Çankırı Karatekin University
Graduate School of Health Sciences

Master of Science Thesis

ASSESSMENT OF FAMILY HEALTH NURSE SERVICES IN PRIMARY HEALTH CARE CENTERS IN DİWANIYAH CITY, IRAQ

Mustafa Shaalan Nafnaf NAFNAF

Advisor
Asst. Prof .Dr. Ramazan Serdar ESMER

Co-Advisor
Prof . Dr. Amean A. YASIR

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THESIS ADVISOR

Asst. Prof .Dr. Ramazan Serdar ESMER

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ACCEPTANCE AND APPROVAL

We testify that the Master student Mustafa Shaalan Nafnaf NAFNAF - Student ID: 208205233 at Çankırı University - Institute of Health Sciences - Department of Public Health Nursing has been examined and defended his thesis entitled (Assessment Of Family Health Nurse Services İn Primary Health Care Centers İn Diwaniyah City, Iraq) and after fulfilling all the necessary conditions determined by the relevant regulations, We saw, as jury members whose signitures below, that the thesis (is sufficient to obtain a master's degree in public health nursing)..

Advisor **:** Asst. Prof. Dr . Ramazan Serdar ESMER

Co-Advisor **:**Prof . Dr. Amean A. YASIR

Examining Committee Members:

Chairman **:** Asst. Prof. Dr.Ramazan Serdar ESMER
Department of Oral and Maxillofıcial Surgery
Çankırı Karatekin University

Member **:** Asst. Prof. Dr.Özgün YILDIRIM
Department of Oral and Maxillofıcial Surgery
Çankırı Karatekin University

Member **:** Asst. Prof. Dr.Onur ODABAŞI
Department of Oral and Maxillofıcial Surgery
Ankara Yıldırım Beyazıt University

Approved for the Graduate School of Health Sciences

Prof. Dr. Özcan ÖZKAN
Director of Graduate School

ETHICS STATEMENT

I present to you my Master's thesis entitled Assessment Of Family Health Nurse Services İn Primary Health Care Centers İn Diwaniyah City, Iraq, under the supervision and guidance of my research supervisors, including idea and hypothesis, and certify that I have written it according to ethics and scientific values, upon which scientific research is based in writing the thesis

Signature

August 2022

Mustafa Shaalan Nafnaf NAFNAF

ABSTRACT

ASSESSMENT OF FAMILY HEALTH NURSE SERVICES IN PRIMARY HEALTH CARE CENTERS IN DİWANIYAH CITY, IRAQ

Mustafa Shaalan Nafnaf NAFNAF

Master of Science in Nursing

Advisor: Asst. Prof Dr. Ramazan Serdar ESMER

Co-Advisor :Prof . Dr. Amean A. YASIR

August 2022

Background : Primary care Centers have acceptable procedures that can be used by families in the community. A standard service was provided by the Iraqi Ministry of Health in order to improve the quality of health care in Iraqi hospitals.

Objective : Nursing services in family health units of primary health care centers in Al Diwaniyah will be reviewed. It will contribute to the study by finding the health and nursing needs and challenges of each household and improving the health and nursing services of family members.

Method : A suitable sample consisting of 200 nurses was selected using the appropriate sampling method with the G.Power program and these samples were collected from 20 primary health care centers. scale, alpha = 0.82 from Cronbach. The interview took 10-15 minutes. Data collection took place between 22 November 2021 - 22 April 2022.

Results : Nurses 55% did not receive any nursing care. that nurses are 25-35 years old 39.5% in terms of age. stated that the number of nurses is more than men and that 52.5% of the total sample has a diploma 36%, the majority of the sample is composed of single nurses according to marital status and constitutes the highest percentage 68%.

Conclusion : There is a significant effect on the performance of nurses between the age of the nurses and the years of experience in the family health, there is no statistical significance between the education level of the nurses and the services they provide.

Keywords : Evaluation, Family, Nurse, Primary health care.

ÖZET

Irak, Diwaniyah'daki Birinci Basamak Sağlık Merkezlerinde Aile Sağlığı Hemşirelerini Hizmetlerinin Değerlendirilmesi

Mustafa Shaalan Nafnaf Nafnaf

Hemşirelik, Yüksek Lisans

Tez Danışmanı: Dr.Öğr.Üyesi Ramazan Serdar ESMER

Eş Danışmanı :Prof . Dr. Amean A. YASIR

Ağustos 2022

Arka plan : Birinci basamak sağlık hizmeti Merkezleri, topluluktaki insanlar ve aileler tarafından kullanılabilecek bilimsel, sağlam ve sosyal olarak kabul edilebilir prosedürlere ve teknolojiye sahiptir. Irak hastanelerinde sağlık tedavisinin kalitesini artırmak amacıyla Irak Sağlık Bakanlığı tarafından standart bir hizmet sağlanmıştır. Özel gereksinimli çocuklar ve aileler bu inançların, tutumların ve uygulamaların odak noktasıdır. Zira çoğu aileler için sağlığı korumak en önemli önceliktir. Aile sağlığı hemşireliği yönteminde veri toplamak aşamasında aile sağlığı hizmetleri sağlarken mantıklı bir yol izlenmelidir.

Amaç : Divaniye'deki birinci basamak sağlık Merkezleri aile sağlığı birimlerindeki hemşirelik hizmetleri gözden geçirilecektir. Her hanenin sağlık ve hemşirelik ihtiyaçlarını ve zorluklarını bulup aile üyelerinin sağlık ve hemşirelik hizmetlerinin geliştirerek çalışmada katıkıda bulunacaktır.

Yöntem : Çalışma Divaniye birinci sağlık hemşireleri tarafından sağlanan hizmetlerin aile değerlendirme yöntemi kullanılarak betimleyici ve kesitsel yönetem kullanılmış olup çalışma Irak Divaniye valiliği'ndeki birinci basamak sağlık kliniklerinde yapılmıştır. Sağlık Bakanlığı,Birinci Basamak Sınıflandırma Dairesi'ne göre birinci basamak sağlık merkezleri sektörlerine (Sağlık Sektörü 1). (Sağlık Sektörü 2) olarak ayrılmıştır.G.Power programı kullanılarak uygun örnekleme yöntemi kullanılarak 200 hemşireden oluşan uygun bir örnek seçilmiş olup bu örnekler 20 birinci basamak sağlık ocağından toplanmıştır. 10 birinci sağlık sektörüne ait sağlık merkezleri ile 10 ikinci

sağlık sektörüne ait sağlık merkezleridir. Irak Sağlık Bakanlığı - Aile Sağlığı Hizmetleri araştırma aracı için onay vermekle birlikte araştırmacıdan da izin alınmıştır. Bilimsel araştırmaya nazaren çeşitli Irak üniversitelerinden hemşirelik alanında doktora derecesine sahip bir takım uzmandan oluşan bazı uzmanlar ve danışmanlar bu anketin içerği tez başlığı ile uyum sağlanması için bazı değişiklikler yapmışlardır. Anket, aracının güvenilirliği ve geçerliliğini ve görüşme yöntemini doğrulamak amacıyla oluşturulmuştur. Anket öğeleri arasındaki uyumu değerlendirmek için istatistiksel bir analiz aracı olup ölçek, Cronbach'tan alpha = 0.82 ile hesaplandığı gibi uygun bir iç tutarlılık kriterine sahiptir. Çalışma araçlarının bileşenleri açık ve anlaşılırdı.Tüm hemşireler için görüşmeler yapılmıştır. Görüşme başına yaklaşık 10-15 dakika süre aldı . Veri toplama işlemleri 22 Kasım 2021 - 22 Nisan 2022 tarihleri arasında gerçekleşmiştir.

Bulgular : Çalışmanın sonuçu olarak; birinci basamak sağlık merkezlerinde aile sağlığı hemşireleri tarafından sağlanan toplam hizmetlerin, bu sonuçların çoğunluğunun istatistiksel bir kesme noktasına dayandığını göstermiştir. İstatistiklere göre, hemşirelerin %55 hiçbir hemşirelik bakımı almamıştır. hemşirelerin yaşı açısından 25-35 yaşındaki olanlar %39.5 oluşturduğunu göstermektedir. Cinsiyete gelince, hemşire sayısının erkeklerden fazla olduğunu ve toplam örneklemin % 52,5 'ini oluşturduğunu göstermektedir.Hemşirelerin eğitim düzeyi için, örneklemin %36 diploma sahibi olduğunu, medeni duruma göre ise araştırma örnekleminin büyük çoğunluğunu bekar hemşirelerden oluşturduğunu ve yıllara göre en yüksek yüzdeyi %68 oluşturduğunu belirtmiştir. Aile sağlığı birimindeki deneyime dair örneklemin %44 bu alanda 2-7 yıl arasında deneyime sahip olduğu ve aile sağlığı alanında hemşirelik kadrolarına yönelik eğitim kurslarına ilişkin sonuçlar ortaya çıkmıştır. çoğunluğunun bu tür kurslara katıldığı ve %64 olduğu belirtilmiştir. Yerleşim alanlarına gelince, kırsal nüfusun yüzde 59'unu oluşturan düzensiz sayıda hemşire vardı.

Sonuç : Bu çalışmadan aile sağlığı biriminde hemşirelerin sağladığı aile sağlığı hemşirelerinin hizmetlerinin kapsamlı değerlendirmesini çıkardık. İstatistiksel analiz sonuçlarına göre gerekli seviyeye gelmiş hizmetler bulunmaktadır. Hemşirelerin yaşları ile aile sağlığı birimindeki yılların deneyimi arasında performansları üzerinde anlamlı bir etki olduğu, hemşirelerin eğitim düzeyi ile sağladıkları hizmetler arasında istatistiksel bir anlamlılık olmadığı saptanmıştır. Hemşirelerin cinsiyeti ve eğitim kursları performansları üzerinde olumlu etki olup hemşirelerin ikametgahı ile onların

aracılığıyla sağlanan hizmetler arasında istatistiksel anlamlılık olduğu tespit edilmiştir. Irak'taki çatışmalar nedeniyle bakım eksikliği, malzeme yetersizliği ve zayıf ya da yetersiz sağlık çalışanları ya da yeterli olmayan destek hizmetleri nedeniyle kötü durumda birinci basamak sağlık merkezlerinin yanı sıra Irak hükümeti sağlık tesislerinin rehabilitasyonuna acil bir ihtiyaç vardır.

Anahtar Kelimeler : Değerlendirme , Aile , Hemşire, Birinci basamak sağlık.

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Mustafa Shaalan Nafnaf Nafnaf

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INDEX OF ABBREVIATIONS AND SYMBOLS

PHC : Primary Health Care

PHCS : Primary Health Care Center

MOH : Ministry of Health

WHO : World Health Organization

UNICEF : United Nations International Children's Emergency Fund

EBP : Evidence-Based Practice

MICS : Multiple Indicator Cluster Survey

IMCI : Integrated Management Of Childhood Illness

GIVS : Global Immunization Vision And Strategy

CBE : Clinical Breast Exam

HIV : Human Immunodeficiency Virus

AIDS : Acquired Immunodeficiency Syndrome

CD : Communicable Diseases

STDS : Sexually Transmitted Diseases

MS : Mean of scores

SD : Standard Deviation

SPSS : Statistical Package For The Social Science

ANOVA : Analysis Of Variance

NS : Non Significantly

N : Number

DF : Degree Of Freedom

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1. INTRODUCTION

Primary health care (PHC) is a kind of health care based on scientifically sound and socially acceptable procedures and technology used by people and their families in a community. Only by the full participation and payment of a fee can the community and country maintain their self-reliance and self-determination at all stages of advancement. Preventive healthcare is an approach to health that goes beyond the traditional healthcare system and focuses on social policies that promote health equity (Pandve 2019).

At the center of primary health care is the family health service. Through family health services, we may achieve the vast goal of the individual, community, and national health, an essential component for all family health service sectors. Family health is defined as the ability to carry out specified tasks about other social, political, economic, and healthcare systems (Kaakinen *et al.* 2018). PHC may be provided in Iraq's primary health care centers (PHCs). The Iraqi Ministry of Health (MOH) provided a standard service package to enhance the quality of health treatment in Iraqi hospitals (Altaha *et al.* 2017).

Family health services have been studied and promoted most prominently in the context of children's health, especially in relation to chronic illnesses in children. This approach may be seen from a different angle when dealing with children and their families. Children and families with special needs are the focus of these beliefs, attitudes, and practices. That each family is unique, that the family is the child's constant in their life, and that the family is the expert on the child's talents and requirements are what this program focuses on (Saleh *et al.* 2015).

Health services for families aim to find and analyze family health difficulties while ensuring that the family is aware of and accepts their position. Assist the family's health needs through nursing services; To help members improve their abilities to care for their families, assist them. Maintaining the whole family's health is a top priority, and resources should be used to do so. Family health services may provide complete health

care to a community. There are several benefits to using family health services. In the family health nursing method, data collection follows a logical path to family health care. To solve family health issues, there are five stages to follow: Clinical records, nursing history, consultations with experts, readings from literature, and interviews with patients are only a few of the methods used to gather information (Martin *et al.* 2013).

