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Review Article

The Role of the Community Nurse in Promoting Health and Human Dignity- Narrative Review Article

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Abstract

Background: Population health, as defined by WHO in its constitution, is out "a physical, mental and social complete wellbeing". At the basis of human welfare is the human dignity. This dimension requires an integrated vision of health care. The ecosystemical vision of Bronfenbrenner allows highlighting the unexpected connections between social macro system based on values and the micro system consisting of individual and family. Community nurse is aimed to transgression in practice of education and care, the respect for human dignity, the bonds among values and practices of the community and the physical health of individuals. In Romania, the promotion of community nurse began in 2002, through the project promoting the social inclusion by developing human and institutional resources within community nursery of the National School of Public Health, Management and Education in Healthcare Bucharest. The community nurse became apparent in 10 counties included in the project. Considering the respect for human dignity as an axiomatic value for the community nurse interventions, we stress the need for developing a primary care network in Romania. The proof is based on the analysis of the concept of human dignity within health care, as well as the secondary analysis of health indicators, in the year of 2010, of the 10 counties included in the project. Our conclusions will draw attention to the need of community nurse and, will open directions for new researches and developments needed to promote primary health in Romania.

Keywords: Health, Welfare, Respect and dignity, Community nurse, Health

Introduction

The definition of health as it is formulated in the WHO Constitution from 1948 draws attention of the scientific world and of the practicing health care providers to the complexity of human nature, the dynamics of the risks it is exposed to and the need for activation and cooperation of protective factors. At the basis of the complex physical, mental and social welfare, which is considered equivalent to human health, are autonomy and the respect of human dignity.

Horton (1), who places dignity at the heart of health care ethics, recalls its definition given by Immanuel Kant, the philosopher who sees human dignity as an unconditional and incalculable value, which cannot be subject to negotiation. Jonathan Mann argued that human rights are reflected in health services only to the extent that care offering respects human dignity (2). Freedom, autonomy, capacity and human dignity are associated to the individual right to health (3) such as poverty and social inequality, the last having strong impact on health, obstructioning the emergence and recognition of human dignity (1, 3). Dignity and respect are universal values that we experience, perceive and that manifest in our interactions with others, encouraging each other as partners of the

interaction. Marmot (3) states that respect for human dignity represents the attitude that should dictate the way we treat patients. An act of care which does not reflect these universal values turns the care recipient in an object that finds itself at the mercy of carers. Human dignity is given by the recognition of human greatness (4).

The respect for human dignity requires empathy, meaning an emotional resonance with each other, with those in distress, when talking about health care actions. The lack of respect for human dignity seems impossible in the interaction with human beings. When the attitude of lack of respect towards individual dignity is present in human interactions, the state of stress induced and maintained has a consistent negative impact on health and health carers (1, 3, 5). Jonathan Mann, whose work is often cited in studies of human dignity within health care (1, 5, 6), speaks of four types of violations of human dignity: to be ignored or insufficiently acknowledged, to be seen only as a member of a group and not as an individual, to have your personal space transgressed without your permission, to be humiliated, subject of humiliation. Health care is addressed to the sick persons in distress. This specific of the process of care requires a direct interaction with the person.The foundation of the services that provide care to persons in need, regardless of age, consists of respecting human rights, promoting autonomy, respect for the dignity and welfare of recipients. The hippocratic principle: primum non nocerae', contains implicitly the respect for human dignity and the avoidance of any inconvenience that may affect the success of care. When a person exposed to risk needs care and health services, the respect of his dignity and privacy is essential to prevent his depersonalization and loss of sense of control over life (7). The respect for human dignity translates into the involvement in taking decisions that concern his health and autonomy (4). The statistics show that loss of control on existential situations through which the individual passes is accompanied by an increase in cardiovascular disease (1). What we propose in this paper is to expose the dignity concept with impact on the success of health carers. Considering the attitude of respect of human dignity as compulsory and inherent to practices of the community nurse, we highlight statistical differences on the health estate of population in relation to the existence and functi-onality of the network of community nurses and health mediators (HS) from the communities that we focus our attention in this paper.

Defining the concept of dignity

Human dignity, a concept promoted by all regulations regarding human rights, is generally too little defined, being seen as a self-evident concept (5). In the recent years, a rich literature has florished regarding the reflection on this concept, and the practices based on it in human beings interventions. The definitions of concepts are not universally accepted and while some authors consider respect and privacy of the person as values integrated in the concept of dignity (8), other authors consider it as a value in itself. Walsh (8) defines human dignity as a person's right to choose and maintain control over health care benefits and respect arises as a facilitator of this right, through recognizing the person's qualities as a beneficiary.

