Vulnerable Population Assessment

Immaculate Anebere

Chamberlain College of nursing

Date 01/27/2016

Vulnerable Population Assessment

**Introduction**

Carson is a City in Los Angeles County in California State and in United States of America. Some of the most top priority of vulnerabilities to health in Carson community arechronic diseases, obesity, overweight and mental health as well as access to care. Economic trends affecting the population are such as unemployment, housing problems and lack of education. Some of the barriers that affect the community are such as immigration and cultural barriers such as language and low income earning that leads to poor living conditions and poverty. There are also risks factors such as overweight and obesity, crime and violence, poverty as well as education attainment. However, there are some strengths like education and health programs like flu vaccinations in Carson. Though inadequate, Carson community has resources such as healthcare centers and programs, education entities and recreation facilities.

**Description of the Carson Community**

Wallace et al. (2012) states that Carson community has a diverse demographic composition with the Hispanic being the largest ethnic group; Hispanic/Latino, 44.9%, white 7.4%, African-American 6.5%, Asian 35.6%, native Hawaiian and Pacific Islander 2.2%, American Indian 0.1% and the multiple 3.3%. According to the 2010 census, Carson has a population of 91,714 with more females than males. The population comprises of more youths, 23.2%, as compared to that of the elderly, above 65 years of age, 12.8%. Most of the people in Carson are English speakers, followed by Spanish speakers. Carson has a vast population percentage of overweight and obesity victims, with a high prevalence of young adults. In addition, most of the people suffering from obesity and chronic ailments such as HIV/AIDS are the Hispanics/Latino.

**Trends/events affecting the group**

Broz et al. (2014)contends that unemployment rate in Carson steadily decreased since 2010 to 2014, with 15.8% in 2010, 15.5% in 2011, 13.8% in 2012, 12.4% in 2013 and 10.6% in 2014. Poverty trends has also changed between 2009 and 2013 whereby only 10.5% in Carson live below 100% poverty and 29.6% below 200% poverty. The people mostly below the federal poverty level are those infected with HIV, low income earners. These people have stressors such as young children that may tend to affect physical and mental health for family members, people with crime records trying to reenter the community and immigrants and refugees from the Southeast Asia who are non-English speakers. Such poverty levels leads to insufficient accessibility to healthy foods, stress and trauma and poor environments. Thus, chronic ailments such as asthma, heart disease, hypertension, diabetes, obesity and mental health issues. The rates of HIV/AIDS diagnoses have decreased between 2011 and 2013 with 27, 22 and 16 respectively per 100,000population (Broz et al., 2014).

**The strengths, risks factors and barriers**

A major risk factor is overweight and obesity which mostly affects the Hispanics and African Americans due to their poor eating habits and culture (Babey, Wolstein, Diamant, Bloom & Goldstein, 2012). Poverty as well as education attainment are also risk factors for the vulnerable population. Homelessness is a factor that leads to inaccessibility of housing. Housing conditions may impact both physical and mental health conditions due to molds and pests besides overcrowding for instance. Affordable housing can only be accessed in neighboring areas which are highly polluted and full of crime. There are immigration as well as cultural barriers for instance for the Japanese and Cambodian and thus language is one of the barriers to healthcare accessibility in Carson. Cost for health care services is very high and only few individuals afford. Besides costs, lack of insurance may also lead to delayed healthcare accessibility (DeNavas-Walt, 2010). Most non-English speaking people cannot afford school fees. Lack of education and awareness in regards to chronic diseases is a barrier to health services. However, despite the language barrier, there is a strength of literacy or other education with only 11.6% with limited English. Community vaccines for flu have been provided at the doctors’ offices, Kaiser and community clinics; 58.5% of up to 17 years, 34.5% of people between 18 and 65 and 57.4% of people above 65 years of age

**Resources**

Carson is advantaged by some assets and resources utilized in addressing the community health. The resources are such as; outstanding colleges and universities for provision of better education to handle healthy daily habits such as the Los Angeles Unified School District and the Compton Unified School District which both serve the Carson community. Outdoor recreation facilities, such as the City of Carson, Parks & Recreation Department are other resources in the community. Moreover, there are organizations involved in addressing the risks of obesity and diabetes in the Carson community such as Centro Salud es Cultura that offers culturally significant health education as well as Zumba programs for families to practice physical activities (Bilton, 2011). However, the resources are inadequate and therefore limited to the Carson community. For instance there is lack of exercise and physical activity in the community. In addition, the community suffers inadequate dietary education health programs as well as poor nutrition. There is also insufficient health insurance alongside affordable healthcare services. AsBureau (2011) asserts, these gaps are not new to hospitals, community activists and public health officials.

