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Knowing an Indigenous Aeta Community Through Caring: Implications of Nursing as Caring for Community Health Nursing Education

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ABSTRACT

Introduction: Indigenous communities continue to experience health inequities shaped by socioeconomic vulnerability, environmental conditions, and limited access to health services. Community profiling is a fundamental activity in Community Health Nursing and provides an opportunity to know communities as caring persons whose health practices are grounded in cultural meaning.

Materials and Methods: A descriptive community profiling study was conducted using secondary community survey data collected from 2010 to 2014 in Sitio Monicayo, an Indigenous Aeta community in Mabalacat City, Pampanga, Philippines. Data included demographic characteristics, socioeconomic conditions, environmental factors, health status indicators, and available community resources.

Results: The community demonstrated steady population growth, persistent poverty, high rates of school non-attendance, fluctuating family planning practices, and improving housing conditions following community-based housing initiatives. Environmental challenges remained, particularly in waste disposal and water access. Maternal and child health indicators revealed inconsistent breastfeeding practices and incomplete immunization coverage, alongside continued reliance on traditional healers with increasing acceptance of biomedical services.

Conclusions: Viewing community profiling through the lens of Nursing as Caring highlights the importance of knowing Indigenous communities as caring collectives whose health decisions are shaped by culture, relationships, and lived realities. Integrating caring-centered community assessment into Community Health Nursing education strengthens students' capacity to deliver culturally congruent, ethical, and relational care for Indigenous populations.

1. INTRODUCTION

Indigenous communities continue to experience health inequities shaped by socioeconomic disadvantage, limited access to services, and historical marginalization. In the Philippine context, Indigenous Aeta communities face challenges related to education, housing, and maternal–child health, all of which influence community well-being. Community Health Nursing plays a central role in addressing these concerns through population-based assessment, health promotion, and sustained engagement with communities.

Community profiling is a core activity in Community Health Nursing, providing a structured approach to understanding population characteristics, health conditions, and available resources. When conducted through repeated engagement rather than episodic visits,

community profiling allows nurses and nursing students to observe how health practices evolve over time and how communities organize care within their cultural and relational contexts.

From a Nursing as Caring perspective, caring is understood as a way of knowing persons and communities through relationships rather than as a series of tasks or interventions (Boykin & Schoenhofer, 2001). Caring science further emphasizes that health behaviors are expressions of meaning shaped by culture, relationships, and lived realities (Ghanbari-Afra et al., 2022). In Indigenous settings, this perspective aligns with community caring frameworks that recognize communities as active participants in sustaining health rather than passive recipients of care (Iwamoto, 2023). However, community assessment in nursing education often remains focused on biomedical indicators and short-term data collection, which may limit deeper understanding of Indigenous health experiences (Locsin & Betriana, 2024).

Recent studies highlight the importance of longitudinal community immersion in shaping nursing students' perceptions of community care, cultural safety, and ethical practice (van Iersel et al., 2019; Wilson et al., 2022). Despite this, there is limited documentation on how community profiling conducted during sustained nursing student immersion reflects caring processes and contributes to Community Health Nursing education, particularly within Indigenous contexts.

This study aimed to describe the community profile of one of the Aeta sitios in Pampanga using longitudinal data gathered during sustained Community Health Nursing immersion and to examine how these findings illuminate community health conditions as expressions of caring. Anchored in Nursing as Caring, the study seeks to demonstrate the educational value of caring-centered community assessment in preparing nursing students for culturally responsive and ethical practice.

2. MATERIALS AND METHODS

Study Design

This study employed a descriptive community profiling design using secondary, longitudinal data derived from documented community surveys and annual profiling reports. The analysis was retrospective and focused on describing community characteristics and trends over time rather than examining causal relationships or individual-level change.

Study Setting

The study was conducted in one of the Indigenous Aeta sitios in Pampanga**,** which served as a community learning site for Community Health Nursing. The community is geographically situated within a semi-urbanized area and is located at a distance from major commercial centers and tertiary healthcare facilities, factors that influence access to social and health services.

