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Perspective of Health Care Providers about Barriers of Instructional Programs: A Qualitative Study

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Abstract

Background: The education presented to the clients by the health care personnel can guarantee the well-being of the individuals and stimulate sound health care behaviors in them. Recognizing the barriers to health education enhances the understanding and knowledge of preventive services.
Objectives: The present study aimed at investigating the perspective of health care providers about barriers of instructional programs in Iran.
Methods: This qualitative study was conducted in the urban health care centers of Sanandaj, West of Iran, in 2016. Using purposive sampling, 15 experienced employees in charge of health care education were included in the study. Data were collected through individual interview and group discussions, observation and field notes, were and analyzed by conventional content analysis. To confirm the accuracy and strength of the data, credibility, confirmability, and transferability components were taken into account.
Results: The results of data analysis yielded 5 major categories: (1) health center related problems; (2) lack of preparation for education; (3) clients' problems; (4) personal problems of the personnel; and (5) organizational factors. The participants reported the significance of intra- and intersectoral cooperation and coordination in implementation of health care education programs and the need for further attention from authorities to health care education.
Conclusions: The findings revealed that presentation of health care education is a complicated issue, which is influenced by various factors. Also, the success of educational programs in health care centers is not merely an intrasectoral enterprise rather it requires the cooperation of the public media and related organizations, support of the society and attention of families and authorities to health education.

Keywords: Health Centers, Health Education, Personnel, Qualitative Research

1. Background

Health education is a precious tool that plays a pivotal role in prevention, early diagnosis, treatment of diseases (1), change in behavior, and maintaining and promoting health (2). In Iran, health education and primary health care services are provided in health houses and health care centers, which are premises for the planning, quality promotion, management, and health assessment. Health care centers, where the doctors and health experts are working, collect the health care data and are decisively involved in the design and implementation of health education (3). Health care personnel, as an inseparable part of the health care team (4, 5), are responsible for disease prevention (4, 6), and play a major role in health education (7). They have been recognized as health workers, liaison between the government and professional organizations (8) and a cultural intermediary between people and health care providers (4, 5). On the one hand, the education provided to the clients by the health care personnel can ensure the health of the people and cultivate healthy behaviors (9). On the other hand, lack of providing appropriate education can cause lack of knowledge, improper understanding and use of preventive measures, increased health costs, and low adaptability of people with life (10).

In Iran and other countries, some studies have investigated health education obstacles and have reported such factors as lack of manpower, budget and educational space (11), job dissatisfaction (1), cultural obstacles, fear and anxiety in expressing health behaviors, and lack of using new educational models and styles (12, 13). These studies, however, have merely evaluated the barriers to education

and a special domain in the opinion of a specific group and have disregarded the perspectives of the personnel of health care centers. The obstacles that the health care staffs encounter in educating the health care manners to the clients is the domain that was investigated in the current study using qualitative content analysis. Studies adopting a qualitative approach are able to analyze social phenomena from all perspectives and present a deep understanding of the experiences and viewpoints of the people (14).

2. Objectives

Considering the imperative role of education in fulfilling physical, mental, and social needs of the clients and development of the society through providing targeted health care services (1, 15), the importance of health care centers in formation of health behaviors (8), and scarcity of qualitative research based on the recognition of health education barriers together encouraged the researchers to explore barriers of instructional programs from the perspective of health care providers.

3. Methods

This study investigated the barriers to health education from the viewpoint of the health care personnel using conventional content analysis in Sanandaj, a city located in the West of Iran, in 2016. A total of 15 health care personnel were selected using purposive sampling and were subsequently interviewed. The participants were recruited from 15 different health centers in Sanandaj. The inclusion criteria in this study comprised of being an employee of a health care center, the ability of speaking clearly, and being interested in participating in the study. Participants were excluded if they had less than 3 years of experience in health education. Data collection methods included semi-structured individual and group interviews and note-taking during and after interviews. The interviews were conducted by the corresponding author, who is experienced enough in conducting qualitative interviews and has published qualitative papers using this technique.

Data collection commenced with permission from the research council of Kurdistan University of Medical Sciences, according to the participants' own choice of time and place. Interviews were conducted based on a predetermined interview guide (Table 1) and were voice recorded.