Although the concept is vague, it is the epicenter of health care and health workers, even in the absence of a definition; they have a good intuition of it (9). Le Coz and Kachner (4) believe that "respecting the dignity of others is seen in the willingness to listen, dialogue, with full loyalty and authenticity ...". Nora Jacobson (6), in a meta-analysis of the existing papers on human dignity, establishes a usage of the therm at three levels: as an attribute of the relationship between god and man, as an attribute of the relationship between the individual and the society and as an attribute of the individual, placed between determinism and freedom. Nora Jacobson (6) speaks of two types of dignity: individual and social.

Cultural influences on the concept of dignity

At the individual level, human dignity is implicit to the concept of quality, values, life, as well as personal values; at the societal level, it is a concept sine qua non associated to healthy human interaction, representing, at the same time, a spiritual value (5). Therefore, respect for individual dignity

should be reflected both in the way we interact with the human being in pain when we provide needed care, as well as in social health policies aimed at wellbeing of persons (3).

Dignity and respect, as spiritual values, are profoundly influenced by the culture of the society. Romania is considered a strong traditionalist country with values that are predominantly dictated by the act of survival (10). Dignity and respect are more difficult concepts to be placed in the value chain of such a society. Non-participation, an attempt to solve problems without asking for help, feeling that life is hard instilled in children's education, obedience, violent rejection of all social categories that do not subscribe in the social norms of common mind, the power of religion are characteristics of such a society. Showing respect and dignity in human interaction is likely to fade. Despite the cultural context, the way in which a person is seen and treated by others with whom they interact will affect the self-image of the person regarding his value; the respect for others will become self-respect and a sense of personal dignity. Through educational function, family, school, community communicate those values to the children, thereby perpetuating from one generation to another, the specific cultural frame.

The ecosystem vision promoted by Bronfenbrenner (11) states that the health system is placed at the macro social level, being strongly influenced by the values of society. In his most recent writings (12), he draws attention upon the fact that overlapping systemic levels are circumscribed by the kronosystem that introduces the time coordinate. The kronosystem favors both maintaining and changing their systems.

In the specific cultural framework of Romania, the reconfiguration process of the health system requires a fundamental review and guidance, from a human rights perspective. A real quality of health care change may result not so much from the acquisition of advanced techniques, but rather from the implementation of values of dignity and respect in the care act (1). On the other hand, as indicated by the systemic view, such a change would reflect and could positively influence the cultural framework of our society, as a whole.

Respecting dignity within health care

Experience shows that human rights succeed to overcome rethorics and to have an impact on the medical services only to the extent where patients are directly involved in receiving care (13). Patient involvement is the essence of primary health care.

The community nurse is the professional who operates his activity by meeting the beneficiaries in their vital areas, at their homes. Such meetings require attitudes that reflect respect for human dignity of beneficiaries because 'Privacy, Dignity and Respect are all fundamental elements of interpersonal interactions." (13). Intensive promotion of primary health care, stipulated by WHO Declaration from Alma Ata (14) conducted to the increase of medical and social care staff within the community. This staff, with a strict training beyond medical training, is usually a member of the community and thus has credibility and respect, which increases the efficiency of proper behavior and educational impact of his interventions with the community members.

In Romania, promoting primary care at community level, as well as the system of values which these interventions rely upon, started relatively late, the first community nurses being trained only in the years 2002-2005 (according to UNICEF report, 2006). Recent standards of community nurses emphasize aspects regarding the attitude of respect towards the individual, family and community within primary health care and especially health education. Through the direct interventions of community nurses, but also indirectly, as a result of these interventions, victims of family or community violence, poor families, marginalized families, discriminated social groups, benefit equally, of health care, thus preventing the violation of human dignity (5). While official statistics of the health system are less sensitive to situations of failure, they Kingdom, in 2008, following an analysis of the quality of mental health care, "the director for quality commissioned a training programme for all grades of staff that would enhance nursing care through improving awareness of the need for respect and dignity as an integral part of the patient." (13). Mariana Chilton (5) creates an

enlightening picture on the negative consequences, at multiple levels, of the violation of human dignity (Fig. 1). When discrimination, violence, gender inequality, poor education level and inadequate housing conditions lead to increased risk behaviors, stress / anxiety and depression, these, in turn, will generate an increased vulnerability, reflected in the endocrine production of cortisol and leptin, and repeatedly, the incidence of contagious diseases such as HIV / AIDS, STDs, tuberculosis and cardiovascular disease, hypertension and nutrition will increase.

