into the healthcare system, contacting and communicating needs to obtain an appointment, successfully traveling to and finding the actual site of care, interpreting written materials, and relating to clock and calendar skills. People with low literacy skills are frequently denied access to health care by virtue of their inability to successfully negotiate these tasks.

Illiteracy affects cost of care and the quality of care. It is a significant component of patient adherence to care regimens and hospitalizations in numerous circumstances, such as pregnancy, diabetes, AIDS, asthma, advanced age, sexually transmitted diseases, cardiac surgery, rheumatoid arthritis, psychiatric conditions, women's health, rural residents, immigrants, mental health, older adults, and payer status (Agency for Health care Research & Quality [AHRQ], 2004; Baker et al., 2002; Institute of Medicine [IOM], 2003). Without exception, populations within the context of these circumstances have high prevalence of illiteracy in proportions that mirror the findings from the NALS data. People with literacy problems commonly do not understand instructions and demonstrate less comprehension of their illness or condition.

Consequences of illiteracy include both poorer health outcomes and increased healthcare costs.

In fact, costs of health care may be as much as four times greater for those who read at or below a second grade level than for the general populace (U.S. Department of Health and Human Services, 2000). It is estimated that low literacy increases annual healthcare expenditures by \$73 billion in 1998 dollars (National Academy on an Aging Society, 2015). Research has shown that people with documented low literacy have a 52% higher risk of hospital admission as compared to those with functional literacy, even after controlling for age, social and economic factors, and self-reported health (Baker et al., 2002). Low literacy is also associated with higher use of expensive emergency services (AHRQ, 2004). Furthermore, client illiteracy was reported as the highest predictor of poor asthma knowledge and ineffective use of metered-dose inhalers (Williams, Baker, Honig, Lee, & Nowlan, 1998).

Acknowledging the pervasive influence of illiteracy on the quality of care in the United States, the IOM (2003) has identified literacy as one of the top three areas that cut across all other priorities for improvement in the nation's health. Literacy is required for self-management and collaborative care, the other two priority cross-cutting areas.

*Health literacy.* Since the mid-1990s, the term *health literacy* has been used in medical literature to address the literacy problem. Health literacy is defined as the ability of an individual to obtain, process, and understand basic health information and services needed to make appropriate health decisions. Health literacy encompasses the ability to read and comprehend instructions on prescription bottles, appointment slips, and other essential health-related materials required to successfully function as a patient. It includes the ability to understand basic health information, the ability to effectively handle the healthcare system, and the ability to understand consent forms. Health literacy necessitates reading, listening, analytical, decision making, computation, and application skills as well as the ability to apply these skills to

health situations (American Medical Association, 1999; Glassman, 2014).

Illiteracy specifically increases health risks in women. Women with no or low literacy cannot read or interpret informational pamphlets, directions on prescribed or over-the-counter medications, or diet instructions. A mismatch of vocabulary and skill is problematic and inability to comprehend graphics and pictures pose additional, and for many patients, insurmountable challenges (Doak et al., 2001). Literacy is a complex skill that necessitates much more than simply reading words. It includes many components, such as decoding, comprehension, and retention of information. The development of literacy involves a series of stages. It is not a "free-standing skill" yet requires integration of related life skills to navigate the healthcare system, effectively perform self-care, and make healthcare decisions.

Health and health care add unique aspects to the concern for women's literacy. Health and health care can have a temporary or long-term effect on literacy skills. Situations such as anesthesia due to surgery, blood loss, or acute pain may temporarily impair one's decoding, comprehension, and recall skills. Sustained medical conditions can interfere with mentation, cognition, and attention on a longer-term basis. Delayed mental development, neurological conditions such as Alzheimer's disease and stroke, and psychological disorders such as depression or anxiety may impair literacy skills and the ability of the patient to interact effectively with providers. Sensory impairments can adversely affect literacy. Visual difficulties were in fact associated with a substantial number of NALS participants that tested in the lowest level of literacy (Kirsch et al., 2002).

