TURKISH REPUBLIC OF NORTHERN CYPRUS

NEAR EAST UNIVERSITY

HEALTH SCIENCES INSTITUTE

To Determine the Satisfaction of The Community for the Services Provided by Health Organization on Self-Care and Response to Emergencies

By

QASIM AZEEZ ALI

SUPERVISOR
ASSOC. PROF. Dr. HATİCE BEBİŞ

NICOSIA, 2020

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CONFIRMATION

To the Directorate of Health Sciences Institute;

This thesis study was accepted by the jury on 24.08.2020 as a Master's Thesis in the Nursing Program of the Near East University Institute of Health Sciences.

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STATEMENT (DESTATEMENT (DECLARATION)

I hereby declare that the work carried out in this thesis itself was produced and originated entirely by myself in the Department Publich Health Nursing at Near East University. This thesis has not been submitted for any degree or other prusposes and I certifiy that the intellectual content of this thesis is the products on my own work and that all the assistance received in preparing this thesis and references has been acknowledged. I obtained all the information in academic and ethical rules.

Qasim Aziz Ali

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I would like my thesis to be a reason for developing the services provided by health organizations, especially zhian Health Organization in Iraq and refugee and IDP camps.

Special thanks to all my family members, they are the reason for my excellence in all fields, thank my friends and colleagues who helped me make my thesis successful.

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Qasim Azeez Ali

ENGLISH ABSTRACT

To Determine the Satisfaction of The Community for the Services Provided by Health Organization on Self-Care and Response to Emergencies

Introduction: Self-care has a remarkable effect on the health and treatment of the individual and is defined as the ability to improve and maintain the health of the individual.Individuals can be equipped with self-care skills and capacity by increasing their awareness about health issues, and non-governmental organizations can play an important role in health education in human health.

Objective: The aim of this study is to determine the role of Zhian Health Organization as one of the active healthcare NGOs to verify their self-health systems and respond to emergencies.

Methods: This study was conducted using descriptive cross-sectional design. It was held in Basra, Barika, Qushtapa, Kawrgosk and Dara Shkran primary health centers, from February 2020 to August 2020, under the Zhian Health Organization in Arbil, Iraq's Kurdistan Region. The working population was made up of internally displaced people (IDPs) and refugees (N = 120), who could receive services from these health centers in the region. The study sample consisted of N = 120 people selected with the appropriate sampling technique. Participants who volunteered for the study and in accordance with the research criteria were randomly sampled and studied with two groups (intervention group n = 60 and control group n = 60). The intervention group received health care services from the services of Zhian Health Organization more than two before, and the control group applied for these services for the first time. The data were collected by a questionnaire prepared by the researchers, using face to face interview technique and only as post test.

Data Analysis: The collected data were analyzed with the Social Sciences Statistics Package (SPSS version 21) using descriptive and inferential statistics. Findings and Discussion: Most of the participants (52.5%) were female and 47.5% were male. Their ages range from <19 to 58. Most (76.7%) were married and more than 85% had children. Most of the participants in both the intervention (91.7%) and control (78.3%) groups were extremely satisfied. The relationship between primary health care centers and satisfaction level was not significant in the intervention group (p = 0.041), and it was concluded that the intervention group was more satisfied. The nurses had different roles, including educators (33.3%), primary care providers (25.0%), case managers (16.7%), counselors (16.7%), and nurse advocates (8.3%).

Conclusion and Suggestions: According to the results of this study, it is recommended to develop well-structured health education programs in primary health care centers. It will be easier for the participants to increase their self-care awareness and consequently use the service, early diagnosis and treatment in primary health care centers.

Keywords: Healthcare satisfaction, personal care, primary health care, NGO role

TÜRÇE ÖZET

Toplumun Bir Sivil Toplum Sağlık Örgütü'nün Öz Bakım ve Acil Durumlara Müdahale Konusunda Verdiği Hizmetlerden Memnuniyetini Belirlemek

ÖZET

Giriş: Öz bakım, bireyin sağlığı ve tedavisinin dikkate değer bir etkisine sahiptir ve bireyin sağlığını geliştirme ve sürdürme yeteneği olarak tanımlanır. Bireyler sağlık konularında farkındalıklarını artırarak öz bakım becerileri ve kapasitesi ile donatılabilir ve bu bağlamda sivil toplum kuruluşları sağlık eğitimine insan sağlığında önemli bir rol oynayabilir.

Amaç: Bu çalışmanın amacı, Zhian Sağlık Örgütü'nün öz sağlık sistemlerini doğrulamak ve acil durumlara yanıt vermek için aktif sağlık hizmeti STK'larından biri olarak rolünü belirlemektir.

Yöntemler: Bu çalışma tanımlayıcı kesitsel tasarım kullanılarak yürütülmüştür. Basra, Barika, Qushtapa, Kawrgosk ve Dara Shkran temel sağlık merkezlerinde, Şubat 2020'den Ağustos 2020'ye kadar Irak'ın Kürdistan Bölgesi Erbil'deki Zhian Sağlık Örgütü'ne bağlı olarak gerçekleştirildi. Çalışma popülasyonunu bölgede bulunan bu sağlık merkezlerinden hizmet alabilen, ülke içinde yerinden olmuş kişiler (IDPS) ve mülteciler oluşturuyordu (N=120). Çalışma örneği, uygun örnekleme tekniği ile seçilen N=120 kişiden oluşuyordu. Araştırmaya gönüllü olan ve araştırma kriterine uygun katılımcılar rastgele örnekleme yöntemi ile alındı ve iki grupla çalışıldı (girişim grubu n=60 ve control grubu n=60). Girişim grubu **Zhian Sağlık Örgütü**'nün hizmetlerinden birçok defa sağlık himeti almıştı, control grubu ise bu hizmetler için ilk defa başvuruda bulunmuştu. Veriler, araştırmacıların hazırladığı anketle, yüz yüze görüşme tekngi kullanılarak ve yalnızca post test olarak toplanmıştır.

Verilerin Analizi: Toplanan veriler Sosyal Bilimler İstatistik Paketi (SPSS versiyon 21) ile tanımlayıcı ve çıkarımsal istatistikler kullanılarak analiz edilmiştir.

Bulgular ve Tartşma: Katılımcıların çoğu (% 52.5) kadın,% 47.5'i erkekti. Yaşları <19 ila 58 arasında değişmektedir. Çoğu (% 76.7) evliydi ve% 85'inden fazlasının çocukları vardı. Hem müdahale (% 91.7) hem de kontrol (% 78.3) gruplarına katılanların çoğu son derece memnundu. Birinci basamak sağlık merkezleri ile memnuniyet düzeyi arasındaki ilişki müdahale grubunda anlamlı değildi (p = 0.041), müdahale grubunun daha memnun olduğu sonucuna varılmıştır. Hemşirelerin farklı rolleri vardı, gibi eğitimciler (% 33.3), birinci

basamak sağlık hizmeti sunucuları (% 25.0), vaka yöneticileri (% 16.7), danışmanlar (% 16.7), ve hemşire savunucuları (% 8.3).

Sonuç ve Öneriler: Bu çalışmanın sonuçlarına göre, birinci basamak sağlık merkezlerinde iyi yapılandırılmış sağlık eğitimi programlarının geliştirilmesi önerilmektedir. Katılımcıların kendi kendine bakım bilincini arttırmasına ve buna bağlı olarak birinci basamak sağlık merkezlerinde hizmeti kullanma, erken teşhiş ve tedaviye ulaşmaları kolaylaşacaktır.

Anahtar Kelimeler: Sağlık hizmeti memnuniyeti, kişisel bakım, birinci basamak sağlık hizmeti, STK rolü

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ABBREVIATIONS

CMR:	Clinical Management of Rape
HC:	Host Community
HF:	Health Facilities
IDP:	Internally Displaced Person
KI:	Key Informant
KII:	Key Informant Interview
PSS:	Psychosocial Support
RH:	Reproductive Health
GBV:	Gender-Based Violence
ZHO:	Zhian Health Organization
MOH:	Ministry of Health
FP:	Famly Planing
NGO:	Non-Governmental Organizations
PHC:	Primary Health Care
PCPs:	Primary Care Providers
WHO:	World Health Organization
UNFPA:	United Nations Population Fund
UHC:	Universal Health Coverage
ACA:	Affordable Care Act
NICE:	National Institute for Clinical Excellence
CHPS:	Community-based Health Planning and Services
STI:	Sexually Transmitted Infections

INTRODUCTION

1.1. Problem Definition

The individuals' ability to promote and maintain their health is referred to as self-care. Raising awareness of healthcare issues is the first requirement for self-care. In this regard, a significant role is played by non-governmental healthcare organizations. There has been a rise in self-care health interventions since the beginning of the primary healthcare movement (Dalma et al, 2012), fueled by an elevated focus on empowering women (Murray et al, 2017), promoting the older people' internal capacity, and the role of self-care in the management of chronic diseases, including mental wellbeing (Lucock et al, 2011).

As defined by the World Health Organization, self-care is "the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a health-care provider". Self-care is highly significant for individuals particularly in low-resource settings such as regions with natural disasters and wars where it is quite challenging to have access to professional medical care. Healthcare systems can also benefit from self-care, such as improving health coverage and decreasing the level of burden on the healthcare providers (WHO, 2010; WHO, 2013). An emergency is a situation that causes health, life, property, or environment to undergo some levels of risk. Healthcare non-governmental organizations (NGOs) are primarily aimed at providing healthcare and rehabilitation services, and most of them work on health development and emergency response (Tucktuck et al, 2017).

Self-care can include a set of capacities and activities. It can be taken into account from two complementary dimensions; one is related to the association between self-care and the health system: people-centered and system-centered, and the other one aims to improve the individuals' self-care capacity (Narasimhan et al, 2019). An important component of effective management and prevention of a health condition is the individual's ability and capacity to use the available health resources and make wise health-related decisions. Health outcomes are determined by the individual's ability to get access to and use familial and societal resources which have a role in personal autonomy and agency. Therefore, self-care is figuring out methods to make good self-care possible and prevent cultural and social pathogenesis of self-medicalization (Dowrick & Frances, 2013). As a result, the ability to meet self-fulfillment, psychological, physiological, and physical needs is significant (Godfrey et al, 2011).

Since the ISIS invasion in 2014, there has been a rise in the number and prevalence of emergency situations in Iraq and the Kurdistan Region. There are a number of active healthcare NGOs in the Kurdistan Region of Iraq, which have been active since the overthrow of Saddam and invasion of ISIS. Such NGOs have served the region a lot during healthcare emergencies caused by war and natural disasters. Optimal results can be obtained while handling healthcare emergency situations if the public are trained how to carry out self-care practices. NGOs need to activate self-care practices by holding relevant programs of training the public, so that they can handle the emergency situations with more success (Nazar et al, 2010; Nazar et al, 2012).

Emergency situations that can have negative impacts on public health are increased by different factors like behavior, beliefs, healthcare services, socio-economic environment, population profile, physical environment, and political context (Musoke et al, 2014). Since the overthrow of Saddam in 2003 and later the invasion of ISIS in 2014, there has been an increase in emergency situations in Iraq and the Kurdistan Region of Iraq. The swarm of internally displaced people (IDPs) and refugees particularly to the Kurdistan Region due to its relative stability compared to other parts of Iraq has also added to emergency situations. There have also been some natural disasters like earthquakes and floods in the region recently, which has worsened the emergency situation. Therefore, healthcare NGOs need to adopt appropriate measures to handle emergency situations in the region. Self-care health interventions have been introduced as the most promising new approaches contributing to universal health coverage (UHC) particularly in emergency situations (WHO, 2019). It is the responsibility of the healthcare system and the related organizations (both NGOs and public entities) to establish a self-care system and boost self-care practices among the public, so the people know how to survive in disasters and emergencies.

Since self-care can promote and improve wellbeing and health, it is a significant element of people-centered care (WHO, 2013). In a people-centered care system, more emphasis is on self-fulfillment, empowerment, and psychological needs (WHO, 2010) and the individuals' self-care capacity rather than on technical activities (Brady, 2018).

So far, there have been no established self-care practices in Iraqi Kurdistan, resulting in an increased rate of casualties and loss in case of healthcare emergencies. In this regard, the active healthcare NGOs and the healthcare system in Iraqi Kurdistan region need to adopt appropriate

measures in order to train people about self-care practices and establish a self-care system in order to reduce the rate and severity of consequences in emergency situations.