Data Sources and Variables

Data were obtained from consolidated community profile reports prepared during Community Health Nursing activities conducted by nursing students and faculty as part of sustained Related Learning Experiences (RLEs) from 2010 to 2014**.** These reports were based on routine community surveys and observational assessments conducted annually.

The variables included:

- Demographic characteristics: population size, sex distribution, and number of families
- Socioeconomic indicators: poverty status and educational participation
- Environmental conditions: housing type and physical living conditions
- Health indicators: maternal and child health services, infant feeding practices, and immunization status
- Community resources: availability of educational institutions, health services, and civic or people's organizations

Data Analysis

Data were analyzed using descriptive statistics**,** primarily frequencies and observed trends across the five-year period. Results were organized according to major domains relevant to Community Health Nursing practice, including demographic, socioeconomic, environmental, and health-related indicators.

Ethical Considerations

The study utilized aggregated, non-identifiable secondary data generated from routine community profiling activities conducted for educational and service purposes. No personal identifiers were included, and no direct interaction with community members occurred during the analysis. As such, the study posed minimal ethical risk and adhered to principles of confidentiality, data protection, and ethical use of educational records.

3. RESULTS

Guided by a Nursing as Caring perspective, this section presents descriptive interpretations of the community profiling data collected from 2010 to 2014. Findings are organized according to demographic, socioeconomic, environmental, and health-related indicators relevant to Community Health Nursing practice. Each subsection begins with reference to the corresponding table, followed by a brief interpretation of observed trends.

Demographic Characteristics of the Community

Table 1 shows that the total population increased from 422 in 2010 to 487 in 2014. Across all years, the sex distribution remained relatively balanced, with males accounting for 48.6%–51.9% and females for 48.1%–51.4% of the population. The number of families ranged from 85 to 95, peaking in 2013, and remained generally stable despite population growth. These findings imply increasing population density within a stable family structure, suggesting sustained and growing demand for community-based health and social services.

Socioeconomic Status of Households

Table 2 indicates that the majority of households were consistently classified as economically poor throughout the five-year period, ranging from 79.6% to 90.3% annually. Households classified as not poor accounted for a smaller proportion, ranging from 9.7% to 20.4%, with the highest proportion observed in 2014. The predominance of economically poor households implies persistent socioeconomic vulnerability that may influence access to health care, education, and basic services.

Educational Participation

Table 3 shows that individuals not attending school consistently comprised the majority of the population, ranging from 68.9% to 84.4% across the study period. School attendance ranged from 15.6% to 31.1% and did not exceed one-third of the population in any given year. High levels of non-school attendance imply potential long-term challenges related to educational attainment, health literacy, and future workforce participation.

Housing and Environmental Conditions

Table 4 demonstrates a substantial increase in concrete housing over time, rising from 16.0% in 2010 to 76.3% in 2014. In contrast, housing made of light materials declined from 17.3% to 1.1%, while mixed-type housing decreased from 20.0% in 2010 to none by 2014. The shift toward more durable housing implies improvements in physical living conditions, although earlier variability suggests uneven environmental development over time.

Maternal and Child Health Indicators

Infant Feeding Practices

Table 5a shows that breastfeeding was the most common infant feeding practice across most years, ranging from 33.3% to 70.0%. Mixed feeding increased notably to 44.0% in 2013 before declining to 23.1% in 2014, while bottle feeding ranged from 8.0% to 50.0% across the study period. Variability in infant feeding practices implies differences in maternal caregiving behaviors and access to infant feeding support over time.

Immunization Status

Table 5b indicates that complete immunization coverage improved over time, increasing from 35.0% in 2010 to a peak of 80.0% in 2013, before declining slightly to 65.4% in 2014. Incomplete immunization remained present across all years, ranging from 20.0% to 66.7%, while never-immunized cases persisted at low levels. The continued presence of incomplete and non-immunized infants implies persistent gaps in preventive health coverage and follow-up services.