The child's needs and the family are considered when making choices about services and assistance. Recognizes and respects the capabilities and conditions of each family member. There has been a shift in Iraqi family health care from the biological components of a child's disease to the child's visual impairment. The Principles emphasize the significance of the family in a child's life and encourage the method families to choose to take within their family. Equally necessary components of the phrase "healthcare."This is the way to win. Patient care is likely to improve in quality and safety due to the assistance provided. There is a need for better communication between patients' families and healthcare professionals. With patients and family concerns in mind, families are more comfortable working with specialists in a care plan, and professionals are on board with what families expect from medical intervention, resulting in a more efficient allocation of healthcare resources and increased patient and family satisfaction (Beever *et al.* 2017).

Families need affordable health care that includes services for mental health issues (mental illness and substance abuse). Each of these elements is within reach of the government and helps families in their attempts to maintain a healthy lifestyle. People's ability to escape poverty is closely linked to their overall health. For families to thrive economically, their children must be well prepared for the challenges they will face in school, and teens must participate in productive, high-quality activities. For this reason, the health of family members is crucial to its ability to provide, nourish and care for all its inhabitants (Khan *et al.* 2021). The following are some examples of family health care: Nutrition is the process by which nutrients are taken in and used to help people stay healthy and stay healthy for a long time. That includes health promotion and illness prevention to acute and long-term disease treatment (Dimaria-Ghalili *et al.* 2014).

To promote public health, nurses play a vital role in their communities. Nurses have traditionally focused on preventing sickness and changing people's health-related habits to promote health and prevent disease. Oral health care professionals, including dentists, dental hygienists, and dental assistants, aid dentists in maintaining oral health. Scaling and polishing, as well as educational and promotional campaigns to avoid tooth decay, gum disease, oral cancer, and other oral illnesses, are among the duties of dental health professionals. Iraqi specialists, including dentists, only allow certified dental health practices." Dental offers nurses to help dentists in dental treatment on the side of the chair, as well as undertake other tasks connected to infection control, dental surgery preparation, and patient care." (Williams *et al.* 2013).

Family health nurses work in an environment that is not always conducive to providing nursing care, making their work challenging. The relationship between two forms of primary health care assistance, one traditionally oriented towards biomedicine and the other oriented towards a family health approach, has been thoroughly investigated; as their occupations' intellectual aspects have become more prominent, so too has the number of people and positions available to them. A wide range of health-related skills and competencies have been developed, including the ability to analyze one's and one's family's health requirements and collaborate with others in making decisions and negotiating (Lorenz *et al.* 2018).

When providing medical treatment, maternity and newborn nurses pay close attention to the requirements of the patient's loved ones. A nurse's role is to assist families in adjusting to the arrival of new members. The lady and her family should be treated with dignity and respect. Medical professionals pay considerable attention to and respect the wants and concerns of their patients. Family members benefit from the positive and helpful advice they get from these experts. Whenever possible, members of the patient's family are encouraged to become involved in the treatment and decision-making process. A multidisciplinary health care team includes patients and their families (Perry *et al.* 2017). In the same line as public education, public health is a service delivered to the whole population rather than just a tiny subset. As a result, many fundamental public health initiatives help low-income families, their children, and people of all income levels (Hahn and Truman 2015).

1.2 Importance of the Study

Multifaceted health care programs for families started to emerge in the late twentieth century, and they have since evolved into a wide range of services. Some of the most desirable locations include: Health care must be safe, efficient, and patient-centered (Davis *et al.* 2015). Determining the amount to which predicted outcomes have been realized and the occurrence of unexpected impacts are all aspects of healthcare assessment, including defining the treatment objective and monitoring PHC inputs (Schmied *et al.* 2014).

As a way to evaluate performance, patients' perceptions of healthcare quality may be used. Therefore, it is possible to conduct a PHC evaluation, or to monitor PHC performance from the patient's viewpoint, by asking about their experiences with PHC and their level of satisfaction with the service they received. These kinds of assessments may be used to identify potential problem areas. Furthermore, a patient-centered approach to problem-solving may be aided by a qualitative examination of the patients' experiences. Patients' evaluations of PHC quality are primarily based on survey data, even if qualitative techniques are increasingly used to assess patient care (Fowler *et al.* 2015).

The importance of primary care to the health of the population and the structure of the health care system has been well acknowledged in scholarly literature. Primary care-based health systems, in theory, improve the health care network's efficiency: For starters, primary health care is more accessible than specialized care, and it can better address the types of complaints that people bring up when they seek help from a healthcare provider. In addition, it helps to organize and rationalize the use of resources (both primary and specialized) by focusing on health promotion, maintenance, and improvement (Rossiter *et al.* 2017).

There were no site statistics on maternal health. Recent efforts to resolve long-term mother-infant-child health disparities have been made. A "life cycle" presentation was adopted to enhance patient care and safety. Early delivery, poor maternal health, and a longer wait for prenatal treatment are all associated with unintended pregnancy.

Prenatal health activities aim to improve pregnant women's and their families' health while also examining the effectiveness of evidence-based treatments and social compliance concerns (Petersen *et al.* 2016).

It focuses on pre- and post-natal care as an essential part of family health, including maternity services, since appropriate treatment may lead to favorable pregnancy outcomes and healthy babies. It is one of the long-term aims of thousands of maternal health improvements. It was determined whether or not women were aware of the importance of prenatal and postnatal care, vaccinations, inquiries, dietary factors, signs of an impending pregnancy, contraceptives, and their own conduct. The parameters for each one had been laid forth. This research aimed to determine the level of competence of family health nurses in their work. ” Rural and urban places are included. Knowledge, science, and culture all play a significant role in maternal and neonatal health care. People's attitudes, beliefs, and behaviors are examined in the study. Mortality and morbidity may be reduced by clearly understanding, taking the appropriate actions, and putting this knowledge into practice. Therapy during the duration of the pregnancy and the postpartum period. After that, seeing early warning signs and getting medical help from the suitable sources are crucial (Alkema *et al.* 2016).

Health care workers may save lives by being better educated, and facilities for mother-and-child health care can be more enjoyable for patients and professionals. Even though free fitness services for mothers have been introduced, it is recommended that a scientific team be established to care for children in each region, as well as training men and women in firmly sealed prenatal skills, abortion treatment, breastfeeding management, and some of the main initiatives taken by authorities to improve adequate access to fitness treatment centers. Due to these new guidelines, maternal mortality may be lowered (Mustafa 2020).

The United States Basic health services were established by the Iraqi Ministry of Health to serve as the basis for all primary health care institutions to increase the quality of treatment for Iraqis. The entire health care system covers all the management, resources, activities, and outcomes of health care. A health service's

effectiveness is measured in terms of whether it increases the likelihood of desired health outcomes, is compatible with current professional knowledge, and meets the expectations of health care consumers (Altaha *et al.* 2017).

Maternal and child health care and other services have seen considerable improvements in children's health, especially chronic childhood diseases. This approach offers a more comprehensive view of how children and their families should interact with each other. It's a set of guidelines, procedures, and responses to providing social services to children and families. Families with special needs children. Because each family is an integral component of a child's life, this curriculum acknowledges that families are the best experts on the skills and conditions of their children (Ahmed and Islam 2012).

Taking care of one's family's primary health care needs is a big responsibility, and many best practices can be found in these tasks. Assistive technology Placing health-care personnel close to people's homes facilitated the initial point of contact. It is feasible to provide long-term care because each region maintains a comprehensive list of its residents, and each team is responsible for every person there. The scope of multidisciplinary teams' work has expanded in recent years. Active care is similar to proactive care in that it looks for issues before patients arrive at the health facility. Additionally, public health initiatives such as contact tracing and vaccination programs vary from country to country (Macinko *et al.* 2015).

Family health care services are provided to families, an essential component of societies and the social unit that constitutes society. Primary health care clinics must be able to provide this service competently. Consequently, the present research should evaluate family health services to determine their adequacy, as well as the relationships between such health care services and the characteristics of health care professionals such as staff nurses (James *et al.* 2014).

One of the nurse's expertise is in the field of family health. As defined by the World Health Organization, it is a form of acceptable primary health care reorganization comprised of a multidisciplinary team responsible for the population of a particular area. The concept is a one-of-a-kind healthcare approach that puts the needs of families

at the center of care. Primary care nurses were under the supervision of community health agents, some of the closest people to patients in their daily lives. Other professionals may be in charge of management, which is not a job particularly assigned to nurses under current law. Monitoring one's actions and setting personal objectives for lifelong learning is at the core of this kind of activity. Power relations are widespread in society, permeating all parts of our lives, from the workplace to our social interactions. Because power is also a catalyst for the growth of knowledge, it will be examined from the perspective of partial relations rather than merely from the position of oppression and its negative expressions. It is essential to look at the consequences of the processes and knowledge-power relations formed in the workplace when confronted with this issue. There may be new questions about how supervision is done and new ways to act if these relationships are revisited (Silva *et al.* 2014).

1.2 Statement of the problem

The current research focuses on evaluating the services provided by nurses in the family health unit who work in primary health care clinics in Diwaniyah, Iraq. In addition to keeping track of the points' strengths and weaknesses and the severity of the problems, it is essential to find appropriate answers by addressing as many issues as these nurses face.

1.3 Hypotheses of the study

H0: There is no relationship between nurses and health services provided in the family health unit in the primary health care centers in the city of Diwaniyah.

H1: There is a relationship between nurses and health services provided in the family health unit in primary health care centers in Diwaniyah.

1.4 Objectives of the Study

1. Nursing services in family health units at primary health care institutions in Diwaniyah are to be reviewed.

2. We find the nursing and health needs of each family member..
3. The involvement of family members in the development and delivery of health care and nursing services.

1.5 Limitations

Among the difficulties and obstacles encountered during the period of collecting samples were in health centers in rural areas, where the number of nurses was few, and the difficulty of collecting samples there, as they differed from health centers in the city center.

2. LITERATURE REVIEW

2.1 Family Health Services

In the late 1970s, specialists in the area of health care services were still debating health issues that may have been prevented and remedied with the medical knowledge and technological advancements available at the time (Fracolli *et al.* 2014). Generally speaking, primary health care is the initial point of contact with the healthcare system, often achieved via a family physician. Populations must get contact, continuous, comprehensive, and coordinated health care that is not discriminated against on the basis of gender, illness, or particular organ abnormalities (Gocan *et al.* 2014).

Family Health is a specialization of medicine that provides comprehensive health care to people of all ages and ethnicities. Individuals and families of all ages and genders receive continuous and comprehensive health care in this department, which also provides an initial consultation for all diseases and members of the body based on the patient's knowledge and experiences in the context of their family and community, with a particular emphasis on disease prevention and health promotion. According to the World Organization for Family Health, the goal of family health is to provide everyone with personalized, comprehensive, and continuous care within the context of a family and community framework (Jackson *et al.* 2013).

A family health care service is considered a community health component. It is more than the total of an individual's health; it is a unit of healthcare delivery (Stanhope and Lancaster 2019). Family health is defined as a healthy interaction between family members that allows each member of the family to achieve their physical, mental, social, and spiritual well-being to the greatest extent possible.(Fadlon and Nielsen 2019).

In the context of primary health care, it is critical to track the growth and development of the child. Child care should be understood as a specific moment of care during which the child is evaluated. The perspective expanded to include the mother and the

family community entails identifying weaknesses and encouraging access to the required behaviors (Andrade *et al.* 2013).

It is paying particular attention to elements detrimental to early childhood development. Furthermore, child health care allows for the control and respect of the mother-child relationship, as well as the sharing of experiences and the formation of a mother/family partnership to provide care that protects the child and improves its health and quality of life (Britto and Ulkuer 2012). It focuses on the health needs and recognizable responses of women, their spouses, and families to actual or possible health issues related to childbearing (Brantlee Broome-Stone 2012). Health hazards are most significant in the first 28 days. Still, the first five years of life are the most harmful for children in many industrialized nations because of their vulnerability to infections and other diseases (Kebede 2013).

2.2 Maternal and Child Services

The WHO defines maternal health as the state of a woman's health before, during, and after delivery and the postpartum period. As a broad category, child health encompasses children's physical, mental, and social well-being from conception through puberty. In the first 28 days of life, newborn health includes a baby's physical and psychological well-being. As a result, they are often seen as a whole, as they are all interconnected. If a mother is in good health throughout pregnancy, it significantly influences the health of her unborn child. If their mother dies, their offspring have a three- to tenfold increased risk of dying (Akseer *et al.* 2017).

Efforts to rehabilitate clinical practices and strengthen scientific evidence as a resource for patient safety are now being made in modern times. However, evidence-based practice (EBP) in nursing has been introduced gradually and represents the translation of scientific results into the issue of clinical practice (Bostrom *et al.* 2013).

As a result, qualitative research design contributes to the advancement of human accomplishment and integration (Gagliardi and Dobrow 2011). Maternal and child nurses face challenges to EBP, such as a lack of time and expertise, despite the

abundance of current scientific data (Dalheim *et al.* 2012). During discussions on Primary Health Care (PHC), the Brazilian model of family-centered care, notably in maternity and child health, it is acknowledged that nurses must adopt autonomous and scientifically justified acts, particularly in child health care (Gasparino *et al.* 2013).

