Discovering the Culture of Your Community

Culture is not just about ethnicity. Rather, it is about the way in which a community uses space and time, its lifeways, and the manners in which people are organized and interact. It also includes the ways in which health is promoted, illness is prevented, and care is provided. From a systematic examination of the community’s culture, we begin to identify a community’s health problems, but, more importantly, we also discover a community’s assets and strengths—the cultural capital needed to accomplish the goals of Healthy People 2020. This chapter offers a protocol for gathering, organizing, and interpreting information about the culture of a community.

Chapter 5 Objectives

- Learn a systematic and comprehensive procedure for gathering and recording the environment, population, and social organization of a community.
- Develop strategies for identifying a community’s assets and strengths as well as its health problems.
- Use comparison and contextual analysis to determine the impact of community culture on health and illness.
Community Culture Inquiry

The assessment and analysis of community culture uses a process of community assessment developed by Conrad Arensberg (1954, 1955, 1961) and his work with Solon Kimball (Arensberg & Kimball, 1965) to facilitate the integration of anthropology in community development and social services. It approaches the study of communities through assessment of three interrelated aspects of a community:

- Its physical environment
- Its population
- Its social organization

Contained within each of these components of community culture are subcomponents, which, when assessed, provide additional information with which to gain a greater understanding of a community.

This community culture inquiry is not intended to be exhaustive; rather, it provides a systematic and meaningful framework in which to organize community-culture information based on similar categories. The most important goal is not to complete every category and subcategory but to have a spirit of curiosity and discovery as the community is assessed in an orderly, systematic way and to manage the information so that it is most useful. The skills the community/public health nurse uses to collect information for the community cultural inquiry include:

- A review of databases to identify relevant statistics specific to this community.
- Communication with key informants, stakeholders, and others from the community, each of whom provides valuable insights regarding the community’s assets and areas in need of improvement.
- Direct observation of the community and its people and resources, as well as virtual observation of relevant Internet resources, such as mapping tools and community-related websites.
Research in literature sources to illuminate understanding of similar communities and target populations and to identify evidence-based community programs that may prove valuable for the community being assessed. As data are obtained and analyzed, a meaningful picture of the community—its assets and strengths—is identified along with its dimensions of weakness.

This holistic examination of the community’s culture uses strategies that are not unlike the ethnographic methods used by anthropologists when they enter a culture unknown to them. Although the strategies may be similar, the goals of the community/public health nurse and the ethnographic researcher are quite different: The researcher is interested in developing new knowledge that will help explain the relationship of human behavior to health and illness, but the goal of the community/public health nurse is to gain a comprehensive understanding of community culture to build a community’s capacity for better health. The nurse assesses for cultural capital that can be deployed to mobilize community action as well as to identify features of the community that may at first appear to be unrelated to health but, in fact, are valuable community assets for constructing and implementing a culture-based, healthy community agenda.

**The Physical Environment of a Community**

The physical environment and geographic location of a community include the space and the time it occupies. The *spatial aspect* of a community refers to its natural dimensions (e.g., hills, rivers, forests, or oceans) as well as its human-made environment (e.g., highways, buildings, bridges, and street plans). Together, these compose the *setting* (e.g., rural county, urban neighborhood, or coastal village) in which the target populations work and live (Eberhardt & Pamuk, 2004). In addition to space, the physical environment of a community occupies time. Communities have a history and a future that influence what can be accomplished in the present. They outlive individual members and successive generations, ranging from infants to seniors, and reflect an orderly progression of the population through days, seasons, and years. The community’s history and future ambitions are just as much a part of community life as its rivers, roads, and buildings.
Spatial Dimensions of Community Life

Communities occupy and use space and its contents in different ways and are shaped by it. For example, many of the original cities that grew in the northeastern United States were built around a waterfall to power the textile or paper mills on which their economies were based. The typical settlement pattern in such communities consisted of worker houses built on flat ground, while the owners and high-level managers lived in more elegant accommodations in the hills. Examples of this type of settlement can be found in communities throughout New England. Midwestern rural and agricultural communities, in comparison, were settled on farms and in family-dominated clusters of houses located in a more egalitarian manner, along roads leading to the town’s “main street” commercial and service centers.

The spatial aspect of community life is a good place to initiate a culturally informed community assessment, because it does not necessitate extensive interviews or informal discussions with residents. Through direct observation, reference to maps, reviews of community and industry web pages, and drawings of community diagrams, much can be learned about a community, its assets and resources, and its potential and actual health problems. Most communities have fairly detailed maps that can be obtained from the Internet, local planning departments, or municipal or county offices. Popular mapping resources on the Internet that can be helpful include Google Earth, Google Maps, and SimplyMap.

A formal map is a good place to start; however, regardless of the availability of Internet mapping resources, driving around and walking through the community give the nurse a closer perspective on the major topographical features and social institutions.
Community/public health nursing practice begins with knowing where nursing and healthcare services are to be provided. It is therefore necessary to start by identifying the physical boundaries and the size, expressed in square miles, of the geo-political territory to be served. Depending on the type of community, the size of its population, and the way in which people are distributed, it could be geographically small, such as a city block, or it could encompass several rural counties. The physical size of a community in square miles will strongly influence the amount of funding and resources available for community practice. Providing community/public health nursing services for a large population concentrated in a few city blocks is likely to be very different from, but equally as demanding as, providing services for a small population scattered over many square miles.
Regional Position

Suggested Activity
Acquire a map that demonstrates the regional position of the community. Then do the following:

■ Identify whether the community is a town, county, borough, village, or part of a municipality.

■ Identify types of services that are available to community members. What resources are needed to access these services (e.g., transportation, membership, or insurance)?

■ Identify where and how far community residents need to go to obtain various services.

■ Describe commuting relationships between this community and other communities. What are the implications for daily living activities, such as work, kinship, and leisure?

■ Determine the distance, in time and miles, to the nearest urban center.

■ Read a local news source and speak to local community members to explore how the community relates to the geo-political units in which it is located.

Critical Thinking Questions: What additional discoveries have I made during this activity? What additional information would be helpful for me to include?

The regional position of a community indicates how it is situated in relation to other communities—whether it is a satellite to a larger city or other municipality or it is a center to which smaller communities are linked on a daily basis. The degree to which it is isolated from surrounding communities will influence the community’s strengths and problems. For example, in a community that is remote, the community/public health nurse may need to mobilize lay community members to become health educators or emphasize self-help programs, such as first-aid readiness and health literacy. When trusting relationships with
community members are cultivated, there can be many advantages to working in communities where kinship and neighbor networks provide meaningful social support and can be mobilized more easily.

The regional position of the community is significant, because many problems cannot be resolved merely at the local level. For example, people may live in community A but are getting sick where they work, in community B. These commuters who travel from the suburbs to the city and back to the suburbs may unknowingly be transmitting communicable diseases from one location to another.

In addition to work ties, strong social ties often exist between members of communities that are widely separated geographically. For example, many Puerto Rican families living in New York City send their children to Puerto Rico during summer vacations to stay with grandparents. It would be difficult to understand the culture of the specific neighborhoods in New York City without consideration of these families’ ties in Puerto Rico. Similarly, it is not unusual for migrant farm workers in the Midwest to return to their home countries when the harvesting season is over to check on their relatives and, for some, to seek less-expensive healthcare.

**Geo-Physical and Climate Factors**

**Suggested Activity**

Do the following:

- Identify the natural features of the environment that serve as an organizing force in the district/community (e.g., rivers, mountains, plains, or coast).

- Identify the human-made features of the environment that serve as quasi-organic forces (e.g., superhighways, high-rise apartment complexes, industrial parks, bridges, tunnels, shopping malls, and sports arenas).

- Record the climate conditions of the area (e.g., precipitation, winds, and temperature range).
A community’s geo-physical and climate factors, such as mountains, rivers, or coastline, may be organizing forces in community life. New construction sites are common features of the landscape on urban island settlements, such as Hong Kong, Singapore, and Manhattan, where older buildings are regularly being razed and replaced by newer, taller ones. In contrast, such cities as Los Angeles and Dallas sprawl indefinitely into their environments. Although some geo-physical and climate features, such as mudslides, floods, forest fires, and earthquakes, impose various threats to the health of a community, others provide opportunities for recreation and community gatherings. Human-made physical features, such as multiline highways, bridges, tunnels, and clusters of high-rise buildings or industrial parks, serve as semiorganic forms that affect the health of communities and human activity. For example, superhighways, uniting several communities, help centralize social and economic activities, expanding support for a healthy community agenda. At the same time, they may physically divide previously connected neighborhoods and contribute to potential health hazards, such as traffic accidents, air pollution, and harmful noise levels.