1.2. Aims of the study

The aim of the study is to determine the role of Zhian Health Organization as one of the active healthcare NGO's in activating self-care systems and responding to emergency situations. In order to come up with results, the following questions were posed:

- What is the role of Zhian health Organization NGO in activating self-care systems?
- What is the role of Zhian health Organization NGO in responding to emergency situations?
- What is the role of different members of Zhian Health Organization NGO in activating self-care systems and responding to emergency situations?
- How can we improve the role of Zhian health Organization NGO in activating self-care systems?
- How can we improve the role of Zhian health Organization NGO in responding to emergency situations?

2. BACKGROUND OF THE STUDY

2.1. Health education

Health education refers to the education which is pertinent to health. In health education profession, people are educated about health (McKenzie et al, 2009). It covers different areas, including sexual and reproductive health education, spiritual health, intellectual health, emotional health, physical health, social health, and environmental health (Donatelle, 2009).

Another way to define health education is through the principles which people follow and result in the promotion, maintenance, or restoration of their health. However, like health to which numerous definitions have been propose, health education has also been defined in various ways. According to the Joint Committee on Health Education and Promotion Terminology of 2001, health education refers to "any combination of planned learning experiences based on sound theories that provide individuals, groups, and communities the opportunity to acquire information and the skills needed to make quality health decisions" (JCT, 2011).

According to the World Health Organization, health education is defined as "comprising of consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health" (ITGSE, 2018).

2.2. Person-centered care: From ideas to action

Health system reform across the UK is mainly aimed at enabling people to play active roles in their health. Patients already undertake a vast portion of their day-to-day care; however, if healthcare services do not support and involve individuals in their health actively, they will not gain much. The relationship between professionals and patients requires nothing less than a transformation. In this regard, effective techniques and that tools facilitate patient participation in their health care are also required (de Silva, 2011; de Silva, 2012).

As active participants in their health care, people can play many diff erent roles. In this regard, self-management and shared decision making are most highlighted roles in which individuals are their own health managers and make their health-related decisions. These two roles can be taken into account as the components of a broader person-centered philosophy of care; however, they are different in terms of their practices and concepts. By reviewing related

literature and clinical and understanding the conncetion between these two, one can figure out they can be implemented (Boger et al, 2013; Ryan et al, 2014).

Confusion about the connection between these forms of collaborative care has a further consequence which is not only a problem with definitions, but it can lead to very real implementational consequences. Understanding whether these are grounded in the same skill sets, behaviors and values or not can be beneficial for the attempts to embed self-management support and shared decision making in mainstream health care. There is also much to be obtained from understanding whether the practice and policy environment provides the same opportunities and drivers for change and whether it is associated with similar challenges or not (NHS, 2011; Lhussier et al, 2013).

2.3. The effects of education on health

Individuals' health cannot be affected merely by health education and apart from other factors. Another highly significant factor which interacts in many significant ways with education as an influence on health is referred to as income. Therefore, assessing their independent impacts is difficult. However, according to relevant empirical investigations, both income and education have remarkable effect on health (Chewning et al, 2012).

Individuals who have higher levels of education are willing to have healthier behaviors and better well-being and health. As a significant mechanism for enhancing individuals' well-being and health, education can lead to a remarkable decrease in human suffering, lost earnings, the associated costs of dependence, and the need for health care. Education can also assist with community, family and personal well-being; human relationships; promotion and maintenance of healthy lifestyles; positive choices; nurturing and support of human development. In this regard, the results of a study carried out in the US showed that an additional year of schooling in American individuals born between 2000 and 2010 leads to a reduction of death possibility the next 10 years by 3.6% (Saffron et al, 2011). According to the results of another study, an additional year of schooling in Swedish men born between 2010 and 2019 results in a decrease of 18.5% in the risk of bad health (Neil et al, 2019).

In their study of middle-income countries such as Uganda, Liliana and Christiaan (2019) ran and assessed a primary school construction project so as to specify how health was influenced by education. The results of their study indicated that child mortality dropped by about 10% from an average level of 22.5% as a result of a rise in the average number of years of education in the household. Moreover, the probability of smoking among American women during their

pregnancy has been reported to decrease by 5.8% as a result of their college enrolment and stay in college for a minimum of 2 years. This decrease is a large impact because of the fact that on average only 7.8% of the women in the sample smoked during pregnancy (Liliana & Christiaan, 2019).

Education can have negative effects as well. For example, uptake of preventative care might rise as a result of education, which can result in a short-run rise in healthcare costs but long-term savings. Also, individuals who have more education may take advantage of healthcare provision. In addition, education might lead to increased consumption of some forms of illicit drugs and sometimes alcohol. Finally, although depression seems to be prevented by education, research has shown that education has much less substantial effect on general health or happiness (Gakidou et al, 2010; Behrman, 2015).

It is also significant to pu emphasis on the fact that to the extent that education affects health occurs as a result of impacts on features of the self, particularly self-concepts and attitudes, then if the quality of education is not suitable to the individual's developmental needs, education can have directly unfavorable effects (Behrman, 2015).

2.4. The role of the health sector

Public health specialists are responsible for preventing and managing emergencies and disasters. It is noteworthy that success in disaster reduction is measured by rate of preserving life and health. In emergency sitations, health professionals will always be called upon to to lead (e.g. in the case of epidemics) and collaborate (e.g. in search and rescue operations). Therefore, in the face of disasters, health workers undertake the most visible and challenging responsibilities. As a result, their failure to accomplish their duties well leads to huge costs, including both lives lost and political and technical losses (Agüero & Bharadwaj, 2014). Implementing activities for disaster reduction, influencing national policies, and conceptualizing strategies areamong other responsibilities undertaken by public health professionals during disasters and emergency situations (Chou et al, 2010; Agüero & Bharadwaj, 2014).

The cornerstones of disaster prevention include the concepts of vulnerability, hazard, and risk with which health professionals are well familiar. They are also well aware of the apparent dualities of cure versus prevention and disease versus health. Similar rules and principles govern disaster reduction and disease prevention which are postulated in the philosophy of Primary Health Care and in the public health model (Keats, 2016). Human life and health can

be affected by any kind of disaster, and in this regard, it is crucial to evaluate in emergency situations. Moreover, similar to other disaster reduction strategies, health professionals utilize epidemiological surveillance which is a kind of early warning. Most disaster-relevant policies, including environment, habitat, safe water, food security, and population, are affected by health data and advice influence (Neil et al, 2019). Preparedness for emergencies at least in clinical terms is part of any health-related training to a certain extent. In a broader perspective, health experts and health services are present in a field that is matched by few others with regard to implementation capacity and acceptance by the beneficiaries (Makate, 2016).

Disaster reduction has specifically attracted the attention of the health sector because years of health development can be offset by a single disaster. Health services and facilities are invaluable assets for a country, its ministry of health, local authorities, and private investors. Sometimes emergency needs impose an unexpected overload upon the scarce resourcesof the health sector, which causes the health sector to be penalized (Neil et al, 2019).

In addition, each phase of disaster reduction can be remarkably affected by public health. Preventive care, including food safety, environmental sanitation, family planning, vector control, and immunizations can reduce a large number of vulnerabilities and hazards. Health advice and data are crucial for most inter-sectoral policies. If hospitals are not hazard-resistant, they might be destroyed when they are most needed. Through referral systems and contingency plans, which should be activated in case of disaster, health has remarkable impact on preparedness. Nutritional and health data play a significant role in early warning systems for all institutions and sectors. Cost-effectiveness of all other efforts can be ensured by decreasing suffering and death (Keats, 2016; Makate, 2016; Neil et al, 2019).

2.5. Mediation and moderation effects of education

If parents are educated, their children's health can be affected remarkably. An example of income can be used to describe this. The family's level of education has a direct effect on family income, such that the education level impacts income, and income in turn has an effect on children's health. Therefore, income might be begarded as a mediator of inter-generational education effects (Susana et al, 2019). However, the parents' education might also be protective because it decreases the level of risk to the health of the children, caused by low levels of income or poverty. In other words, families that have low income but relatively higher education levels might be better able to make for and be resilient against the influence of low

income on a child's health than parents having similar low income but lower levels of education (Su et al, 2019).

2.6. Healthcare management

There is a elevated global emphasis on chronic care management which is characterized by a complex interplay between healthcare system factors, healthcare providers, and patients (Carmen et al, 2016). Healthcare reforms initiated by the Affordable Care Act (ACA) in the United States result in modification that move to pay-for-performance model from the fee-for-service reimbursement model. The number of medical services was rewarded in the fee-for-service reimbursement model, while in pay-for-performance model, restrained costs, improved quality, and improved patient outcomes are encouraged and highlighted (Sommers & Bindman, 2012; Epstein, 2013; Damberg et al, 2014). These changes reflect transformational modifications for delivery systems and practitioners and for patients' beliefs, attitudes, and values. As recognized by delivery systems, patients are account for a significant resource in the process of health care because they make required lifestyle adjustments to enhance their health, decide whether or not to follow treatment regimens, and perform care management tasks on a daily basis. Without the patients' engagement, even the best practices on the part of healthcare providers will not result in optimal health outcomes and constrain costs (Ory et al, 2013).

These changes are mainly made by primary care providers (PCPs) who play a pivotal role in assisting patients achieve the required ends and outcomes. Many PCPs; however, have not received any training with regard to patient activation and support of patient self-management. In addition, they do not perceive themselves and their roles as clinicians like this. That is why a number of them do not accept or follow the strategies which involve partnering with patients to support patient behavior change and enhance self-management; therefore, they ignore it as not being a significant part of their profession (Hibbard et al, 2010; England, 2015).

Reviewing th literature reveals limited evidence for patients' positive perceptions of providers supporting self-management and patient engagement in self-management behaviors (Schmittdiel et al, 2008). Moreover, there are very few studies focusing on providers' beliefs about the significance of supporting patients in management of their health conditions (Dominique et al, 2019). In cases where a clinician has certain set of behaviors which might lead to lesser or greater patient activation, they can be considered as a point for making modifications that can finally lead to improvement in healthcare outcomes (Kimberly et al, 2016).

As a relatively novel measure of clinician support for patient activation, evaluating the role of PCPs in a single accountable healthcare organization is considered to be one of the major steps toward assessing the significance of the patients' role. In this regard, Carmen et al (2016) have studied how PCPs' views influence the patients' role following the frequent engagement of the PCPs in partnership-building and collaborative behaviors with patients to support behavioral change and self-management. According to the results of their study, compared with PCPs with low CS-PAM scores, those who have high CS-PAM scores are much more willing to engage in patient behavior change approaches and supportive self-management. There is positive correlation between improvements in level of patient activation and positive PCPs' belief in the patients' role in self-management (Carmen et al, 2016).

2.7. Educational status of therapeutic patient with chronic diseases

Aproximately 80% of the treated diseases in healthcare practice outside the hospital are chronic. Although medical research helps much of the treatment be significantly efficient, its quality is not satisfactory all the time. This is negatively affected by the fact that numerous patients fail to follow the instructions such that treatment is followed correctly by fewer than 50% of them (Janevic et al, 2012). Research has shown that patients are not well aware of their condition and that help has provided for a few of them in order to manage their treatment. There are a large number of physicians who are remarkably competent in treatment and diagnosis; however, too few of them teach their patients to should the management of their condition. Failure to teach patients might be due to various reasons, including lack of awareness of the need to do so or very limited time. Another reason is related to the fact that the primary training of most health care, particularly medical care providers, is basically on t he basis of diagnosis and treatment selection (Sell et al, 2016).

Although patients might acutely take advantage of therapeutic patient education, it seems to be a crucial part of the treatment of long-term diseases and conditions like the ones listed below (Ghahari et al, 2010; Sell et al, 2016).