Healthcare providers have contributed to the health literacy dilemma. In the past, providers, in their listening, speaking, and written interactions with patients have had a tendency to ignore the literacy variable in care, and as such, increased the literacy challenge for their patients

(Doak et al., 2001). The readability level of written healthcare instructions, booklets, and informed consent forms is often substantially higher than the reading skills of patients in the general care population (Cutilli, 2007; Doak et al., 2001; Fobis & Aligne, 2002). Providers tend to seriously underestimate the literacy problem in patients, tend not to be knowledgeable about illiteracy, are frequently inattentive to the literacy needs of patients, and interact differently with patients who admit to literacy problems (Doak et al., 2001; Schillinger et al., 2003). Patients with low literacy are likely to experience difficult interactions with healthcare providers and tend to avoid seeking care because of stigma and shame (Arthur, Geiser, Arriola, & Kripalani, 2009; Katz, Jacobson, & Kripalani, 2007).

Functional illiteracy directly creates health vulnerability in women. Illiteracy is pervasive in patient populations, and healthcare providers cannot rely on self-disclosure or education level to identify all patients with health literacy needs. Women with the greatest health needs are also the same individuals who do not have the tools to navigate the complex U.S. healthcare system. Currently there is a major mismatch between patient literacy skills and provider communication styles and health materials. Solutions addressing this intersection of healthcare needs and illiteracy include interventions that will identify those with literacy deficits as well as close the gap between health information and low-literacy individuals. Efforts at this level involve improved literacy screening measures, using multiple education strategies, addressing the needs of patients with limited English proficiency, and incorporating technology to address the learning needs of low-literacy patients. Although these strategies may well lessen the gap between the provider's style of oral and written communication and the patient's level of literacy skill, they may essentially be skirting the core issue related to vulnerability.

As discussed earlier, literacy problems create health risks. By using methods that ignore

or accommodate the literacy deficit, providers essentially propagate the illiteracy problem by perpetuating the predominant tertiary care focus in the current system of health care. Literacy affects women's lives in foundational ways through the creation of social stigma and prejudicial attitudes, and diminishing the ability to navigate within complex systems throughout society that include health care and beyond to housing and money management. Literacy is a core driver of vulnerability in this country and needs to be addressed as an integral aspect of health care. Providers need to improve their own sensitivity and skills in working with low-literacy patients. They can improve the health of their patients by increasing patient literacy. Strategies that involve partnering with communities and community-wide agencies, such as schools, community centers, and libraries, can help to develop patient literacy skills, and thereby decrease their health risk.

## SOCIAL JUSTICE

The ethical principle of justice is often defined in the forms of social, distributive, and market justice. A common definition of social justice is a concern for the equitable distribution of societal benefits and burdens (Redman & Clark, 2002). Social justice is also, albeit less often, defined as changing social relationships and institutions to promote equitable relationships (Drevdahl, Kneipp, Canales, & Dorcy, 2001). Social justice is also considered as doing what is best for an individual or group according to their needs and the fundamental principle that human beings have inalienable rights (Pacquiao, 2008). Distributive justice is fair, equitable, and appropriate distribution of resources according to justified norms that structure the terms of social cooperation (Beauchamp & Childress, 2001). Market justice posits that people are entitled only to goods and services that they acquire according to guidelines of entitlement (Young, 1990).

Upon closer examination, certain distinctions become apparent between these forms of justice. Social justice is concerned with making equitable—that is, fair and just—the balance between societal benefits and burdens. It posits that social rights exist, but that collateral responsibilities come with those rights (Lebacqz, 1986). Social beings are meant to both give and receive, using equity (being just, fair, and impartial) as a framework for relating to one another. Equity implies that persons must conduct themselves with reasonableness and moderation when exercising their rights. Distributive justice involves equality more than equity; this concept is used more often to discuss the allocation or distribution of services and goods in society (Young, 1990). Equality focuses on giving the same access and resources to different groups (Sellers and Haag, 1992). Social justice advocates explore social relationships including how those relationships form the basis for the allocation of goods and services (Young, 1990). Social justice focuses on equity, because many theories of social justice assert that “equal” does not mean “just” (Lebacqz, 1986). Thus, the concepts of social and distributive justice are somewhat parallel, yet have different primary foci of study (Drevdahl et al., 2001).