Additionally, it addresses the needs of the growing fetus from conception through delivery and the infant from that time forward. Having a baby is a normal, healthy part of life, and the focus of maternity and child health nursing practice is on promoting and preventing illness in mothers and children. Although global and national vital data show that maternal and child health is improving but remains a severe problem, maternal and child health is considered a component of PHCdefinition (Atif *et al.* 2015).

According to research, children's and mothers' health has been demonstrated to significantly influence overall community health (Rahman *et al.* 2013). Women's health is another topic of concern in high health care because of the biological impacts of reproduction that make women more prone to health issues (Rubin *et al.* 2017). Maternal health issues, such as insufficient health care, poor cleanliness, inadequate birth management, and a lack of necessary infant care, are the leading causes of maternal and neonatal mortality and impairment worldwide (Tuncalp *et al.* 2015).

Health care for pregnant women and their infants focuses on prevention and treatment. Health education and illness prevention and treatment are the primary focus of prenatal care, followed by infant and child health care (including the upkeep of growth charts and vaccination records), family planning, and postpartum care (Joseph 2020). The World Health Organization (WHO) has established IMCI strategies for one month to five years. In these procedures, you'll find guidelines for diagnosing, treating, and referring unwell children, educating their caregivers, and immunizing them as appropriate (Renfrew *et al.* 2014).

According to the WHO Bank for Child Health and the Poverty Working Group, a basic set of six preventative and two therapeutic activities might significantly reduce the burden on children. An essential part of preventing disease is taking care of a pregnant

woman and her baby from conception until the time she gives birth. Medical treatment should be sought as soon as possible if the patient cannot manage their sickness at home (Brizuela *et al.* 2019). Women's wellness-directed primary preventive treatments have four basic objectives: keeping balance; perspective, and priorities in life; building and sustaining good relationships, a healthy sense of self, and a physically fit body; and avoiding acute and chronic disease. (Dickson *et al.* 2015).

2.3 Maternal and Child Health in Iraq

The war has a disproportionately negative impact on women and children. Medical services are disrupted, and health workers are less prepared to deal with medical crises due to the war's effects (Bhutta and Black 2013). The high rates of maternal, newborn, and infant mortality are due to a combination of factors, including damage to infrastructure, health facilities, and the flight of healthcare workers, as well as disruption of access to critical information and social services, as well as displacement of the population and exposure to violence (Southall 2011). Years of violence have caused the latest conflict to stall growth in the preceding lower child death rates and births. According to statistics released in the UNICEF survey of the world's children in 2012, 15 percent of babies in Iraq are born with low birth weight, accounting for more than half of all fatalities among children under the age of five. In 2015, the maternal death ratio was projected to be 50 per 100,000 live births. In addition, fertility rates are high. From 1990 to 2010, the general fertility rate declined from 6.1 to 4.7, although it remained higher than other nations in the area. Iraq continues to have limited access to reliable and updated data on MNCH indicators, with the most recent Multiple Indicator Cluster Survey (MICS) performed in 2011 (Moazzem Hossain *et al.* 2018).

Role of Nurse

Professional skills and education, the role of an educator, client advocate, and contact with community resources are all crucial while working with the mother-child group. More than two-thirds of all nursing practice in PHC programs are devoted to prenatal and newborn preventative health care (Halcomb *et al.* 2016). There are many things a nurse does for pregnant women in the first trimester, including educating them about

healthy eating and exercise, as well as warning signs and symptoms of complications, as well as fetal development. They also keep tabs on the progress of the pregnancy, provide emotional support, and monitor the woman's blood pressure and other signs of complications. They also monitor the woman's progress (e.g., edema, urinary protein). Monitor fetal heart tones, blood pressure, and other symptoms of problems to assist the client in commencing preparation for the baby's delivery and educate the mother about labor and the labor process as the pregnancy progresses. As the due date approaches, the nurse's job transforms into one of education, preparation, and support for the woman and her family as they make choices about how to care for their unborn child, whether they want to breastfeed or bottle-feed, and what vaccinations they should consider (Schlunegger *et al.* 2021).

2.4 Immunization Services for the Mother and Child

It is generally accepted that vaccinations are the most cost-effective medical intervention available in the fight against mortality and illness (Remy *et al.* 2015). They are getting vaccinated as a youngster opens the door to a lifetime of comprehensive health care, which is a fantastic thing in and of itself. Vaccination programs for children have also eradicated many pediatric infectious diseases, making them one of the most remarkable triumphs in public health in medical history (Hendrix *et al.* 2016).

Immunization programs have shown to be very effective in eradicating or decreasing the occurrence of infectious illnesses in industrialized countries, such as the United States, Canada, and Europe. For example, in the United States, childhood vaccines are increasingly considered essential for health promotion (Ventola 2016). Vaccination rates in the industrialized world have increased significantly during the previous decade (Mihigo *et al.* 2017).

Despite these developments, vaccine-preventable illnesses remain a severe public health issue in many developing nations (WHO 2015). Towards the close of the twentieth century, there was also a discovery that more than 3 million children die each year in impoverished nations due to diseases such as measles and pertussis, as well as

more than a quarter-million children who are permanently handicapped by poliomyelitis (Greenwood 2014). When it comes to placing a high value on health and evaluating the quality of health results, South Asian nations have the poorest records of any emerging country (Kruk *et al.* 2018). It is the best way to avoid many communicable illnesses among children and adolescents. Since adults began receiving routine immunizations, vaccine-preventable diseases have decreased by 99 percent (El-Bahnasawy and Morsy 2015).

Mothers and children are the primary beneficiaries of the Expanded Immunization Program, one of the most widely administered and well-established health initiatives in the world, according to the World Health Organization (WHO). Maternal and child health and survival therapies may be integrated with immunization services because of their features. WHO and UNICEF's Global Immunization and Vision Approach (GIVS), introduced in 2006 and covers the years 2006–2015, has increased attention to this strategy as one of four critical areas of importance (WHO 2018). Prevention of illness by vaccination helps all individuals and has a beneficial effect on global health, national and local economics, and social welfare (Rodrigues and Plotkin 2020).

Role of Nurse

Medical experts agree that vaccines are one of the most cost-effective ways to prevent death and sickness (Remy *et al.* 2015). When children are vaccinated at an early age, they open the door to comprehensive health care for all children. Vaccination programs for children have also eradicated many pediatric infectious diseases, making them one of the most remarkable triumphs in public health in medical history. The study by (Hendrix *et al.* 2016). Vaccination programs may eliminate or significantly reduce many infectious diseases in developed nations such as the United States, Canada, and Europe. The importance of children's vaccinations, for example, is rising in the United States (Ventola 2016). Industrialized nations' vaccination rates have risen dramatically during the last decade (Mihigo *et al.* 2017). Vaccine-preventable illnesses are a serious public health problem in many developing nations, even though progress has been made on their development (WHO 2015). By the twentieth century, researchers had discovered that measles, infant tetanus, and pertussis killed over 3 million children

annually in developing nations. In comparison, poliomyelitis left over a quarter of a million children permanently crippled (Greenwood 2014). South Asian countries have the worst records of any rising governments regarding valuing health and assessing the quality of health outcomes (Kruk *et al.* 2018). This is the most effective strategy for preventing infectious illness transmission among children and teenagers. There has been a 98% decrease in vaccine-preventable illnesses since the introduction of routine immunizations for adults (El-Bahnasawy and Morsy 2015).

The Expanded Immunization Program, one of the world's most extensively administered and well-established health efforts, is targeted at pregnant mothers and their children. Its qualities have given birth to "integrating" additional maternal health and child survival treatments with vaccination services. Since WHO and UNICEF selected this integration as one of four essential priority areas in the 2006–2015 Global Immunization and Vision Approach (GIVS) framework, launched in 2006, there has been a surge in interest in this approach (WHO 2018). Vaccination is suitable for everyone and has a positive impact on global and local health, national and regional economies, and social well-being. (Dube and MacDonald 2020).

2.5 Breast Feeding Services

Breastfeeding has a significant role to play in improving public health. After six months of life, the World Health Organization (WHO) advises that newborns continue to breastfeed in combination with nutritious complementary meals (solids) until they are at least two years old or older (Sun *et al.* 2017). To guarantee that all women and their infants experience the health and social advantages of breastfeeding, the WHO/UNICEF initiative works with health care providers, doctors, and mothers. To support optimal practice in baby feeding, maternity units should meet the ten-step program established using practice guidelines to encourage and support breastfeeding. Before a business can be labeled "baby-friendly," it must complete all ten stages outlined above. The introduction of programs has been linked to an increase in the adoption of breastfeeding, according to research conducted in various maternity settings across several nations (Gomez-Pomar and Blubaugh 2018). To increase the number of women receiving prenatal, antenatal, and postpartum care who are aware of

the benefits of breastfeeding, who begin, continue, and exclusively nurse their infants, and who exclusively breastfeed. To help moms achieve their nursing objectives and overcome any obstacles or hurdles they may have, pediatric clinicians should be informed and educated on current breastfeeding practices. Public awareness and education on the advantages of breastfeeding, as well as the dangers associated with not supporting breastfeeding, are the primary goals of this project (Balogun *et al.* 2016).

Role of Nurse

A woman's choice to start or continue breastfeeding may be influenced by midwives and other health professionals, especially those in the field of midwifery. When it comes to nursing, many women rely on the advice of their female friends and relatives (WHO 2016).A health care provider lacking enough breastfeeding expertise and guidance may impair how well they help a nursing mother in need. Several studies have shown that nurses participating in breastfeeding assistance had erroneous knowledge and bad attitudes regarding breastfeeding or did not have adequate information to assist women (Almeida *et al.* 2015).

2.6 Integrated Management of Children's Illness

In 1992, the Globe Health Organization and the United Nations Children's Fund (UNICEF) began developing the International Malaria Control Initiative (IMCI) plan, which more than 100 nations have adopted worldwide. The adoption of the IMCI method has excellent outcomes in reducing childhood mortality and enhancing the overall quality of life for young children all across the globe, particularly in developing countries. Every year, about (10) million children die before reaching the age of five, with the vast majority of these deaths being caused by avoidable and curable illnesses (Boschi-Pinto *et al.* 2018).

The World Health Organization/Unicef recommendations for Integrated Management of Childhood Illness (IMCI) provide simple and practical techniques for preventing and managing the primary causes of severe illness and death in young children. The clinical recommendations promote evidence-based evaluation and treatment via a syndrome

approach that encourages pharmaceutical products' reasonable, adequate, and cost-effective use. The instructions include procedures for determining a child's vaccination and nutritional status, instructing parents on how to administer treatments at home, monitoring a child's eating and providing counseling to resolve feeding difficulties, and guiding parents on when to return to a health institution. The technique is intended for use in outpatient clinical settings when diagnostic equipment, drugs, and chances to perform sophisticated clinical procedures are restricted, such as in emergency departments (WHO 2014).

Integrated case management is based on the identification of cases using primary clinical symptoms and the use of empirical therapy. The utilization of as few clinical indications as feasible is the goal. The signals are based on professional clinical judgment and research findings, achieving a careful balance between sensitivity and specificity. Unlike accurate diagnosis, treatment plans are designed according to action-oriented classifications. They cover the most common illnesses indicated by each categorization and their symptoms (Carai *et al.* 2019). It is possible for physicians, nurses, and other health workers who work with unwell babies and children aged one week to five years to employ the IMCI approach. Case management is performed in a first-level facility, such as a clinic, a health center, or an outpatient section of a hospital (Nguyen *et al.* 2013).

Although the IMCI standards cover the vast majority of the key reasons why a sick kid is brought to a clinic, they do not address all of them. A youngster who returns with persistent difficulties or less frequent diseases may need extra attention. The kid is sent to a hospital for special care if the sickness does not respond to routine therapies or if the youngster becomes extremely underweight or keeps returning to the clinic. Case management may be successful only via prompt attendance at a professional health worker's office. If a family waits until their kid is unwell before taking them to a clinic, or if they take the child to an unskilled provider, the youngster is more likely to die due to the sickness. Case management practice includes educating families on when it is appropriate to seek medical attention for a sick kid. On two distinct sets of charts, the case management procedure is explained: one for children aged 2 months to five years and another for children aged 1 week to 2 months (Gera *et al.* 2016).

Role of Nurse

Nurses are the primary role players in educating parents about their newborn's health status. Preemptive, high-quality education may decrease the stress of eventual abnormal screening findings and make follow-up easier (Hockenberry and Wilson 2018). Educating pregnant parents about newborn screening may be difficult due to the wide variety of illnesses and the little time they have to learn about the screening process. When it comes to newborn screening, most parents prefer to know about it while pregnant and before the baby is delivered (DeLuca *et al.* 2013). Families should be informed of the screening process and what to anticipate if their newborns require further examination. This information should be included in instructional booklets for parents and caregivers (Frankova *et al.* 2019).

2.7 Breast Cancer Screening Services

For breast cancer screening, a woman's breasts are examined for any signs or symptoms of the disease before deciding whether she has cancer. Breast cancer screening is based on a comparison of the recommendations of several notable organizations. Women's health care professionals must offer them information on the best screening options. When you and your healthcare provider explore the benefits and risks of a screening test before selecting which one is appropriate for you, you are making an informed and collaborative choice (McKinney *et al.* 2020).