**Land Use**

**Suggested Activity**

Describe how land in the community is designated for use (e.g., residential, recreational, commercial, industrial, agricultural, official, and spiritual or religious use). Describe the patterns of land use by the people in the community:

- Areas used by all members of the community
- Areas used by specific community members (e.g., old, young, women, and ethnic groups)
Communities create various kinds of boundaries. Some have settlement patterns with sections of the community designated for specific purposes, such as residential, commercial, industrial, governmental, spiritual, or recreational use. In other communities, residents sleep, eat, work, play, and worship within the range of a few blocks; there is no geographical separation of various community activities. The designation of different locations for different community functions generates patterns where community members live, work, congregate, and play. Areas used by local residents, government, and corporate interests may differ in community history and community engagement. Commercial centers, houses of worship, recreational centers, schools, or industrial complexes bring community members together for certain periods of the day or week, while their widely scattered homes take them in separate directions for the remainder of the time. It is important to identify areas where people congregate naturally to reach many residents at the same time. For example, in some communities, the most efficient way to reach larger numbers of adults might be through their places of employment, while in others it may be at religious services. These locations where people congregate naturally are part of a community’s cultural capital and may be leveraged for health-promotion purposes.

Communities may be organized according to special characteristics of the residents, such as ethnicity or religion (e.g., Little Italy, an Amish community, or Chinatown), by economic class (e.g., the “ghettos”), or even by occupation, such as enclaves of artists and musicians or university faculty. Health disparities may be prevalent in subcultures within a community. In addition, many communities have been and continue to be characterized by segregation (Acevedo-Garcia, Lochner, Osypuk, & Subramanian, 2003), which was one of the principal reasons for the movement to desegregate school districts. Specific groups may informally
designate a particular area of the community as their own “turf” and create boundaries that are not visible to the outsider but are well known and well respected by local residents.

A community has unspoken “rules” by which residents abide, and they govern where people go in a community. These rules have important implications for health planning and intervention. For example, a lead-screening program was held at a fast-food restaurant on a Saturday. A favorite gathering spot for young families on the weekend, the restaurant was considered an ideal site for reaching preschool-age children. In terms of the number of children screened, it was extremely successful; however, in terms of reaching the population most at risk, the program failed. No one had taken into consideration that the lower-income families with the highest-risk children who were most likely to have lead exposure would be unlikely to bring their children to a fast-food restaurant outside their own neighborhood. A better understanding of the use of space by people in the community and how different groups have different access to space could easily have averted the problem and saved the expense of an additional program.

**Suggested Activity**

Describe and/or create a “photo journal” documenting the following:

- Acquire pictures of the range of housing types in the community. What are the worst and the best housing conditions?
- Describe housing options available for lower-income community members.
- Map the types of housing on a street map.
Housing plays an important role in providing a safe, healthy, comfortable, and aesthetically pleasing context for individual and family growth. In addition to providing shelter and protection from the elements, housing is directly related to the quality of family relationships and to the psychological and physical dimensions of health. The type of construction and the placement of housing units in
relation to each other and to community gathering points influence the ways in
which residents interact. For example, apartment buildings with a common court-
yard, swimming pool, or laundry area may be more likely to foster more interac-
tion among building residents than a high-rise, dormitory-like building where one
rarely sees the person who lives in the apartment next door. Many cities, such as
Chicago, have replaced high-rise dwellings with three-story, townhouse-type
housing for this reason.

Access to a piece of land for gardens or recreation is another important feature of
housing. Many innovative urban planners have transformed vacant lots into vege-
table gardens, subdivided and tended by community members. In addition to
solving the aesthetic and safety problems that accompany vacant lots, such gar-
dens provide city residents with the opportunity to produce, preserve, and per-
haps even sell fresh food. Such community gardens also can become a focal point
for community activity, such as outdoor markets, and they can bring urban resi-
dents together and help improve access to fresh foods for some populations that
may otherwise reside in food deserts.

Housing must be examined in relation to the characteristics of the people residing
in the community. It may be very difficult for immigrants who were living in
adobe, single-story homes with detached kitchens to adjust to the high-rise hous-
ing of urban centers. Housing units that were constructed for one group, such as
young families, may not work as well for elders who require elevators, wheelchair
ramps, and perhaps different kinds of lighting. Most modern housing is electrici-
ity-dependent and subject to energy crises in summer or winter months, creating a
potentially serious problem for older adults. Finally, abandoned housing has gen-
erated a widespread community-safety problem, attracting gang members, illicit-
drug users, and homeless urban squatters.
Transportation

Suggested Activity
Do the following:

- Obtain transit maps of buses, subways, ferries, and waterways. Include a list of the costs of transportation.

- Map patterns of movement within and between residences, workplaces, commercial centers, healthcare centers, recreation centers, and schools.

- Outline major arteries, available routes, and public and private transportation options.

- Identify the dominant means of transportation observed. For example, list the use of private vehicles, public transportation, taxicabs, trains, bicycles, walking paths, skateboards, or other means of transportation.

- Describe the transportation links between the community and the nearest urban centers. How accessible are key health-related resources to the community’s most vulnerable persons (e.g., persons who are elderly, disabled, in poverty, or homeless)?

- Identify the locations of sidewalks and their safety for residents in the community.

- List the methods of community-wide communications (e.g., texting alert systems, radio stations, and severe weather and emergency alerts) that serve the community.

- List the ways people receive news and information. Include newspapers, bulletins, television, the Internet and electronic resources popularly used in the community (e.g., smartphone apps, Facebook pages, Twitter, Instagram, and other forms of social media), and those that provide public health programs.
The communication system is a critical capacity-building tool. Social media, cell phones and text messaging, radio, television, newspapers, and the Internet link individuals and groups within and outside the community for health education, disaster preparedness, and public participation in health planning and policy. Health editors of blogs, smartphone apps and popular Facebook pages, local newspapers, school principals, physical education teachers, school nurses, local

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**Critical Thinking Questions:** What additional discoveries have I made during this activity? What additional information would be helpful for me to include?

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The designation of different zones for various community functions and events requires a transportation system to move people from one activity to another. In addition to knowing how land is used in the community, it also is necessary to understand the ways in which people use the network of roads, waterways, and other public transportation. This is especially important for the most vulnerable groups of people, who may have limited resources or abilities to reach health services.

When a hospital in a large city decided to close its pediatric clinic, a nearby hospital began to plan for the influx of families it assumed would be drawn from the closed service. It was the closest hospital by distance; however, the journey required a transfer from one bus line to another. Most mothers found it more convenient to go to another clinic that was actually farther away but could be reached on one bus line, without the inconvenience of a transfer.

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**Communication**

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television and radio health programs, religious leaders of local houses of worship, and church bulletins are examples of cultural capital that can be mobilized to disseminate information about health and to encourage the participation of community residents in health programs. Some nurses have launched newspaper columns, smartphone apps, Facebook pages, blogs, and television and radio programs to bring health information to the public. Internet services and social media are continuing to grow in their capacity for public communication, although the advantages of print media cannot be discounted: Health officials in a very ethnically diverse city found the most effective and efficient way to reach its multicultural population was through several well-read ethnic newspapers that each translated the information into the language of its readers. The community/public health nurse and community-partner health-promotion efforts will be most effective when you know the communication methods used by the various target populations within a community.

**Mental Maps**

A famous cartoon depicts a New Yorker’s perspective of the United States, which, looking west, includes first New Jersey and then the West Coast with nothing in between except Chicago; this is an example of a mental map. Persons living in Missouri, Montana, or Alabama are likely to have very different but perhaps equally distorted mental images of the United States. Community residents may also have a view of their surroundings that departs greatly from the actual geography. For several years, social scientists have used mental maps (including drawings by residents of their communities) to discover the interface of the psychological topography with the physical topography. In doing so, they have identified invisible peaks of psychological stress where residents are afraid to enter and valleys of safety where they feel comfortable and unafraid.

The names and nicknames applied to certain neighborhoods and sections of the community also tell much about how various neighborhoods are viewed. It is not unusual, for instance, for recently gentrified neighborhoods to have two names: one that is used by the residents who were born and grew up in the neighborhood and another that is used by the wealthier newcomers. This use of two names to describe the same place is telling: It may mirror social and economic differences
between the two types of residents and suggest not only how various residents perceive themselves but also how they perceive others. It alerts us that there might be a need to use a different strategy for community action with each category of resident.

As with the “turf” aspects described earlier, sacred areas, areas of fear or safety, and other psychological features are superimposed on the physical features. Often, they are not obviously demarcated, so they may go unnoticed by the newcomer to the community. Sensitivity to mental maps is important, however, for understanding the perception people have of their environment and ensuring access to healthcare services for all populations in a community. Learning about the mental map of the community may be accomplished by reading about the community and its history, but most importantly by talking with various members who represent the diverse groups within the community.

**Suggested Activity**

Do the following:

- Record sections of the community distinguished by the residents themselves and the names or nicknames that are applied to them. When possible, speak with a cross-section of the community to gain different perspectives.
- Map the areas of the community that frequently are avoided or identified as unsafe.
- Map areas of the community that are designated as sacred or historical, such as ancient burial grounds and memorial parks.

Critical Thinking Questions: What additional discoveries have I made during this activity? What additional information would be helpful for me to include?
**Temporal Dimensions of Community Life**

Every community has daily, weekly, monthly, seasonal, semiannual, and annual cycles of activities that compose the cultural use of time. These temporal factors are especially important in community/public health nursing practice, because timeliness is often a critical factor for successful capacity building. If immunization programs are offered at a time when they are inaccessible to community residents, the participation rate will be low. Public health issues requiring legislative action are likely to get the most visibility and candidate support close to elections.