Table 1: The major long-term diseases and conditions which required more detailed therapeutic education (Van et al 2017; WHO, 2019)

Different conditions	Types of disease
Renal disorders	Renal insufficiency, Dialysis
Respiratory system	Cystic fibrosis, Chronic obstructive pulmonary disease, Bronchial asthma
Nervous system	Visual disability and blindness, Parkinson's disease, tetraplegia and other traumatic brain injuries, Paraplegia, Multiple sclerosis, deafness, Hearing loss, Epilepsy
Musculoskeletal system and connective tissues	Rheumatoid arthritis, Osteoporosis, Osteoarthritis, Neck and back disorders, burns (sequelae), fractures, Limb amputation, Fibromyalgia, Arthritis and allied conditions,
Mental and behavioral disorders	Depression, Alzheimer's disease and Dementia, alcohol, drugs, tobacco and other substance abuse,
Infections	Tuberculosis, Poliomyelitis (sequelae), HIV/AIDS
Endocrine, nutritional and metabolic disorders	Dysfunction, Thyroid gland, Obesity, Diabetes mellitus, Addison's disease
Digestive system	Malabsorption, Gastroduodenal ulcer, Crohn's disease, Colitis, Cirrhosis
Circulatory system	Rheumatic heart disease, angina, Ischaemic heart disease, Claudication, Cerebrovascular disease (stroke), Cardiac insufficiency, Arterial hypertensive disease
Blood	Thalassaemias, Haemophilia
Allergies	Stomas (laryngotomy, gastroenterostomy), Cancer (all sites), Cancers and sequelae,
Other	Occupational injuries (sequelae),Organ transplant (sequelae)

Various kinds of therapeutic patient education are proposed in different settings of health care; however, their design and teaching are usually arbitrary and poor. There is an evident need for therapeutic educational programs of better quality. Patients often begin to deal with their disease by themselves; however, healthcare providers should utilize therapeutic patient education to make their patients' attempts more productive (Van et al 2017).

2.8. Management recommendations and treatment challenges

The combination of targeted treatment, early intervention and the use of treatment goals in line with improving the overall knowledge of patients is a new approach in medicine, which has been implemented in several disciplines over the last 5–10 years (Prato et al, 2010; Smolen et al, 2010).

A European Consensus group from 19 European countries, for the first time, has developed a combination of enhancing the patient's knowledge with individual treatment goals in various

diseases for promoting the consistent use of available therapies to improve patient care (Mrowietz et al, 2011). Thus, patients' perception of the effect of treatment will be increasingly incorporated in their treatment, and medical specialists will become more experienced to recognize the psychological aspects of patients' diseases (Kragballe et al, 2014).

In a similar way, as indicated by extra research studies, modifications lifestyle like taking measures to control depression, monitoring and modifying cholesterol levels within recommended ranges, exercising three times a week for 30 minutes, altering lifestyle to achieve an ideal BMI, and cessation of smoking need to be made in the overall care of patients (Kimball et al, 2008). Moreover, according to the recent National Institute for Clinical Excellence (NICE) guidelines for the assessment and management of patients' health state, healthy lifestyle information and support for behavioral change tailored need to be provided to the patients by health professionals so as to meet the individuals' needs (NCGC, 2012). However, according to the results of a new content analysis, very little attention is paid to behavioral modification skills in post-qualification curricula for health professionals in general practice. Moreover, there was no evidence of post-qualification training competencies pertinent to the provision of long-term support of modifications in lifestyle behavior and little or no reference to evidence-based approaches (Keyworth et al, 2014).

2.9. Patients with chronic diseases

Over the recent years, there has been a remarkable increase in non-communicable diseases like coronary artery disease, obesity, hypertension, and diabetes in the Kurdistan region of Iraq. The reason for this increase can be sought in unhealthy dietary patterns, lack of exercise, and lifestyle changes. Other reasons include smoking which has become a culture, consumption of fast food, popularity of soft drinks and artificially sweetened fruit juices, unhealthy diet (like excessive use of dates, bakery items, and fatty food) and decreased physical activity. All of the abovementioned factors can directly affect type 2 diabetes mellitus (T2DM), hypertension, coronary artery disease (CAD), and the risk of obesity (Salah et al, 2019).

Health status in the Kurdistan region of Iraq has faced with numerous challenges the most important of which being changes in lifestyle. According to estimates of the World Health Organization (WHO), non-communicable diseases will soon account for the main global cause of mortality and morbidity in Iraqi Kurdistan. Research has shown that patients suffering from chronic diseases fail to follow their doctors' instruction and usually cannot increase physical

activity or modify their dietary habits, which ends up in a higher risk of complications, especially among patients with hypertension and T2DM (Ali & Haydar, 2017).

Using either participation in health education seminars on general topics or tailored patient education to teach patients of chronic diseases about health profoundly influence the patients' knowledge and understanding of the risk of carelessness about their health. Survival can prolong and quality of life can improve through fundamental and lasting changes in the lifestyle and compliance with the doctor's orders regarding the pharmacological treatment regimen (Saleh et al, 2016). A large number of studies have now focused on how patient compliance is affected by health education. In the early 1980s, a meta-analysis which included a total of 320 articles on patient education indicated that compliance and lifestyle improvements can be positively affected by patient education, and that compliance was successfully changed as a result of patient education (Karadakhy et al, 2016).

In UAE, diet-related diseases were well addressed and focused on in a comprehensive integrated community-based intervention program for promotion of health and primary, secondary, and tertiary levels of prevention of non-communicable diseases. According to the results of another review study, nutrition-related chronic diseases can be efficiently managed through collaborative health education interventions (Abdelrahim, 2009).

Secondary level of prevention of non-communicable diseases is mostly accomplished by primary healthcare (PHC) centers all over the world. In PHC approach, people are regarded as those who are responsible for their own health; therefore, they need to be empowered with require knowledge in order to enable them to make decisions about their lifestyle and health. Therefore, obtaining good health is ensured following people's making their own decisions about their daily life routines and activities (Hossain et al, 2012). According to PHC principle, all people have the right to be provided with effective, affordable, practical healthcare services. Adoption of healthy lifestyles can be quaranteened through health awareness and education, whereby not only diseases can be prevented but also risk of complications caused by these diseases will be reduced. However, patients of chronic diseases (like hypertension and diabetes) are the target group of health education. Such patients pay regular visits to PHC centers in order to follow up their health status or replenish the supply of their drugs. Therefore, the primary and secondary levels of prevention will be provided with appropriate tools and facilities (Alvin, 2015).

2.10. Non-pharmacological treatments

For improving the overall health condition of patients, various non-invasive and non-pharmacological treatment approaches are commonly used. One of these non-pharmacological treatments is modifying lifestyle-related and psychological interventions which are the elaborated approaches that are mentioned within the present study (Smith et al, 2009).

2.10.1. Lifestyle change interventions

Many unanswered questions remain concerning the potential links between lifestyle factors and overall health conditions of patients. However, in recent years, there has been an increased interest in determining how lifestyle choices may affect the lives of patients' health conditions (Debbaneh et al, 2014; Karppinen et al, 2015). As stated previously, several studies have found that the overall health condition of overweight or obese patients is at risk more than others (Gisondi et al, 2015). Furthermore, obesity may reduce the effectiveness of treatment and increase the likelihood of adverse effects. In addition, a low-calorie diet with moderate weight loss (i.e., 5–10% of body weight) increases the responsiveness of obese patients to systemic treatment (Jensen et al, 2013). However, the question of whether weight loss may decrease the disease severity seems less clear. Some studies have shown positive results on disease severity after diet and exercise or after adherence to the Mediterranean diet (Barrea et al, 2015).

A recent review addressed the effects of different weight loss interventions on the patient's health condition (Debbaneh et al, 2014), where a number of studies suggested that weight loss may lead to health improvement and that such interventions may serve as a preventative and adjunctive therapy. Furthermore, this review revealed that gastric by-pass operations appear to be beneficial in some patients but that larger prospective studies are necessary to explain further the efficacy of these interventions.

There may be a negative link between obesity and exercise activity. In patients with poor health conditions, decreased levels of physical activity, possibly because of physical and psychological factors are more common (Torres et al, 2014).

2.11 The role of healthcare NGOs in health education in the world

The World Bank has defined non-governmental organizations (NGOs) as “private organizations that pursue activities to relieve suffering, promote the interests of the poor, protect the environment, provide basic social services, or undertake community development”. NGO can carry out their activities on international, national, or local scales. As important

partners of many governments – while remaining independent from governments, NGOs play an important role in the formation of societies around the world. Based on the global health partnerships (GHP) report, in 2015 there were more than 40,000 NGOs in the world, which shows a high growth from the 1990's (GHP, 2015). They have different; however, research (23%) and economic development and infrastructure (26%) are the major two categories. NGOs are typically considered to be precious health research partners for development. It should be noted that research is regarded as a wide process which involves both knowledge production and down- and up-stream activities required for its effectiveness and relevance, including knowledge translation and priority setting. By supporting effective and relevant research studies, NGOs have made and continue to make essential contribution in health research (Suguna & Surekha, 2016).

A very heterogeneous group of organizations form NGOs. Many NGOs are provided with their required funding by governments; therefore, they can be questioned if their operation is independent or not (Moran, 2014). That is why some claim that NGOs are in fact subcontractors of their supporting governments. In addition, NGOs play various roles, including development. However, MSF, which is the first medical humanitarian organization, focuses on mere humanitarian work and intends to keep itself away from the "development-oriented" manner of thinking. It should be stated that medical humanitarian action needs to be independent of initiatives that recommend models for models for society and development. However, there is this belief that increasingly humanitarian action should work within specified strategic frameworks of peace-building activities and long-term development perspectives (Peirson et al, 2012).

Operational and action research is primarily conducted by NGOs that are involved in health research; however, some also carry out other sorts of research like policy research, health services research, translational research, product development research, social science research, and epidemiological research. Limited funds directed toward populations suffering the world's greatest health problems and inequitable distribution of research efforts account for a major global health research issue. In this regard, it has been stated that only 10% of all health research fund is used to address 90% of the world's burden of disease, particularly in developing countries (Ali et al, 2017). Due to this imbalance, major attempts have been made to redirect research funds and efforts to the health problems dominating low- and middle-income countries. Ensuring that the proposed measures to break the vicious cycle of poverty and ill health are on the basis of evidence, health research tries to figure out whether the

available resources are utilized in the most effective and efficient way possible (Soderberg & Phillips, 2015).

2.12. The role of healthcare NGOs in health education in the Kurdistan Region

The gaps can swiftly be filled by healthcare workers and the local medical school teaching staff. The healthcare system and medical education have improved over the past decades as a result of the dedication of this groups of professionals, and the assistance of different NGOs in bothe developed countries and developing ones like the Kurdish region of Iraq. Moreover, the the Kurdistan region of Iraq has started to have more free interaction with the world although there have been various of physical accessibility. It should also be noted that the passage of experts or equipment has been disrupted by neighboring countries through their borderlines (Tawfik & Khoshnaw, 2010).

Following the UN Security Council adopted resolution 986 (the ‘oil for food program’), 13% of the total allowed sum of oil export money of Iraq is devoted to purchasing necessary humanitarian needs and medicine to the Kurdish administration (Zangana, 2015). As a result of this, the infrastructure of the region has been improved to some extent, especially in the areas of provision of health services and education. Using this budget, Duhok and Sulaimania medical schools have recently been established. The UK medical community has helped these schools to be recognized by the General Medical Council. In the last few years, various technical schools for qualifying pharmacy assistants, laboratory technicians and other professions allied to medicine, two nursing colleges, and two dentistry schools have also been started (Abdel et al, 2015; KRSO, 2016).

3. METHODOLOGY

3.1. Study Design

A quasi experimental and none equivalent control group post test study design was carried out.

3.2. Study setting

This study was conducted in Zhian Health Organization Camp in Erbil city of Kurdistan region- Iraq over a period of 6 months from February 2020 to August 2020.

Zhian health organization (ZHO) was established in 2003 in Erbil city by a number of physicians, medical staff and social workers and was in registered as NGO in Iraq under the code "IZ341319" on 10/3/2003 and recognized as a health, social, humanitarian, independent and non-governmental organization. ZHO has active branches in Erbil, Kirkuk, Sulaimaniyah, Ninawa, and Halabja. Its objectives are arrangement and supervision of mobile medical teams that are able to spread awareness and provide therapeutic services to many individuals in the camps, village, and dispute areas. It also coordinates with government ministries and departments to raise health awareness and the level of health services. It has also extended its cooperation with different national and international organizations, including CADCA, Colombo Plan, ICSP, ADF, and Official partner of the UNFPA in Kurdistan region-Iraq and UNICEF.