The initial questions were as follow: "Express your experiences about providing health education to clients."; and "What educational requirements did you face during instructional programs?" Then, follow-up questions were asked according to the respondents' answers. Also, the interviewer observed and checked for nonverbal expression of feelings, determined who interacts with whom, grasped how participants communicated with each other, checked definitions of the terms that participants used in interviews, and observed events that informants might be unable or unwilling to share with the interviewer. At the end of each interview, notes were taken from each interview. The mean time of individual and group interviews was 52 and 33 minutes, respectively. Interviews were conducted in the counseling room or a silent room and continued until data saturation (This point of closure is arrived at when the information being shared with the researcher becomes repetitive and contains no new ideas) (16).

Seven stages of interview including thematizing, designing, interviewing, transcribing, analyzing, verifying, and reporting were taken into consideration (17). Data were collected during 8 individual interviews, 2 group discussions (groups of 3 and 4 persons), and 6 observations and filed notes, which were analyzed simultaneously by 3 coders. Seven stages of interview including thematizing, designing, interviewing, transcribing, analyzing, verifying, and reporting were taken into consideration (17). Data were analyzed by conventional content analysis. Conventional content analysis means the extraction of the objective content and is more than what is presented in the written data; in fact, it includes obtaining the themes and overt and covert patterns from the content of the participants' data (16). During the content analysis, first, the interviews were transcribed and reviewed several times to obtain the overall view. Then, meaning units were determined, relevant codes were extracted, and according to similarity, proportionality and adaptability were inserted into subcategories. The subcategories were divided into categories, and themes were acquired. The highest variations of samples were considered as age, gender, major, education, years of service, and health education history, and family's income.

MAXQDA (Version 10) software was used to facilitate data analysis in import and export process, listing and classification, repeated comparison of various data, and recovery of quotations.

Reviewing the accuracy of the statements expressed by the participants in the manuscripts, returning the findings to the participants for members check, long-term involvement of the researcher with data and health care centers, and establishing rapport with participants were strategies used to ensure rigor and accuracy of the findings. To obtain confirmability of data, the research team conduced the analysis independently (3 coders), compared their findings, and in cases of disagreement, they held discussions until they reached an agreement. For peer checking, 3 faculty members (research methodologist, health education specialist, and educational expert) reviewed the

Table 1. Interview Guide

Introduction Key	**Components**
Thank you	I want to thank you for taking the time to meet with me today.
Your name	My name is …
Purpose	I would like to talk to you about your experiences about providing health education to clients. We will recognize barriers to health education from the perspectives of the health personnel. The results that can be helpful for the health trainers, experts of health care centers, non-communicable diseases centers, and the media and health policymakers in designing educational interventions.
Confidentiality	All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent
Duration	The interview should take less than an hour
How interview will be conducted	I will be taping the session because I don't want to miss any of your comments. Although I will be taking some notes during the session, I can't possibly write fast enough to get it all down. Because we're on tape, please be sure to speak up so that we don't miss your comments.
Opportunity for questions	Remember, you don't have to talk about anything you don't want to and you may end the interview at any time.
Signature of consent	Are there any questions about what I have just explained?
	Are you willing to participate in this interview?
	Interviewee …Witness … Date …
Questions[a]	What educational requirements did you face during instructional programs? Please explain why.
	What were some barriers, if any, that you encountered? Please elaborate.
	How did you overcome the barrier(s)? Please explain why.
	What efforts can be taken to Increase the efficiency of health education programs?
	Notes:
	Observations:
Closing Key	**Components**
Additional comments	Is there anything more you would like to add?
Next steps	I'll be analyzing the information you and others gave me, I'll be happy to send you a copy to review, if you are interested.
Thank you	Thank you for your time.

[a] No more than 15 open-ended questions. Ask factual before opinion. Use probes as needed.

analysis report and confirmed the findings. The dependability of the findings was ensured by early transcribing, precise recording of the work procedures, and using mixed method of data collection in different times and places. Variance according to age, gender, major, education, years of service, and health education history, and family's income indicated that the findings were applicable in other contexts (transferability) (16, 18).

