



## Barriers of Health Education from the Perspective of School Health Trainers: A Qualitative Study

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#### Authors

Fallahi A.<sup>\*1</sup> PhD,  
Nemat-Shahrbabaki B.<sup>2</sup> Ms,  
Ebtekar F.<sup>3</sup> PhD,  
Moradi L.<sup>2</sup> MA

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### ABSTRACT

**Aims** Schools health education can ensure the health of society and encourage health behaviors among the students. This study was carried out to explain the barriers of health education from the viewpoint of the school health trainers, using qualitative content analysis.

**Participants & Methods** This qualitative study was conducted at the schools of Sanandaj, located in the west of Iran in 2016. Using purposive sampling, 15 school health trainers with health education experience were included in the study. The data were collected through individual interview, group discussion, observation, and field notes, and were analyzed by conventional content analysis. To ensure the accuracy and consistency of data, the acceptability, confirmability, and transferability parameters were taken into account.

**Findings** The results yielded 5 major categories, including “shortage of educational facilities”, “poor educational planning”, “student’s challenges”, “trainer’s problems,” and “poor administrative system”.

**Conclusion** Considering the barriers to health education programs at schools, authorities are required to pay more attention to promotion of health and inter-sectoral and extra-sectoral collaboration, as well as emphasizing the close relationship of home and school.

**Keywords** Health Education; School; Barriers; Qualitative Research

<sup>1</sup>Social Determinants of Health Research Center, Research Institute for Health Development, Kurdistan University of Medical Sciences, Sanandaj, Iran

<sup>2</sup>Health Network of Sanandaj, Kurdistan University of Medical Sciences, Sanandaj, Iran

<sup>3</sup>Department of Midwifery, Faculty of Nursing & Midwifery, Kurdistan University of Medical Sciences, Sanandaj, Iran

#### \*Correspondence

Address: Social Determinants of Health Research Center, Research Institute for Health Development, Kurdistan University of Medical Sciences, Sanandaj, Iran. Postal Code: 6617713446

Phone: +98 (87) 31827507

Fax: +98 (87) 33665159  
arezofalahi91@gmail.com

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## Introduction

Health is considered the main dimension of the human life [1], commencing from the childhood, especially during the school age. As an ideal place, school plays a pivotal role in delivering the health information [2, 3], building attitude and self-efficacy [4], and forming the health-related behaviors in students [2, 5]. School is one of the most important formal organizations that helps the physical and mental well-being of children by providing a healthy environment and teaches them creativity, responsibility, and innovation.

Economic productivity and favorable material and manpower investment are possible to occur when the health of students and school personnel is provided [6].

School health education can guarantee the health of society, stimulate healthy behaviors [7], and prevent nonsocial behaviors [8] through providing information about diseases and their prevention methods [2]. Lack of health education can bring about unfavorable consequences such as heart disease, cancer, dental disease, and mental illness [9].

More than 6000 health trainers work in the domain of health education at Iranian schools [10]. The health trainers play a crucial role in the physical and mental health of students by educating proper health behaviors [11]. The trainer-student relationship, trainer position, family and trainers as good examples of positive health behaviors, and duration of training are factors affecting school health education [12]. Further development of educational resources and facilities, booklets and curriculum are other significant factors [13].

Several studies have been carried out on barriers to health education around the world, including Iran [12, 14, 15]. They have addressed issues like cultural obstacles, trainers' fear, and anxiety in expressing health behaviors, shortage of skilled professionals, legal permit [16], parents' disregard of school health education [12], and lack of using new teaching methods and approaches [17] as challenges of health education at schools. However, these studies have merely analyzed the educational obstacles of a specific domain and have ignored the opinion of the health trainers. This study aimed at finding the barriers to school health trainers during the process of teaching health behaviors to students. Studies with a qualitative approach are able to investigate the social phenomena from all dimensions and provide a deep understanding of the experiences and viewpoints of different people [18].

In general, the students' emphasis on presenting health education by the health trainers [12], the role and position of schools in establishing the values, social norms and health behaviors [19], low efficacy of health education interventions at schools [7], health trainers' dissatisfaction with their position [16], and lack of qualitative studies addressing health

education problems at schools were the factors that motivated the researchers of the present study to analyze the barriers of health education in the opinion of the school health trainers. The results of this study would be helpful for the health promotion authorities to design and implement useful and effective interventions in order to prevent the diseases and promote suitable health behaviors in students.