3.3. Sample selection

In order to choose the participants, purposive sampling method was utilized. The participants of the present study were N=120 individuals who were selected from among internally-displaced persons (IDPs) and who were provided with healthcare services by physicians, nurses, and other health workers who were working and in Zhian Health Organization camp during the time of the study.

The selection has been divided for two group control and intervention, the first group participant were including men (n=28), women (n=32), and they were using services for the first time. The Intervention group which was the second group are including men (n=29), women (n=31),. Intervention group were those participant took services more than one times while the control group were those participants who had not received healthcare services but had heard about Zhian Health Organization through other people and whose feedback and

opinion about the organization and staff were gathered through face-to-face interview and completion of the questionnaires.

3.4. Study tools

In the present study, a researcher-designed questionnaire was used to collect required data. The questionnaire was composed of 2 sections.

3.4.1. Participant data questionere

1. First section was demographic information of patients, including gender, age, residency status, marital status, number of children, and income source/generator.

2. The second section included some feedback questions aimed at gathering data on the respondents' opinion about the healthcare services they were provided by Zhian Health Organization.

In order to check the validity of the questionnaire, some experts in the field provided their views, and to ensure that the questions were understandable for the respondents, they were completed by the healthcare providers through interview with the respondents who were provided with sufficient explanations whenever and wherever required. The validity and reliability of the questionnaire and the comprehensibility of the questions were checked by seeking some field experts' views and making required modifications.

3.5. Data collection

The collected data were analyzed with the Social Sciences Statistics Package (SPSS version 21) using descriptive and inferential statistics. The intervention and control groups included those participants who had received healthcare service from Zhian Health Organization, and data on their feedback on the services and staff were collected by completing the questionnaires for them in through face-to-face interviews.

The questionnaire interview was used to Data collected, and the time and place of the interviews were chosen according to the participants' desire and comfort. Each interview lasted a maximum of 30 minutes.

3.6. Ethical considerations

In order to take ethical consideration into account, ethical approval was obtained from the Near East University Scientific Researches and Ethics Committee (YDU/2020/81-1088) and Zhian Health Organization (12.01.2020/8973). Moreover, after introducing himself to the

participants, the researcher explained the research aims and duration and obtained their written consent while assuring them that obtained information would be treated as strictly confidential as possible.

3.7. Data analysis

The collected data were analyzed using Statistical Package for the Social Sciences (SPSS version 21) in order to achieve final results. For this purpose, descriptive statistics, calculation of central inclination indexes, mean and indexes of dispersion, absolute frequency and percentage, correlation coefficient, t-test, and ANOVA tests were used. A p-value of <0.05 was considered as significant for all tests.

4. RESULTS

Table 2: The participants' demographic data

Variables		Intervention Group (taken serves group)		Control Group (First time visiting)	
		N	**%**	**n**	**%**
Facility	Dara shkran PHC	**20**	**33.3**	**21**	**35.0**
	Basrma PHC	15	25.0	14	23.3
	Qushtapa PHC	10	16.7	10	16.7
	Kawrgosk PHC	10	16.7	10	16.7
	Barika PHC	5	8.3	5	8.3
Age	< 19 years	7	11.7	9	15.0
	19-28 years	**23**	**38.3**	**21**	**35.0**
	29-38 years	19	31.7	**21**	**35.0**
	39-48 years	7	11.7	6	10.0
	49-58 years	4	6.7	**3**	**5.0**
Gender	Male	28	46.7	29	48.3
	Female	**32**	**53.3**	**31**	**51.7**
Marital status	Divorced	12	20.0	12	20.0
	Married	**46**	**76.7**	**46**	**76.7**
	Single	2	3.3	2	3.3
Children	Yes	**52**	**86.7**	**54**	**90.0**
	No	8	13.3	6	10.0

The results of the present study showed that 60 participants referred to primary healthcare centers for the first time (called control group), and 60 participants referred to primary healthcare centers for more than one time (called intervention group). In both groups, Dara Shkran and Basrma PHC centers were most frequently referred to.

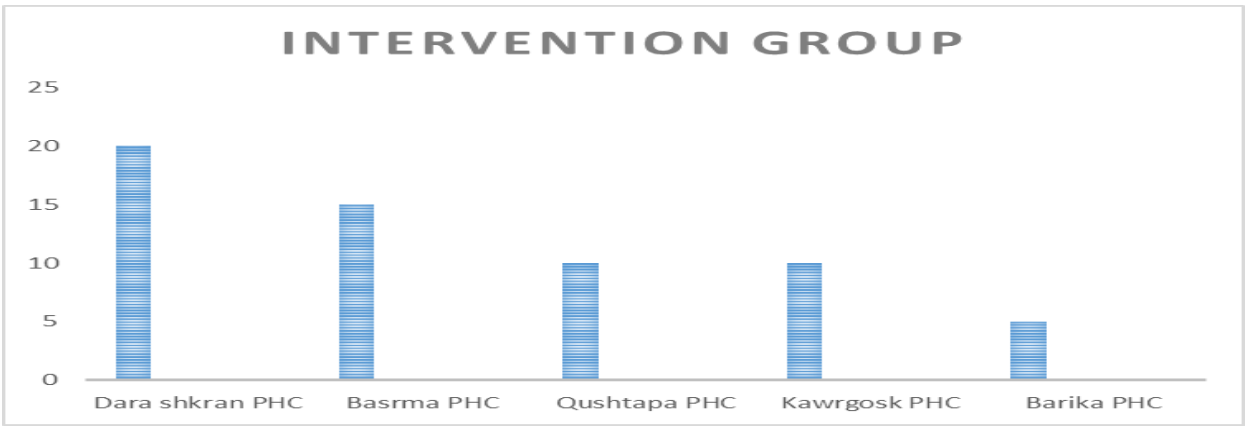

Figure 1: Facility Participants at each location

In terms of their age, age groups 19-28 and 29-38 years accounted for most PHC clients in both groups. In both groups, the number of female referents was slightly more than males. Participants in both group were refugees. Regarding their marital status, most of the participants in both groups were married (76.7% in both groups). Most of the participants in both groups had children (See Table 4.1).

Table 3: Services and facilities

Variables		Intervention group (taken serves group)		Control Group (First time visiting)	
		n	**%**	**n**	**%**
Who is the main income generator of your household?	Myself	19	31.7	15	25.0
	Spouse	37	61.7	39	65.0
	Parent	4	6.7	6	10.0
How easy was it for you to access this facility?	Easy	60	100.0	60	100.0
	Difficult	0	0.0	0	0.0
What challenges do you face accessing the facility?	Family restrictions	20	33.3	37	61.7
	Arranging childcare while I am at facility	30	50.0	23	38.3
	Security situation	6	10.0	**0**	**0.0**
	Check points	4	6.7	0	0.0
What services did you receive at the facility today?	Ante Natal Care	16	26.7	7	11.7
	Post Natal Care	10	16.7	13	21.7
	Family Planning	10	16.7	22	36.7
	Treatment of STD and Reproductive Tract Infections	12	20.0	6	10.0
	GBV Awareness sessions	12	20.0	12	20.0
How did you find out about the service?	Neighbor	22	36.7	20	33.3
	Relative/family member	18	30.0	30	50.0
	Outreach from health facility	20	33.3	10	16.7
Did you pay for services received at this facility?	No	60	100.0	60	100.0
	Yes	0	0.0	0	0.0

According to the results, most of the participants sought healthcare services for their spouses, followed by themselves and parents. All participants in both groups stated that it was easy to have access to their required facilities. Family restrictions and arranging children while seeking healthcare help were respectively the most frequently challenges faced by intervention group (with 37 and 23 cases, respectively), while arranging children with 30 cases and family restriction with 20 cases were the challenges mentioned by control group.

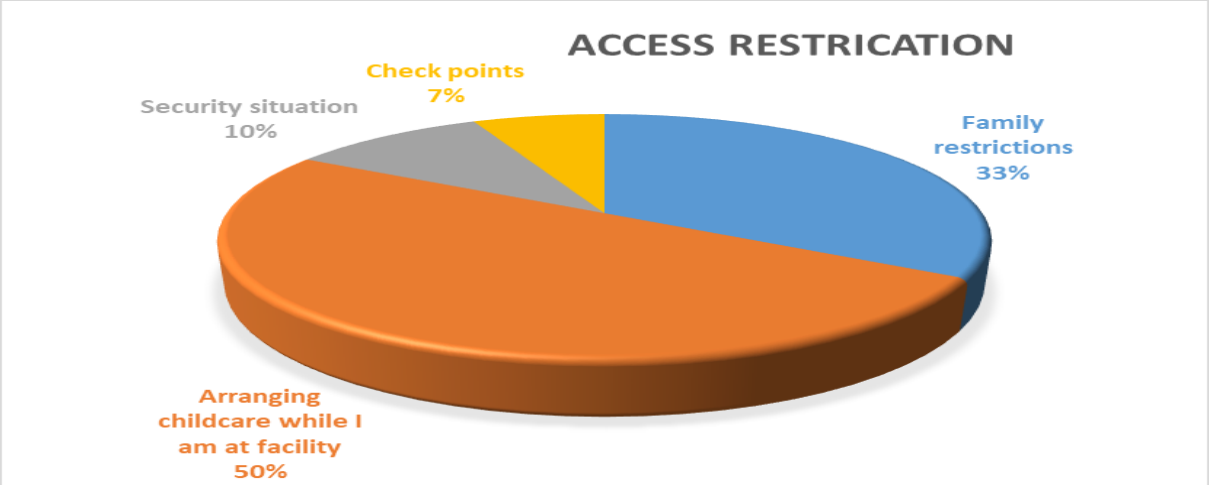

Figure 2: Illustarte access restrication for the health facilities service

The services most frequently received by intervention group on the day of data collection were family planning, postnatal care, and gender-based violence (GBV) awareness sessions, respectively. Control group sought antenatal care, treatment of sexual transmitted infections, postnatal, and family planning more frequently, respectively. Intervention group stated that they found out about the services mostly through their relative/family members and neighbors, while control group through their neighbors and outreach from health facility. Both groups stated that they did not pay for the healthcare services they received (See Table 4.2).

Table 4: The participants' attitude toward facility services of the organization

Variables		Intervention group (taken serves group)		Control Group (First time visiting)	
		n	**%**	**n**	**%**
How important is it for you to have received this service today?	Absolutely essential	30	50.0	31	51.7
	Very important	21	35.0	19	31.7
	Of average importance	9	15.0	10	16.7
How satisfied are you with the services you received in the facility today?	Extremely satisfied	41	68.3	20	33.3
	Satisfied	19	31.7	36	60.0
	Not satisfied	0	0.0	4	6.7
Were you satisfied with the staff behavior during your visit to the facility?	Extremely satisfied	42	70.0	31	51.7
	Satisfied	18	30.0	27	45.0
	Not satisfied			2	3.3
Were you satisfied with the level of privacy provided during your visit to the facility?	Extremely satisfied	38	63.3	27	45.0
	Satisfied	22	36.7	33	55.0
Please describe what could have been done better	Welcoming	13	21.7	11	18.3
	Respectful assistance by staff	27	45.0	7	11.7
	Provision of information related to treatment	6	10.0	10	16.7
	Waiting time	5	8.3	10	16.7
	Staff assistance to help feel comfortable	5	8.3	18	30.0
	Services provided	1	1.7	4	6.7
	Confidentiality	3	5.0	0	0.0
Are there other places (incl. people) that you can access where similar services to the ones provided at this facility are available?	No	60	100	60	100

Regarding the importance of the services received on the day of data collection, most of the participants in both groups referred to the services as absolutely essential. Intervention group were satisfied (60%) and extremely satisfied (33.3%) with the services, while 68.3% of the participants in control group were extremely satisfied and 32.7% were satisfied. Also, 51.7% and 45% of the participants in intervention group were respectively extremely satisfied and satisfied with the staff behavior, and 70% and 30% in control group were extremely satisfied and satisfied with the staff behavior, respectively. Regarding satisfaction with privacy, 55% and 45% of intervention group were respectively satisfied and extremely satisfied, while 63.3% and 36.7% of control group were extremely satisfied and satisfied, respectively. According to intervention group, staff assistance to help feel comfortable and welcoming could have been done better, while control group stated that respectful assistance by staff and welcoming could have been done better. All participants in both groups stated that they could not have access similar services anywhere else (See Table 4.3).