The present study was approved by the research council of Kurdistan University of Medical Sciences. Ethical approval was obtained from the research ethics committee of the same university. The researcher considered all relevant ethical issues such as informed consent, confidentiality, anonymity, providing enough information about the research, and right of withdrawal at any stage. Oral and written informed consent was obtained.

4. Results

A total of 15 participants, 7 males and 8 females, with the age range of 30 to 48 and work history of 5 to 22 years were included in the study. They were selected from 15 health care centers of Sanandaj. Demographic characteristics of the study participants are presented in Table 2. The analysis of participants' experiences revealed 642 primary codes, which were analyzed into 74 codes after mixing them for similarity and adaptability, 24 subcategories, and 5 major categories. Table 3 demonstrates the categories and subcategories of the health care personnel about the barriers to health education.

Table 2. Demographic Characteristics of Study Participants

Participants	Age	Sex	Years of Experience in Health Education	Education	Degree	Family' Income
P1	30	Male	22	Associate	Family health	Bad
P2	32	Female	7	Bachelor	Public health	Average
P3	32	Female	13	Associate	Family health	Average
P4	30	Male	18	General practitioner	Dentistry	Good
P5	35	Female	9	Master	Medical health management	Average
P6	48	Male	10	Master	Psychology	Good
P7	33	Male	8	Associate	Family health	Bad
P8	33	Female	21	Master	Medical health management	Average
P9	35	Male	5	Associate	Disease fighting	Average
P10	39	Female	8	General practitioner	Dentistry	Good
P11	47	Female	7	Associate	Disease fighting	Average
P12	35	Female	5	Phd	Psychology	Average
P13	36	Female	20	Associate	Family health	Bad
P14	43	Male	12	Bachelor	Public health	Bad
P15	42	Male	18	Bachelor	Public health	Average

4.1. Health Center Related Problems

The issues associated with health care centers were divided into 5 subcategories (Table 3). The participants in this category reported such codes as lack of facilities for the clients' comfort, inadequate budget to run health education programs, spending health education budget on other areas, lack of access to health centers, and congestion of clients in health centers.

One woman stated (P_{11}) (participant): "A friendly environment should be created so that clients feel the trust and comfort, but we do not have even a small room for education and have a minimum of facilities." (Feeling of wonder).

Another woman mentioned (P_3): "With regards to education, classes and audio-visual equipment are needed, which are not available in most health centers… Most of the women, owing to long distance, come to centers with their husbands… They are very restless, which negatively affects the education of the personnel."

One man stated (P_9): "The health centers or other organizations pay no heed to education. Look, they neither allocate any budget to education nor they do something useful…." (Feeling of wonder).

The personnel stated that health care centers, the most important centers providing health services, are directly involved in providing the well-being of the individuals and the society. Absence or lack of quick, on time and inexpensive access to these centers as well as shortage of place and educational aids not only minimizes the significance of these centers and their education but also directs the people from preventive behaviors to treatment. The participants asserted that the space, location, and building of treatment spaces and clinics have been cared for, but the environment and equipment of health centers have been disregarded.

One of the participants stated (P_1): "The clients may have been in the queue for a long time and gotten tired consequently, or they may have a school child so they want to come back soon. This makes them ignore the education. Also, due to crowdedness, the health personnel cannot present the required educations."

They believed that if the government takes these issues (the environment and equipment of health centers) into account, it not only proceeds in the direction of health culture and prevention but also provokes the understanding of the value of health education and necessity of performing preventive health behaviors in the mind of the public.

4.2. Lack of Preparation for Education

"Lack of attention to personal differences of the clients" and "inappropriate educational content" were 2 subcategories of "lack of preparation for education". Repetitive and complex content, outdated subjects, absence of educational needs assessment, poor educational content, long education process, inapplicable educational

Table 3. Categories and Subcategories of the Urban Health Care Personnel About Barriers to Health Education

Categories	Subcategories
Health center-related problems	Inappropriate educational space
	Lack of educational facilities
	Economic problems of health centers
	Lack of access to centers
	Crowdedness of health centers
Lack of preparation for education	Lack of attention to individual differences of clients
	Inappropriate educational content
Clients' problems	Lack of social support
	cultural factors
	Economic problem
	Lack of knowledge
	Non-priority of health education
	Psychological problems
Personal problems of personnel	Cultural condition of personnel
	Psychological problems of personnel
	Lack of appropriate communication skills of personnel
	Lack of specialized skills of personnel
Organizational factors	Administrative problems of education
	Mismanagement in health centers
	Role of media
	Lack of intra- and intersectoral cooperation
	Poor supervision and assessment
	Career problems of personnel
	Shortage of manpower

materials, lack of classification of the learners, lack of attention to incentive, and interest, and age of the clients were the problems mentioned by the participants.