The worldwide toll of cancer plays a significant role in this. According to estimates, new cases will climb from 10 million in 2002, with 60 percent of those cases coming from poorer nations by 2025. A breast cancer diagnosis in women is the top cause of death from cancer globally, according to the World Health Organization (WHO). Standard age incidence is lower in poorer nations than in industrialized ones. However, this varies geographically. Breast cancer affects not just the patient but the whole family. Despite societal shifts, women continue to play a central role in family life. As a result, breast cancer significantly affects the lives of the affected lady and her loved ones. Planned measures, such as establishing policies for early identification and screening of breast cancer, must be developed and implemented by the Ministry of

Health. Healthcare professionals should be included in the debate and development of programs for illness management in addition to everyone else (Sung *et al.* 2021).

Early detection and access to care panel reiterated that women must be encouraged to seek care and have access to adequate, inexpensive diagnostic tests and treatment at all resource levels. According to the group, all women should be educated about breast health to increase their chances of early detection. Basic facilities could benefit from improvements such as clinical breast examination (CBE) training for affected and unaffected women, opportunistic screening with CBE, demonstration projects or trials of organized screening using CBE or breast self-examination, and feasibility studies for mammographic screening. Individuals with breast cancer who have died and their tumor stages must be informed and their death documented for this research to be complete (Ginsburg *et al.* 2020).

Role of Nurse

Detection and prevention of breast cancer are critical roles for nurses, but they may be challenging. Even though mammography is the most effective screening method for low-risk women over 50, it misses 10% of breast abnormalities in the older population and 25% in the younger group (Jacobs *et al.* 2014). Women's breast cancer screening strategies should be customized depending on their age, health, and risk assessment, as well as their beliefs and personal preferences (Yilmaz *et al.* 2013). Nurses who specialize in women's health care should have easy access to evidence-based information and be able to use it in their clinical practice. If you deal with women, you need to be able to educate them about topics such as breast anatomy and abnormalities, breast cancer risk factors, and the benefits and downsides of different breast screening procedures. Nurses use this information to assist women in making educated decisions about the screening treatments most suited to their circumstances (Gabriel *et al.* 2016).

2.8 Physical Examination for Adults

During a physical examination, the doctor thoroughly evaluates the patient's physical and mental condition. It is the systematic gathering of objective information about a

person that is either seen or obtained via examination procedures that is the basis of a physical evaluation. It is the procedure of physically inspecting the patient's body to discover whether or not they have any physical abnormalities. The purpose of a physical examination is to acquire accurate information about the patient's health status from the patient. The examiner must be able to recognize, interpret, and synthesize the information gathered to provide a complete evaluation. Inspection, palpation, percussion, and auscultation are the four cardinal principles of physical examination; "Teach the eye to see, the finger to feel, and the ear to hear" are the words to live by (Jarvis 2018).

The evaluation of the patient or customer starts as soon as the first interaction occurs. This category includes the apparent condition of health, degree of awareness, and indications of suffering. Physical examination includes taking note of the overall height and weight, skin color, clothes, grooming, personal hygiene, facial expression, stride, odor, posture, and other physical characteristics. Because situating and moving the client during the examination interfere with reliable findings, the evaluation of vital signs is the first step in physical assessment. In addition, specific vital signs may be collected during the review of each separate bodily system (Toney-Butler and Unison-Pace 2018).

Role of Nurse

The professional nurse's role in assessing a patient's problems is crucial. Depending on the nurse's education and experience, she may or may not participate in the review process. Nurses in primary care settings may conduct a complete physical examination of patients. The usage of medications that may be found in the environment should be taught to a nurse who is being educated to detect abnormal health circumstances. Maintaining a patient's room in a warm, comfortable, and private environment is part of the nurse's job description (Kourkouta and Papathanasiou 2014).

The nurse practitioner's clinical assessment is based on accurately collecting and interpreting relevant subjective and objective biopsychosocial data. Inspection, percussion, palpation, and auscultation are four of the physical examination's core

objective data-gathering processes (hearing sounds). As a common source of clinical information, nurses in many countries depend on patient biological reviews to supplement their knowledge. Comprehensive exams are standard in advanced nursing practice at the Master's level; however, problem-focused physical examinations are more common in nurses' daily routines (Douglas *et al.* 2015).

A new obligation for many nurses in the United Kingdom who are increasing their scope of advanced clinical practice is the physical examination of a patient. Nurses in both the community and acute care settings might benefit from using a physical assessment framework to help them through the process of completing a physical examination. In the framework presented here, the following steps are taken in the next order: determining why the assessment is being performed; collecting a health history; deciding on a comprehensive or focused approach, and examining the patient using the examination techniques of examination palpation, percussion, and auscultation. The next phase, the interpretation of the clinical data, which results in either the recognition of an anomaly or the identification of a differential diagnosis, then serves as the foundation for clinical decision-making in the patient. In this section, we will present a complete, head-to-toe evaluation to illustrate how this physical assessment paradigm might be used in clinical practice (Maybin *et al.* 2016).

2.9 Non-Communicable Disease Control Services

All of these services are geared toward encouraging a healthy lifestyle and risk assessment, identifying, assessing and beginning treatment, and referring patients in an emergency case. In some nations, infectious illness continues to be the most severe public health risk. Non-communicable diseases were responsible for 40 percent of worldwide mortality and 43 percent of the global disease burden in 1999; by 2020, these percentages are anticipated to rise to 73 percent and 60 percent, respectively, as non-communicable diseases continue to progress (Hunter and Reddy 2013).

A condition that lasts a long time, The disease's impact on a person's health is not limited to death. Chronic illness may be quantified by determining how many excellent years have been wasted due to the ailment. Studies show that developing countries

suffer the most significant number of DALYs due to lower respiratory infections, pregnancy (including HIV/AIDS), meningitis, and diarrheal illnesses (Murray *et al.* 2012).

Role of Nurse

Many community health nurses are engaged in preventing and treating chronic illnesses and their consequences on individuals and groups of people. The nursing process is a representation of these efforts. Nurses will play a key role in chronic illness management's primary, secondary, and tertiary preventive phases. Health promotion and risk factor reduction are at the heart of primary prevention. Modification nursing intervention is a screening for risk factors in the context of risk factors. Secondary prevention includes educating the public about the warning signs and symptoms of chronic illness, screening for existing chronic disease, and aiding in treating chronic disease. Nurses can do many activities to assist in tertiary prevention of chronic conditions: encouraging the client to follow the treatment regimen, helping the client maintain function in natural systems so that they can regain function (bowel training, physical therapy), and monitoring the health of the client. (Tsolekile *et al.* 2014).

2.10 The welfare of the Disabled Services

Health care and rehabilitation, education, vocational training, and career possibilities are restricted or non-existent for many persons with disabilities. During the years of war in Iraq and all of the natural and artificial calamities around the country, the number of disabled individuals has climbed to nearly two million (Miles 2013). Over the last several years, the attitude to disability has shifted away from a medical perspective to a social one. This argues that impairment develops due to the interplay between persons with a health condition and their surrounding environment (Oliver 2013).

People with disabilities come in all shapes and sizes, from all walks of life and social strata, and exhibit a broad spectrum of reactions and coping mechanisms across Iraq and the world. Consequently, people with disabilities encounter various challenges in

their everyday lives, including hurdles related to social and physical impediments such as stigma and discrimination, a lack of proper health care, and inadequate transportation. Due to their limitations, people with disabilities are more likely to suffer from poor health, poorer educational achievement, reduced economic opportunities, and higher rates of poverty. As a consequence of this, individuals are ostracized and excluded from participating in their communities. World Health Organization (WHO) assistance in strengthening and enhancing disability registration in Iraq and its Ministries of Health aims to make health systems more inclusive and responsive to those with impairments. Policy formulation, training, and technical help are some ways this support might be provided. Decision-makers can assess the burden of disability in Iraq using the data collected via this registration system. This data will be valuable in developing future strategies and plans to improve access to services for those most need them (Montgomery *et al.* 2021).

Role of Nurse

People with disabilities may benefit from short-term nursing interventions designed to help them improve their physical function or social skills to be more self-sufficient in their daily activities and social interactions. They help people with disabilities who want to work in a private firm, etc., get the knowledge and skills they need to join the workforce for a certain amount of time via appropriate training. They also provide training and job opportunities for persons with disabilities who cannot work in the private sector. At night and on vacations, those who live in a shared home are given advice and aid in their daily routines. Nurses and social workers often interact with patients with intellectual disabilities. However, nurses and social workers have a limited influence on detecting mental health concerns and harmful behaviors despite their crucial role (Gobbens *et al.* 2012).

2.11 Health Education Services

The World Health Organization (WHO) defines health promotion as educating, inspiring, and aiding individuals in adopting and sustaining healthy activities and lifestyles. Advocating for environmental changes is essential to attain this aim, doing

professional training and research to achieve this goal, and advocating for healthy habits and lifestyles. There are four main objectives of health education programs: to educate people about how to keep their bodies in good shape and minds in good condition, to build an informed body of opinion and knowledge (such as that of a social worker or a schoolteacher), and to facilitate the proper use and acceptance of medical measures (Ungar *et al.* 2014).

A medical approach to health education was also adopted at the onset, emphasizing strengthening and improving the health of the family rather than the individual's health. This featured issues such as Maternal and Child Health Care (including contraception), Family Planning (including immunization), Nutrition, and various other topics. Over the past few years, its approaches have focused on human biology, nutrition, sickness control, mental health, accident prevention, and healthcare services (Sade and Peres 2015). In addition to face-to-face consultations with clients, health education campaigns in high-risk areas, social mobilization for different health programs, health education materials, and media are utilized to deliver these services. All clients who come to PHC services get proper health education, information, and encouragement (Kabir *et al.* 2021).

When it comes to promoting community health, health education is a critical component of every implemented plan. Health education services are a vital component of health care since they aim to promote healthy behaviors that contribute to overall well-being via education. There has been a great deal of debate about the function of health education, and it has developed into a legitimate profession in its own right (Sharma 2021).

Role of Nurse

A nurse's primary role as a health care provider and educator is educating patients and others about health care. They often participate in the creation of population-based programs for health education while also providing regular health education services to individuals, families, and groups. Educators study the need for education and the

incentive for learning, generate and deliver health-related information, and evaluate the effect of health education on the population (Shanafelt and Noseworthy 2017).

In improving public health, nurses play a vital role as educators. Even at the patient's house, the nurse's job is to educate people about the importance of good health and well-being. It is more than simply sharing information in health care to assist individuals in adopting better lifestyle practices. Through health education ideas, nurses may help patients achieve their health goals in a way that is consistent with their lifestyles, values, and beliefs. Education is one of the primary roles of a nurse, as mentioned in the Standards of Clinical Nursing Practice. This includes people's health and treatment choices, health promotion, sickness prevention, and peaceful death, among other things (Saprii *et al.* 2015).

Their entitlement to be educated about diagnosis, treatment, dangers, benefits, costs, and other options balances these duties. An essential element of the nurse's responsibility is to guarantee that individuals have the right to know about their health and to assess and support their physical, emotional, and spiritual responses to that knowledge. In addition, the nurse's work description includes providing personalized health education and counseling to patients (Kim and Jeon 2018).

In some instances, nurses are referred to as "health care coordinators" for the patients they are responsible for. The nurse and the patient develop a relationship based on the individual's interests and need to help select and use appropriate health care. These concepts aid the nurse in determining a person's preparedness for health education, providing technical knowledge, and assisting them in implementing health care skills at home. These tactics also aid the nurse in supporting behavior change while meeting the person's access to appropriate health information and their freedom to make health-related choices for their reasons. People's understanding of their health is critical to lowering their dependency on the healthcare system. As educators for public health, nurses have traditionally played an important role, sometimes acting full-time as coordinators for the educational services of a health organization or institution. In the case of health educators, marketing tactics may be used to boost the success of health education programs targeted at specific groups. The health education specialist assists

other nurses and health care professionals in developing and implementing educational initiatives (Salmond and Echevarria 2017).

2.12 Nutrition Health Services

Health-related treatments that concentrate on nutrition and weight management are a significant part of the whole package (Mozaffarian *et al.* 2012). Insufficient nutrition may lead to many health problems, including long-term disease, disability, and even death. Underweight, hypertension, iron deficiency, high cholesterol, and obesity are five of the top ten health concerns traced back to a person's diet or lifestyle choices (Romero-Martnez *et al.* 2013). For example, women's and children's nutritional health may be improved by various programs and treatments specifically targeted at them. Services include promoting good nutrition, preventing, and treating malnutrition (Lenters *et al.* 2016). Additionally, healthy eating habits are critical for newborns, toddlers, and adolescents of all ages (Tiwari *et al.* 2016).

Role of Nurse

Nurses can educate and advise patients on the importance of nutrition in promoting health and preventing sickness because of their frequent and extensive contact with patients in the community (Nimmagadda *et al.* 2019). When working in primary health care, nutrition education is an essential element of nurses' duty, mainly when dealing with pregnant women. (Ehlers *et al.* 2014).