Table 5: Satisfaction level of the intervention and control groups

Level of satisfaction	Intervention group		Control group	
	n	%	n	%
Satisfied	5	8.3	13	21.7
Highly satisfied	55	91.7	47	78.3
Total	60	100.0	60	100.0

Comparing the two groups in terms of their satisfaction showed that most of the members in the intervention (91.7%) and control (78.3%) groups were highly satisfied (See Table 4.4).

Table 6: Association between PHC and level satisfaction intervention and control groups

PHC	Intervention group						p-value X^2	Control group						p-value X^2
	Level Satisfaction							Level Satisfaction						
	Satisfied		Highly satisfied		Total			Satisfied		Highly satisfied		Total		
	n	%	n	%	n	%		n	%	n	%	n	%	
Basrma PHC	0	0.0	15	100.0	15	100.0	0.225	0	.0	14	100.0	14	100.0	0.001
Barika PHC	0	0.0	5	100.0	5	100.0		0	.0	5	100.0	5	100.0	
Qushtapa PHC	2	20.0	8	80.0	10	100.0		0	.0	10	100.0	10	100.0	
Kawrgosk PHC	2	20.0	8	80.0	10	100.0		7	70.0	3	30.0	10	100.0	
Dara shkran PHC	1	5.0	19	95.0	20	100.0		6	28.6	15	71.4	21	100.0	
Total	5	8.3	55	91.7	60	100.0		13	21.7	47	78.3	60	100.0	

The results indicated that the relationship between PHC centers and level of satisfaction was not significant in the intervention group (p=0.225), while a significant relationship was found between these two variables in the control group (p=0.001) (See Table 4.5).

Table 7: Association between age and level satisfaction in intervention and control groups

Age	Intervention group						Control group					
	Level Satisfaction						Level Satisfaction					
	Satisfied		Highly satisfied		Total		Satisfied		Highly satisfied		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
< 19 years	0	.0	7	100.0	7	100.0	2	22.2	7	77.8	9	100.0
19-28 years	1	4.3	22	95.7	23	100.0	2	9.5	19	90.5	21	100.0
29-38 years	2	10.5	17	89.5	19	100.0	4	19.0	17	81.0	21	100.0
39-48 years	1	14.3	6	85.7	7	100.0	3	50.0	3	50.0	6	100.0
49-58 years	1	25.0	3	75.0	4	100.0	2	66.7	1	33.3	3	100.0
Total	5	8.3	55	91.7	60	100.0	13	21.7	47	78.3	60	100.0
	P= 0.556 $X^{2=}$ 3.013						P=0.080 $X^{2=}$8.328					

According to the obtained results, there was not a significant relationship between age and level of satisfaction in either of the groups (p>0.05). It means that regardless of their age, the participants were satisfied with the services they received (See Table 4.6).

Table 8: Association between sex and level satisfaction intervention and control groups

Sex	**Intervention group**						**Control group**					
	Level Satisfaction						**Level Satisfaction**					
	Satisfied		Highly satisfied		Total		Satisfied		Highly satisfied		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Male	2	7.1	26	92.9	28	100.0	5	17.2	24	82.8	29	100.0
Female	3	9.4	29	90.6	32	100.0	8	25.8	23	74.2	31	100.0
Total	5	8.3	55	91.7	60	100.0	13	21.7	47	78.3	60	100.0
	P=0.565		X^2=0.097				P= 0.313		X2=0.647			

*Fisher's Exact Test

The results of the study demonstrated no significant association between sex and level of satisfaction in the intervention group (p=0.565) or the control group (p=0.313). It means that the participants' satisfaction with the services was affected by their sex (See Table 4.7).

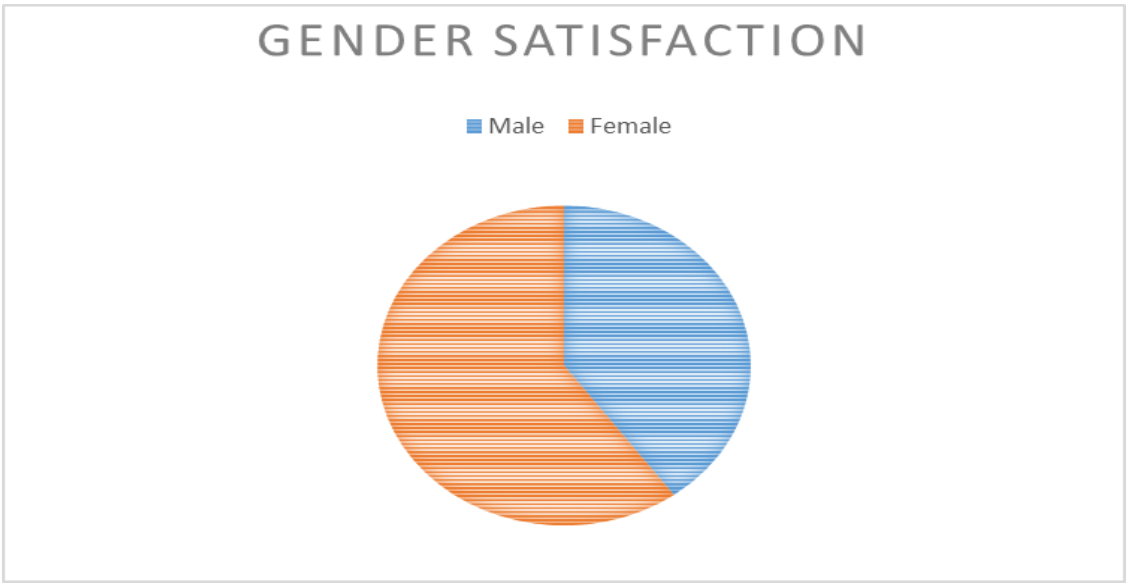

Figure 3: Male and Female statification of the health service

Table 9: Association between marital status and level satisfaction in intervention and control groups

Marital Status	Intervention group						Control group					
	Level Satisfaction						**Level Satisfaction**					
	Satisfied		Highly satisfied		Total		Satisfied		Highly satisfied		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Divorced	1	8.3	11	91.7	12	100.0	2	16.7	10	83.3	12	100.0
Married	4	8.7	42	91.3	46	100.0	11	23.9	35	76.1	46	100.0
Single	0	.0	2	100.0	2	100.0	0	.0	2	100.0	2	100.0
Total	5	8.3	55	91.7	60	100.0	13	21.7	47	78.3	60	100.0
	p= 0.909 X2= 0.189						p= 0.648 X^2= 0.866					

As revealed by the results of the study, no significant association was found between marital status and level of satisfaction in both groups (p>0.05), which reveals the fact that the participants' satisfaction was not affected by their marital status.

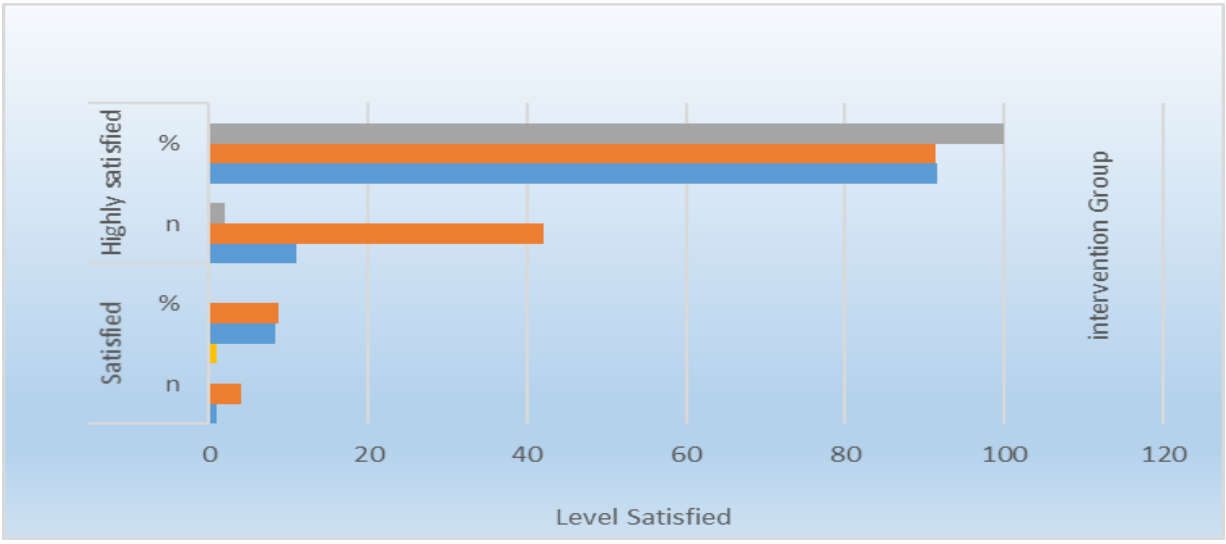

Figure 4: represent level satisfication of intervention group.

Table 10: Comparing the satisfaction level means between the intervention and control groups

Variable	**Group**	**N**	**Mean**	**Std. Deviation**	**Std. Error Mean**	**t-test**	**Sig. (2-tailed)**
Level Satisfaction	Control	60	2.7833	.41545	.05363	-2.064	**.041**
	Intervention	60	2.9167	.27872	.03598		

Comparing the intervention and control groups in terms of their satisfaction level indicated a significant difference between them, such that the intervention group was more satisfied with the services they had received (t= -2.064, p=**.041).**

Table 11: The roles played by the nurses working in Zhian Health Organization

The roles played by the nurses	Frequency (n)	Percentage (%)
Educators	20	33.3
Primary care providers	15	25.0
Case managers	10	16.7
Counselors	10	16.7
Nurse advocates	5	8.3
Total	60	100

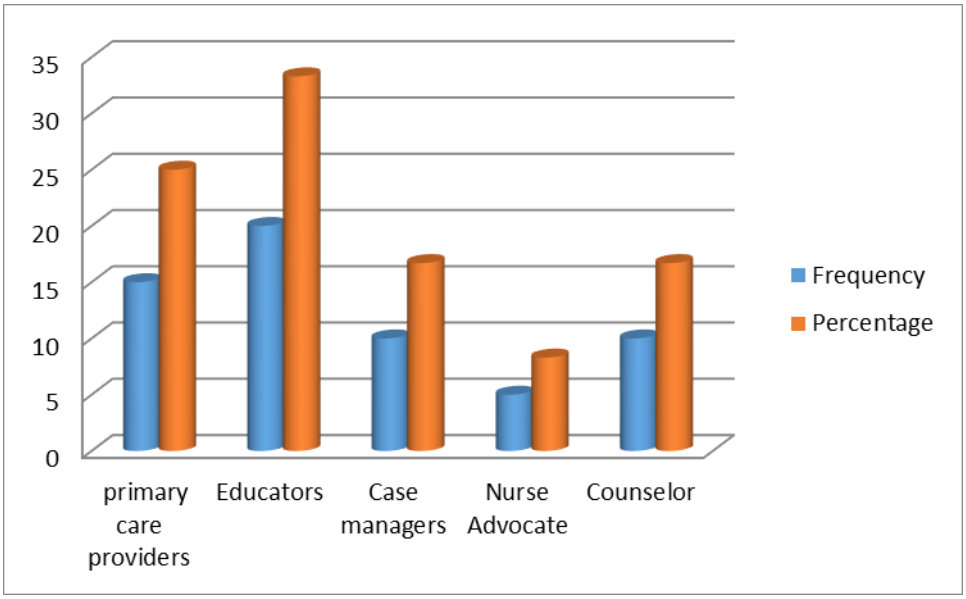

Figure 5: The roles played by the nurses working in Zhian Health Organization

The results of the study indicated that 20 out of 60 nurses (33.3%) worked as educators in ZHO, 15 (25%) as primary care providers, 10 (16.7%) as case managers, 10 (16.7%) as counselors, and 5 (8.3) as nurse advocates (See Table 11 and Figure 4).