**Community Health Problem Diagnosis**

Grounding on this assessment, alongside the Healthy People 2020 objectives, one priority community heath challenge that a community nurse would impact on is obesity and overweight. In regards to the statistics in the disease Control and Prevention, of the entire Carson population, more than one third adults hardly practice aerobic exercises and 80% do not access aerobic physical activities (Babey, Wolstein, Diamant, Bloom & Goldstein, 2012). Regular physical activities not only improve health but also improves cardiovascular respiration, decrease composition of body fat, reduce depression as well as risks of cancer. Besides implementation of health education programs, community nurses may advice individuals on the importance of routine exercises.

Additionally, they may advice people on the importance of healthy eating habits as well as the risks that may occur. According to the research, most African American and Hispanics suffer obesity not only because of cultural factors, but also due to lack of awareness of obesity as a disorder (Wallace, Torres, Sadegh-Nobari, Pourat & Brown, 2012). NWS-6.2: Increase the proportion of physician office visits made by adult patients who are obese that include counseling or education related to weight reduction, nutrition, or physical activity (US Department of Health and Human Services: Healthy People 2020, 2016, Objectives. Nutrition and Weight status)

**Conclusion**

In conclusion, Carson Community, which mainly comprises of the Hispanic/Latino ethnicity is a vulnerable community in California. The community mainly suffers obesity and overweight due to high poverty levels. Therefore few can acquire/afford healthy lifestyle, access education, and recreation and health facilities. However, though inadequate, there are resources such as education centers, healthcare centers as well as recreation centers. Some of the hindrances to a healthy community are due to cultural diversity such as language barrier, poor economic status leading to poverty and lack of adequate education programs. Risk factors for obesity and overweight as well as education attainment impact the community health. Therefore, recommendable community needs are such as adequate health education programs to not only educate but also create awareness of the risk factors for improvement of health in the community. Programs for healthy lifestyle and aerobic activities may be implemented.

**References**

Babey, S. H., Wolstein, J., Diamant, A. L., Bloom, A., & Goldstein, H. (2012). Overweight and obesity among children by California cities–2010.*UCLA Center for Health Policy Research and California Center for Public Health Advocacy*.

Bilton, M. (2011). Community health needs assessment. *Trustee*, *64*(9), 21-24.

Broz, D., Wejnert, C., Pham, H. T., DiNenno, E., Heffelfinger, J. D., Cribbin, M., ... & Paz-Bailey, G. (2014). HIV infection and risk, prevention, and testing behaviors among injecting drug users—National HIV Behavioral Surveillance System, 20 US cities, 2009. *MMWR Surveill Summ*, *63*(6), 1-51.

Bureau, U. S. C. (2011). American Community Survey 5-Year Estimates. 2011. *S1903-Median Income in the past*, *12*.

DeNavas-Walt, C. (2010). *Income, poverty, and health insurance coverage in the United States (2005)*. Diane Publishing.

Office of Disease Prevention and Health Promotion. (2011). US Department of Health and, Human Services: Healthy people 2020. *Office of Disease Prevention and Health Promotion, US Department of Health and Human Services*.

Solari, C. D., Cortes, A., Henry, M., Matthews, N., Morris, S., Khadduri, J., & Culhane, D. P. (2014). The 2013 Annual Homeless Assessment Report (AHAR) to Congress, Part 2.

Wallace, S. P., Torres, J., Sadegh-Nobari, T., Pourat, N., & Brown, E. R. (2012). Undocumented immigrants and health care reform. *UCLA Center for Health Policy Research, Los Angeles, Calif, USA*.