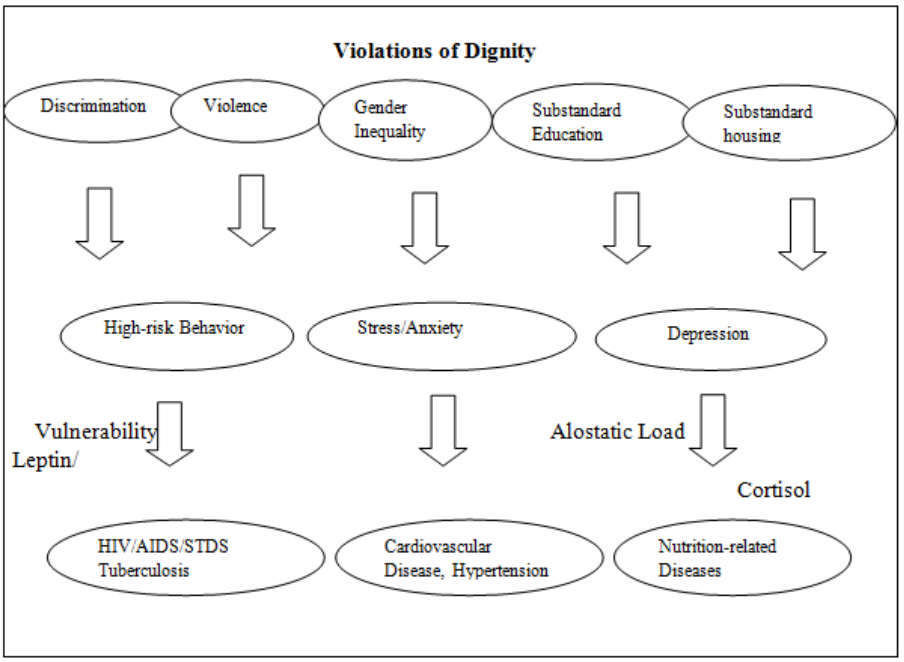


Fig. 1: The way in which the violation of human dignity affects health estate (Taken and adapted after M. Chilton, 2006, *P.*219)

Components of the concept of dignity applied in health care

WHO (15) calls for countries to develop health systems in which citizens are treated with respect towards their dignity. The standard equation of this idea, used internationally, is: Respect for a person = Autonomy + Confidentiality + Dignity. "Dignity is often associated with freedom, and their combination covers a set of human rights that are emblematic for what human development means: reasonable living standards, adequate nourishment and health care." (1).

In 2006, Mariana Chilton spoke about the concept of human dignity as being still insufficiently explored in the world of public health. Citing other authors who have promoted the concept of dignity in health care, Vanessa Lynne Griffin-Heslin (9), provides an analysis of the concept of dignity applied in care services, emphasizing the four essential components of this concept: Respect, including self-respect , respect for others, respect for privacy, confidentiality, confidence and trust in others; Autonomy, which refers to being able to choose, to allow others take decisions, to be able to take decisions, responsibility, respect for individual rights, needs , independence; Capacity (empowerment), meaning to feel important, valuable in relation with others, increasing self-esteem, sense of worth, modesty and pride; Communication, involving to allow time for exchange of information, explanation of information, understanding information, comfort, verbal and nonverbal communication. In a study supported by the European Commission, the team led by Gillian Woolhead (16) investigates the meaning and importance of respecting the dignity in health and social care of the elderly in six European countries. Woolhead & All (16) identifies four types of dignity: the dignity of merit, which follows from the position and social status; moral dignity, which is the moral autonomy or the integrity of self-esteem; dignity of personal

identity, specific to elderly population and reflects the sense of identity and self-respect; Menschen-wurde' which refers to the respect due to a person, regardless of their current health, but simply because he is a human being. In their conclusions, the team stated "Dignity, especially that of personal identity as well as the one related to menschenwurde was strengthened or, on the contrary, damaged, depending on the quality of communication between the patient and the professional." (P. 367). This impact of comm-unication on human dignity, which is the subject of care, is manifested through: forms of addressing, politeness and respect for privacy, foster a sense of personal value and including the person in the decision process regarding care.