**Community History**

**Suggested Activity**

Do the following:

- Determine the historical events that are important to the development and life of the community.
- Record the date and circumstances surrounding the settlement of the community.
- Describe patterns of population growth since the community was first settled, including waves of migration, immigration, and outmigration. Describe recent and current patterns of population growth or loss. What factors have contributed to these changes?
- What are examples of milestone events important to members of the community, including natural and human-made events? Examples include job growth or loss and economic changes; wars; major social events; community accomplishments; opening of new roads, railroads, or bridges; and disasters.
- Obtain a historical map of the community and designate the place and time of major physical alterations. If you do not have access to a historical map, ask longtime community members about major physical alterations.
The community of today is largely a result of its history. Specific events and trends have worked to shape the place and its people. Knowledge of the history of the community is important for tracing and interpreting patterns of health problems over time and predicting those that will occur in the future. Understanding the local history is essential for strengthening a healthy community agenda by framing it in local traditions. Historical details of the community are not as important as a general knowledge of what has made the community what it is. A history may have already been written about the community that is available online or in the local library, either because the area has a particularly interesting history or because it was done as part of a community event or celebration. If no recorded history is available, explore other sources, such as interviews with older or longtime residents, newspaper series, public records, census reports, school records, directories, deeds and old maps, and church records.

**Cyclical Population Movement**

To plan and implement public health action, it is very important to know the daily, weekly, seasonal, semiannual, and annual changes in the population. The movement of people from one place to another generally takes place with a degree of regularity and needs to be included in the community assessment to ensure the health and safety of community residents. For example, to ensure the safety of children coming and going to school, it is necessary to know when automobile traffic is heaviest and when children could be more likely to encounter risks to their safety.

- Create a timeline of changes in community settlement patterns, such as a shift from downtown to suburban and then back to downtown.
- Include major economic trends in the community on the timeline.
- Include major political trends on the timeline.

Critical Thinking Questions: What additional discoveries have I made during this activity? What additional information would be helpful for me to include?
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Seasonal changes in the population often include major shifts in population, such as tourists and college-student workers who expand the population in the summer months on Cape Cod or double the population of Amherst, Massachusetts, from September to May. These seasonal fluctuations in population size have profound public health implications. The tourists who populate the New England ocean-resort towns and “snowbird” migrations of retired adults to Florida in the winter months present resource challenges for creating safe environments that range from water rescue to sanitation to restaurant inspection to traffic safety.

Economic Cycles

This category of the community inventory includes temporal variations in the local economic structure, including cyclical variations in productivity, employment, occupation, income, and expenditures. The influence of seasonal variation in the local economy on health and healthcare is apparent in agricultural communities. In communities where agricultural sugar cane production is the main economic activity, for example, hundreds of workers are employed during a 6-month
period in the field to cut the cane and in the factory to process it into sugar. During this time, cash is in the greatest circulation, and people have the resources to pay off their debts and make new purchases. It is also the time when utilization of healthcare services increases dramatically, reflecting that people are often taking care of problems that have been deferred during the leaner months. Additionally, seasonal work patterns and industries, such as agriculture and construction, have high rates of traumatic deaths (Healthy People 2020), requiring public health safety intervention.

Psychological Cycles

Communities have periodic cycles when either psychological elevation or depression is generalized throughout the population. In most American communities, holidays and other times of ceremonial activity are seen as periods of high levels of anticipation and enthusiasm, with opportunities to be with family and to renew old friendships. These are also the time periods with the greatest incidence of suicide. Often, euphoric seasons are followed by dysphoric periods when the excitement of the holidays is over, work has resumed, bills must be paid, and weather keeps people indoors and isolated from friends and recreational activity.

Suggested Activity

Do the following:

- Record weekly, monthly, and seasonal work patterns, such as regular periods of unemployment, cycles of productivity, and seasonal occupational changes.
- Record periodic changes in income and expenditures. Ask a community member and a local business owner how the community is affected by population shifts.

Critical Thinking Questions: What additional discoveries have I made during this activity? What additional information would be helpful for me to include?
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The first warm days then bring a return of euphoria, with the anticipation of spring and summer and the resumption of social interaction and physical activity.

**Suggested Activity**

Chart on a 12-month calendar the psychological cycles of the community:

- When does the community experience periods of euphoria and dysphoria (e.g., memories and pride during football seasons; memories of sorrow from a community tragedy, such as a tornado, flood, or violent event)?
- Festivities and holidays: Are there community activities, such as parades and festivals, that take place during the year that commemorate local or national holidays or special events? What are the themes with a special identity that are important to some of or all the community members?
- Chart leisure and recreation periods in the community. Are there days of the week or seasons of the year typically used to relax, enjoy recreation, or vacation?
- Identify periods of widespread melancholy. What are the possible contextual and historical reasons for this occurrence?

**Critical Thinking Questions:** What additional discoveries have I made during this activity? What additional information would be helpful for me to include?

Student health centers report similar patterns. Each semester begins with the excitement of new classes and new friends. Then as the semester wears on, students are faced with assignments, tests, and papers to be completed, and a fairly predictable midterm dysphoria sets in. At that point, it is common to hear students say they cannot wait for the semester to be over and even express doubt as to whether they will be able to complete their course of study. During these periods of stress, absenteeism is most likely to occur, comparatively minor complaints take on an enhanced significance, and visits to health services increase. At the
same time, faculty members feel equally stressed—perhaps in response to students—creating a system-wide emotional decline. In comparison, during periods of euphoria, it is not uncommon to hear students say, “I don’t have time to get sick; I’m getting ready to go home for the holidays,” or, “I’m not going to miss homecoming just because I have the flu.” During these periods, complaints are minimized, and health-service utilization decreases.

**Cyclical Crises**

**Suggested Activity**

Do the following:

- Chart recurring crises on an annual calendar/schedule, and determine whether these crises are experienced by some or most of the community members.

- List the sporadic crises that have occurred over the past 20 years. How well did the community cope with the crises? What factors contributed to effective or ineffective coping? How long did it take for community members to regain a sense of normalcy following a crisis?

Critical Thinking Questions: What additional discoveries have I made during this activity? What additional information would be helpful for me to include?

Practically all communities have crises that recur on a fairly predictable schedule. Spring flooding, annual flu epidemics, hurricane season, and winter fires are common examples of critical events that take place more or less regularly. According to *Healthy People 2020*, drowning, the second-leading cause of injury-related death in children and adolescents, is a seasonal event. Because seasonal events are relatively predictable, public health measures can be instituted to attempt to either prevent such events or minimize the damage that will accompany them. Some communities may experience an unexpected crisis of major proportion as a result of nature or a human-made disaster. Examples of natural crises include the
effects of an F5 tornado that destroys a whole community; a major hurricane, such as Hurricane Katrina; or an out-of-control wildfire that rapidly burns many homes. Human-caused crises can create widespread emotional trauma, perhaps due to ethnic discord, gun violence, or the betrayal of trust of a public figure who turns out to be an embezzler or sexual abuser.

Nurse midwives practicing in a remote and mountainous community reported bringing pregnant women across the river each year before the rainy season, when the normally shallow and easily fordable river began to swell. This is an example of anticipating problems and finding ways to ameliorate them or soften their impact.

Following the unexpected shooting of a beloved public school teacher by a former student who became violent, the community deeply mourned the loss of the teacher. The community also mourned the imprisonment of the former student, who was once an endearing young person but developed a mental illness that went untreated due to barriers to care and lack of understanding about mental illness. The community deeply mourned this dual tragedy for many years following the event. A positive outcome was that gradually the community’s conversations about the lack of mental-health services improved awareness and increased resources directed toward their development.

Community action can involve presenting a prevention program on summer safety, including water safety and first aid, at the end of the school year, which could reduce the number of events over the summer and equip children to provide assistance. Hurricanes, tornados, forest fires, seasonal floods, and other seasonal disasters require an educated citizenry who knows where to go and what to do to help others minimize the impact of a disaster.

In addition to the seasonal crises, other disasters have the potential to occur. Fires, tornados, tsunamis, earthquakes, major epidemics, mining disasters, nuclear disasters, and terrorist attacks all require preparation. The goal is to develop and maintain the community’s capacity for readiness to reduce the impact of such an event by having a community plan in place. In a healthy community, the potential
for such crises is identified, and a plan is in place for an interprofessional team that includes health- and human-service professionals, such as sanitation and safety engineers, police, communications networks, and rescue teams. In a healthy community, such problems as lack of health services or gun violence are identified, and culturally informed community action is mobilized.

**The Population of a Community**

An examination of a community’s culture must include a review of the main reason a community exists: the people who live and work in the community. The number of people in a community and their attributes influence a community’s ability to create a healthy future. The population can be examined as a whole, in terms of its size, growth, and distribution. It also can be examined in terms of the bio-cultural and socioeconomic characteristics of its members. These characteristics tell us much about the kinds of public health problems that can be anticipated; they also provide information about the strengths and assets of the population for facilitating a healthy community agenda. As you learned from studying communities, they experience environmental changes. This is also true of their populations. For example, a population’s demographic profile may change, with a larger percentage of the population being age 65 and older. Additionally, depending on how it is defined, a population may include residents who spend only part of the year or part of the week in the community, or even those who come there every day for work or school but return to another community at night.