One of participants stated (P_7): "I think people should be divided from the socioeconomic standpoint; for example, something which is a problem in the lower class group may not be a big deal in the upper class group."

Most of the personnel complained about the shortages of appropriate educational models as well as repetitive and old contents.

One woman stated (P_8): "If the education is too specialized, there will be no incentives to learn on the part of the trainee … The educational content should be updated, not repetitive. Moreover, the educational contents are not objective and perceptible."

They also stated that outdated and repetitive educational content made the clients tired and discouraged them.

4.3. Clients' Problems

The clients' problems were classified into 6 categories (Table 3). couples' inattention to the health of each other, client's cultural features and false health beliefs, literacy level and low knowledge of clients, lack of tendency to watch educational programs through media, clients' impatience, and lack of motivation, low self-efficacy, failure to understand the severity of diseases, and failure to understand the benefits of health behaviors were the codes classified in these subcategories.

One woman stated (P_1): "Husbands are very important. They can patiently accompany their wives, who constitute the majority of the clients of the health centers, but they are oblivious themselves."(feeling of sadness).

One of the results of this study was that educational plans would be ineffective if the concerns of clients such as socioeconomic and psychological problems were not resolved and they were not in a stable and healthy mental condition.

One woman described (P_4): "How can a person who has no house and no money be receptive to the education on reinforcing housing to prevent disasters?"

Most of the clients regarded enhancing motivation, self-efficacy, and cultural and economic conditions of clients as vital factors, affecting every health education intervention.

One of the participants said (P_{12}): "Some clients have no incentive to learn, do not talk and give us no appropriate feedback from education. We sometimes get no feedback from the trainees and do not know what the problem is."

Another participant mentioned (P_4): "People have no tendency toward health education; they pay more attention to treatment. Their priority is not health at all."

The participants contended that first the clients' understanding and knowledge of health education concepts and preventive behaviors should be promoted. Then, families should be consulted on social and psychological issues to reinforce their attitude toward health and its priority in life; and finally, health education ought to be presented to them.

4.4. Personal Problems of the Personnel

Personal problems of the personnel were classified into 4 categories (Table 3). Literacy level, life style, and social status of employees, lack of motivation, belief, and in-

terest in the job were some codes that participants mentioned.

One of the participants stated (P_{15}): "Occasionally, an employee comes from a different culture and is working in the system. She/he is not familiar with the culture of people, which makes education not to be as effective."

Absence of self-confidence, lack of knowledge about job responsibilities and missions, negative attitude of some personnel toward the role and position of health education, lack of sympathy and friendliness with the trainees, absence of proper verbal communication, lack of skills in attracting people, guiding and controlling the trainees, and inability to create motivation in clients were the codes that were included in the main category "personal problems of the personnel."

One of the participants said (P_6): "The health providers should be motivated, self-confident, and active in providing the services; otherwise, education will not be effective."

Another participant mentioned (P_{12}): "We have poor communication skills and no sympathy and friendliness with the client. We are very much distant from them."

One of the participants stated (P_{13}): "An educator should be familiar with the principles of education methods and use of educational technology and aids."

It can be inferred that interest and incentive of the personnel could prevent the presentation of repetitive contents, higher expenses, and longer boring lectures. However, in spite of being aware of these challenges and problems, they did not make an attempt to eliminate these unfavorable factors or strengthen the favorable elements. Nonpriority of health education was the main concern of the participants and an interesting finding of this study. Although health education was the major responsibility of the health care personnel, they were not interested in it and did not consider it a priority in their workplace.