Market justice is based on honoring the rights of people who have earned entitlement to privileges. Market justice allows inequality as long as those inequalities result from a fair market system. In other words, only those who earn rights can receive their entitled privileges in a market system. Individuals who earn no rights do not have secured privileges. Rather than being a parallel model to social justice, market justice is an opposing model. These two viewpoints diametrically oppose each other yet exist simultaneously.

Although somewhat distinct, all forms of justice may coexist to varying degrees. For example, some healthcare services in the United States are given as needed, such as care to children who are orphaned. In other cases, minimal health care is given, such

as the medical and dental benefits associated with Medicaid. Persons who can afford more treatment or faster treatment may get those services as well if they can pay a particular price, such as to health clinics that offer expanded services to clients who can pay access fees.

Social injustice is created by oppressive situations. Social injustice is often conceptualized as a personal act with social justice as the individual response to that act (Liaschenko, 1999; Olsen, 1993), or in a wider, more complex perspective in which unequal distribution of resources and access influences healthcare delivery, health status, and health actualization or achievement of optimal health (Austin, 2001). Social justice is fundamental to advocating for elimination of health disparities by ensuring the basic human right to access to quality health care (Pacquiao, 2008). To be effective in promoting justice, injustice must be dealt with on many fronts, specifically antecedents of injustice, the processes of injustice, and the results of injustice in society (Holland & Henriot, 1983). This concentration on the creation and recreation of injustice will help to focus attention on points of intervention. Social justice can then be addressed in terms of social justice awareness, amelioration, or transformation (Holland & Henriot, 1983).

*Social justice awareness.* Social justice awareness involves exploring how one perceives others as vulnerable or privileged. Awareness requires asking critical questions about how systems of domination and oppression promote categorizations such as *vulnerability* and *privilege*. Social justice awareness is temporal; an ongoing process that requires viewing from different angles, contexts, and frames of reference. Social justice awareness of an issue of major health and social concern to women may involve conducting a self-interview as well as client interviews on how the issue affects women’s health. The healthcare professional would explore how health is related to the health or social issue and record her/his own thoughts prior to interviewing clients affected or not affected by the issue.

The next step would be to interview women who are and those who are not affected by the health or social issue. These women would be asked how the issue may or may not influence their health, and their thoughts would be recorded. A literature review would then be conducted on aspects of the issue and health. The initial thoughts should be compared to the knowledge gained in the interview and review of relevant literature. It is likely that awareness of the relationship between the issue and health will increase.

*Social justice amelioration.* Social justice amelioration entails addressing the immediate results or antecedents to unjust conditions. In the short term, social justice amelioration remedies urgent or semi-urgent concerns, but it does not change the conditions that continue to create the injustice. Amelioration requires a direct attempt to address the situation of the clients who are affected by the health or social issue. However, the situation is often addressed by treating the most immediate concerns of a person affected by the issue. The conditions that created the issue remain.

*Social justice transformation.* Social justice transformation involves redressing unjust conditions by changing the structures that cultivate those unjust situations. Transformation directs individual actions toward long-range, methodical solutions to unjust situations. Social justice transformation also necessitates critically deliberating about the conditions that produced the injustice. A critical exploration into the conditions that created the injustice and the relationship of the injustice to health services allocation, current health status, or future health attainment are necessary as part of any attempt to change or develop just health and social policies that would restructure the system.

A social justice agenda recognizes that vulnerable populations of women are not treated equally in society. Social justice gives moral privilege to the needs of the most vulnerable group in an effort to promote justice within society at large. As vulnerability among women is minimized or eliminated,

the moral agency of those privileged can be simultaneously elevated. Social justice is an essential concept in promoting just health and social relationships for vulnerable women in society.

## CULTURAL DIVERSITY AND CULTURAL COMPETENCE

Cultural diversity has become a priority in health care owing to the changing demographics and economics of the growing multicultural world and the long-standing disparities in the health status of people from culturally diverse backgrounds (Campinha-Bacote, 2003). Women from culturally diverse backgrounds are often at risk for marginalization, in which they experience discrimination, poor access to health care, and resultant illnesses and traumas from environmental dangers or violence that make them vulnerable to a wide range of health problems (Hall, 1999; Hall, Stevens, & Meleis, 1994).