**Population Size, Density, and Distribution**

An understanding of the population begins with knowing not only how many people reside in the community but also how they are distributed. *Rural localities*, defined as communities with fewer than 2,500 residents, compose 25% of the American population. Some health-related needs are unique to rural conditions and lifestyles, and the Affordable Care Act is working to address them through the expansion of rural-community health center services. At the same time, we know that many urban neighborhoods also have unique public health issues,
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Depending on the size of the community, it may contain urban and rural sections and areas of high and low population density. In addition to current size and density, changes in the population create new public health concerns. This begins with an accounting of population trends over the past several years, including patterns of migration—to and from the community—movement of immigrants ranging from lack of affordable housing, street-safety problems, and gang violence to poor nutritional resources and food deserts due to an absence of grocery stores and fresh produce.

**Suggested Activity**

Do the following:

- Record the size of the population of the community.
- Identify weekly changes in the population. Do the numbers and characteristics of people in the community vary throughout the week?
- Identify seasonal changes in the population. Do the numbers and characteristics of people in the community vary by season?
- Describe the density of the population (that is, the number of people per square mile).
- Map the distribution of the population between urban and rural areas.
- Describe population changes and factors leading to those changes over the last 20 years. For example, consider economic changes, disasters, development of major businesses, and migration patterns. If migrating populations have recently entered the community, where are these people migrating from, and how is the community responding to their migration?

Critical Thinking Questions: What additional discoveries have I made during this activity? What additional information would be helpful for me to include?
and refugees, and natural increases or decreases in size, determined by birth and death rates. These population shifts can have a substantial impact on community resources and the healthcare system.

**Temporary Subpopulations**

**Suggested Activity**

Do the following:

- Identify the people who enter the community on a daily basis but do not live there.
- Identify the people who stay in the community on a weekly basis.
- Record the seasonal subpopulations residing in the community. Describe how many people are in the community during each season:
  - Tourists
  - Military personnel
  - Seasonal workers
  - Students

Critical Thinking Questions: What additional discoveries have I made during this activity? What additional information would be helpful for me to include?

Some communities include special groups, such as military personnel, summer residents, students, migrant workers, or other groups who may reside in the community but are not of the community. In some instances, such groups may contribute to the economy of the community and bring positive attributes that enhance the cultural capital of the community. On the other hand, they may strain community resources, compromising the community’s capacity for health. In any case, the presence of these groups must be accounted for to ensure the future health of the community. This includes identifying their numbers, major
characteristics, roles within the community, strengths, prevailing health risks and problems, and the resources they can offer to build the community’s capacity for health.

**Biological Composition: Age and Sex**

**Suggested Activity**

Do the following:

- Record the median age of the population.
- List the percentages of the population who are in the following age ranges: 0 to 5, 6 to 14, 15 to 19, 20 to 34, 35 to 49, 50 to 64, 65 and over, as well as the older population subgroups of 65 to 74, 75 to 84, and 85 and over.
- Compute the dependency ratio of the population.
- Identify the sex composition of the population. How many people identify as male, female, homosexual, bisexual, transgender, or other?
- Identify the sex ratio of the population based on the sex composition.
- Compute the age/sex quotient of the population based on the sex composition.

**Critical Thinking Questions:** What additional discoveries have I made during this activity? What additional information would be helpful for me to include?

When providing direct care to individual patients, it is necessary to know their biological characteristics to make accurate nursing diagnoses and formulate appropriate care plans. The same principle holds true when providing care to an entire community. The age and sex distribution of a population tells us much about the kinds of health concerns that residents of the community are likely to experience now and in the future, as well as their impact on the health of the community. Age and sex are, perhaps, the most fundamental of the biological
characteristics, because so many community health problems are linked to gender and stage of development. For example, the aging of populations and reduction in communicable diseases throughout the United States have mandated a shift in a major emphasis from infectious disease and child health to management of chronic illness and the needs of elder community residents.

In statistical compilations, the age of a population is presented as the percentage of the population that falls into prescribed categories. The utility of age categories, however, depends on the community. For example, if a setting has a large proportion of older adult citizens, the “over 65” group might be subdivided into “young elders,” ages 65 to 74; “mid-elders,” ages 75 to 84; and “frail elders,” ages 85 and over. At the same time, two of the adult categories might be collapsed into one large group from ages 35 to 64, simply because the community does not have large numbers of individuals in those particular age groups. In other words, the categories should be refined in a way that reflects and is most useful for the particular community being evaluated.

The proportion of the population that is typically not in the labor force is considered to be more likely economically and socially dependent on the rest of the population and is therefore computed as the dependency ratio. The dependency ratio is the number of people ages 0 to 14 plus the number of people ages 65 and older, divided by the number of people ages 15 to 64. It also is the proportion of the population that is likely to require the most health resources. It is therefore a significant figure for public health considerations.

Men, women, and transgendered people differ in the kinds of health problems they experience and the manner and frequency with which they use health services. Acknowledging that some sex-specific health problems are biologically based, Healthy People 2020 highlights gender as one of the five categories in which health disparities must be addressed, yet it emphasizes that the longer life expectancy in females cannot be attributed solely to biological factors (National Center for Health Statistics, 2012). The sex ratio of a community helps us understand and predict prevailing health concerns and the need for resources. As the sex that bears children and generally lives longer, it is not surprising that women use more health services than men do. Furthermore, health problems that were
once attributable primarily to the male population, such as cardiovascular disease, now are emerging with increasing frequency among females. A high sex ratio—that is, a predominance of either males or females—signals a need to review community services for men, women, and children.

Once the age and sex composition of the community has been determined, it is useful to cross-tabulate these two factors to determine the sex ratio in each age category. This greater refinement of age and sex data permits even more predictability as each age group moves to the next developmental stage. For example, it is usually assumed that the ages-65-and-older category is predominantly female, but a closer investigation of the community may reveal that military service and migration have left particular communities lacking in males in one age group but increasing in proportion in another. For several years, the older adult population in Chinese communities in many U.S. cities was predominantly male, reflecting the wave of Chinese immigrant men who came to the United States in the first half of the 20th century as laborers. As each age group moves through its next developmental sequence, its sex composition will have an impact on the health of the community and the necessary health services.

**Ethnic and Racial Groups**

Race and ethnicity constitute another of the factors highlighted by Healthy People 2020 that are linked to health disparities in this country. According to the U.S. Census Bureau, approximately 36.3% of the U.S. population belongs to a racial- or ethnic-minority population (U.S. Census Bureau, 2008b). Ethnicity and race are two distinct categories that often are misapplied (Drevdahl, Phillips, & Taylor, 2006; Phillips & Drevdahl, 2003; Wolf, 1994). *Ethnicity* is the complex of traits that identify a group of people based on such characteristics as common ancestry, language, and/or religion. *Race*, on the other hand, is a more controversial concept. Although we commonly think of race as a biological attribute based on a person’s phenotype and genotype, contemporary social science conceptualizes race as a socially constructed category. In the United States, for example, a person whose appearance (or phenotype) is “White” is often considered “Black” if his mother happens to be African American. “Hispanic” is a common racial
Neither race nor ethnicity can be determined from an individual’s phenotype or genotype. But because census reports and health surveys often use categories that label people as White, Black, or Hispanic, it is important to have a basic understanding of race. With the geographical clustering of populations and a resultant common gene pool, it is not unusual for specific health problems to have genetic origins and thus appear with greater frequency in some groups than in others. It is well known, for example, that sickle-cell anemia is found more often in African American and Caribbean American populations, Tay-Sachs disease in some Jewish groups, skin cancer in those of northern European ancestry, and diabetes in American Indian groups. Certain groups also have inherited resistance to specific diseases. Cancer rates, for instance, are comparatively low in American Indian populations. Thus, at the community level, race and ethnicity can inform the identification of risk for problems likely to require public health action, such as screening and health education.

**Suggested Activity**

Do the following:

- List the various ethnic/racial groups found in the community.
- Calculate each ethnic/racial group’s percentage of the total population.
- Record the percentage of the population that identifies itself as multiracial.
- Determine the homogeneity or diversity of the various racial and ethnic groups.

Critical Thinking Questions: What additional discoveries have I made during this activity? What additional information would be helpful for me to include?
Many health problems correlated with particular ethnic groups are not caused by an inherited predisposition but rather from the social position, socioeconomic status, or conditions of employment of particular groups or subgroups. The combination of biological and social factors can result in variable health status. For example, the higher rate of hypertension in some African American and other groups has been related to the stress associated with a lifetime of discrimination (Dressler, 2004). Race and ethnicity have a profound influence on the health and sustainability of communities. They can be the source of community conflict, isolation, uneven distribution of resources, poor health, and, ultimately, health disparities. On the other hand, diversity can richly enhance cultural capital and be a source of strength in mobilizing and uniting communities.