4.5. Organizational Factors

The organizational factors were classified into 7 categories (Table 3). In this category, the participants frequently reported such problems as absence of efficient education system, lack of correct educational planning, deficient training courses of students in apprenticeship programs of universities, inadequate attention of ministry of health and related authorities to health education, employment of inefficient and irrelevant manpower, disproportionate number of personnel and clients, absence of clear and transparent regulations and guidelines for education, lack of intersectoral cooperation, lack of monitoring and assessment system, multiple careers, job burnout, and inadequate salary of the trainers.

One of the participants said (P_7): "Honestly, the system does not care about education at all. It has no content and method of presentation. The personnel are rarely aware of the useful educational methods; therefore, they do not present correct education."

Another participant mentioned P_5: "There is little incentive left for the personnel, and this may be due to not receiving enough attention, lack of reward for education, and the feeling of not being appreciated."

One participant stated (P_{14}): "Insufficient workforce is one of the major causes of lack of education due to a large number of referrals."

All participants demanded more attention on the part of the health authorities to health education, assessment system, and intersectoral cooperation.

One participant said (P_2): "There is no intersectoral cooperation. When a topic is presented in a health center, it is not in line with other organizations like municipality, schools, and educational organizations; they should act in one direction."

One of the participants stated (P_6): "There is no appropriate monitoring and assessment system to control the presented education. It is only performed on the written documents; i.e., documentation is emphasized rather than the output or outcome of the programs."

The participants stated that authorities' disregard the personnel's feedback on health education; hey further contended that the government's concentration on treatment, poor attitude of managers toward education, and lack of policies lead to failure of educational programs in health centers. They demanded reassessment, investigation, encouraging administrative rules, and government support in health education programs.

One of the participants said (P_3): "Inadequate salary along with its big gap with the treatment sector is major cause of absence of incentive in personnel. Given this and the busy schedule of the staff, they do not have any motive for education. You expect them to provide education without any reward!" (feeling of sadness).

5. Discussion

The findings of this study revealed an overview of these obstacles in the health care centers of Sanandaj, Iran. The results were reported based on the real experiences of the involved people in natural settings. In general, this study clarified some of the hidden aspects and covert issues of health education that have not been taken into account in Iran.

One of the barriers to health education mentioned by the personnel was the problems of the health care centers such as insufficient budget, materials and educational aids, and crowdedness. Araujo et al. reported lack of facilities and operational problems (1), and Cho indicated lack

of provision of budget as the obstacles ahead of establishing relationships between service providers and receivers (19). Thus, health education materials and tools are important resources for improving education and reinforcing and developing verbal information (20).

As the results indicated, the government can specify separate educational space and equipment in the health centers and allocate separate budget to each health center. Also, using the educational space of other public places and organizations not only resolves this problem to some extent but also makes the significance of health education more prominent in the society.

The participants stated that disregarding individual differences of the clients and inappropriate educational content reduce the efficiency of education. The learners' differences in skills, knowledge, and attitude cause the failure of desirable education. Individual differences are one of the inevitable facts in all educational environments; however, it is not possible to consider all these differences. Due to shortage of educational space, individual educations not only solve no problem but also add to the problems. Therefore, these differences can be considered in groups, and educational content can be designed based on the differences and needs of the individuals. Precise information about the characteristics, skills and knowledge of the clients about education prevents the frequent use of educational facilities and leads to better understanding of the content. A study showed that individual differences can often make the relationships complicated and affect learning (21). On the other hand, simple educational content with sociocultural compatibility enhances the value of the materials and understanding of the content. Moreover, content should be analyzed by the experts of the field and be presented with encouraging methods (20). The educational content should use simple language and be tangible, applicable, and objective in the everyday life of the people. The educational needs should not merely be determined by the health caregivers and professionals, rather in designing the educational content, the needs of the clients should be assessed though qualitative and quantitative methods to design educational content tailored to the needs of the clients.

The participants of this study contended that improper cultural, economic, social, and psychological conditions of the clients were the major barriers to health education. In line with the present research, some studies have shown that lack of social support challenges the formation of health behaviors (19, 20). Other surveys have reported that the patients' lack of knowledge (22), absence of psychological readiness and motivation for communication (23), lack of interest in changing the behavior (24, 25), and financial and cultural (26) concerns of the clients to receive services are principal barriers to health education. To provide better health services to the clients and increase the efficiency of the presented education, it is essential that all health caregivers, educational authorities, and health care providers learn communication and counseling skills. In addition, consultations will be more effective and prevent the incidence of more acute social and psychological problems if they are provided in advance in the health centers.