Cultural competence is important and particularly useful for healthcare providers in caring for women who are vulnerable. It necessitates being sensitive to the differences in culture of one's constituents and behaving in a way that is respectful of a person's values and traditions while performing those activities or procedures necessary for the person's well-being. Cultural competence is based on an insightful understanding of culture and its substantial influence in the lives of people. This depth of understanding advances respect for, and minimizes negative consequences of, cultural differences (Pacquiao, 2008).

In the United States, care that is culturally competent is acknowledged as a pathway to remove barriers to access to health care and reduce health disparities. Promotion of cultural competence is entrenched in a commitment to preserve and protect fundamental human rights. Advocacy for social justice is intrinsic in culturally competent care of vulnerable populations. (Pacquiao, 2008).

Although the literature presents many methods and ideas for developing cultural competence, there is general agreement that cultural competence occurs on affective, cognitive, and behavioral levels, and self-awareness is a key indicator of success. A variety of methods are available for developing cultural competence in healthcare professionals. Immersion programs provide an exceptional way to induce cultural competence, although they are costly and time consuming. Immersion programs are powerful learning experiences at all levels because they enable participants to experience different cultures out of their usual safe context. Simulation is another method for developing cultural competence, and these activities provide a setting in which participants can practice communication and problem solving as well as develop self-awareness (Meltzoff & Lenssen, 2000). Cross-cultural communication exercises can help in the development of skills needed to overcome barriers in this regard (Shapiro, Hollingshead, & Morrison, 2002). Preparation of didactic materials for developing knowledge about groups is a useful point of reference for healthcare providers who provide care to diverse patients. Didactic materials frequently provide information regarding diverse cultural groups such as perceptions of illness, patterns of kinship and decision making, and comfort with touch. Multicultural training courses are also available, and are easier and less costly to operate than immersion programs.

## RESILIENCE

*Resilience* is the ability of individuals to adapt in the face of adversity, trauma, or tragedy. It is a characteristic that allows people to adapt to significant sources of stress that can result from family and relationship problems, or workplace and financial stressors (Newman, 2003). Resilience is also viewed as the capability to bounce back in spite of considerable stress or adversity (Place, Reynolds, Cousins, & O'Neill, 2002), and as the

ability to cope successfully despite adverse circumstances (Rutter, 1985). It is an ability to adjust easily to or recover quickly from illness, change, depression or misfortune (*American Heritage Dictionary*, 2006; *Merriam-Webster*, 2011). Resilience is viewed as both a personality trait and as a dynamic process (Luthar, Cicchetti, & Becker, 2000). This dynamic process is highly influenced by protective factors and enables people to recover from adversity and go on with their lives (Dyer & McGuinness, 1996).

Concept analyses of resilience identified antecedents and consequences of the concept. *Antecedents* are events or incidents that occur before the occurrence of the concept and *consequences* are circumstances that result from the concept (Walker & Avant, 2005). Findings indicate that the main antecedent of resilience is adversity (Earvolino-Ramirez, 2007). In addition to adversity, three other antecedents were identified. These were interpretation of the event as either physically or psychologically traumatic, the cognitive ability to interpret adversity, and a realistic worldview as opposed to false optimism or depressive attitude (Gillespie, Chaboyer, & Wallis, 2007). Consequences of resilience were found to be integration, control, adjustment, growth (Gillespie et al., 2007), effective coping, mastery, and positive adaptation (Earvolino-Ramirez, 2007). Concept analyses also revealed defining attributes, which are clusters of characteristics most frequently associated with the concept and most frequently present when the concept occurs (Walker & Avant, 2005). Defining attributes of resilience were found to be rebounding/reintegration, high expectancy/self-determination, positive relationships/social support, self-esteem/self-efficacy, flexibility, sense of humor, hope, and coping (Earvolino-Ramirez, 2007; Gillespie et al., 2007). The importance of conducting concept analyses lies in the acquisition of knowledge about the concept of resilience that contributes to the construction of theoretical models that will test the concept. Research then

progresses to examine the effectiveness of strategies and interventions that enhance resilience in vulnerable populations.