Prejudice and discrimination have not been confined to groups of color, as the histories of the Irish and of the Eastern European Jews in 19th- and early-20th-century America attest. In cases where discrimination has been legally sanctioned, such as with African-American populations until the 1950s, the quality and quantity of prejudice have been particularly deplorable. For example, well into the 20th century, laws prohibited African Americans from patronizing many restaurants, hotels, healthcare facilities, and educational institutions. The unique circumstances of African-American populations must be acknowledged to appreciate the vast differences in opportunity that have characterized various ethnic and racial groups over time (Carlson & Chamberlain, 2004).

**Suggested Activity**

On the *Healthy People 2020* home page, compare the leading cause of death among the different ethnic and racial populations.
Occupation, Income, and Education Level

**Suggested Activity**

Do the following:

- Record the per capita income in the community.
- Record the mean and median family income and household income.
- Record the percentage of the population with an income below the poverty level.
- Record the percentage of school-age children receiving “free and reduced lunch” services.
- Record the percentage of the population receiving public assistance.
- Record the unemployment rate by age and sex.
- Identify the percentage of females in the workforce.
- List the major occupational categories of the population—for example, professionals, technical workers, managers, officials, proprietors, artisans, operatives, farmers, laborers, and domestic workers. Which occupations are considered “high risk”?
- Evaluate the mean and median income in relation to the cost of living. Ask local community members what they know about income sufficiency and the cost of living.
- Determine the percentage of the population over age 25 that has completed high school.
- Determine the percentage of the population over age 25 that has completed college.

Critical Thinking Questions: What additional discoveries have I made during this activity? What additional information would be helpful for me to include?
Income, occupation, and education influence many aspects of health and healthcare. There is no question that populations with high rates of unemployment, poverty, and public assistance will experience more public health problems (Rodwin & Neuberg, 2005; Szwarcwald, da Mota, Damacena, & Pereira, 2011; Webb, Simpson, & Hairston, 2011). Generally, the problems in poorer communities are more complex, because the resources to resolve them are less accessible. According to the Secretary’s Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020, inequality in income is highlighted as a key social and physical environmental-health determinant underlying health disparities (Healthy People 2020).

Interpreting the impact of occupation and income requires evaluating indicators, such as average income per household, within the local economic context. For example, an average family income of $50,000 per year may be more than sufficient to meet the household needs of families living in some rural areas of the United States but totally inadequate for a similar family residing in Southern California or Boston, Massachusetts. Differences in economic profile are associated with other differences, such as age distribution or ethnicity. Evaluating the income level of a population must be done in relation to the cost of living within the same region.

In addition to the income level, the occupational composition of the population affects the health of a community. For example, mining and textile manufacturing pose high public health risks for respiratory problems. The proportion of adult females in the workforce signals the need to determine the effects of employment and occupation on women’s health, including fertility. It also raises the question of whether there is a sufficient number of high-quality day care centers for the young children of working mothers.

Finally, mothers’ education levels are a universal predictor of child health and development worldwide. Because a large component of public health intervention is educational, the educational and health-literacy statuses of women in the community are important indicators. Education, similar to income, requires evaluation in relation to the context. In some communities, a high-school education is meaningful and will be the standard even for the community’s most prominent citizens. In other communities, it may represent the most minimal preparation.
Residential and Household Characteristics

Suggested Activity

Do the following:

- Record the percentage of the population over age 16 that is currently single, married, divorced, and widowed.
- Determine the number of family units in the community.
- Determine the average population per household.
- Record the percentage of single-person households in the community.
- Record the number of owner-occupied households.
- Record the number of tenant-occupied households.
- Record the percentage of the population living in substandard housing.
- Record shelters or temporary housing available for vulnerable groups of people, such as homeless people, domestic-violence victims, runaway youth, and people with disabilities. Describe the quality of housing available.
- Record the percentage of community members that reside in Section 8 (low-income) housing. Is this type of housing available in a single region of the community, or is it scattered throughout the community?

Critical Thinking Questions: What additional discoveries have I made during this activity? What additional information would be helpful for me to include?

Different kinds of household configurations distinguish neighborhoods and communities. The prevailing domestic units may consist of young singles or old singles, single parents and their children, grandparents and grandchildren, or any number of combinations, as well as the conventional nuclear family. Because the household generally is the unit of personal healthcare, it is important to know how many households are in the district. A population of 3,000 divided into 500 households will create very different public health considerations than a population of 3,000 divided into 1,500 households. One-person households may present
special public health challenges, especially if the person is disabled or in the senior-citizen age group.

Because most people spend one- to two-thirds of their lives at home, housing has a profound influence on the health of the population, including the growth and development of children and the functioning of families. Households considered crowded or substandard in one community may be acceptable in another community. The number of owner-occupied homes as opposed to renter-occupied homes often is used to indicate the stability and investment of residents in making their community a safe and attractive place to live. In some communities, however, renters are highly invested in their neighborhoods—emotionally and economically—and are as vigilant as homeowners are about maintaining the quality of their buildings and their community.

The Social Organization of a Community

In Healthy People 2020, one of the overarching goals includes creating social and physical environments that promote good health for all groups. Social environments are linked to health-related quality of life and life satisfaction. According to the U.S. Department of Health and Human Services in Healthy People 2010:

The social environment has a profound effect on individual health, as well as on the health of the larger community, and is unique because of cultural customs; language; and personal, religious or spiritual beliefs. (p. 19)

The three lenses through which we will describe and analyze the social relationships and interactions that compose the community’s culture are as follows:

- Community institutions
- Horizontal stratification of the community
- Vertical segmentation of the community
Community Institutions

Institutions are standardized patterns of social behavior typified by a regular cycle of activities, specific groupings and personnel, and an accompanying set of rules and ideology. The presence and ongoing functioning of institutions give a community its character and its sense of stability. When an activity or a social behavior is institutionalized, it is no longer dependent on a specific person or persons to make it happen. Rather, it has taken on a life of its own. The institution of marriage is a good example. It is not something each individual invents as he or she reaches adulthood, for it is an established social pattern. And although each person has a choice of whether to partake in the institution of marriage, it is nonetheless clearly established as a normative expectation of adult life for many in our society. Marriage has a set of rules, formal and informal, that govern its performance. Formal rules relate, for example, to whom people can marry, the age at which a person can become married without parental consent, and who can officiate at a marriage. Less formal rules, on the other hand, might govern the appropriate age difference between marriage partners or who may be invited to a wedding.

Just because something is institutionalized does not mean it is incapable of change. It simply means change will require some kinds of societal reorganization. Using the same example, it is easy to see that the institution of marriage has undergone remarkable changes within the past 30 years. These changes include the following:

■ The age at which many people are choosing to marry

■ The ease with which a divorce is obtained

■ The roles each of the partners assumes

■ The number of times people are married

■ The number of unmarried couples who live together

■ The number of same-sex couples who live together or marry
Moreover, new institutions always are developing to meet societal needs that currently are not being addressed by existing institutions. The changing pattern of marriage in our society has created a need for standardized ways of dealing with divorce and the custody of children. Because divorce was less common in the past, the activities and rules surrounding becoming unmarried were not standardized, and each couple was left to work out a solution in its own way and on its own terms.

The community inquiry related to community institutions does not attempt to cover all aspects of culture or all the institutions that constitute a community’s culture; rather, it explores the major categories of institutions that one is likely to find in almost all communities. They also are the most useful categories for guiding public health practice. They include economic, government, domestic, religious, education, and recreational and voluntary institutions. Depending on the community, different institutions assume different levels of significance, and institutions not included in the list may be more important to your assessment. The critical factor is not a detailed account of every institution but the ability to identify institutions and understand how they are linked to the health of the community. Health-related institutions have been omitted, intentionally, from this section, because they are discussed in detail in Chapter 6, “Determining the Health of Your Community,” which focuses exclusively on health, the healthcare infrastructure, and institutional health organizations.

**Economic Forces**

Like all institutions, the economy of a community can be viewed as cultural capital and as cultural liability. Economic leaders can be powerful allies in making communities healthy places in which to work, raise families, live in quality housing, receive an education, and grow old comfortably. At the same time, the health of a community may be endangered by an economy dominated by greed and grounded in the exploitation of specific populations, the creation of social and health disparities, or the degradation of the environment and natural resources. The degree to which economic opportunity, such as employment and financing, is available to all sectors of the population is an indication of the economic health of the community.
Understanding the economy that fuels community life and the changes that have taken place over the years permits the most fundamental understanding of current and future health problems. In a healthy community, some resources are reinvested into the well-being of community members. In contrast, potentially dangerous ecological changes, environmental hazards, and/or the physical, psychological, and social problems associated with low wages or unemployment (Worthman & Kohrt, 2005) or job loss (Burgard, Brand, & House, 2007; Grunberg, Moore, Greenberg, & Sikora, 2008; Sikora, Moore, Greenberg, & Grunberg, 2008) can be caused by questionable economic values. These problems pose significant threats to the health and well-being of community members. An assessment of health and safety factors of the local economy involves two components:

- Economic impact on the environment, including air, noise, water, and food pollution

Suggested Activity

Do the following:

- Describe the major economic base of the community—for example, manufacturing, industrial, wholesale, retail, resort, education, health, government center, commercial center, or diversified.
- Describe the relationship between employers and employees or workers and management.
- List the major employers in the community.
- Describe the role of workers’ associations, such as unions.
- Chronicle the changes in the economy over the last 10 years.
- Summarize the effects these economic changes have had on the community.
- Describe the health and safety factors associated with local industry.