Furthermore, the participants declared that lack of specialized and communication skills and personal and psychological problems partly affected their education. In line with the results of this study, a study indicated that lack of motivation and tendency, hopelessness, and disinterest of the trainer in his/her own professions were some of the important communication barriers to health education (12). In a study, it was reported that lack of communication and informational skills of trainers played a significant role in impeding their communication with patients (27). Also, the cultural status of the service providers should not be disregarded (26).

By creating a dynamic and specialized environment, the university should not only provide a ground for development of its personnel but also create an environment in which they become motivated and skillful staff. Organizations should not merely consider the expertise of the personnel and authorities or the needs of the organization; they need to consider the interest, motivation, and personal characteristics of the individuals. The health care systems should also proceed to remove economic, social, and psychological problems of their employees and create a friendly educational environment, hold meetings and camps, and arrange various entertainments for the personnel to help solve their problems.

Organizational factors such as lack of appropriate management and assessment, absence of intra- and intersectoral cooperation, and educational problems such as lack of time were other barriers to health education in the opinion of the personnel. Many studies have reported time as an important obstacle to education and have demonstrated that time is should be increased to establish communication (20, 28, 29). Another study reported lack of intra- and intersectoral cooperation, absence of monitoring and evaluation programs, lack of conspicuous administrative regulations, lack of health education priority by policymakers and positive attitude towards it, insufficient attention to the trainers' feedbacks, and achievements as barriers to health education (30). The participants stated that the responsibilities of the personnel in health centers are so complicated and diverse that have made them ignore education. A study revealed that numerous responsibilities have resulted in superficial attention of the personnel to education and have prevented the establishment of

proper relationship between patients and nurses (31).

Low salary was another major challenge of the health care personnel in the current study. When management is not performed correctly and personnel are not given salaries and benefits commensurate with their job duties, motivation loss and inefficient education occur as a result. The following measures are believed to reduce organizational factors: allocation of separate budget and provision of integrated educational programs compatible with other organizations and under supervision of ministry of health, avoidance of parallel activities in intra- and interorganizational sectors, reforming the monitoring and assessment system by the given experts, implementation of a payment system based on the performance, establishment of an integrated network of information, and statistics for planning and policymaking.

The health care authorities can take practical measures to eliminate the major barriers in providing health education to clients and minimize the obstacles with higher priorities. They can also adopt a supportive role by allocating more time to education, presenting special information to employees about the educational principles and methods, preparing, and providing educational materials and resources to the personnel and clients, running seminars, and considering an appropriate place for education.

The findings of this study revealed that the principal concerns of the personnel of health centers in providing health education to clients were nonpriority of education and ignoring health education by the clients, personnel of health centers, authorities, and other concerned organizations. The success of educational programs in health care centers was not merely an intrasectoral attempt, but a major part of it was associated with cooperation of the media and organizations, society support, and attention of authorities and clients to education. Also, the sociocultural and economic context and psychological conditions of clients were believed to be taken into consideration.

Although the results of this study improved our understanding and knowledge of the barriers to health education from the perspectives of the health personnel, the study had some limitations. First, the health education obstacles were studied from the viewpoint of the personnel of urban health centers through qualitative content analysis, whose results are not generalizable to other conditions and places. Second, the barriers to health education were explained based on the perspectives of experienced health education personnel, which may be different in the opinion of less experienced and young employees. Third, the personnel participated voluntarily in the study, whose viewpoints may be different from those who were not inclined to take part in the study. Therefore, future studies are suggested to investigate the barriers to health education among various demographic groups as well as different urban and rural areas. Moreover, the followings can be investigated by researchers in future studies: explaining the reasons for lack of motivation, job burnout and satisfaction among the health care personnel, managerial strategies to promote the interest and incentive of personnel, and identifying the strategies of the health care trainers to provide useful education. The results of this study can be helpful for the health trainers, experts of health care centers, non-communicable diseases centers, the media, and health policymakers in designing educational interventions.

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Footnotes

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