5. DISCUSSION

The examination of referral within a system requires consideration of all its parts. The components of a referral system include initiating and receiving facility with the patients in between them. Referral standards in an efficient and effective referral system facilitate the referred patients to be accompanied by a trained health worker (Awoonor et al, 2015). Based on the data obtained in the present study, about 70% of the patients who referred to primary healthcare centers for the first time and for more than one time were the age range of 19-38 years. Moreover, all of the participants who referred to primary healthcare centers were refugees, and more than 75% of them were married and had children. As the results revealed, the rate of referring to health care centers among various age groups was not the same, which may be due to the fact that different age groups have different levels of need for medical and healthcare services. Another reason can be related to the inadequate number of healthcare workers being on duty at the time of referrals or because the caretakers do not have emergency medical conditions (Elizabeth et al, 2017).

Due to demographic changes between countries, different age groups distribution, risk factors, and economic and epidemiological contexts, it is hard to establish a unique primary health care system that suits all countries. In the present study, in both groups, more than 60% of the participants stated that the main income generator of their household was their spouse, which may be because of the special social condition of the geographical area of study and the conditions of the refugees in the camps. Moreover, primary healthcare services in both groups of the participants provided in such a way that all of them had easy access to the facilities. This finding is in line with the WHO (2002) which mentioned that primary healthcare centers focus on easily obtainable preventive and curative primary care services, and referrals to secondary and tertiary hospitals. In both groups, family restrictions and arranging childcare while the participant was at the facility were the main challenges to the participants faced while trying to have access to the facilities. Based on the results of the study carried out by Steven et al (2016), due to challenges induced by family restrictions in the process of giving health care services, providing the future of home health care is an important facility that the vast majority of services provided in the home are provided by family caregivers, sometimes referred to as informal services. The phrase of future of home health care grossly underestimates the critical role family caregivers play in the care of patients at home (Johnson et al, 2016).

One of the most important services that should be provided within healthcare services is gender-based violence (GBV) awareness sessions, which was also considered in this study. In

accordance with the new training curriculum of WHO, health care for women subjected to intimate partner violence (IPV) or sexual violence is one of the most important steps toward improving their health care. It aims to help providers know how to identify and respond to the clinical needs of women survivors, particularly those experiencing sexual violence or intimate partner/domestic violence (WHO, 2013). The impact of GBV among refugee populations varies by region and context but may include increased risk of HIV and other sexually transmitted infections (STIs) as indicated by study in DR Congo; depression and post-traumatic stress disorder documented among refugee populations; as well as short- and long-term health, economic, and social sequelae for individuals, families, and communities documented in a variety of geographic locations globally (Hannah et al, 2016). In the present study, seeking antenatal care, treatment of STIs, postnatal, and family planning was more frequently considered significant.

As reported by Umar et al (2019), the lack of infrastructure, especially laboratory facilities, makes it difficult to diagnose pregnancy complications and other risks timeously. The inability to do so hampers primary health services. Space constraints at community-based health planning and services (CHPS) compounds contribute to regular overcrowding and delays the regular provision of services. This has led to clients being frustrated and complaining that the situation resembled the old ways of primary health care, where overcrowding was persistent (Arthur, 2012). Coupled with the above is the lack of the requisite number of health staff at the CHPS compound and other supporting health facilities (Umar et al, 2019). In the present study, approximately all participants declared that they feel comfortable and satisfied with the staff and they could not have access to similar services anywhere else. Moreover, the participants were more satisfied with some facilities than others, which may be due to the availability of more appropriate facilities in those centers. In line with the results presented by Umar et al (2019), in some centers with staff who were more patient, the participants were more satisfied. Moreover, Jakobsson and Holmberg (2012) suggested that physicians and hospital staff all ought to focus on the direction to improve as well as enhance the quality of service delivery.

As reported by Elsadig et al (2015) and Faiza et al (2019), an important part of the questionnaire that should be considered is privacy issues that participants need to be sure that they are safe and the privacy of their responses is guaranteed. In line with these studies, in the present study, centers with the highest level of privacy satisfied participants more. The association of the participants' age and their level of satisfaction with staff behavior is a bit complex. However, it may be a function of the age distribution of all participants of the study

as mentioned by Runtang et al (2018). Similarly, in the present study, there was not any significant association between the participants' age and their satisfaction with staff behavior. Additionally, all participants, regardless of their age group, received appropriate primary health services equally. However, in their study, Kavanaugh et al (2006) reported that participants with ages 40-49 years showed the lowest level of satisfaction. This may be because of the medical staff in this age group may be at their peak of their career and have "professional plateau" reactions, which manifest as significant burnout. Anyway, in the present study, it is demonstrated that all participants even with different age groups received a similar level of privacy while receiving healthcare services. Moreover, there were not any differences among men and women in receiving various primary healthcare services, and all the participants were equally satisfied. Contrary to the results of the present study, Bertakis et al (2000) demonstrated that women use more healthcare services than men; therefore, women have higher medical care service utilization and higher associated charges than men. Although the appropriateness of these differences was not determined, these findings have implications for health care. Moreover, all men and women in the present study were similarly satisfied with the level of privacy during receiving healthcare services by PHC facilities.

Due to the fact that the primary healthcare centers provide vaccination and family planning, and also in most developing countries men are at work and do not have much time, so they mainly prefer to use private sector services. Therefore, the private sector in these countries has an important role in the lesser utilization of public services in men and highly educated people (Mohammad and Rima, 2011). In their study, Mohammad and Rima (2011) demonstrated that there were not any differences between men and women regarding any of the various levels of satisfaction. However, all participants in the present study were refugees, and the men were more satisfied with primary healthcare staff, which may be due to the cultural and social differences in participants of this study. Married people need primary healthcare services more than other marital statuses. Thus, they use PHC more than others (Tariq and Abdurrahman, 2016). Investigation of the effect of marital status on the level of the participants' satisfaction with the services demonstrated that there is not any significant association among these two factors. In line with these results, Elsadig et al (2015) declared that gender and marital status have no effect on the level of satisfaction with the services provided by PHC centers. Moreover, there was not any association among the marital status of the participants with the satisfaction level of privacy while receiving healthcare services. Additionally, all participants who visited primary healthcare centers for the first time and more were satisfied with prepared

medical services. So, there was a high association between the number of times a person visits the medical centers and their level of satisfaction (Emadi et al, 2009).

The results of the present study proved that all the achieved satisfaction scores are due to the provided high level of medical services. Therefore, it was expected that all the participants would be satisfied with the staff's behavior. The more times the participants refer to the primary healthcare centers, the more satisfaction level of privacy will be achieved. This may be due to the higher level of being familiar with those centers which the participant refers to.

The resilience and sustainability of the Kurdistan Region of Iraq's primary care system are being threatened by the severe and protracted security, humanitarian, economic, and political crises. Anyway, the level of satisfaction with the services provided by PHC centers in the Kurdistan region of Iraq is high. This study has shown that the overall satisfaction of medical staff is affected by many variables, including those found to be statistically significant in the previous sections. However, satisfaction is not only limited to these factors. Although patient satisfaction did not show any statistically significant differences in the demographic data of enrolled patients, some variables still approached statistical significance and deserve further study for verification.

Primary health care could be recommended as a comprehensive and suitable strategy to provide health services in public health. Paying attention to client satisfaction is a basic step for quality improvement and should be done intermittently. The package of services in primary health care may affect client satisfaction degree. Patients' sociodemographic features have a significant impact on the level of their satisfaction. The most important sociodemographic features include gender, occupational status, marital status, and income level. Therefore, potential factors that have an effect on patient satisfaction levels need to be taken into account. Health ministry bureaucrats in the Kurdistan Region and Iraq can utilize the results of the current study in order to develop new strategies and prioritized programs for improving healthcare systems, and aid health providers to objectively asses patient satisfaction and evaluate feedback.

Health promotion is a key component of healthcare organizations. By promoting the health of individuals, families, communities, and populations, healthcare organizations help transform the health of individuals, the society, and the healthcare system. Within the health education literature and within the practice, the terms health promotion and health education have mistakenly been used as interchangeable concepts. In reality, health education and health

promotion are distinct activities. The concept of health promotion, which focuses on socioeconomic and environmental determinants of health and participatory involvement, includes the narrower concept of health education, while health education involves giving information and teaching individuals and communities on how to achieve better health, a common role within healthcare organizations (Whitehead, 2008).

Health education has been defined as those "activities which raise an individual's awareness, giving the individuals the health knowledge required to enable them to decide on a particular health action" (Sanjiv & Preetha, 2012). Whitehead (2008) defined health education as "activities that seek to inform the individuals on the nature and causes of health or illness and the personal level of risk associated with their lifestyle behavior. Health education seeks to motivate individuals to accept a process of behavioral change through directly influencing their values, beliefs, and attitude systems. In contrast, health promotion involves the social, economic, and political changes to ensure the environment is conducive to health, which requires a medical expert to educate individuals about their health needs, but also demands that the medical experts play a role in attempting to address the wider environmental and social issues that adversely affect people's health (WHO, 2009).

The resilience and sustainability of the Kurdistan Region of Iraq's primary care system are being threatened by the severe and protracted security, humanitarian, economic, and political crises. Anyway, the level of satisfaction with the services provided by PHC centers in the Kurdistan region of Iraq is high. This study has shown that the overall satisfaction of medical staff is affected by many variables, including those found to be statistically significant in the previous sections. However, satisfaction is not only limited to these factors. Although patient satisfaction did not show any statistically significant differences in the demographic data of enrolled patients, some variables still approached statistical significance and deserve further study for verification.

Primary health care could be recommended as a comprehensive and suitable strategy to provide health services in public health. Paying attention to client satisfaction is a basic step for quality improvement and should be done intermittently. The package of services in primary health care may affect client satisfaction degree. Patient satisfaction level was significantly influenced by their sociodemographic features, particularly income level, marital and occupational status and gender. Therefore, it is essential to take into consideration potential factors that can influence patient satisfaction levels. The study results can influence health ministry bureaucrats in Iraq and the Kurdistan Region to develop new strategies and prioritized

programs for improving healthcare systems, and aid health providers to objectively measure patient satisfaction and evaluate feedback.Overall, this thesis it should be developing well structure the health education and promotion programme which is remarkable steps toward enhancing people's selfcare awareness that can be well implemented in primart healthcare cetneters (PHCC).

The nurses working in PHC centers affiliated with ZHO were found to play various roles, including educators, primary care providers, case managers, counselors, and nurse advocates. In their role as educators, nurses raise the patients' knowledge about their health status, as a result of which the patients can understand their health issues and improve their self-management (Bergh et al, 2015). Providing this service by nurses can also lead to an increase in patient satisfaction (Murdock & Griffin, 2013). That is why the level of patient satisfaction was quite high among the clients of the studied centers. Another important role played by the nurses was providing primary care. Provision of primary care by nurses has been referred to as a significant factor in improving the management of public health (Margolius & Bodenheimer, 2010; Hutchison et al, 2011). The nurses were also case managers. In this role, nurses coordinate all dimensions of the care of individual patients, which can have significant effect on patient satisfaction and clinical outcomes (Carayon et al, 2015). This can be a good justification for patient justification in the preset study.

The third role played by the nurses was providing counseling services to the clients. In this regard, research has indicated that the relationship between nurses and patients and providing counselling services to patients can play a significant role in quality of healthcare services and the patients' self-management of their own health status (Molina-Mula & Gallo-Estrada, 2020). Finally, the nurses in the PHC centers had the role of advocates. With regard to the importance of nurses as nurse advocates it has been stated that in this role, nurses support the patient's best interests while respecting the family's important role. By participating in healthcare team meetings with the patient and family, they attempt to clarify any communication problems and ensure information from the healthcare team is complete and correct, which in turn leads to improvement in patient satisfaction and clinical outcomes (Fahlberg & Dickmann, 2015). The collective effect of the various roles played by the nurses can be regarded to be a reasonable justification for patient satisfaction with the services they received in ZHO and with the staff.

6. CONCLUSION AND RECOMMENDATION

6.1. CONCLUSION

The present study that was carried out in order to determine the effect of health education on people treatment in the primary healthcare (PHC) centers affiliated with Zhian Health Organization led to the following findings:

- The PHC centers provided all age groups (ranging from <19 to 58 years old) with primary healthcare services.

- Most of the clients were married (76.7%), indicating the fact that married people require more primary healthcare services, particularly those related to childbirth and family planning.

- Access to the PHC facilities was stated to be easy; however, family restrictions, arranging childcare while referring to the centers, and security situations were referred to as some challenges in this regard.