Critical Thinking Questions: What additional discoveries have I made during this activity? What additional information would be helpful for me to include?
Economic direct influence on the health of citizens, including the conditions of employment, income, financial stress, and socioeconomic dislocations

In some communities, it is relatively easy to describe the local economy and its influence on community health, particularly if it has a single economic base—for example, a farming village, a tourist resort, or a manufacturing facility. In others, however, it may take several months or even years to reveal the true economic basis of a community. Many immigrant populations support their communities of origin with monthly remittances from relatives who have migrated to the United States. Similarly, communities may have an “underground” economy based on such activities as the sale of illicit drugs (Dreher, 1982b). In fact, the economic significance of such activities underlies much of the failure to reduce drug abuse in inner cities.

Government, Politics, and Law-Enforcement Issues

*Government* is the official structure, set of activities, and officials entrusted with the authority to make decisions on behalf of the community and to create and enforce the laws and policies that administer the community. *Politics* is a system of social relations in which access to and exercise of power are played out through *law enforcement* and in which *power* is defined most elementally as the ability to influence. Although politics exists at every level of human organization, people feel the effects most keenly at the local level of government. This is where governmental decisions enter the lives of citizens on a daily basis, such as the schools their children attend, the roads on which they drive, the police protection they receive, how their property is zoned, how waste is removed and sanitized, and the taxes they pay. A community culture inquiry must include the identity of local public officials, how they were vested with authority (elected, appointed, or inherited), and how they vote on issues of health and welfare. This is essential information for explaining current health issues, understanding current public health priorities and programs, and mobilizing the community for future health action. Political parties may or may not be represented at the most local level, and it is not uncommon to have two or three independent candidates running for office, each with his or her own individual agenda and constituency. On the other hand, many communities have a dominant political-party affiliation that party
leaders acknowledge through governmental assistance in return for community-wide support.

**Suggested Activity**

Do the following:

- Describe the formal structure of the local government.
- Identify local sources of public revenue (property and sales taxes).
- Describe the election process.
- List the elected representatives for the community and their party affiliations.
- Summarize the political-party representation in the community, including recent trends.
- Describe the law-enforcement organization for the district.
- Describe the penal system.
- Describe community members’ perceptions of how accessible and responsive local representatives are to community members.
- Describe community members’ perceptions of the sufficiency of the law-enforcement and penal systems in the community.
- List any current or recent political controversies in the community. Are any community health implications associated with these controversies?
- Summarize the local government’s health department and officials responsible for overseeing the health of the community (e.g., list the main programs of the local health department).
- Specify the local government’s budget for health.
- Specify the voting records of elected officials on health issues.

**Critical Thinking Questions:** What additional discoveries have I made during this activity? What additional information would be helpful for me to include?
The *tax structure* is the place in which economic institutions and political institutions come together. The concern of citizens over an increasing tax burden created by government initiatives—no matter how wholesome for the public they may be—is very real and can be a major deterrent in planning and implementing a healthy community agenda. The scattering of nuclear power plants throughout the northeast corridor of the United States in previous decades, for example, provided tax relief as well as employment opportunities for the citizens of small towns. Although this trend generated some local resistance—centered mainly on health and safety hazards for future generations—the short-term tax-reduction advantages to citizens were difficult to counter.

**Domestic Issues**

The terms *household* and *family* often are used synonymously, generally because in American society, they often refer to the same group of people. Family, however, refers to those related by kinship ties, whether by blood, adoption, marriage, or convention; and household refers to those who share a living space. Although these are grossly oversimplified definitions, it is easy to see that depending on how family is defined, it is possible to have households composed of more than one family and families comprising more than one household. Communities differ greatly in the ways their populations are organized into families and households. Some are divided into single-household units, occupied by nuclear families consisting of a mother and a father or a same-sex couple and their unmarried children. Others are much more complex and contain a variety of domestic arrangements. Extended families may occupy several households located in proximity, with extensive and routine visiting among them. In migrant-worker and refugee communities, it is not uncommon to have several unrelated individuals and families occupying the same household.

The household is just as important as the family. Households generally are composed of people who eat and sleep in the same dwelling and who are in routine (usually daily) contact. It is common for household members to have mutual caregiving functions, although it is not at all unusual for these functions to be shared by family members and others who are not part of the household. Because the household often is the unit of personal healthcare, trends in household structure...
and the implications for the health of the public are important to monitor. In some communities, it is not uncommon for multiple individuals who are unknown to each other to rent separate bedrooms but share the rest of the house. This type of household may entail no familial or close relationship, but the space and facilities are shared, and the residents live in close contact. This kind of housing arrangement can be seen in communities with a shortage of housing or where the cost of renting one’s own space is prohibitive.

**Suggested Activity**

Do the following:

- Describe the variation in domestic composition of households.
- Report the percentage of single-parent households.
- Determine the average number of children per household.
- Report the percentage of unmarried heterosexual couples living together.
- Report the percentage of unmarried same-sex couples living together.
- Ascertain the expected roles of family members—for example, mother/father, husband/wife, child/parent, and child/grandparent. Identify distinctions that exist in same-sex couple households.
- Describe the norms and rules governing courtship and marriage.
- Determine the legal age for marriage without parental consent for heterosexual and same-sex couples.
- Find out the average age at which people are first married.
- Report the rates of divorce, separation, and annulment.

**Critical Thinking Questions:** What additional discoveries have I made during this activity? What additional information would be helpful for me to include?
The norms governing family, marital, and domestic life underpin some of our most ingrained institutions and often differ widely from culture to culture. It is imperative to set aside our own values regarding domestic life and not criticize how families are organized in households in other communities. For example, rather than supposing that the children of divorced parents are victims of a broken family, we could reframe them as children who have the benefit of belonging to two households with loving and protective parents. Moreover, in situations where there is only one parent, unofficial or “adopted” mothers and fathers often emerge from among friends, relatives, and neighbors to create a more healthful psychological environment than that which existed when the biological parents occupied the same household.

Another kind of family structure that has emerged over the past two decades is that of same-sex couples, including those who have married or publicly declared their commitment and share a residence, sometimes also raising children. Most recently, the Supreme Court has declared the right of same-sex couples to marry, although it continues to be controversial in some states and communities. Because the level of social acceptance of a gay/lesbian sexual orientation has been uneven, Healthy People 2010 set forth sexual identity and orientation as a topic in which health disparities occurred. In Healthy People 2020, lesbian, gay, transgender, and bisexual health has been added as a new topic area.

For gay men, health issues include HIV/AIDS, substance abuse, depression, and suicide, while for lesbian women, some evidence points to higher rates of smoking, alcohol abuse, obesity, and stress. For both groups, personal safety and mental health are critically important issues (Healthy People 2020). The CDC State of Aging and Health in America report (2013, p. iii) has prioritized the need to address lesbian, gay, bisexual, and transgender (LGBT) aging and health issues.

The social conventions pertaining to the sequence of courting, living together, marrying, and having children differ greatly from society to society. Some couples choose to not marry yet live as committed partners, often due to economic considerations. For those who marry, marriage may be arranged without a period of courtship, and pregnancy may occur without marriage. In some cultures, it is common to attend a marriage ceremony in which all the children (and sometimes
the grandchildren) of the couple are members of the wedding party. Traditions that may appear exotic to the outsider are supported in their communities (Dreher & Hudgins, 2010; McElroy & Townsend, 2004).

Religion

**Suggested Activity**

Do the following:

- List, by religious affiliation, the churches, temples, mosques, and other places of worship attended by residents in the community, and locate them on the map.
- Determine the size and average attendance and days and times of the week that each congregation participates in religious activities.
- Identify whether the congregations have websites and which elements of the groups and/or worship centers could potentially be leveraged for the healthy community agenda and/or community action.
- Identify which religious groups are increasing in membership and which are decreasing.
- List the names of the clergy of the various churches and/or worship centers.
- Describe the role each religious facility plays in the healthcare of the community (e.g., does it have a parish or faith-community nurse?).
- Identify the religious groups that have taken leadership positions for neighborhood or community health activities.
- Identify minority religious groups in the community.
- Identify agnostic/atheist groups in the community.
- Describe religious expression observed in the community (e.g., Crosses, Star of David, Star and Crescent, Om, or Ahimsa hand).

**Critical Thinking Questions:** What additional discoveries have I made during this activity? What additional information would be helpful for me to include?
The health of a community is heavily influenced by local religious institutions in the organization of services and as vehicles of social and economic support for their members. Although many of the earlier direct-care functions have disappeared, some religious groups remain strong community advocates for health and bring considerable cultural capital to the public health table for migrant health, senior citizen–health promotion, care of preschool children, neighborhood improvement, and school-violence abatement. The Catholic Church, for example, is the largest provider of nongovernment healthcare and education in the United States. Faith-based philanthropies, such as Jewish Federation and Catholic Charities, provide substantial community benefit to underserved populations and are important private-sector partners with local public health departments.