Family Planning Practices

Table 6 shows that family planning acceptors increased markedly from 20.0% in 2010 to 76.5% in 2012, followed by a decline to 43.0%–46.3% in subsequent years. Non-acceptors remained numerically higher in most years, accounting for 53.7%–80.0% of the population except in 2011 and 2012. Fluctuations in family planning participation imply changing reproductive health practices influenced by access, preferences, and community context.

DISCUSSION

The findings of this study demonstrate how community profiling enables nurses and nursing students to understand Indigenous communities as relational, meaning-making collectives rather than as aggregates of isolated health indicators. The demographic growth observed in Sitio Monicayo, alongside a relatively stable number of families, reflects continuity in communal life shaped by shared caregiving responsibilities and collective decision-making. Within Nursing as Caring, such demographic patterns are understood as expressions of sustained relationships through which communities care for present and future generations (Boykin & Schoenhofer, 2001). This interpretation is further reinforced by caring science and emerging theories of community caring, which position communities themselves as active agents of care rather than passive recipients of health services (Ghanbari-Afra et al., 2022; Iwamoto, 2023; Locsin & Betriana, 2024).

The period covered in this analysis (2010–2014) corresponds to the years when the College of Nursing conducted sustained Related Learning Experiences (RLEs) in the Aeta community. During this time, nursing students and faculty engaged in repeated and longitudinal community immersion rather than episodic outreach, an approach shown to deepen students' understanding of community care, continuity, and relational engagement (van Iersel et al., 2019). This sustained immersion allowed for systematic documentation of community trends while fostering trust and mutual familiarity—conditions identified as essential for effective family and community nursing practice (Dellafiore et al., 2022).

Persistent socioeconomic vulnerability and low educational participation observed during the RLE period highlight the structural contexts within which caring is enacted. Caring science emphasizes that such conditions shape how care is prioritized and negotiated, rather than signaling indifference to health needs (Ghanbari-Afra et al., 2022). Cultural safety scholarship similarly stresses that ethical nursing practice requires reflexivity and responsiveness to lived realities, particularly in Indigenous contexts (Wilson et al., 2022; Bhandari et al., 2025). These insights align with adaptive and relational leadership models, which emphasize flexibility, trust-building, and shared problem-solving in complex community settings (Maritsa et al., 2022; Sott & Bender, 2025).

Improvements in housing conditions observed during the study period suggest progress in environmental safety and dignity—key foundations of caring environments (Alikari et al., 2022). Variability in maternal–child health practices and family planning participation further reflects caregiving decisions shaped by cultural values, access to services, and relational priorities. Research on nurse–patient and nurse–community relationships consistently demonstrates that caring relationships enhance autonomy, engagement, and quality of care (Molina-Mula & Gallo-Estrada, 2020). Nursing as Caring and ethical frameworks of cultural competence therefore affirm the importance of honoring families and communities as capable decision-makers rather than passive recipients of health directives (Boykin & Schoenhofer, 2001; Theodosopoulos et al., 2025).

Although the data were collected more than a decade ago, their relevance remains significant. They provide a longitudinal baseline illustrating how caring-centered immersion experiences shape both community outcomes and nursing education. In the current context of heightened emphasis on cultural safety, ethics, and community-based care, these findings underscore the enduring value of knowing communities through caring as a foundation for responsive and ethical Community Health Nursing practice.

LIMITATIONS AND RECOMMENDATIONS

This study utilized secondary community profiling data from 2010–2014, which may not capture recent demographic and health changes within the Aeta community. The findings are context-specific and derived from a single Indigenous setting, limiting generalizability to other populations. Despite these limitations, the study underscores the enduring value of sustained student nurse immersion in Indigenous communities. Nursing programs are encouraged to institutionalize longitudinal community placements that allow students to engage in repeated, relationship-centered interactions. Such immersion experiences are essential for cultivating Nursing as Caring in practice, enabling students to understand communities holistically, practice culturally safe care, and develop ethical, relational competence in real-world Indigenous contexts.