Resilience has been studied in various situations of vulnerable women. For example, in an investigation of body image dissatisfaction and resilience in college women, findings suggested that women who had a positive relationship with their parents were more resilient and therefore demonstrated less body image dissatisfaction (McGrath, Wiggins, and Caron, 2010). In a phenomenological study of Asian immigrant women in the United States who survived child sexual abuse, resilience strategies reported by these women included the use of silence, sense of hope, South Asian social support, social advocacy, and intentional self-care. The findings suggested that these strategies allowed the women to heal and move on with their lives (Singh, Hays, Chung, & Watson, 2010).

Elderly women often face adversity in their older years, as evidenced by decreasing functional status, declining health, increased stress, poorer living conditions, and experiencing negative life events (Hildon, Montgomery, Blane, Wiggins, &

Netuveli, 2010). Factors that are salient to resilience in older women have been identified. Having social connectedness with family, friends, and community provided a support mechanism as well as allowed older women to extend themselves to help others. Spiritual grounding was also important to older women in providing a higher power to lean on, which provided meaning and purpose to their lives. Resilient older women were found to take a “head-on” approach to adversity to move forward through life challenges (Kinsel, 2005). Terminally ill older adults facing death exhibit resilient behaviors by redefining self, embracing religion and spirituality in times of uncertainty, maintaining social relationships, and defending their independence as the end of life approaches (Nelson-Becker, 2006).

Additional research needs to be conducted on resilience and resilient attributes to enhance the resilience process in vulnerable populations of women. Obtaining increased understanding of how some women remain resilient despite facing adversity will likely lead to successful implementation of strategies and interventions for others.

## Research Review

What are the ethical challenges of conducting research with vulnerable populations of women?

Mkandawire-Vallmu, L., Rice, E., & Bathum, M. (2009). Promoting an egalitarian approach to research with vulnerable populations of women. *Journal of Advanced Nursing*, 65(8), 1725–1734.

A history of human rights abuses that have occurred worldwide in human subject

research has brought recognition of the need for further development of standard ethical guidelines for conducting research with human subjects. Although ethical standards have been instituted globally, and advances have been made to help protect the rights of research participants, research activities have also expanded and become more complex, especially regarding research with vulnerable populations. The need to include women,



ethnic minorities, and members of other vulnerable groups, who historically have been underrepresented in research, is substantial. Scholars are thus confronted with the question of how to conduct this research in an ethical and respectful manner.

The authors used feminist qualitative research perspective in their discussion of issues surrounding conducting research with diverse populations of vulnerable women. Feminist research is a method of engaging with women during the research process and in writing about women's lives, that prevents further marginalization and contributes to their liberation.

Recognizing the need for increased understanding of low income women with limited education and limited access to health care, the authors conducted three separate but similar research studies using focus groups and individual interviews with low income women from Malawi, women diagnosed with schizophrenia in the United States, and rural indigenous Aymara women of the highlands of Peru. An important issue that came to light in the conduct of these three studies was how power disparities between researchers and participants influenced women's decisions to participate in the studies and give informed consent. The authors strongly perceived that women might have based their decisions to participate in the research studies on the unequal power between themselves and the researcher or the healthcare provider/agency worker facilitating recruitment. The authors posited that participation in research by women of lower socioeconomic strata may be

done out of obligation to the researcher who is perceived as possessing greater power and privilege than themselves. Moreover, many women might be fearful of displeasing their healthcare providers, and this fear might lead them to participate in research as an effort to please their providers. Low literacy levels of women who participated in the studies were acknowledged as an influential factor associated with power differentials between the researchers and participants that affected the informed consent process.

In addition to concerns regarding women's true motivations for participating in research, the authors described dilemmas related to compensation of participants for taking part in a study. Compensation of too high a value could be perceived by participants as coercive due to their financial need, and compensation of too low a value could be perceived by participants as devaluation of their input into the research.