- The primary healthcare services for which the clients referred to the centers were antenatal care, postnatal care, family planning, treatment of sexually-transmitted infections, and GBV awareness sessions.

- Most of the clients were satisfied with the primary healthcare services they received on the day of data collection, staff behavior, and privacy level.

- There were significant relationships between PHC centers and client satisfaction with the services ($p=0.022$), client satisfaction with staff behavior ($p=0.000$), and satisfaction with privacy level ($p=0.004$).

- Participants' age had no significant relationship with their satisfaction with the services ($p=0.966$), staff behavior ($p=0.567$), and level of privacy ($p=0.476$).

- Participants' sex had no significant relationship with their satisfaction with the services ($p=0.359$) and level of privacy ($p=0.168$). However, the relationship between sex and satisfaction with staff behavior was significant ($p=0.037$).

- The participants' marital status had no significant association with their satisfaction with the services ($p=0.882$), staff behavior ($p=0.515$), and level of privacy ($p=0.648$).

- Participants who referred for the first time and those who referred more than once were significantly different in terms of their satisfaction with services ($p=0.000$) and level of privacy (0.033), but not regarding their satisfaction with staff behavior ($p=0.065$).

- The nurses played various roles, including educators, primary care providers, case managers, counselors, and nurse advocates, which can be considered as a good justification for high level of patient satisfaction in both groups.

6.2. RECOMMENDATIONS

Based on the results of the study, the following recommendations were made;

1. Future researchers are recommended to carry out similar studies with larger sample size so as to generalize the results and findings to other regions in the Kurdistan region-Iraq.

2. Future researchers are recommended to investigate the effect of other variables affecting client satisfaction with primary healthcare services, including type of disease, follow-up duration, prescribed medicine, etc.

3. Ministry of Health and healthcare organizations are recommended to utilize the findings and results of the present study in order to promote people treatment through health education.

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8. Appendix

8.1: Questionnaire

Client Feedback (CFF) Form for Health Facilities (HF)	
#	**Section A: Facility Information**
A.1	**Name of Facility:** …… ……..
A.2	**Location of Facility** **A.2.1** Governorate: .... **A.2.2** District: .... **A.2.3** Sub-District: .... **A.2.4** Community: ....
#	**Section B: Metadata on the respondent**
B.1	Please enter your age: ……..... ..... years old
B.2	Please specify your sex: (Select one) □ Male □ Female
B.3	Please specify which of the following categories applies to your residency status: (Select one) □ Refugee □ IDP □ Host-community
B.4	Please specify your marital status: (Select one) □ Divorced □ Married □ Widowed

	□ Not married
B.5	**B.5.1** Do you have children? (Select one) □ Yes □ No ***If yes,** **B.5.1.1** please specify how many: ……
B.6	Who is the main income generator of your household? (Select one) □ myself □ spouse □ sibling □ parent □ child □ Other, please specify: ……
#	**Section C: Feedback Questions**
C.1	How many times have you been to this facility in the past 3 months? (Select one) o First time o 2-5 times o More than 5 times
C.2	How easy was it for you to access this facility? (Select one) o Easy o Not Easy

C.3	What challenges do you face accessing the facility? (Select all that apply) o Security situation o Lack of transportation o High transportation cost o Check points o Family restrictions o Location of facility o No accompanying person o Not acceptable from the community o Arranging childcare while I am at facility o Facility hours of operation are not convenient o Sometimes the clinic is closed unexpectedly (when it's supposed to be open) o I am sometimes refused services at this facility o High cost of services at this facility o Other, please specify: …… ……..
C.4	What services did you receive at the facility today? (Select all that apply) □ Ante Natal Care □ Post Natal Care □ Normal Delivery □ Caesarean Section □ Family Planning □ Miscarriage/ Post- abortion care □ Treatment of Sexually Transmitted Infections / Reproductive Tract Infections □ Treatment as a result of violence □ RH Awareness sessions □ GBV Awareness sessions □ Other Service, please specify: …… …….....
C.5	How did you find out about the service? (Select one) o Neighbor o Referral o Relative/family member o Outreach from health facility o IEC materials o Other, please specify: …… ……..

C.6	Did you pay for services received at this facility? (Select one) o Yes o No ***If yes:** **C.6.1** Please specify which services …… ……..... **C.6.2** Did you pay the partial or full cost of the service? (Select one) o Partial o Full cost
C.7	How important is it for you to have received this service today? (Select one) □ Absolutely essential (I could not have received the service anywhere else and without this service I would suffer) □ Very important □ Of average importance □ Of little importance □ Not important at all
C.8	How satisfied are you with the services you received in the facility today? (Select one) o Extremely satisfied o Satisfied o Not satisfied
C.9	Were you satisfied with the staff behavior during your visit to the facility? (Select one) o Extremely satisfied o Satisfied o Not satisfied
C.10	Were you satisfied with the level of privacy provided during your visit to the facility? (Select one) o Extremely satisfied o Satisfied o Not satisfied

C.11	Please describe what could have been done better (Select all that apply) o Welcoming o Respectful assistance by staff o Provision of information related to treatment o Waiting time o Staff assistance to help feel comfortable o Services provided o Financial costs incurred to receive services o Confidentiality o Privacy o Infrastructure (waiting room, consultation room, etc.) o Availability of medication / medical equipment o Other (please specify) ……
C.12	Were you given sufficient information with regard to your treatment? (Select one) o Yes o No (please explain): ……
C.13	**C.13.1** Are there other places (incl. people) that you can access where similar services to the ones provided at this facility are available? (Select all that apply) o Yes o No ***If yes:** **C.13.1.1** please say where (Select one): □ At another health facility (specify name and location) *Name:* …… *Location:* …… □ Pharmacy □ In my home □ In the home of a certified midwife □ Other, (please specify)

	…… ……..

Key Informant Interview (KII) Questionnaire for Health Facilities (HF) - Staff
Also to be used in RH facilities with integrated GBV component (e.g. awareness raising sessions, PSS, etc.)

Target KI: For gynecologists and midwives (if not available, the main doctor or nurse)

#	Section B: Background on the Key Informant
D.1	Please specify your sex: (select one) □ male □ female
D.2	Please select your current professional role at the facility (select all that apply) □ Gynecologist □ General Physician □ General surgeon □ Midwife □ Nurse □ GBV Case Manager □ Facility Manager □ Pharmacist □ Health Information Officer □ Logistician □ Other, (please specify) …….……..... .....
D.3	D.3.1 Please indicate your professional background(s) based on formal education and certification: (Select all that apply) □ Gynecologist □ General Physician □ General surgeon □ Pediatrician □ Midwife □ Nurse □ GBV Case Manager □ Pharmacist □ Health Information Officer □ Logistician □ Other, please specify: ……..... D.3.2 Number of years Practiced: (Select one) □ Less than 1 year □ 1-2 Years □ 3-4 Years □ 5+ Years

	D.3.3 Please indicate the highest Certificate / Diploma you have received: ……..... D.3.4 Please indicate the length of study for the highest Certificate / Diploma you have received: (Select one) □ Less than 1 year □ 1-2 Years □ 3-4 Years □ 5+ Years
#	**Section E: Key Informant Questions**
E.1	What reproductive health services are provided at this facility? (Select all that apply) □ Family planning (contraceptive, IUD, counselling on FP...) □ Treatment of gynecological infections □ Ante-natal care □ Post-natal care □ Child birth services (BEmOC) □ C-sections □ Blood transfusion □ Post-abortion/miscarriage care □ Clinical management of Rape (CMR) □ Psycho-Social Support for GBV survivors □ RH Awareness sessions □ GBV Awareness sessions □ Early cancer detection □ Pediatric (child health care) services □ Non-communicable disease services (NCDs) □ Referral services □ Other (such as Tetanus-Toxoid vaccinations, RH and neo-natal laboratory tests, neonatal services, nutrition services, etc.) - please specify: …… …..…… …… …..……
E.2	In your opinion, what are the most useful RH services provided in this facility and why? …… …… …… …… …… ……

E.3	C.3.1 What type of RH service do you think the community needs and are not provided in the facility? …… …… …… …… E.3.2 Can people access those missing RH services somewhere else nearby? (Select one) □ Yes □ No E.3.2.1 If yes, where? …… …… …… …… …… …… …… …… …… …… E.3.2.2 If no, how do they cope? …… …… …… ……
E.4	E.4.1 Is there another place nearby where people can receive the same level of care as this facility, with regards to RH services? (Select one) □ No, this is the only possible place □ Yes, there is one other place nearby □ Yes, there are several other places nearby E.4.1.1 If yes, please say where. (Select one) □ At another health facility (please specify name and location)

	Name: …… *Location:* …… …… □ Pharmacy □ In the home of a certified midwife □ Other, (please specify) …… …….. …… …….. …… ……..
E.5	What are the facility's actual working hours? E.5.1 How many working hours per day? …… …….. …… …….. E.5.2 How many days per week? …… …….. …… …….....
E.6	E.6.1 Are there night-shifts at the facility? (Select one) □ Yes □ No E.6.1.1 If no, why? …… …… …… …… …… ……

E.7	Do you think that the number of staff is enough compared to the number of patients? **E.7.1 (Select one)** □ Enough male staff □ Not enough male staff **E.7.1.1** If not enough male staff, please explain why: …… …… …… …… …… …… **E.7.2 (Select one)** □ Enough female staff □ Not enough female staff **E.7.2.1** If not enough female staff, please explain why: …… …… …… …… …… …… **E.7.2.1** How did you cope with these challenges?

Client Feedback (CFF) Form for Health Facilities (HF)	
#	**Section A: Facility Information**
A.1	**Name of Facility:** …… ……..
A.2	**Location of Facility** **A.2.1** Governorate: **.....** **.....** **A.2.2** District: **.....** **.....**

	A.2.3 Sub-District: .... **A.2.4** Community: ....
#	**Section B: Metadata on the respondent**
B.1	Please enter your age: ……..... ..... years old
B.2	Please specify your sex: (Select one) □ Male □ Female
B.3	Please specify which of the following categories applies to your residency status: (Select one) □ Refugee □ IDP □ Host-community
B.4	Please specify your marital status: (Select one) □ Divorced □ Married □ Widowed □ Not married
B.5	**B.5.1** Do you have children? (Select one) □ Yes □ No ***If yes,** **B.5.1.1** please specify how many: …… ……
B.6	Who is the main income generator of your household? (Select one) □ myself □ spouse □ sibling □ parent □ child

	□ Other, please specify: …… ……..
#	**Section C: Feedback Questions**
C.1	How many times have you been to this facility in the past 3 months? (Select one) o First time o 2-5 times o More than 5 times
C.2	How easy was it for you to access this facility? (Select one) o Easy o Not Easy
C.3	What challenges do you face accessing the facility? (Select all that apply) o Security situation o Lack of transportation o High transportation cost o Check points o Family restrictions o Location of facility o No accompanying person o Not acceptable from the community o Arranging childcare while I am at facility o Facility hours of operation are not convenient o Sometimes the clinic is closed unexpectedly (when it's supposed to be open) o I am sometimes refused services at this facility o High cost of services at this facility o Other, please specify: …… ……..
C.4	What services did you receive at the facility today? (Select all that apply) □ Ante Natal Care □ Post Natal Care □ Normal Delivery □ Caesarean Section □ Family Planning □ Miscarriage/ Post- abortion care □ Treatment of Sexually Transmitted Infections / Reproductive Tract Infections □ Treatment as a result of violence □ RH Awareness sessions □ GBV Awareness sessions □ Other Service, please specify:

	…… …….....
C.5	How did you find out about the service? (Select one) o Neighbor o Referral o Relative/family member o Outreach from health facility o IEC materials o Other, please specify: …… ……..
C.6	Did you pay for services received at this facility? (Select one) o Yes o No ***If yes:** **C.6.1** Please specify which services …… ……..... **C.6.2** Did you pay the partial or full cost of the service? (Select one) o Partial o Full cost
C.7	How important is it for you to have received this service today? (Select one) □ Absolutely essential (I could not have received the service anywhere else and without this service I would suffer) □ Very important □ Of average importance □ Of little importance □ Not important at all
C.8	How satisfied are you with the services you received in the facility today? (Select one) o Extremely satisfied o Satisfied o Not satisfied
C.9	Were you satisfied with the staff behavior during your visit to the facility? (Select one) o Extremely satisfied o Satisfied o Not satisfied

C.10	Were you satisfied with the level of privacy provided during your visit to the facility? (Select one) o Extremely satisfied o Satisfied o Not satisfied
C.11	Please describe what could have been done better (Select all that apply) o Welcoming o Respectful assistance by staff o Provision of information related to treatment o Waiting time o Staff assistance to help feel comfortable o Services provided o Financial costs incurred to receive services o Confidentiality o Privacy o Infrastructure (waiting room, consultation room, etc.) o Availability of medication / medical equipment o Other (please specify) ……
C.12	Were you given sufficient information with regard to your treatment? (Select one) o Yes o No (please explain): ……
C.13	**C.13.1** Are there other places (incl. people) that you can access where similar services to the ones provided at this facility are available? (Select all that apply) o Yes o No ***If yes:** **C.13.1.1** please say where (Select one): □ At another health facility (specify name and location) *Name:* …… *Location:* ……

	□ Pharmacy □ In my home □ In the home of a certified midwife □ Other, (please specify) …… ……..