Many religious institutions play a significant role in reducing health disparities with funds, equipment, and health and social-support services, such as cooking and housekeeping, disease prevention, and health-promotion activities. Even if they do not participate directly, religious institutions often lend their facilities to community health services, such as after-school programs for teenagers, child day care centers, senior centers, and sites for health fairs. Like other institutions, organized religions not only have buildings and activities; they have leaders and officials who are likely to have considerable influence in the community and can support particular health projects. Religions are key institutions for resolving community health problems (Peterson, Atwood, & Yates, 2002).

Prevailing religious beliefs involving diet, pregnancy, family planning, and terminal illness must be considered in the development of community health education and programming. Furthermore, certain religions may impose injunctions on common public health screening or prevention procedures. Finally, the relationship between religiosity and mortality, suggested more than 30 years ago in the Alameda County Study by Lisa Berkman and Leonard Syme (1979), has been confirmed, with continued lower mortality rates for frequent attendees of religious services. This correlation appears to be explained by improved health practices, increased social contact, and more stable marriages (Strawbridge, Cohen, Shema, & Kaplan, 1997) as well as more emotional support, a sense of spiritual connectedness, optimism, and better health in old age (Krause, 2002).
Education

**Suggested Activity**

Do the following:

- Describe the local governance of the public school system.
- Identify pre-college-level schools—including public, alternative, and private—that serve the population, and locate them on the map.
- Determine the number of families who homeschool their children.
- Determine the approximate enrollment in each school or program.
- Describe the administration of the local public school system, including the following:
  - The function of the school board
  - The composition of the school board
  - How board members are elected or appointed
- Describe how the superintendent of schools is selected.
- List the names of the principal of each school.
- Describe the function and role of the school nurse. For example, how many people (children and school personnel) is the school nurse responsible for? Who are the ancillary personnel assisting with the care of the children? What type of training do school personnel receive to manage medication and health concerns when the nurse is not available?
- Describe other health services, including health and physical education curricula, offered through the schools.
- What kinds of special services are available for children with physical and mental disabilities?
- Identify the educational institutions that are used for adult learning in the community.
The local school is a vital influence in the life of the child and family, and the school system is an essential component of a community’s cultural capital. In addition to traditional screening in the form of physical, vision, and hearing exams, the school system provides free and reduced lunches and some breakfasts for low-income children as well as after-school care. School nurses work with trained ancillary personnel to manage acute and chronic health conditions and engage in health promotion, with educational and screening programs for such issues as depression, drug abuse, sex education, dental health, vision, nutrition, and hygiene. Some schools also provide primary care with school-based health clinics staffed by nurse practitioners, offering healthcare for low-income and uninsured children who may otherwise encounter barriers to healthcare services.

Many schools have a strong sense of community and are the setting for family fun nights and health fairs where children as well as their families can learn about health-related topics together. Schools maintain information about the numbers of children receiving free and reduced lunches, which helps identify pockets of low-income families who may have greater needs for health surveillance and services. School records on absenteeism provide an excellent source of data for case-finding and epidemiological investigations. Developing relationships with the principal, school secretary, and teachers of each school creates a foundation for efficiently reaching the majority of children and families in a community. Many states mandate the employment of a school nurse at the elementary and secondary levels. The role of the school nurse encompasses the totality of the school-health program, incorporating primary, secondary, and tertiary prevention strategies and creating a healthy school environment that provides a safe, supportive social environment and learning milieu for all children.
School boards differ in the degree of influence they exert on schools. Some retain great control over every aspect of school life, while others leave the administration to the principal and limit their input to financial matters. The composition and philosophy of the board influence school health programs. In addition to getting to know the principal and teachers, it is valuable to meet the board members, especially those with a known interest in health topics, to enlist their support in building community capacity.

Adult-education classes have become increasingly popular and provide an effective mechanism for offering health-related courses, such as CPR and emergency care, parenting, and stress reduction. Expert faculty members can assume a leadership role in promoting a healthy community agenda. The effectiveness of our schools and colleges and the ability of public health workers to reach all members of the community are central to public health.

Recreation
Play and recreation are important components of all societies. Recreation is directly related to health in its capacity for providing exercise, for meeting physical and psychological challenges, and for offering relaxation and stress relief. The promotion of organized recreational activities, such as at supervised playgrounds and parks, has been a significant public health intervention for reducing accidents and promoting the safety of children. Recreation generates social interaction in the form of teams and clubs that can break down barriers and create the sense of unity that symbolizes a healthy community.

Recreation also can also be engaged in by taking time to relax and enjoy books, magazines, radio, television, and the Internet. These recreational activities also serve a communication function and are important resources for public health education, particularly in the area of health promotion, prevention of disease, and personal management of health problems. The Internet provides ready access to a range of health information and rapid communication. Practically all women’s and family magazines have health columns. Television shows, movies, soap operas, and novels deal with a variety of health problems, including driving while intoxicated, teenage suicide, drug abuse, family violence, living with chronic
illness, Alzheimer’s disease, and death and dying. Sensitively written and framed within the cultural experience of the audience, they can be valuable teaching tools as well as vehicles for mobilizing community action (for example, through a community reading program). The timing of health education or health-screening programs to immediately follow a television drama that has generated the interest of the public can help ensure its success.

**Suggested Activity**

Do the following:

- Describe how community residents spend their leisure time.
- Locate and identify recreational areas and facilities. These include formal recreation facilities (e.g., parks, playgrounds, theaters, zoos, golf courses, public pools) and informal recreational facilities (e.g., streets, vacant lots, swimming holes).
- Describe the quality, accessibility, and use of recreational facilities.
- Locate publicly supported facilities, commercial facilities, and/or age-designated facilities (e.g., for children, adolescents, senior citizens).
- Describe where children go to play.
- Note the times of the day and the week generally reserved for leisure activity.
- List the agencies and personnel specifically concerned with community recreation and leisure.

**Critical Thinking Questions:** What additional discoveries have I made during this activity? What additional information would be helpful for me to include?

Although recreational and leisure facilities offer distinct advantages for the purpose of promoting the health and safety of community residents, they can also generate community health problems. Excessive alcohol consumption or a “binge-drinking culture,” for example, can have serious consequences for communities.
The safety and sanitation of public recreational facilities is another component of community practice. Broken bottles and rusty cans left in the park or on a beach can cause serious injuries. Some leisure and play activities place the participants at risk of personal injury and therefore require appropriate community resources to prevent and manage potential injuries. Although individuals and groups should not be prevented from the pleasures of mountain climbing, motorcycle riding, driving ATVs, scuba diving, running marathons, cycling, and playing football, they all carry considerable risk for injury and cost that may be borne by the community. Such sports as boating, snowmobiling, skiing, or skating may require public health–initiated regulations, injury-prevention programs, and trauma services.

Voluntary Associations

**Suggested Activity**

Do the following:

- Identify the voluntary organizations in the community by type:
  - Social
  - Economic
  - Religious
  - Educational
  - Political
  - Recreational
- Identify the leaders of each organization.
- Identify when, where, and how often they meet.
- Identify informal associations and groups within the community.

Critical Thinking Questions: What additional discoveries have I made during this activity? What additional information would be helpful for me to include?
A culturally acceptable and efficient way to establish partnerships for action is to engage existing community groups. Voluntary associations are very important assets in a community to help in building community capacity. They represent strength in leadership and membership that can be readily deployed by community/public health nurses to solve community problems and promote community health. Each of the institutions already discussed has its own voluntary associations consisting of groups of individuals who are bound together by a common interest. Therefore, there are many kinds of voluntary associations based on their stated purposes. One category, for example, consists of those based on common socio-demographic characteristics, such as age (teen groups, young adults), ethnicity (Polish American clubs, Sons of Cuba), and attendance at the same school (alumni associations, fraternities and sororities). Often, local branch associations are tied into national organizations and are highly formalized, such as the Masons or Elks clubs. Organizations that are national or international in scope are important resources for obtaining support from outside the community.

Typical economic voluntary associations are the chamber of commerce, trade associations, professional societies, or Kiwanis clubs. Occupational groups form to control and oversee various aspects of their trades or professions. Government and political associations, political-party branch organizations, and citizens’ councils, such as the League of Women Voters, usually function to influence legislation locally and/or nationally. Voluntary associations also provide protective services, such as fire and police protection. Parent-teacher associations are perhaps the best-known of all educational voluntary associations, but others include voluntary library services and bookmobiles as well as travel societies, book clubs, and honor societies. Organized religion has led the way in establishing voluntary associations to carry on community activities. Church brotherhoods or women’s committees, the YMCA, the YWCA, B’nai B’rith, and Jewish community centers are all examples of religious voluntary associations. Many recreational and artistic activities also are organized on a voluntary basis, including athletic clubs, choruses, bridge clubs, dance and theater groups, and chamber-music ensembles.

Voluntary groups ordinarily are formalized with titles and charters, regular meetings, and criteria for membership. Other groups are more informally organized
but equally important. These include teenagers who routinely meet in the local shopping mall, elders who eat breakfast at the same restaurant every morning, and men who gather each evening on a street corner or play chess in the park. Even though such informal groups are more difficult to identify and appear to be leaderless, they may have even more community influence than formal groups and provide a constituency that could lend valuable support in creating and implementing a culturally informed healthy community agenda.