2.13 Communicable Diseases Control Services

Chronic illnesses caused by infections spread from one person to another are called communicable diseases (CD) (Brauer and Castillo-Chavez 2012). These services are involved with treating infectious diseases, with a particular emphasis on prevention, early diagnosis, and the starting of actions to prevent transmission and substantial morbidity as well as a severe impairment. The monitoring and reporting of illness is a crucial element of the activities. Depending on the specific disease, there are a variety of activities that can be included in the fight against communicable diseases prevention

and control, such as immunization, case detection and treatment, vector control, zone control, and environmental control, such as ensuring that people have access to clean water and sanitary methods for disposing of waste and excreta (Ismail *et al.* 2016).

Antibiotics, behavioral and physical factors, and genetic tampering are among the many ways to improve public health control of infectious diseases. Other approaches include increasing resistance to environmental dangers, improving hygiene and nutrition, boosting immune system function, and reducing reliance on antibiotics (Lukwago *et al.* 2019).

Many factors must be considered when dealing with infectious diseases, including identifying the problem, controlling disease spread by understanding transmission mechanisms, developing effective therapies for those diseases that are new or haven't been seen before, and requiring help for health care workers dealing with mysterious outbreaks. Actions in the primary, secondary, and tertiary prevention phases may be taken to address these four difficulties. Nursing intervention in primary prevention is focused on preventing the incidence of illnesses. It involves activities such as vaccination, post-exposure prophylaxis contact notification, and other direct preventive measures specific to particular communicable diseases, among others (e.g., educating clients on the mode of transmission and preventive actions) (Manfredi and D'Onofrio 2013).

Role of Nurse

Nurses in this field may utilize a variety of ways to prevent and control infectious illnesses. As a result of the lack of vaccines against many of these diseases, nurses must take extra steps to protect children and adolescents from contracting infectious diseases in addition to vaccination (e.g., HIV, AIDS, and other sexually transmitted infections). The organization's efforts include providing prenatal care screening pregnant women for HIV/STDs, teaching the general public and families about good hygiene and water supply protection, and pushing for proper sanitation and safe food and water sources (Pati *et al.* 2018).

2.14 Legal Considerations of Maternal–Child Health Care

Health care has many ethical difficulties to contend with in every facet. Many ethical dilemmas arise while treating patients under the legal age of consent while simultaneously caring for their unborn children in maternity units. As a result, the rules governing reproductive health care and rights are complex and vary from state to state. Caring for potential families must address these difficulties with extra care. Legal action may be taken by patients who are unfamiliar with the medical reasons for new technologies "for example, assisted reproduction, motherhood alternative, and taking samples from the umbilical cord, and safety of new drugs with children, and the decisions of the end of the age," especially if the patients are not aware of the cause or medical necessity for these procedures (Kim *et al.* 2017).

Nurses are ethically capable of preserving the requirements of their patients, including their privacy, and they are aware of the quality of nursing care for people and the other healthcare professionals team. Health care providers must guarantee that patients may see their medical records if they want while ensuring the confidentiality of their medical records from others. Nurses know the need for patient privacy, but sadly, they don't practice at the same rates. Patients frequently ignore the need to protect their medical records' privacy (Duffy 2011).

Having a firm grasp of the scope of practice and care that a nurse may deliver, as defined by state rules, might make it easier to stay within the bounds of legality in your work as a nurse. Documentation is required to support the actions. Children who feel harmed by health care workers may sue while praying at the legal age, which is why this is a long-term issue for parents. This implies that a nursing note produced now might be upheld for up to 21 years in the future, if necessary. The legal implications of specific measures or care are examined in the subsequent chapters when procedures or treatment approaches are outlined in more detail. To avoid significant financial losses in the case of professional misconduct or carelessness, it is highly advised that all nurses take personal responsibility for their financial security. As a result, "To ensure that pregnant women are fully informed of any risks connected with surgery or test,

nurses must be careful in their actions. There are other methods for contacting a parent who isn't there, such as phone calls or emails." (Whitney and Rosenbaum 2011).

2.15 Ethics for Health Care Professionals in Maternal and Child Care

It is described as the standard conduct of health care providers found in the individual's dedication, secrecy, and interpersonal connections. We are dedicated to enhancing performance while safeguarding the system's integrity and the provision of health care. The Company's Productivity It is my professional and moral responsibility to acknowledge all customers serving me - whether they be consumers, workers, employers, physicians, organizations, or members of the general public (Tarzian *et al.* 2015).

1. Fairness, decency, and accountability in the performance of one's professional responsibilities.
2. Maintain the level of productivity specified in practice standards for the quality of healthcare professionals as stated in the bars.
3. It is necessary to earn the trust and confidence of all clients, according to the question
4. Health care practitioners must adhere to practice rules to maintain consistency.
5. Adherence to all applicable laws and refrain from engaging in the dishonest, incorrect, or deceptive activity.
6. Promotion of the right to privacy for all individuals to maintain the confidentiality of the information and preserve it to the maximum degree permitted by the law.
7. Employ your experience to advise employers or customers of successful or unsuccessful future management actions to foster informed decision-making.
8. Assist colleagues in their professional development and advancement.

3. METHODOLOGY

Many strategies are employed in this chapter: the research's organizational structure, how it's set up, and how the study instrument is constructed, among other things.

3.1 Design of Study

The study used a descriptive and cross-sectional design using the family assessment approach. Al-Diwaniyah healthcare nurses provide primary healthcare in Iraq. This study aims to examine the services provided by family health nurses.

3.2 Administrative Arrangements

Before collecting the results of the study, official permits were taken. Obtained from the competent authorities as follows:

1. The ethical approval committee of Cankiri University in Turkey approved the study's ethical aspects. **(Appendix 1)**
2. Approval of the research by the Research Committee of the Diwaniyah Health Department / Training and Development Unit**. (Appendix 2)**
3. Issuance of a mission facilitation letter from the Diwaniyah Health Department / Training and Development Unit **(Appendix 3).**
4. The table of experts in the questionnaire. **(Appendix 4)**
5. English proofreading. **(Appendix 5)**

3.3 The setting of the Study

The study was conducted in primary health care clinics in Al-Diwaniyah Governorate, Iraq. According to the Primary Care Classification Department of the Ministry of Health, these facilities are spread across the primary health care sectors. (health care sector 1). (The second health sector 2).

A suitable sample was selected from 20 primary health care centers. 10 health centers belonging to the first health care sector. 10 health centers belonging to the second health care sector

Table 3.1 Distribution of primary health care centers in Al-Diwaniyah city.

Primary Health Care Sector	**Primary Health Care Centers**
First sector of AL- Diwaniyah	AL-Talaea AL-Jazair AL-Takea AL-Forat AL-Hakeem AL-Jadaeda AL-Uruba AL-Sanea AL-Shaafieia AL-Jamia
Second sector of AL- Diwaniyah	AL-Sader First AL-Sader Second AL-Sader Three AL-Sader Four AL-Askan AL-Nahda AL-Jamhory AL-Daghara AL-Wahda AL-Saadiq

3.4 Sample of the Study

An adequate number of 200 nurses might be picked by using the sampling mechanism offered by G Power. The research participants were randomly selected. They are classified into two categories which are as follows:

1. A sample of 200 male and female nurses working in primary health care facilities in Al-Diwaniyah city was selected.
2. The organizational structure of 20 primary health care clinics.

3.4.1 Inclusion Criteria

- The number of nurses was selected according to the following criteria.
- All nurses were chosen from the primary health care centers of the first and second Diwaniyah sectors. The nurses had varying levels of educational attainment.
- All nurses who participated in the study had experience starting from one year and more, males and females.

3.4.2 Exclusion criteria of the sample

- The following individuals were not included in the study.
- Nurses who failed to complete the survey in its entirety.
- Nurses with less than a year of experience are not permitted to practice.
- Nurses who refused to participate in the experiment.

Table 3.2 Distribution of primary health care centers And the nursing staff in the Diwaniyah Health Department (First sector of AL- Diwaniyah).

Primary Health Care Sector	**Primary Health Care Centers**	**No.of Staff**	**Percentage**
First sector of AL- Diwaniyah	AL-Talaea	10	**50%**
	AL-Jazeera	10	
	AL-Take a	10	
	AL-Format	10	
	AL-Hakeem	10	
	AL-Jadaeda	10	
	AL-Aruba	10	
	AL-Sanea	10	
	AL-Shaafieia	10	
	AL-Jamia	10	
	TOTAL	**100**	

Table 3.3 Distribution of primary health care centers And the nursing staff in the Diwaniyah Health Department (Second sector of AL- Diwaniyah).

Primary Health Care Sector	Primary Health Care Centers	No.of Staff	Percentage
Second sector of AL- Diwaniyah	AL-Sader First	10	50%
	AL-Sader Second	10	
	AL-Sader Three	10	
	AL-Sader Four	10	
	AL-Askan	10	
	AL-Nahda	10	
	AL-Jamhory	10	
	AL-Daghara	10	
	AL-Wahda	10	
	AL-Saadiq	10	
	TOTAL	**100**	

3.5 Study Instrument

The Iraqi Ministry of Health - Family Health Services approved the search tool. The Iraqi researcher (Khaled and Abdulwahed 2018) used this technique in the country and obtained permission from the researcher. According to the scientific study, the group of experts and supervisors changed this questionnaire. This committee consists of several 13 experts from various Iraqi universities, where there were 10 experts in the field of a doctorate in community health nursing. And a doctorate in internal medicine nursing, number 2 experts. And a doctorate in community health medicine 1 expert. This questionnaire consists of 11 sections. These sections include particular questions in each area. The total of these questions is 38 questions. **(Appendix 5).**

Part One: This part includes information on the social and demographic characteristics of nursing personnel, such as age, gender, educational level, years of work, and training courses in primary health care.

Part Two consists of 38 questions about family health services provided in primary health care centers. Items are categorized into three levels; 3 (always), 2 (sometimes), and 1 (never).

3.6 Methods of Data Collection

For data collection, a certified questionnaire and face-to-face interview method are used. All nurses are interviewed. Approximately 10 to 15 minutes per interview. Data collection procedures started on (November 22, 2021 to April 22, 2022).

3.7 Pilot Study

The nursing staff is used to select a representative sample of 10 nurses. The services of family health nurses in primary health care facilities were evaluated in this pilot research from January 10 to February 5, 2022.

The purposes of the pilot study are:

1. To validate the questionnaire.
2. Each nurse is interviewed individually, so we can estimate how much time it takes to collect data for each individual.
3. Recognize the best approach needed by the nurse and its beneficiaries. Obtaining information data, knowing the nature of their difficulties may encounter.
4. The results of the pilot research revealed that the questionnaire is easy to understand and that the time required for each interview is around 10-15 minutes.

3.8 Validity of the Questionnaire

An instrument's ability to collect appropriate aggregate data determines whether or not the material it contains is genuine. Using experts with more than a decade of experience in the field, the content viability of the created tool was determined early on to ensure that it was clear, relevant and accurate when evaluating an interesting

idea. The questionnaire was written by 13 experts, including 3 Ph.D. experts in the field of community health nursing from the College of Nursing, University of Baghdad, 2 of them Ph.D. experts in the field of internal nursing from the College of Nursing, University of Baghdad, and 1 an expert faculty member with a A doctorate degree in community health medicine from the College of Nursing, University of Al-Qadisiyah, and 1 an expert faculty member holding a doctorate in community health nursing from the College of Nursing, University of Karbala 1, and 1 an expert faculty member holding a doctorate in community health nursing from the College of Nursing, University of Dhi Qar, and 1 an expert faculty member with a PhD in Community Health Nursing from the College of Nursing, University of Kufa, and 1 an expert faculty member holding a Ph.D. in Community Health Nursing from the Central Technology Center, Al-Balad Technical Institute, Al-Balad Technical University in addition to 1 an expert faculty member in community health nursing from the College of Nursing affiliated with the University of the Prophets, and 1 an expert faculty member with a PhD in Health Nursing The community from the College of Nursing, University of Babylon, and 1 a faculty member from the College of Nursing, University of Al-Muthanna. Experts are requested to review and provide their opinions on the survey instrument, content, clarity, suitability, and adequacy. Some elements have been excluded, and others have been added **(Appendix 6).**

3.9 Reliability of the Questionnaire

A reliability test was performed on 10 nurses using reliability The coefficient as a statistical analysis tool for assessing the fit between Questionnaire items. The scale has a proper internal consistency Standard, calculated by alpha = 0.82 from Cronbach. The elements of the study tools were clear and understandable. The time required to respond to the questionnaire ranged between 10-15 Minutes. As in the table below.

Table 3.4 Reliability Coefficient of the Study Instruments.

Studied Scale	Number Of Items	Value Of Cronbach's Alpha	Rebort	Assessment
Assessment	38 item	0.82	Very Good	Accepted

3.10 Statistical Data Analysis Approaches

We utilized SPSS (Statistical Package for the Social Sciences) and Microsoft Excel to analyze the data collected for this research 2010.

3.10.1 Descriptive approach

The following are the "Frequency and Percent" statistical tables:

$$\% = \frac{\boldsymbol{Frequency}}{\boldsymbol{Sample\ Size}}\ x100$$

Mean of scores "M.s.."