Key Informant Interview (KII) Questionnaire for Health Facilities (HF) - Staff Also to be used in RH facilities with integrated GBV component (e.g. awareness raising sessions, PSS, etc.) **Target KI:** For gynecologists and midwives (if not available, the main doctor or nurse)	
#	**Section B: Background on the Key Informant**
D.1	Please specify your sex: (select one) □ male □ female
D.2	Please select your current professional role at the facility (select all that apply) □ Gynecologist □ General Physician □ General surgeon □ Midwife □ Nurse □ GBV Case Manager □ Facility Manager □ Pharmacist □ Health Information Officer □ Logistician □ Other, (please specify) ……. .....
D.3	D.3.1 Please indicate your professional background(s) based on formal education and certification: (Select all that apply) □ Gynecologist □ General Physician □ General surgeon □ Pediatrician □ Midwife □ Nurse □ GBV Case Manager □ Pharmacist □ Health Information Officer □ Logistician □ Other, please specify: ……. .....

	D.3.2 Number of years Practiced: (Select one) □ Less than 1 year □ 1-2 Years □ 3-4 Years □ 5+ Years D.3.3 Please indicate the highest Certificate / Diploma you have received: ……..... D.3.4 Please indicate the length of study for the highest Certificate / Diploma you have received: (Select one) □ Less than 1 year □ 1-2 Years □ 3-4 Years □ 5+ Years
#	**Section E: Key Informant Questions**
E.1	What reproductive health services are provided at this facility? (Select all that apply) □ Family planning (contraceptive, IUD, counselling on FP...) □ Treatment of gynecological infections □ Ante-natal care □ Post-natal care □ Child birth services (BEmOC) □ C-sections □ Blood transfusion □ Post-abortion/miscarriage care □ Clinical management of Rape (CMR) □ Psycho-Social Support for GBV survivors □ RH Awareness sessions □ GBV Awareness sessions □ Early cancer detection □ Pediatric (child health care) services □ Non-communicable disease services (NCDs) □ Referral services □ Other (such as Tetanus-Toxoid vaccinations, RH and neo-natal laboratory tests, neonatal services, nutrition services, etc.) - please specify: …… …..…… …… …..……
E.2	In your opinion, what are the most useful RH services provided in this facility and why? …… ……

	…… …… …… ……
E.3	C.3.1 What type of RH service do you think the community needs and are not provided in the facility? …… …… …… …… E.3.2 Can people access those missing RH services somewhere else nearby? (Select one) □ Yes □ No E.3.2.1 If yes, where? …… …… …… …… …… …… …… …… …… …… E.3.2.2 If no, how do they cope? …… …… …… ……
E.4	E.4.1 Is there another place nearby where people can receive the same level of care as this facility, with regards to RH services? (Select one) □ No, this is the only possible place □ Yes, there is one other place nearby □ Yes, there are several other places nearby

	E.4.1.1 If yes, please say where. (Select one) □ At another health facility (please specify name and location) *Name:* …… *Location:* …… □ Pharmacy □ In the home of a certified midwife □ Other, (please specify) …… …… ……
E.5	What are the facility's actual working hours? E.5.1 How many working hours per day? …… …… E.5.2 How many days per week? …… ……
E.6	E.6.1 Are there night-shifts at the facility? (Select one) □ Yes □ No E.6.1.1 If no, why? ……

	…… …… …… ……
E.7	Do you think that the number of staff is enough compared to the number of patients? **E.7.1 (Select one)** □ Enough male staff □ Not enough male staff **E.7.1.1** If not enough male staff, please explain why: …… …… …… …… …… …… **E.7.2 (Select one)** □ Enough female staff □ Not enough female staff **E.7.2.1** If not enough female staff, please explain why: …… …… …… …… …… …… **E.7.2.1** How did you cope with these challenges?

8.2. ETHICS COMITY PERMITION

YAKIN DOĞU ÜNİVERSİTESİ
BİLİMSEL ARAŞTIRMALAR ETİK KURULU

ARAŞTIRMA PROJESİ DEĞERLENDİRME RAPORU

Toplantı Tarihi : 30.07.2020
Toplantı No : 2020/81
Proje No :1088

Yakın Doğu Üniversitesi Hemşirelik Fakültesi öğretim üyelerinden Assoc. Prof. Dr. Hatice Bebiş'in sorumlu araştırmacısı olduğu, YDU/2020/81-1088 proje numaralı ve "**To determine the satisfaction of the community for the services provided by Health Organization on self-care and response to emergencies.**" başlıklı proje önerisi kurulumuzca online toplantıda değerlendirilmiş olup, etik olarak uygun bulunmuştur.

Prof. Dr. Rüştü Onur
Yakın Doğu Üniversitesi
Bilimsel Araştırmalar Etik Kurulu Başkanı

8.3. HEALT MINISTER PERMISION

Zhian Health Organization

High committee

Ref: 8973
Date: 12 – 01 – 2020

منظمة (ژیان)الصحیة

مجلس الادارة

To/ Near East University - North Cyprus

RE: Permission to Conduct Research Study

Dear Sir/Madam

This is to certify that **Mr. Qasim Azeez Ali**, who is master student at your university granted permission for research on health care organizations in activating self-care systems and responding to emergency situation, he is free to access and collect data, information and knowledge on Zhian Health Organization (ZHO) for managing reproductive health clinics in refugee and IDPs camps from Oct 2011 to present, which is under the care of UNFPA and UNICEF.

Zhian health organization been established in 2003, in Erbil city, by a number of physicians, medical staffs and social workers, in March 2003 registered as NGO in KRI Code (L-7) and in Iraq under the code (IZ341319) recognized as a healthy, social, humanitarian, independent and non-governmental organization. Z.H.O has active branches in Erbil, Kirkuk, Sulaimanya, Ninewa and Halabja.

I would like to appreciate you most favorite considerations to him and it would be great pleasure for me to see him continuing higher studies at your university, if there is any question regarding to him reference, if you need any further details, please do not hesitate to contact me kawaperdaood@hotmail.com or below cell phone.

Yours faithfully

Mr. Kawa O. Perdawood
General Project Manager
0750 3153281

Z.H.O
Zhian Health Org.

Facebook: https://www.facebook.com/Zhianhealth/
Website: http://www.zhianhealth.org/contact.php
Main Office Address: 3/1/309 Nawroz Community – Near West Erbil Emergency Hospital – 100m Street, Erbil / Iraq

8.4. Qasim Ali Azeez CV

CURRICULUM VITAE

Name:	Qasim Aziz Ali
Date of Birth:	1978
Gender:	Male
Marital status:	Married
Address:	Qaysan Quarter, Erbil / Iraq
Telephone: Mob:	+964 (0) 7504622215
Home:	+964 (0) 7504622215
E-mail:	kasim_ahs@yahoo.com
Citizen Ship:	Iraqi

Languages:	English: written, listening, reading and speaking
	Kurdish: written, listening, reading and speaking (native language)
	Arabic: written, listening and reading

Education Record

Near East University in Cyprus **March 2019 – Present**
Master Taught programe in Public Health

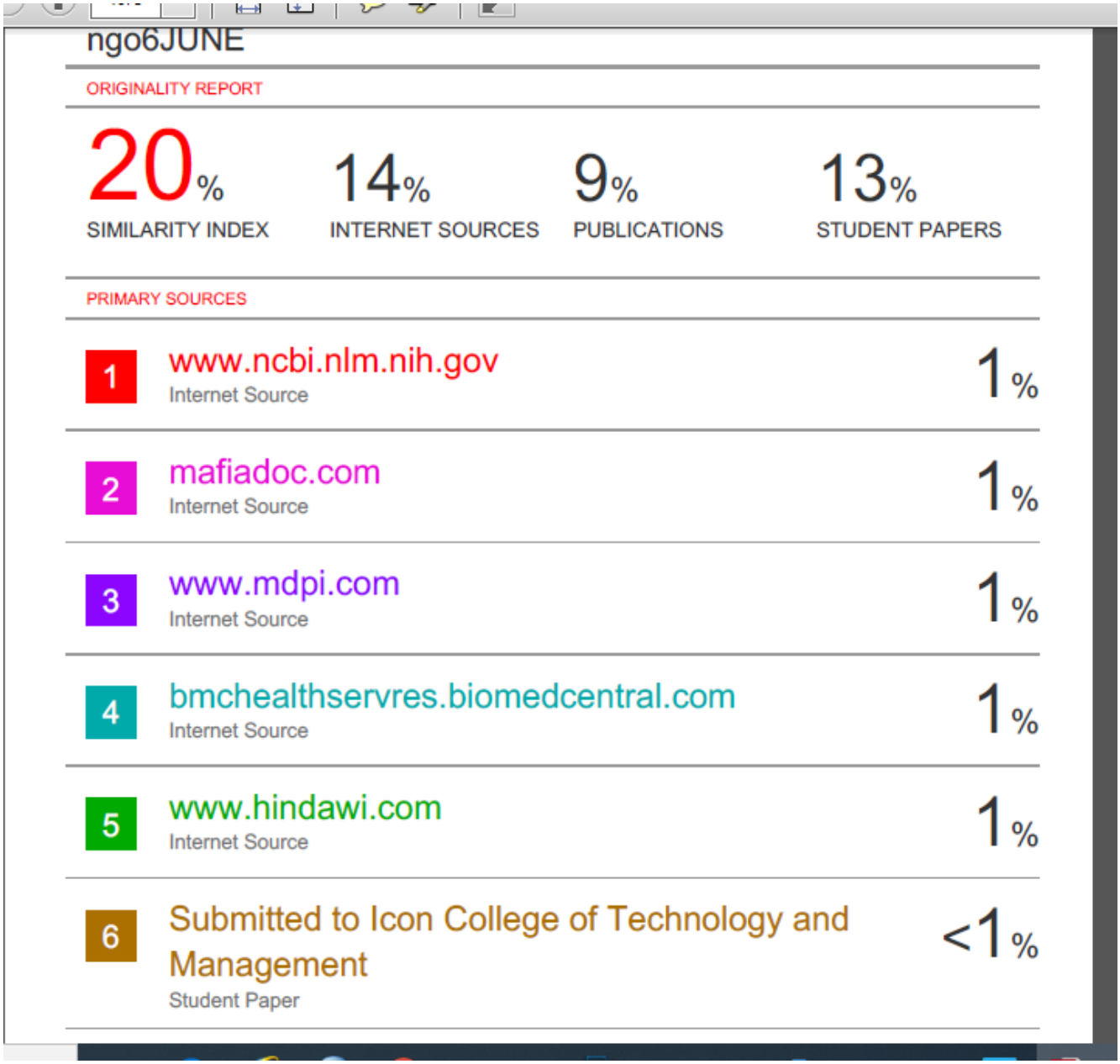
- **MSc project:** The health care organizations in activating self-care systems and responding to emergency situation.

Lebanese University in Dbaye – Lebanon September 2014 – July 2017
MSc. Public Health **Pass**

- **Modules:** Project management, Mathematic, Biostatics, Environment science, Epidemiology, Behavioral sciences, communications, informatics and Public health biology and Management.

- Master of Health Administration - Linked BUSINESS SCHOOL 2018

8.5. TURNITTEN REPORT



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