The theme of our study

We propose here to highlight the impact of respecting human dignity in primary health care services offered by community nurses upon the health of the population in Romania. Exploring the concept of dignity, in the previous paragraphs, indicates that the vast difference between the cares offered by community nurses, compared to specialized medical services, is the inherent presence of an attitude of respect for the patient's dignity and mutual respect in interactions with each other. Given the impact of the attitude of respect for the dignity of the patient in regaining and maintaining health and considering the axiomatic approach in interventions made by community nurses, we try to capture differences regarding health estate of populations in areas benefiting from community nurses compared to areas lacking the presence of them. Comparing the statistics in the year 2010, on areas that have a good community nursery network and areas showing a weaker network, we want to see to what extent the presence of community nurses may be associated with higher health estate of local population. From all available indicators, we selected for our analysis indicators regarding: abortion, tuberculosis, sexually transmitted diseases and number of deaths. The conclusion will argue the need for training and employment of community nurses in all counties, as an infrastructure of a good health system reorganized on the principles of respect towards human dignity.

Framework for exploring the aspects related to dignity and respect towards the patients that benefit from health care in Romania

In 2006, Romania had a number of 485 community nurses and health mediators, located in 23 counties of the country, and Bucharest. Things have not changed much until the start of the project: Promoting social inclusion by developing human and institutional resources within community care, initiated by the National School of Public Health, through POSDRU programs. Within the project, there have been trained a number of 488 community nurses and health mediators in the 10 counties included in the project and there have been equipped 2-3 community health centers from each county. The project of the National School of Public Health has stimulated the interest of healthcare management structures towards the community care. Within the project, for the 10 counties involved, there were developed studies regarding the accessibility to health care services and the need for community nurses and health mediators depending on the risk factors specifical for different areas (Table 1).

This need is evaluated based on evidences and is significantly different from the official recommendations made by the Romanian Government, in which for every 500 inhabitants, a community nurse is needed. (Explanatory memorandum of the Government Decision, nr. 459/2010).

Results

The impact of the community nurses and health mediators network on the communities of the 10 counties

Using statistics reported by the Departments of Public Health (DPH) from the 10 counties, for 2010, we conducted a secondary subgroup analysis on the health indicators, as they appear in each county. The indicators used in our analysis are: abortion, tuberculosis, sexually transmitted diseases and number of deaths. The data in Table 2 shows the values of these indicators as well as the situation of the primary health care networks offered through community nurses and health mediators.

Table 1: The 10 counties from the Central and Western Region included in the project, with the existing network and the demonstrated needed risk factors taken into consideration

County's population 2010	Total needed community nurses	Community nurses employed in 2010/compared with needs n (%)		The difference for needed community nurses employees n %	Total health mediators needed	Health mediators employed in 2010 n %		The difference for needed health mediators employees n %	Total community nurses+ health mediators needed	Community nurses and health mediators employed in 2010/compared with needs n %	
373550	184	34	18	150	82	33	4	12	29	88	217	38	17.5
455210	233	10	4%	223	95	39	11	28	28	72	272	21	7.7
594534	297	0	0	297	100	46	13	28	33	72	343	13	3.8
322821	144	0	0	144	100	15	6	40	9	60	159	6	3.8
223487	105	2	2	103	98	12	9	75	3	25	117	11	9.4
325016	148	18	12	130	88	19	15	79	4	21	167	33	19.7
463964	193	30	16	163	84	12	2	17	10	83	205	32	15.6
579969	376	37	10	339	90	101	41	41	60	59	477	78	16.3
423627	220	25	11	195	89	44	21	48	23	52	264	46	17.4
669968	320	4	1	316	99	33	1	3	32	97	353	5	1.4

Table 2: Health indicators and the situation of the health care networks

Population 2010	Employed community nurses+health mediators 2010	Difference from the appropriate number of community nurses and health mediators	Abortion	Tuberculosis	Sexually transmitted diseases - siphilis	Deaths
373550	38	179	1223	198	33	4517
455210	21	251	1058	431	49	6133
594534	13	330	3606	272	53	5905
322821	6	153	1452	292	8	4294
223487	11	106	2611	72	14	2526
325016	33	134	1930	77	16	3654
463964	32	173	907	323	31	5784
579969	78	399	2864	433	72	7148
423627	46	218	1636	263	46	4516
669968	5	348	2922	558	73	7853