CONCLUSIONS

The community profile of Sitio Monicayo reveals an Indigenous Aeta community navigating demographic growth, persistent socioeconomic vulnerability, improving housing conditions, and ongoing environmental and maternal–child health challenges. Health practices within the community reflect adaptive expressions of caring shaped by cultural traditions, relational responsibilities, and available resources, as observed during a period of sustained nurse–community engagement.

Viewed through the lens of Nursing as Caring, community profiling extends beyond a technical assessment tool and becomes a caring practice that enables nurses and nursing students to know communities as caring collectives rather than as aggregates of health indicators. Embedding caring-centered, longitudinal community assessment within Community Health Nursing education—particularly through sustained immersion experiences—strengthens students' capacity to deliver culturally congruent, ethical, and relational care for Indigenous populations. This approach remains highly relevant in contemporary nursing education, reinforcing the profession's commitment to social justice, cultural humility, and enduring community partnership.

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Table 1. Demographic Characteristics of the Community (2010–2014)

Year	Total Population n (%)	Male n (%)	Female n (%)	Families n
2010	422 (100)	205 (48.6)	217 (51.4)	85
2011	453 (100)	235 (51.9)	218 (48.1)	93
2012	403 (100)	204 (50.6)	199 (49.4)	93
2013	469 (100)	242 (51.6)	227 (48.4)	95
2014	487 (100)	242 (49.7)	245 (50.3)	93

Table 2. Socioeconomic Status of Households

Year	Poor n (%)	Not Poor n (%)	Total
2010	71 (83.5)	14 (16.5)	85
2011	83 (89.2)	10 (10.8)	93
2012	84 (90.3)	9 (9.7)	93
2013	84 (88.4)	11 (11.6)	95
2014	74 (79.6)	19 (20.4)	93

Table 3. Educational Participation of Community Members

Year	Going to School n (%)	Not Going to School n (%)	Total
2010	66 (15.6)	356 (84.4)	422
2011	141 (31.1)	312 (68.9)	453
2012	98 (24.3)	305 (75.7)	403
2013	117 (24.9)	352 (75.1)	469
2014	118 (24.2)	369 (75.8)	487

Table 4. Housing Type

Year	Concrete n (%)	Wood n (%)	Light Materials n (%)	Mixed n (%)	Total
2010	12 (16.0)	35 (46.7)	13 (17.3)	15 (20.0)	75
2011	30 (36.6)	13 (15.9)	31 (37.8)	8 (9.7)	82
2012	27 (34.2)	24 (30.4)	0 (0.0)	28 (35.4)	79
2013	33 (42.3)	20 (25.6)	3 (3.8)	21 (26.9)	78
2014	71 (76.3)	21 (22.6)	1 (1.1)	0 (0.0)	93

Table 5a. Infant Feeding Practices

Year	Breastfeeding n (%)	Bottle Feeding n (%)	Mixed Feeding n (%)	Total
2010	14 (70.0)	3 (15.0)	3 (15.0)	20
2011	4 (33.3)	6 (50.0)	2 (16.7)	12
2012	22 (66.7)	5 (15.2)	6 (18.1)	33
2013	12 (48.0)	2 (8.0)	11 (44.0)	25
2014	12 (46.2)	8 (30.8)	6 (23.1)	26

Table 5b. Immunization Status of Infants

Year	Complete n (%)	Incomplete n (%)	Never Immunized n (%)	Total
2010	7 (35.0)	11 (55.0)	2 (10.0)	20
2011	3 (25.0)	8 (66.7)	1 (8.3)	12
2012	22 (59.5)	13 (35.1)	2 (5.4)	37
2013	20 (80.0)	5 (20.0)	0 (0.0)	25
2014	17 (65.4)	7 (26.9)	2 (7.7)	26

Table 6. Family Planning Practices

Year	Acceptors n (%)	Non-Acceptors n (%)	Total
2010	13 (20.0)	52 (80.0)	65
2011	41 (65.1)	22 (34.9)	63
2012	52 (76.5)	16 (23.5)	68
2013	34 (43.0)	45 (57.0)	79
2014	37 (46.3)	43 (53.7)	80