The authors recognized that nursing researchers need to develop and implement studies with vulnerable populations, and be cognizant that power dynamics have implications for recruitment and informed consent procedures. The authors recommend that research be guided by feminist principles, which will mandate researchers to ensure that research activities contribute to the development of policy that will positively benefit participants and their communities. Furthermore, inclusion of members of vulnerable populations in current debates that stem from ethical dilemmas in research with vulnerable populations will assist in informing policy that guides how research is conducted.

## Chapter Summary Points

- Vulnerability means susceptibility. The specific implication of vulnerability in health care is to be at risk for health problems.
- Vulnerable populations have a greater-than-average risk of developing health problems by virtue of their marginalized sociocultural status, their limited access to economic resources, or their personal characteristics such as age and gender.
- On the whole women are a vulnerable population.
- Significant concepts form the conceptual basis of vulnerable populations, such as risk, social status, social capital, human capital, access to care, cost of care, and quality of care.
- These concepts influence vulnerability and are essential for understanding vulnerability as well as the nature of health care for vulnerable populations.
- Vulnerable populations commonly are affected by health disparities, which are significant differences in overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates.
- Factors such as poverty; racial, ethnic, and gender inequalities; and access to health care contribute to health disparities.
- Vulnerable populations of women include high-risk mothers, the chronically ill and disabled, women with HIV/AIDS, the mentally ill and disabled, alcohol and substance abusers, women who exhibit suicidal or homicidal behavior, abused women, homeless women, immigrants and refugees, lesbian, bisexual, and transgender women, and incarcerated women.
- The care of vulnerable women can be influenced by any number of factors that can increase or diminish access to care, quality of care, and cost of care, as well as affect individual and social resources for coping with vulnerability.
- Health literacy, social justice, cultural competence, and resilience are essential areas in which intervention can promote well-being and positive quality of life outcomes in vulnerable populations of women.

## Critical Thinking Exercise

### *Questions for Seminar Discussion*

1. Discuss the meaning of vulnerability with respect to individuals and groups.
2. How can identifying a group as a vulnerable population cause further marginalization and patronization?
3. What are vulnerable populations and why are they at risk for health problems?
4. What factors marginalize women and increase their vulnerability?
5. Discuss the concepts of risk, social status, social capital, and human capital. How are these concepts linked to women as a vulnerable population?
6. Discuss access to care, cost of care, and quality of care. How are these concepts linked to women as a vulnerable population?

7. How have the changes in the demographics of populations and families over the past 5 decades influenced health disparities in women?
8. What are the specific populations of vulnerable women? What factors specifically increase their vulnerability and health disparities?
9. How do lack of literacy and health literacy influence vulnerable populations of women?
10. Discuss how social justice awareness, amelioration, and transformation might be applied to injustices experienced by vulnerable populations of women.
11. How can cultural competence remove barriers to access of care and decrease health disparities among vulnerable populations of women?
12. Discuss antecedents, consequences, and defining characteristics of resilience. How can nurses and other healthcare providers enhance the resilience of vulnerable populations of women?

## Internet Resources

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Administration on Aging/Administration for Community Living: information and education about home and community-based services to assist the elderly. <http://www.aoa.gov>

Agency for Health Research and Quality: information and education to improve the quality, safety, efficiency, and effectiveness of health care for Americans. <http://www.ahrq.gov/>

Centers for Disease Control and Prevention: information and education about health conditions of vulnerable women. <http://www.cdc.gov/>

National Academy on an Aging Society: information and education about the aging population in America. <http://www.agingsociety.org/>

National Alliance to End Homelessness: information and education about homelessness in the United States. <http://www.endhomelessness.org/>

National Center for Education Statistics: information about education and literacy in the United States. <http://nces.ed.gov/>

Office of Minority Health and Health Disparities: information and education about health disparities of vulnerable populations. <http://www.cdc.gov/omhd/default.htm>

Office of Women's Health: information and education about women's health. <http://www.womenshealth.gov/>

The San Diego LGBT Community Center: information and education about the lesbian, gay, bisexual, transgender, and HIV community. <http://www.thecentersd.org/>

U.S. Department of Health and Human Services Health Resources and Service Administration: information and education about health literacy. <http://www.hrsa.gov/publichealth/healthliteracy/index.html>

Women's Prison Association: information and education about women and criminal justice. <http://www.wpaonline.org>

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