## Participants and Methods

Adopting conventional content analysis, this study explained the perspectives of the health trainers about barriers to health education at schools of Sanandaj, Iran in 2016. A total of 15 health trainers were selected through purposive sampling. The inclusion criteria consisted of a minimum of 3 years of experience in school health education and ability to speak fluently. The exclusion criteria, however, comprised of unwillingness to participate in the study. The samples varied with regard to gender, academic degree, experience, and type of school they were teaching in.

The primary question included "Express your experiences about health education at schools?" Based on the participants' responses, the follow-up questions (such as what are your needs to improve health education in schools?) were formulated. At the end of each interview, notes were taken from the interview. The interviews were performed in the counseling room or a quiet classroom at schools and were continued until the data were saturated (This point of closure is arrived at when the information that is being shared with the researcher becomes repetitive and contains no new ideas) [20]. The data were collected by 6 individual interviews and 2 semi-structured group discussions (groups of 4 and 5), observation, and field notes, and they were simultaneously analyzed. The 7 phases of the interview in this study included thematizing, designing, interviewing, transcribing, analyzing, verifying, and reporting [21]. The mean times of group and individual interviews were found to be 52 and 39 minutes, respectively.

The collected data were analyzed by conventional content analysis [18]. Firstly, the interviews were transcribed and studied again to gain a general insight and to immerse into the data. Then, meaning units were detected and relevant codes were extracted and classified into subcategories according to similarity, proportionality, and consistency. The subcategories were converted to categories and themes were, finally, obtained. MAXQDA 10 software was used for data analysis, listing, and classification, repeated comparison of various data, and recovery of quotations [22]. The acceptability of data was analyzed by reviewing the accuracy of the statements expressed by participants in the handwritten notes, log-term involvement in schools

and immersion in the data, and building rapport with participants, and attracting their attention. The confirmability of data was checked via a review of the interviews, codes, and categories by experts in the field. The reliability of the data was confirmed by early prescription, precise recording of the procedures, integration of time, and data collection methods [18, 23].

The current study was approved by the research council of Kurdistan University of Medical Sciences. For the sake of ethical considerations and protection of the participants' rights, written permission was taken from the concerned authorities, the qualified samples were identified, the objectives of the study were explained, and informed oral and written consent was taken from them. Moreover, the participants were allowed to withdraw from the study whenever they wished.

### Findings

A total of 15 participants, 6 men and 9 women, with the age range of 29 to 47 and work experience of 3 to 12 years were included in this study. They were selected from 4 private and 11 public primary schools of Sanandaj, Iran. Their education included associate, bachelor, and master degrees in psychology (N=2), nursing (N=2), public health (N=9), and biology (N=2).

The analysis of the participants' experiences yielded 522 primary codes that were summarized into 98 codes, 17 subcategories, and 5 major categories after they were integrated in terms of similarity and compatibility. The major categories included "shortage of educational facilities", "poor educational planning", "student's challenges", "trainer's problems", and "poor administrative system". Table 1 presents the categories, subcategories, and remarks of the health trainers about barriers to health education at schools.

**Shortage of educational facilities:** This category consisted of 2 subcategories, including "inappropriate educational environment" and "lack of access to educational facilities". The most important remarks expressed by the participants were the lack of adequate lighting and inappropriate color of classrooms and school setting, busy classrooms, insufficient space for education, and shortage of educational facilities like projector, smart board, and computer. One trainer said (participant 9): "One of the problems is unfavorable space and poor lighting of classrooms, which creates a dark and sleepy environment for the students".

Another trainer stated that primary schools were one of the ideal places to build the attitude and behavior of students. Students spend a lot of time at school during the day; so, it is highly significant to provide them with a favorable environment to generate their enthusiasm and interest in the learning-teaching process and to form good

behavior in them. The trainers also asserted that inappropriate educational environment and lack of access to suitable and up-to-date equipment made the educational environment dull and made the environment inconsistent with the students' expectations, thereby causing disinterest in learning. One trainer stated (participant 12): "We cannot provide a good education because there are no educational facilities like projector at schools".