The average score can be calculated by using the following:

$$M.S = \frac{\sum \text{ri} = 1\text{Fi x Si}}{\sum \text{ri} = 1\text{Fi}}\ x100$$

The test of standard deviation "S.d.".

$$\text{Standard deviation} = \sqrt{\frac{\sum(X - \bar{X})^2}{n-1}}$$

It uses a correlational coefficient "Cronbach alpha" used in estimating the internal consistency of the study tool, which can be calculated by using the following:

$$\alpha = \frac{K}{K-1}\left[1 - \frac{\sum_{i=1}^{K} \sigma_{ii}}{\sum_{i=1}^{K}\sum_{j=1}^{K} \sigma_{ij}}\right]$$

"K is the items number questions."

"σ_{ij} is the investigate covariance between the items"

"i and j. Note the σ_{ii} is the variance not the standard deviation of item I"

3.10.2 Inferential approach

t-test

Independent t-test

To assess the significance difference between overall Family health nurses' services and nurses' demographic characteristics

One Way ANOVA

"Analysis of variance (ANOVA) for equality of Means (testing for coincidence when the mean's parameter is different)."

Source of variance	Sum of square	d.f	Mean square	F
Between Groups	$SS_B = \sum \frac{(\sum xP1)^2}{n} - \frac{(\sum xP)^2}{n}$	$df_B = K-1$	$\frac{MS\beta}{MS\beta}$	$\frac{MSB}{MSW}$
Within Groups	$SS_W = \sum (\sum xP1)^2 - \frac{(\sum xP)^2}{N}$	$df_w = N-k$	$\frac{SSw}{DFw}$	
Total	$SS_T = \sum (\sum xP1)^2 - \frac{(\sum xP)^2}{N}$	$df_1 = N-1$		

Shortcuts for measuring importance compared to the level are used as follows:

NS: Non significantly at probability-value>0.05.

S: Significantly at probability-value <0.05.

4. Results of the Study

This chapter extensively introduces the outcomes of the research in tables, and these refer to the objectives of this study, which are as follows:

Table 4.1 Descriptive Statistic of Socio-Demographic Characteristic of the Study Sample

Demographic Data	Groups	Freq.	%
Age in years	18-25	74	37.0
	25-35	79	39.5
	more than 35	47	23.5
	Total	**200**	**100.0**
Gender	Male	95	47.5
	Female	105	52.5
	Total	**200**	**100.0**
educational level	secondary school	48	24.0
	Diploma	72	36.0
	Degree (BSc)	48	24.0
	Master degree	32	16.0
	Total	**200**	**100.0**
Marital Status	Married	64	32.0
	Single	136	68.0
	Total	**200**	**100.0**
Number of years of experience in the family health unit	2 to7	88	44.0
	8 to 13	49	24.5
	14 to 19	40	20.0
	20 to 25	19	9.5
	26 to 30	4	2.0
	Total	**200**	**100.0**
Have you	Yes	128	64.0

participated in training courses?	No	72	36.0
	Total	**200**	**100.0**
Residency	Urban	82	41.0
	Rural	118	59.0
	Total	200	100.0

(Freq.): Frequency, (%): percentage,

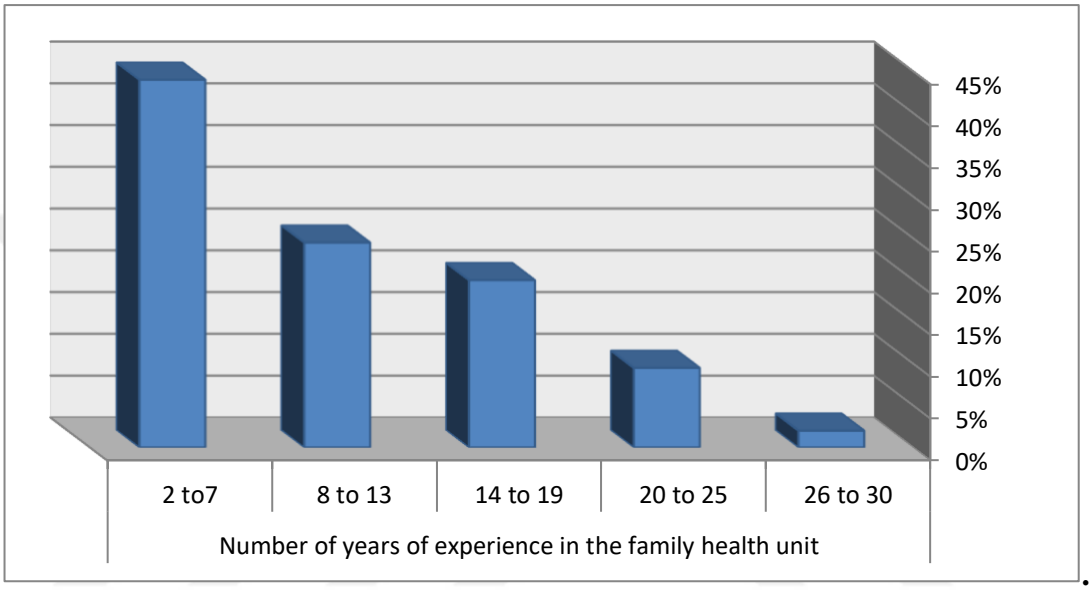

Figure 4. 1 Distribution of Study Sample by the Number of years of

experience in the family health unit.The frequencies and percentages in this table refer to descriptive statistics of sociodemographic information for nurses. The average age of 200 nurses who participated in this research was 25-35 years, which is equivalent to 39.5% of the total. Female nurses are dominant and make up more than half of all nurses versus males 52.5 percent. The results showed that most of the research sample consisted of single nurses and constituted the highest percentage 68 percent. It is clear from the data that most of the study sample consisted of diploma graduates, who formed a considerable rate 36% of the total. Regarding the family health unit, those with 2 to 7 years of experience are over-represented 44 percent. There was a disproportionate number of nurses 59 percent living in rural areas, as evidenced by the statistics. Finally, the vast majority of participants in this research were those who took training courses 64 percent.

Table 4.2 Nurses responses to Nutrition Health Services in primary health care centers.

Items	Rating	Frequency	Percent	m.s	Std.
Promoting the use of iodized salt and foods containing Microelements	Never	127	63.5	1.47	.672
	Some Time	53	26.5		
	Always	20	10.0		
	Total	**200**	**100.0**		
Directing the beneficiary to the harmful effects of junk food	Never	122	61.0	1.56	.761
	Some Time	45	22.5		
	Always	33	16.5		
	Total	**200**	**100.0**		
Statement of the importance of food	Never	60	30.0	1.97	.753
	Some Time	87	43.5		
	Always	53	26.5		
	Total	**200**	**100.0**		
Following food quality and its suitability and access, medical examination, and health education card.	Never	85	42.5	1.88	.848
	Some Time	54	27.0		
	Always	61	30.5		
	Total	**200**	**100.0**		
Total Nutrition Health Services	Never	92	46.0	1.7163	.50604
	Some Time	86	43.0		
	Always	22	11.0		
	Total	**200**	**100.0**		

N 200, cut-off point 0.66, Never (mean of score from 1 to 1.66), sometimes (mean of scores from 1.67 to 2.33), Always (mean of score from 2.34 to 3).

This table depicted the nutrition health services supplied by the nurse in the family unit in light of the statistical analysis cut-off point. 46 percent of the nurses did not deliver services, according to research findings.

Table 4.3 Nurses responses to Breastfeeding Services in primary health care centers.

Items	Rating	Frequency	Percent	m.s	Std.
Supporting and encouraging exclusive breastfeeding.	Never	107	53.5	1.66	.802
	Some Time	51	25.5		
	Always	42	21.0		
	Total	**200**	**100.0**		
Educating the family about the importance of breastfeeding for newborn	Never	109	54.5	1.67	.809
	Some Time	48	24.0		
	Always	43	21.5		
	Total	**200**	**100.0**		
Importance of breastfeeding for the newborn best way to breastfeed.	Never	112	56.0	1.62	.774
	Some Time	52	26.0		
	Always	36	18.0		
	Total	**200**	**100.0**		
Refraining from giving industrial teats or pacifiers.	Never	111	55.5	1.60	.737
	Some Time	59	29.5		
	Always	30	15.0		
	Total	**200**	**100.0**		
Total Breastfeeding Services	Never	111	55.5	1.6400	.75921
	Some Time	47	23.5		
	Always	42	21.0		
	Total	**200**	**100.0**		

N 200, cut-off point 0.66, Never (mean of score from 1 to 1.66), sometimes (mean of scores from 1.67 to 2.33), Always (mean of score from 2.34 to 3).

This table depicts the breastfeeding services offered by the nurse in the family unit in light of the cut-off threshold for statistical analysis. The results show that 55.5% of the nurses never performed the services.

Table 4.4 Nurses responses to Immunization of the mother and child services in primary health care centers.

Items	Rating	Frequency	Percent	m.s	Std.
We are vaccinating mothers during pregnancy.	Never	90	45.0	1.81	.819
	Some Time	59	29.5		
	Always	51	25.5		
	Total	**200**	**100.0**		
Immunization Campaigns, especially vaccines during outbreaks of epidemics	Never	92	46.0	1.75	.781
	Some Time	66	33.0		
	Always	42	21.0		
	Total	**200**	**100.0**		
Educating parents about the importance of vaccines and their impact on children's health.	Never	94	47.0	1.76	.804
	Some Time	60	30.0		
	Always	46	23.0		
	Total	**200**	**100.0**		
Health education of mothers about the immunization program and follow-up.	Never	94	47.0	1.82	.851
	Some Time	49	24.5		
	Always	57	28.5		
	Total	**200**	**100.0**		
Total Immunization of the mother and child services	Never	87	43.5	1.7825	.74866
	Some Time	65	32.5		
	Always	48	24.0		
	Total	**200**	**100.0**		

N 200, cut-off point 0.66, Never (mean of score from 1 to 1.66), sometimes (mean of scores from 1.67 to 2.33), Always (mean of score from 2.34 to 3).

This table displayed the immunization of the mother and child services given by the nurses in the family unit following the statistical analysis cut-off point. According to the findings, 43.5 percent of the nurses never delivered the services in the first instance.

Table 4.5 Nurses responses to Health Education services in primary health care centers.

Items	Rating	Frequency	Percent	m.s	Std.
Implementing health awareness campaigns in the coverage areas.	Never	96	48.0	1.71	.767
	Some Time	66	33.0		
	Always	38	19.0		
	Total	**200**	**100.0**		
Distributing health awareness materials (posters, brochures).	Never	90	45.0	1.74	.758
	Some Time	72	36.0		
	Always	38	19.0		
	Total	**200**	**100.0**		
We are following all health activities for the family.	Never	116	58.0	1.61	.788
	Some Time	46	23.0		
	Always	38	19.0		
	Total	**200**	**100.0**		
Providing lectures to nursing staff working in the health center.	Never	113	56.5	1.60	.751
	Some Time	55	27.5		
	Always	32	16.0		
	Total	**200**	**100.0**		
Total Health Education services	Never	105	52.5	1.6638	.68344
	Some Time	60	30.0		
	Always	35	17.5		
	Total	**200**	**100.0**		

N 200, cut-off point 0.66, Never (mean of score from 1 to 1.66), sometimes (mean of scores from 1.67 to 2.33), Always (mean of score from 2.34 to 3).

Considering the statistical analysis cut-off point, the following table depicts the Health Education services delivered by nurses to children and adolescents in the household setting. According to the findings, 52.5% of the nurses never performed the services in question.

Table 4.6 Nurses responses to services of Physical Examination for Adults in primary health care centers.

Items	Rating	Frequency	Percent	m.s	Std.
I was examining the matter.	Never	116	58.0	1.56	.727
	Some Time	56	28.0		
	Always	28	14.0		
	Total	**200**	**100.0**		
Carrying out all vital events (temperature, breathing, pulse).	Never	116	58.0	1.58	.746
	Some Time	53	26.5		
	Always	31	15.5		
	Total	**200**	**100.0**		
documenting all the medical tests.	Never	112	56.0	1.64	.796
	Some Time	48	24.0		
	Always	40	20.0		
	Total	**200**	**100.0**		
Total services of Physical Examination for Adults	Never	114	57.0	1.5917	.72864
	Some Time	57	28.5		
	Always	29	14.5		
	Total	**200**	**100.0**		

N 200, cut-off point 0.66, Never (mean of score from 1 to 1.66), sometimes (mean of scores from 1.67 to 2.33), Always (mean of score from 2.34 to 3).

This table depicts the services performed by family nurses during a Physical Examination for Adults based on statistical analysis cutoff points. According to the findings, most of the nurses 57 percent never delivered the services.

Table 4.7 Nurses responses to Mother and Child Care Services in primary health care centers.

Items	Rating	Frequency	Percent	m.s	Std.
Recording pregnant' data concerning weight, height, and lab tests.	Never	115	57.5	1.64	.815
	Some Time	42	21.0		
	Always	43	21.5		
	Total	**200**	**100.0**		
Educating pregnant mothers about proper nutrition and exercise.	Never	116	58.0	1.61	.788
	Some Time	46	23.0		
	Always	38	19.0		
	Total	**200**	**100.0**		
Following tests for pregnant women.	Never	115	57.5	1.62	.793
	Some Time	46	23.0		
	Always	39	19.5		
	Total	**200**	**100.0**		
Monitoring the growth and development of newborns in the review card	Never	117	58.5	1.60	.777
	Some Time	47	23.5		
	Always	36	18.0		
	Total	**200**	**100.0**		
Total Health Education Services	Never	114	57.0	1.6163	.76754
	Some Time	47	23.5		
	Always	39	19.5		
	Total	**200**	**100.0**		

N 200, cut-off point 0.66, Never (mean of score from 1 to 1.66), sometimes (mean of scores from 1.67 to 2.33), Always (mean of score from 2.34 to 3).