We selected for our analysis, the above health indicators (abortions, TB, STDs, and deaths) due to the fact that they all have consistency in their negative quality in relation with health. These are health indicators that place Romania in uncomfortable positions in European and international rankings. Regarding abortion, the daily journal Romania Libera from September 15, 2010, indicates that Romania ranks third in Europe. While recognizing that abortion is in a downtrend, and that this happens because of the primary health care network, abortion remains a current situation and attracts the attention of politicians and government. Tuberculosis, a disease of poverty and lack of education, places Romania on the 4th place in Europe, regarding the incidence of the cases. Romania is among the first 10 countries of Europe with regards to the number of patients and on the first place for the incidence of syphilis, the main cause being the lack of education. We are in the top European and international statistics

on deaths caused by tuberculosis, heart diseases, infections, smoking and traffic accidents.
The results are salient: Pearson correlations calculated between the difference of required number of community nurses and health mediators and the existing network (Table 2) and the mentioned health indicators are very high, showing that as the need for community nurses and health mediators, calculated in accordance with risk factors, is larger, uncoated, the broader the manifestations of such health indicators are. In the case of abortion, the correlation is Pearson's r=.57, (*P*=.05); on TB is r=.77 (*P*=.05); on sexually transmitted diseases, the correlation rises to r=.94, (*P*=.05); and regarding death, it has a value of r=.88 (*P*=.05).

Discussions

The secondary analysis is based on the existing statistics about whose accuracy in composition we cannot say anything. This situation represents, generally, a vulnerability of the studies based on existing statistics (17). The choice of the indicators was one based on the available data. On the other hand, we do a quantitative analysis for a task that of community nurses, which we assume and value as targeting a quality of carers. Although the positive or negative direction of the correlations, rather than their values, indicate the need for community nurses and their indispensable place in the community, the values of these correlations are small given the small number of community nurses and health mediators taken into account. To better highlight the correlations between the community nurses network and the quality of community health, we took into account the existing difference between the number of community nurses at each of the 10 counties covered by our study, and the community nurse requirements on each counties, calculated within the project of the National Public Health, Management and Education School belonging to the Health Field. We did this because the numbers expressing the lack of community nurses compared to the needs calculated based on the risk factors mentioned, are larger and allow a better statistical treatment, compared with the numbers regarding the community nurses and health mediators' network existing in the field, in the 10 counties.

Conclusions

Given the importance of the quality of human relations in stimulating healing and immunity capacity of the person community nurses is a condition of a real change in the paradigm of the offer of health services in Romania. As a suggestion, community nurses should not remain isolated, on the edge of medical services, but they need to be valued also as supervisors of medical practice of students (18). The benefit would be mutual, community nurses having support in their current activities and students would have the opportunity to learn how to communicate with the patient based on the values of respect, respect for privacy, human dignity. The differences between medicine in developed countries and developing countries is reflected in the very highest ethical intervention (4). The core of this ethic is human dignity (1). The concept of dignity could act as a catalyst for reviewing the philosophy and practice approach regarding human health care in our country, but also "to improve overall human health and promoting human development" (1). The concept of respect for human dignity and empowerment of the persons are confined to the practice of community nurses and health mediators. The evidence shown above, as well as the development of the concept of respect for human dignity in health care, conducted in this paper, leads to the conclusion that the proliferation of these primary practitioners, in areas with more or less access to specialized health services in Romania, may be the cornerstone of health system change in Romania.
The project of the National Public Health School has demonstrated, based on clear evidence, that the initiation of a network of primary care in the Romanian communities, in accordance with the vulnerabilities and the present risk factors, is less expensive than implementing the government decision, regarding the employment of community nurses. On the other hand, the argumented scientifical request for a community nurse network is

credible and may stimulate the effort of management structures for its realization.

Community nurses are a guarantee of direct increase of the individual and community well-being: directly, through education designed to help maintain health, as well as providing the necessary care for reestablishing it; indirectly by promoting respect towards human dignity. We may say in this respect that through the functions they can perform, community nurses are a pillar for community development, although, in our country, they are still rather in the horizon of desirability.

Ethical considerations

Ethical issues (Including plagiarism, Informed Consent, misconduct, data fabrication and/or falsification, double publication and/or submission, redundancy, etc.) have been completely observed by the authors.

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