Practically all voluntary associations serve functions beyond their stated purposes, including lobbying politicians or helping members acquire jobs or borrow money. In addition, holding offices in voluntary organizations gives people a chance to pursue leadership opportunities and attain status. Many join voluntary associations as a form of recreation, even if the goals of the association are not recreational. Voluntary associations also help newcomers to the community fit in and meet others with similar interests. Voluntary associations provide social guidance, imposing injunctions on the behavior of members and requiring that they conform to specific standards. Alcoholics Anonymous, for example, and other self-help groups have blossomed into a panorama of mutual assistance and support, gaining public attention for addressing such health problems as obesity, smoking, cancer, muscular dystrophy, diabetes, and Alzheimer’s disease. Many groups focused on health issues and problems were inspired and organized on the local level by nurses who recognized that affected individuals could relate to and learn from others with the same problems, knowing they had undergone similar experiences.

**Horizontal Divisions of the Community**

Differences in wealth and status exist in practically all communities, no matter how small and homogeneous they first appear. These differences, when examined at the population level, constitute social classes of people that correlate more or less closely with income, educational level, and occupation. Social class represents categories of people of similar social rank having positions, responsibilities, possessions, and accomplishments of a more or less equal level and value.
For those who are unfamiliar with a particular community, patterns of class stratification and socioeconomic differences between residents may be barely distinguishable, particularly if all citizens in the community have limited access to resources. Residents will often deny the existence of social classes in their communities. Even so, the recognition of socioeconomic differences is of critical importance in understanding the community’s social structure and power relationships. The differences that exist on the community level may not always—in fact, often do not—reflect the class differences that exist on the national level. They are nevertheless consequential for the community and are acknowledged by community members.

Most residents have an awareness of their position in relation to others. It is difficult to find a community where differences in status, income, and access to scarce resources do not exist. Even though social classes are not formally organized groups, like voluntary associations, they have lives of their own. People enter them through birth or marriage or, with some difficulty, through the acquisition of socioeconomic resources and power as they progress through life. Although there is no formal membership process for entering a class, to be counted among a specific rank requires that others judge you to be so. This acceptance often is more difficult to obtain than the more formal membership of voluntary associations.

Suggested Activity

Do the following:

- Describe the major socioeconomic levels in the community.
- Identify the socio-demographic variables and social institutions that distinguish these levels.

Critical Thinking Questions: What additional discoveries have I made during this activity? What additional information would be helpful for me to include?
Generally, it is assumed that income, family name, occupation, residence, and education guide the social ranking of individuals. This is not always the case, however, as the criteria for determining social rank vary from community to community. Any member of the community may assume symbols of high social status, such as manner of dress, etiquette, residence, and car, but these symbols do not mean the person is actually a member of that class. Moreover, the upper echelons as well as members of this individual’s own social rank may criticize him or her for trying to imitate those of a higher social rank. Nor can one assume that wealth and a profession will automatically qualify a resident for a particular social class. Although the actual ranking of individuals or households in terms of their socioeconomic status is not within the scope of this book, we can learn much about the culture of a community simply by the way people group themselves for social interaction—particularly in the areas of recreation and education. Because friendships and social activities often tend to follow class lines, the task of delineating socioeconomic strata for a particular community is not as difficult as one may anticipate. Church memberships may embrace a wide range of social levels, and the workplace may include all ranks present in the community, but it is less likely that people of different classes will socialize routinely. The presence of private schools in a community along with the public school system also provide some clues as to how individuals rank themselves and each other. The horizontal division of the community reveals the most fundamental power structure of the community. The support of people in the upper strata of the community is extremely helpful in accessing certain kinds of cultural-capital and building-community capacity. The same people, however, also can pose serious obstacles or threats to community health action.

**Vertical Divisions of the Community**

In contrast to horizontal divisions of a community, vertical divisions are those sectors in the community that are not necessarily related to socioeconomic status or classes but that nevertheless organize the community into subgroups. Depending on the community, these could be organized according to racial, ethnic, residential, religious, political, or occupational factors. A familiar example of vertical division of a community is the urban neighborhood composed of two or more
dominant subgroups—such as Irish and Italian or African American and Puerto Rican—each of which may or may not express a full range of class or socioeconomic differentiation. Even though they may live side by side, the two groups may vote for different political candidates, have different social clubs, participate in different recreational activities, belong to different religions, and enjoy different family lifestyles. Although they may intermingle on a daily basis, when there is a dispute between representatives of the two factions, it is likely they will support their respective groups.

**Suggested Activity**

Do the following:

- Identify the vertical divisions of the community by type.
- Describe them in terms of differences in their institutions and socio-demographic characteristics.

Critical Thinking Questions: What additional discoveries have I made during this activity? What additional information would be helpful for me to include?

Although people within these diverse segments share a common affiliation, they are rarely homogeneous, with social class, age, and religious differences prompting differences in values and lifestyles. Segment boundaries are permeated through marriage and childbearing so that some residents eventually claim membership in more than one social segment. These are important residents, because they often have influence that spans the whole community. Such vertical divisions are not limited to ethnic groups. Communities may be divided by such characteristics as residence (apartment dwellers, homeowners, and homeless), politics (Republicans, Democrats, and Independents), or religion (Christians, Jews, and Muslims). Traditional conflicts between farmers and ranchers suggest similar factions based on occupation and the competition for land and water. In some cases, vertical divisions in a community are not easily discovered and only become evident in times of conflict.
Similar to classes, vertical divisions in a community may not be formally organized groups in the sense of having regular charters, membership status, formal leadership, explicit rules of behavior, or routine meetings. Rather, they arise when a group of citizens has something in common that differentiates them from another group within the community. Despite the lack of officers, a charismatic leader is often heartily endorsed by other members of the group, someone who is highly persuasive, has the ability to sway large numbers of people, and influences citizen action, including elections.

For many people, the term *community* implies relationships of equality among its members. This discussion of social organization clearly shows that communities are, in fact, complex entities, made up not just of an environment and people but also of diverse institutions, classes, and groups with interests and goals that are sometimes shared and sometimes in conflict. It is important to know which segments of the community can be counted on to support a particular project and which cannot. It also is important to know which themes and activities unite community residents of various classes and segments and which separate them. It may be difficult, for example, to change public policy unless all the dominant segments of a multicultural community support the effort. The strategies for mobilizing citizen action for capacity building are discussed in Chapter 7, “Laying the Foundation for a Healthy Community Agenda,” and Chapter 8, “Leading Culturally Informed Community Action.”

Unlike the tangible physical environment and unlike people, we cannot always see or touch a class, an institution, or a vertical division of a community. A series of diagrams depicting the horizontal and vertical divisions of a community in relation to each other and to community institutions can be very helpful to illustrate the social system and its points of intersection and cleavage. If, for example, the class structure were diagrammed according to religious institutions, it might be found that in some communities, all social levels attend the same church. This would thus be a *point of intersection* in the community—that is, a place where the nurse could reach a broad range of community residents as opposed to a specific segment.
**Suggested Activity**

Diagram the horizontal and vertical divisions of your community to look for points of intersection and points of separation, as in the following example.

**Horizontal Divisions in a Small Town with a Single-Purpose Economy**

<table>
<thead>
<tr>
<th>Stratum</th>
<th>Religion</th>
<th>Economy</th>
<th>Schools</th>
<th>Recreation</th>
<th>Domestic</th>
<th>Housing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper elite</td>
<td>Catholic</td>
<td>Factory owner</td>
<td>Private schools</td>
<td>Tennis</td>
<td>Nuclear</td>
<td>Owners</td>
</tr>
<tr>
<td></td>
<td>Anglican</td>
<td>Professional</td>
<td>Catholic schools</td>
<td>Golf</td>
<td>Older couples</td>
<td>Large single family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Business</td>
<td></td>
<td>Sports fans</td>
<td>Single parent</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Health clubs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middle class</td>
<td>Methodist</td>
<td>Managers</td>
<td>Public schools</td>
<td>Camping</td>
<td>Nuclear</td>
<td>Owners</td>
</tr>
<tr>
<td></td>
<td>Catholic</td>
<td>Commercial</td>
<td>Catholic schools</td>
<td>Sports fans</td>
<td>Single parent</td>
<td>Renters</td>
</tr>
<tr>
<td></td>
<td>Baptist</td>
<td>Teachers</td>
<td>Private schools</td>
<td>Running</td>
<td></td>
<td>New tract housing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Government</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Trades</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Factory workers</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Unemployed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working class</td>
<td>Catholic</td>
<td></td>
<td>Public schools</td>
<td>Bowling league</td>
<td>Large extended</td>
<td>Owners</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Catholic schools</td>
<td>Sports fans</td>
<td>Single parent</td>
<td>Renters</td>
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</tbody>
</table>
Even though the community’s health status has not been addressed directly, simply looking at its environment, its people, and the ways in which people are organized and relate to their environment can help you identify many potential problems and concerns. This inquiry into the culture of a community not only exposes current health problems and predicts future ones; it also reveals the assets, strengths, and cultural capital that can be activated through citizen participation to build community capacity in the most culturally informed way.