Based on the statistical analysis cutoff point, this table depicted the Mother and Child Care Services delivered by nurses to members of a household or family unit. A majority of nurses 57% did not provide these services, according to research findings

Table 4.8 Nurses responses to Non-Communicable Diseases Services in primary health care centers.

Items	Rating	Frequency	Percent	m.s	Std.
Registering high blood pressure and diabetes cases	Never	114	57.0	1.60	.763
	Some Time	52	26.0		
	Always	34	17.0		
	Total	**200**	**100.0**		
Health education about the risk factors for chronic diseases, such as smoking and obesity.	Never	115	57.5	1.58	.746
	Some Time	54	27.0		
	Always	31	15.5		
	Total	**200**	**100.0**		
Emergency follow-up (first aid) and cardiovascular diseases and diabetes device	Never	121	60.5	1.52	.709
	Some Time	54	27.0		
	Always	25	12.5		
	Total	**200**	**100.0**		
Total Non-Communicable Diseases Services	Never	117	58.5	1.5667	.71281
	Some Time	56	28.0		
	Always	27	13.5		
	Total	**200**	**100.0**		

N 200, cut-off point 0.66, Never (mean of score from 1 to 1.66), sometimes (mean of scores from 1.67 to 2.33), Always (mean of score from 2.34 to 3).

This table highlighted the Non-Communicable Diseases Services delivered by the nurses in the family unit following the statistical analysis cut-off point. According to the findings, most nurses 58.5 percent never performed the requested services.

Table 4.9 Nurses responses to Breast Cancer Screening Services in primary health care centers.

Items	Rating	Frequency	Percent	m.s	Std.
Educating people about not ignoring any tumor even if it turned out to be benign.	Never	117	58.5	1.58	.753
	Some Time	51	25.5		
	Always	32	16.0		
	Total	**200**	**100.0**		
attending breast self-examination.	Never	113	56.5	1.60	.757
	Some Time	54	27.0		
	Always	33	16.5		
	Total	**200**	**100.0**		
Registering and supervising laboratory tests for mothers concerning breast disease.	Never	119	59.5	1.56	.741
	Some Time	51	25.5		
	Always	30	15.0		
	Total	**200**	**100.0**		
Total Breast Cancer Screening Services	Never	118	59.0	1.5767	.72808
	Some Time	53	26.5		
	Always	29	14.5		
	Total	**200**	**100.0**		

N 200, cut-off point 0.66, Never (mean of score from 1 to 1.66), sometimes (mean of scores from 1.67 to 2.33), Always (mean of score from 2.34 to 3).

This table depicted the Breast Cancer Screening Services offered by the nurses in the family unit, considering the statistical analysis cut-off point. According to the findings, most nurses 59 % never delivered the services.

Table 4.10 Nurses responses to Care Services for the Disabled in primary health care centers.

Items	Rating	Frequency	Percent	m.s	Std.
Registering disabled cases (with special needs) Statistically	Never	123	61.5	1.52	.716
	Some Time	51	25.5		
	Always	26	13.0		
	Total	**200**	**100.0**		
Providing services to the disabled to receive aids necessary for patients with (amputations, quadriplegia, paraplegia, burns, and traffic accidents).	Never	121	60.5	1.53	.715
	Some Time	53	26.5		
	Always	26	13.0		
	Total	**200**	**100.0**		
Total Care Services for the Disabled	Never	125	62.5	1.5200	.70326
	Some Time	45	22.5		
	Always	30	15.0		
	Total	**200**	**100.0**		

N 200, cut-off point 0.66, Never (mean of score from 1 to 1.66), sometimes (mean of scores from 1.67 to 2.33), Always (mean of score from 2.34 to 3).

This table depicted the Care Services for the Disabled supplied by the nurses in the family unit, based on the statistical analysis cut-off point. According to the findings, 62.5 percent of the nurses never performed the services.

Table 4.11 Nurses responses to Services of Integrated Management of Children Illness in primary health care centers.

Items	Rating	Frequency	Percent	m.s	Std.
Educating parents about the importance of testing for children.	Never	111	55.5	1.64	.790
	Some Time	50	25.0		
	Always	39	19.5		

	Total	**200**	**100.0**		
Conducting examinations for children in the event of disease and incidents of emergency	Never	115	57.5	1.61	.782
	Some Time	48	24.0		
	Always	37	18.5		
	Total	**200**	**100.0**		
disclosing children's genetic diseases.	Never	117	58.5	1.56	.728
	Some Time	55	27.5		
	Always	28	14.0		
	Total	**200**	**100.0**		
Taking blood samples of newborns from the age of 72 hours and up to 2 months	Never	126	63.0	1.49	.694
	Some Time	51	25.5		
	Always	23	11.5		
	Total	**200**	**100.0**		
Total Integrated Management of Children Illness services	Never	114	57.0	1.57 25	.7078 1
	Some Time	54	27.0		
	Always	32	16.0		
	Total	**200**	**100.0**		

N 200, cut-off point 0.66, Never (mean of score from 1 to 1.66), sometimes (mean of scores from 1.67 to 2.33), Always (mean of score from 2.34 to 3).

Integrated Management of Children Illness services offered by nurses in the family unit were shown in this table using the cut-off point for statistical analyses. A majority of the nurses 57 % never delivered the services, according to the research.

Table 4.12 Nurses responses to Communicable Diseases Control Services in primary health care centers.

Items	Rating	Frequency	Percent	m.s	Std.
Health education for the Prevention of Communicable Diseases.	Never	114	57.0	1.61	.769
	Some Time	51	25.5		
	Always	35	17.5		

	Total	**200**	**100.0**		
Educating people about the cleanliness of food and water safety	Never	116	58.0	1.61	.788
	Some Time	46	23.0		
	Always	38	19.0		
	Total	**200**	**100.0**		
Perpetuating the records of the transitional diseases	Never	114	57.0	1.64	.803
	Some Time	45	22.5		
	Always	41	20.5		
	Total	**200**	**100.0**		
Total Communicable Diseases Control Services	Never	115	57.5	1.6167	.77203
	Some Time	47	23.5		
	Always	38	19.0		
	Total	**200**	**100.0**		

N 200, cut-off point 0.66, Never (mean of score from 1 to 1.66), sometimes (mean of scores from 1.67 to 2.33), Always (mean of score from 2.34 to 3).

The Communicable Diseases Control Services provided by family unit nurses are shown in this table using the statistical cut-off point as a reference. Results show that 57.5 percent of the nursing staff did not complete their duties as expected.

Table 4.13 Nurses responses to overall Family health nurses' services in primary health care centers.

Items	Rating	Frequency	Percent	m.s	Std.
Family health nurses' services	Never	110	55.0	1.6332	.62280
	Some Time	57	28.5		
	Always	33	16.5		
	Total	**200**	**100.0**		

N 200, cut-off point 0.66, Never (mean of score from 1 to 1.66), sometimes (mean of scores from 1.67 to 2.33), Always (mean of score from 2.34 to 3).

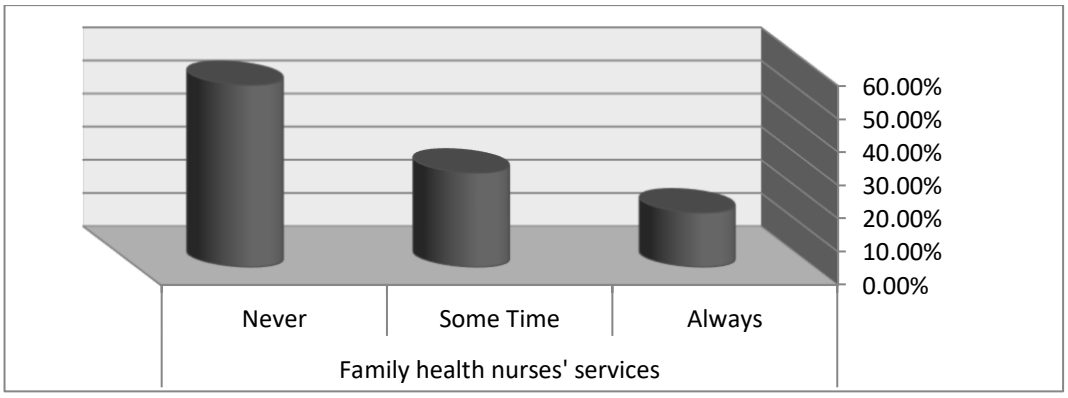

Figure 4.2 Distribution of Study Sample by Family health nurses' services.

This graph displays the total number of Family Health Nurse services provided by the family nurses based on a statistical cut-off point. According to the statistics, 55.0 percent of individuals polled did not get any kind of nursing care.

Table 4.14 Mean Differences (ANOVA) between overall Family health nurses' services and nurses' demographic characteristics**.**

Demographic Data	Groups	Overall Family Health Nurses' Services			F	Sig.
		Never	Sometime	Always		
Age in years	18-25	42	16	16	1.544	.019 S
	25-35	46	23	10		
	more than 35	22	18	7		
	Total	**110**	**57**	**33**		
Educational level	secondary school	26	12	10	.975	.535 NS
	Diploma	40	19	13		
	Degree (BSc)	29	13	6		
	Master degree	15	13	4		
	Total	**110**	**57**	**33**		
Number of years of experience in the family	2 to7	50	22	16	1.931	.047 S
	8 to 13	27	14	8		

health unit	14 to 19	22	13	5		
	20 to 25	10	7	2		
	26 to 30	1	1	2		
	Total	**110**	**57**	**33**		

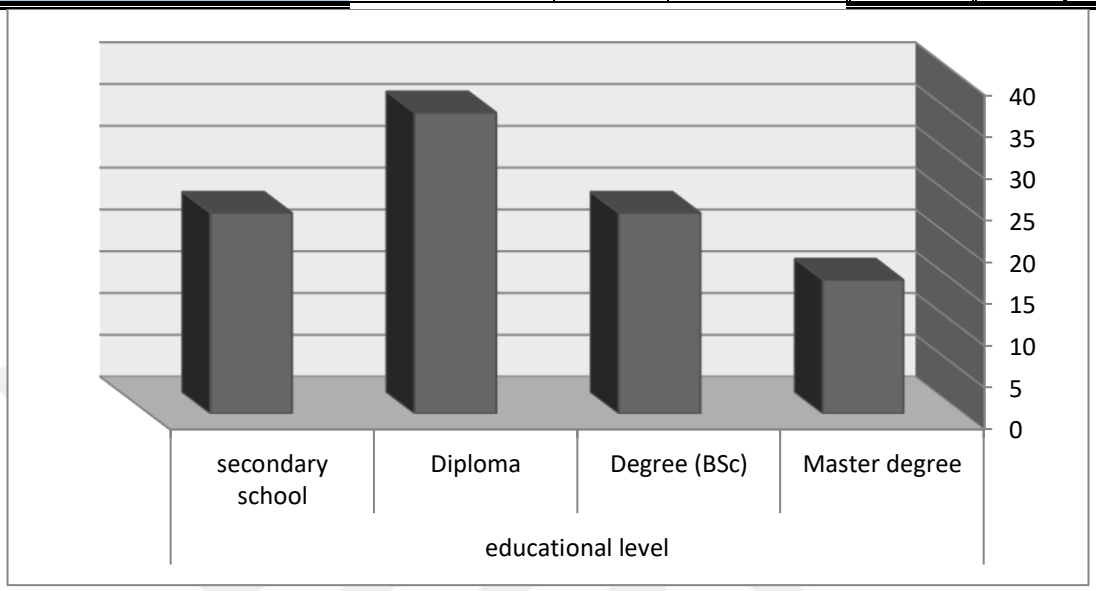

Figure 4. 3 Distribution of Study Sample by their level of education**.**

These results reveal statistical significance between the age of the nurses and the number of years they've spent working in the family health unit, with a p value less than 0.05 indicating statistical significance between the two variables. With a p value of less than or equal to 0.05, there is no statistically significant relationship between the educational level of nurses and the overall quality of family health nursing care.

Table 4.15 mean differences (t-test) between the overall Family health nurses' services and nurses' gender.

Gender		N	Mean	Std. Deviation	t	df	Sig.
overall Family health nurses' services	Male	95	1.5180	.52926	-2.520	198	.013
	female	105	1.7373	.68259			

(n) number, (Ns): Non-significant, (Std) stander deviation, (S): significant, (df): degree of freedom, (T value):independent t-test

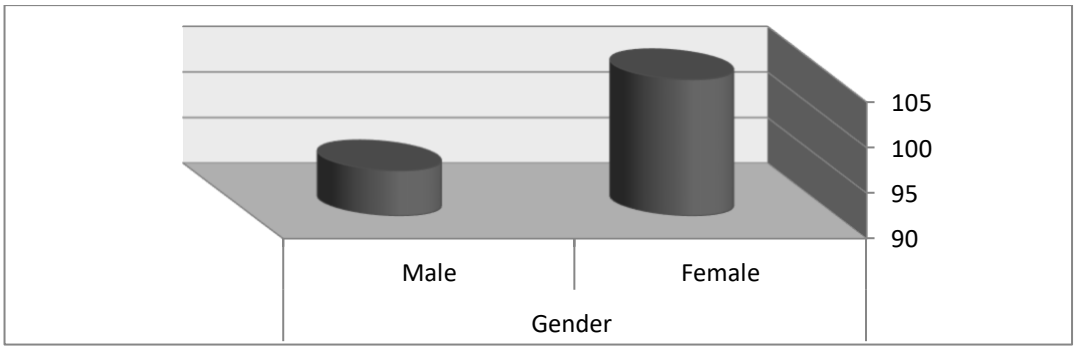

Figure 4.4 Distribution of Study Sample by their gender.

P-value equal to or less than 0.05 suggests a statistically significant link between gender of nurses and total Family health nurses' services in this table.

Table 4.16 Mean differences (t-test) between the overall Family health nurses' services and nurses' Marital status.

Marital status		N	Mean	Std. Deviation	t	df	Sig.
overall Family health nurses' services	Married	64	1.6254	.62808	-.120	198	.904
	Single	136	1.6368	.62260			

(n) number, (Ns): Non-significant, (Std) stander deviation, (S): significant, (df): degree of freedom, (T value):independent t-test.

It's clear from this table that there is no statistically significant relationship between nurses' marital status and their total Family health nurses' services at P-values greater than 0.05.

Table 4.17 Mean differences (t-test) between the overall Family health nurses' services and nurses participated in training courses.

Nurses participated in training courses		N	Mean	Std. Deviation	t	df	Sig.
overall Family health nurses' services	Yes	128	1.6787	.65046	1.381	198	.169
	No	72	1.5523	.56566			

(n) number, (Ns): Non-significant, (Std) stander deviation, (S): significant, (df): degree of freedom, (T value):independent t-test

At a p-value of less than 0.05, this table reveals no statistically significant relationship between the number of nurses who have completed training courses and their complete Family health nurse services.

Table 4.18 Mean differences (t-test) between the overall Family health nurses' services and nurses' residency.

Residency		N	Mean	Std. Deviation	t	df	Sig.
overall Family health nurses' services	Urban	82	1.7349	.68757	1.940	198	.050 S
	Rural	118	1.5624	.56580			

(n) number, (Ns): Non-significant, (Std) stander deviation, (S): significant, (df): degree of freedom, (T value):independent t-test.

This table demonstrates a statistically significant relationship between nurses' residency and their total Family health nurses' services when the p-value is equal to or less than 0.05 in this population.

5. Discussion of the Study Results

5.1. Discussion of the Distribution of the Staff Nurses According to Their Demographic Characteristics

As shown in Table (4.1), the results of this study indicate that the age of the nurses constituted a percentage 39.5% of the study sample within the age group 25-35 years, and this percentage is consistent with the results obtained from the same study for (Aziz 2013) indicated that 34% of the nurses in his study group were between the ages of 25 - 35 years.

As for gender, it indicates that the number of female nurses is more than males, and they constitute 52.5% of the total sample; this result is consistent with (Khaled and Abdulwahed 2018) and who mentioned that the majority of the study sample are female 52%. It is common for nurses to be the most significant proportion because Iraqi society considers them a female profession.

The results of the nurses' educational level showed that 36% of the study sample held a diploma, and this result is consistent with a study conducted by (Abdulwahed and Naji 2015), which constituted 58.6%. Of the sample are graduates of the Institute of Nursing.

The results showed that most of the research sample consisted of single nurses. They constituted the highest percentage 68%, as these results are consistent with the results of the study conducted by (Lorenz *et al.* 2018) where the majority of its results were from single nurses. They constituted 45.5%.

Regarding the years of experience in the Family Health Unit, the results indicate that 44% of the sample ranged between 2-7 years of experience in this field, and this study is consistent with the survey (Hussain and Nouri 2021), where it indicated that 52% of The sample ranged between 1-9 years,

Concerning training courses for nursing cadres in the field of family health care, it was indicated that most of them participated in such classes, and they constituted 64%. This study is consistent with the survey (Khaledand &Abdelwahed 2018) in which the majority of nurses participated in training courses, which amounted to 76%.

As for the residential areas, there was a disproportionate number of nurses 59% who live in rural areas. These results are consistent with a previous study by (Hussain and Nouri 2021), where the majority of results were sampled from nurses living in rural areas.

5.2 Discussion of Evaluation for the Family Health Services in Primary Health Care Centers

5.2.1 Nurses' Practice related to Nutrition Health Services

As shown in Table (4.2), the nutritional health services provided by nurses in the family health unit in the light of statistical analysis found that 46% of the nurses did not offer health services well, according to the results of the study. These results are consistent with a study (Hussainand &Nouri 2021) that found that nurses did not provide nutritional health services.

5.2.2 Nurses' practice related to breastfeeding services

As shown in Table (4.3), breastfeeding services provided by nurses in the family health unit in the light of statistical analysis showed that 55.5% of the nurses did not perform these services at all. These results are consistent with the study (Silvestre *et al.* 2009), where the highest percentage of the effects of his research were from nurses who did not provide breastfeeding services.

5.2.3 Nurses' practice related to Immunization of the mother and child services

Table (4.4) indicates the immunization of maternal and child services provided by nurses in the family health unit according to the cut-off point of the statistical analysis.

According to the results, 43.5% of the nurses did not provide services in the first place. These results are consistent with the study (Husseinand &Nouri 2021), where the results of his research were from nurses who did not provide vaccination services to the mother and child.

5.2.4 Nurses' practice related to health education services

Table (4.5) shows the health education services provided by nurses to children and adolescents in the family environment, taking into account the cut-off point of the statistical analysis. According to the results, 52.5% of the nurses did not perform the relevant services. This study agrees with the previous research of (Whitehead *et al.* 2008), which showed that nurses did not provide health education services in the sample results.

5.2.5 Nurses' practice related to services of physical examination for adults

This table (4.6) shows the services performed by family nurses during the physical examination of adults based on the breakpoints in the statistical analysis. According to the results, most nurses 57% never provided services. This study is consistent with a previous study (Yakuwa *et al.* 2016). This study shows that nurses did not assist in the physical examination of adults.

5.2.6 Nurses' practice related to Mother and Child Care Services

This table (4.7) shows the mother and child care services nurses provide to family members or the family health unit. Based on the cut-off point of the statistical analysis, the majority of nurses 57% did not provide these services, according to the research findings. These results are consistent with the study (North *et al.* 2020), which showed that the nurses in his sample did not provide maternal and child care services.

5.2.7 Nurses' practice related to Non-Communicable Diseases Services

This table (4.8) highlights the non-communicable disease services provided by nurses in the family unit according to the cut-off point of the statistical analysis. According to the findings, most nurses 58.5 percent never performed the required services. These results are consistent with a study conducted by (Duffy *et al.* 2017), showing us that nurses did not perform these services either.

5.2.8 Nurses' practice related to Breast Cancer Screening Services

This table (4.9) shows the breast cancer screening services provided by nurses in the family unit, considering the breakpoint in the statistical analysis. According to the results, most nurses 59% did not provide any services. These results agree with a previous study by (Limlim *et al.* 2013), which showed that most nurses did not offer services either.

5.2.9 Nurses' practice related to Care Services for the Disabled

This table (4.10) shows the disabled care services provided by nurses in the family unit based on a cut-off point for statistical analysis. According to the results, 62.5% of the nurses did not perform the services at all. This study agrees with a previous study conducted by (Dubuc *et al.* 2006), where the majority of the results of his sample were that nurses did not provide health services to care for the disabled.

5.2.10 Nurses' practice related to Services of Integrated Management of Children Illness

This table (4.11) shows the integrated management of Children's Illness services provided by nurses in the family unit using the cut-off point for statistical analyses. According to the research, most nurses 57% did not provide any services. These results are consistent with his study (Adekanye and Odetola 2014), in which the results of his sample for Children's Illness management were almost nonexistent among nurses.

5.2.11 Nurses' practice related to Communicable Diseases Control Services

This table (4.12) shows the Communicable disease control services provided by the family unit nurses. Using the cut-off of the statistical analysis as a guideline, according to the findings, 57.5% of the nurses had never performed the services they were supposed to. This study agrees with a study conducted by (Khaled and Abdelwahed 2018), where his sample showed that nurses did not provide these services as required.

5.3 Discussion of the Overall Practice toward Family health nurses' services

In this table (4.13), all nursing care services provided to patients with health problems are shown. More than half of the nurses did not offer these services correctly, and they constituted about 55 percent of the sample. Because the nurses of the health center did not receive the appropriate training courses and were also not satisfied with the working environment. As a result of the absence of suitable working hours, flexibility in scheduling and vacation time, and sluggish management and supervisory support system, nurses and their families have been significantly impacted—maintenance and the supply of equipment and supplies. Low salaries and a wrong perception of nursing in Iraqi society are other critical factors in determining the number of nurses in the nation. As for their coworkers and healthcare facilities, most nurses were happy with their jobs despite these issues. Our team gave it a lower quality rating than some of the other items, even though the package contains several necessities for new mothers. A lack of resources might also lead to a failure to obey the regulations. (Al-Maliki *et al.* 2012) found that most of their findings came from nurses who were not participating in the study—taking care of everyone in the family, including the elderly.

5.4 Discussion of the Association between Family Health Nurses Services and Demographic Characteristics

This table (4.14) shows a statistical significance between the age of the nurses and the number of years of experience in the family health unit with the complete services of the family health nurses with a p-value equal to or less than 0.05. There is no statistical significance between the educational level of the nurses and the services of the total

family health nurses with a p-value equal to or less than 0.05. These results agree with a previous study conducted by (Chandrakala 2012), in which it was found that there is a relationship between the age of nurses and years of experience in the field of the family health unit.

This table (4.15) shows a statistical significance between the gender of nurses and the services of family health nurses in general when a p-value is equal to or less than 0.05. This statistic is consistent with the study conducted by (Norouzinia *et al.* 2016), where there was a relationship between the gender of the nurses and the health services provided by the nurses.

This table (4.16) shows no statistical significance between the marital status of nurses and family health nursing services in general, with a probability value equal to or less than 0.05. These results agree with a previous study by (Lorenz *et al.* 2018), where his sample showed no statistical significance between the marital status of nurses and the health services provided by them.

Table (4.17) shows no statistical significance among the nurses participating in the training courses and the services of family health nurses in general, with a p-value equal to or less than 0.05. Where these results agree with a previous study conducted by (Silva *et al.* 2014), it was found that there is no statistical significance among the nurses participating in the training courses and health services provided by them.

Table (4.18) shows a statistical significance between the nurses' housing and the services of family health nurses in general when the probability value is equal to or less than 0.05. These results are consistent with a previous study conducted by (Al-Maghrabi 2018), in which he showed that he found in his results a relationship between the nurses' accommodation and the services they provide.

6. CONCLUSION AND RECOMMENDATION

6.1 CONCLUSION

The most significant findings and the study's conclusion are presented in this section. It also contains suggestions that should be taken into consideration. Based on the results of the research and their interpretations, we infer that:

1. The females of the study sample are more than the males, and most of them are in the age group 25-35 years; and they hold a diploma degree and they had 2-7 years of experience working in the family health unit, and most of them participated in training courses in family health care. The results of the research sample of single nurses, the majority of whom live in rural areas.
2. Comprehensive evaluation of the study sample for the services of family health nurses provided by nurses in the family unit. According to the statistical analysis, there are recommended services that were not provided to the required level.
3. The age of the nurses and the number of years of experience in the family health unit affect their performance. At the same time, there is no statistical significance between the nurses' educational level and their services. Also, the nurses' gender and the training courses positively impact their performance, and it was found that there is a statistical significance between the nurses' residence and the services provided by them.
4. There is a severe need for rehabilitation of the Iraqi government's health facilities and primary health care centers, which have "deteriorated" owing to a lack of maintenance, shortage of supplies, poor or insufficient health personnel, or inadequate support services because of the conflicts in Iraq.

6.2 RECOMMENDATION

Based on the stated conclusion, it is recommended that:

1. According to international standards, the Iraqi government and partner decision-makers must urgently need to rehabilitate and provideThe best equipment and requirements for primary health care centers.
2. All nurses in primary health care centers must participate in educational programs related to family health care services. As well as more studies to involve the national level and quality assessment
3. Holding scientific conferences and special courses and organizing workshops and periodic symposia for interested parties. It was developed for nurses working in primary health care centers with practical aspects.
4. Encourage nurses to activate their educational role to prevent disease and raise awareness of the work of unique posters and programs for a strategic plan in health care centers.
5. Family health program practice among nurses should be sufficient. Under the local authorities' supervision, activate the principle of reward and punishment.

   Nurses' residence and the services of the family health nurses.

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APPENDICES

Appendix 1. Ethical Approval From Çankırı Karatekin Üniversitesi

Appendix 2. Ethical Approval From Iraq

Appendix 3: Facilitating A Task From The Diwaniyah Health Department, Iraq

Appendix 4. Table Of Experts In The Questionnaire

Appendix 5. English Proofreading

Appendix 6. Questionnaire

Appendix 7. C.V