**Table 1)** Categories, subcategories, and remarks of the trainers about barriers to school health education

Categories
<b>Shortage of educational facilities</b>
Inappropriate educational environment
Lack of access to educational equipment
<b>Poor educational planning</b>
Inappropriate educational content
Inefficient teaching methods
Disregarding student characteristics
Lack of needs assessment
<b>Student's challenges</b>
Physical problems
Mental problems
Family problems
<b>Trainer's problems</b>
Physical problems
Mental problems
Poor performance
Lack of knowledge
<b>Poor administrative system</b>
Economic problems of school health education
Administrative problems of education
Lack of inter-sectoral and extra-sectoral collaboration
Authorities' negligence of education

**Poor educational planning:** The subcategories of this domain comprised of "inappropriate educational content", "inefficient teaching methods", "disregarding student characteristics," and "lack of needs assessment". The participants argued that factors such as complexity, inapplicability, and incomprehensibility of educational content, incomplete definition of health education in schools, disregarding socio-cultural issues in designing the educational content, designing the educational content by nonprofessionals, conventional and unilateral teaching, repetitive and monotonous teaching methods, lack of attention to age, ability, understanding, interest, intrinsic, and extrinsic motivations and personality traits of students, lack of needs assessment, and failure to identify, and prioritize the health problems were challenges of health education at schools.

One trainer stated (participant 8): "We have to pay attention to such points as clarity of materials and comprehensibility of speech while teaching".

Another trainer said (participant 7): "The health trainers have no teaching models for education, or do not make use of them...Moreover, teaching is mostly unilateral, and students get distracted".

The health trainers also reported the lack of application of educational models as one of the major concerns in designing the health education programs, without which the objectives of educational interventions would not be achieved.

One trainer stated (participant 11): "Students sometimes have no background of the materials, and the materials are difficult for them to comprehend".

Another trainer declared (participant 4): "Education should be started from the young ages; the age-appropriate prioritization of educational materials removes the students' stress".

**Student's challenges:** Student's challenges were classified into 3 subcategories, including "physical problems", "mental problems", and "family problems". The students' challenges in learning the health behaviors in the opinion of the participants included physical diseases (anemia and fatigue), disinterest and lack of motivation in learning the health education issues, lack of sensitivity to and perceived severity of the disease, failure to understand the advantages of health behaviors, isolation, fear of changing a behavior, lack of confidence in performing a health behavior and overcoming the obstacles, low financial means and poverty in family, lack of familial financial support for school health programs, difference in the lifestyle and culture of families, career concerns of parents, family conflicts, parents' lack of skills and knowledge of health issues, parents' lack of attention to the health and preventive behaviors, and parents' lack of a proper relationship with their children.

One trainer said (participant 8): "Sometimes fatigue, anemia, or physical problems of the students make them ignore the education".

Another trainer declared (participant 13): "Some mental involvements like fear of changing a behavior, or any other kind of fear makes students disregard education".

The participants said health education would not be fulfilled unless the students' problems were considered from all dimensions, the home-school gap was dwindled, and family members, especially mothers cared more about the health and preventive behaviors.

One trainer said (participant 3): "Not answering the health questions and ignoring the health behaviors by parents discourage the students to perform health behaviors".

**Trainer's problems:** The trainer's problems consisted of "physical problems", "mental problems", "inappropriate performance", and "lack of knowledge" subcategories. Physical problems, family-oriented mental problems, lack of motivation and interest in the job, job dissatisfaction, and mental problems like depression, anxiety, and aggression were the challenges the health trainers faced with.

One trainer said (participant 2): "Sometimes, the trainer is tired, impatient, or has headache and

physical problems; so, s/he is not in the mood of education".

Participants stated that every human in any age and career needs mental and physical stability as s/he needs food. It was concluded from the participants' statements that creating and maintaining motivation in trainers were a significant matter that oriented and facilitated the health education process. The trainers declared they selected the health education profession with enough motivation, but lost their motivation due to lack of incentives like job benefits during their service.

One of the important findings of this study was that maintaining motivation in the school health trainers was by far harder than creating it in them. Poor educational planning, inadequate skill in employing the teaching methods and approaches, lack of allocating sufficient time to education, not being a good example for students in some health behaviors, poor verbal skill, lack of building trust and friendly relationship with students, ignoring the needs of students, and inadequate knowledge about new educational issues were other problems of the health trainers.

One trainer mentioned (participant 1): "Lack of response to our letters by the education organization and serving in several schools affect education".

The trainers stated they had no comprehensive knowledge of the teaching approaches, so they were not able to apply them to health education.

One trainer stated (participant 2): "Well, sometimes irrelevant major, lack of knowledge, and incorrect responses provided by the trainer confuse the students".

An interesting result was that the trainers were informed of their poor performance and lack of knowledge and skills in running health education, but made no effort to promote their skills and professional expertise. They attributed their poor professionalism to deficiency in the education system of universities and schools, while they were able to solve this problem.

One trainer said (participant 7): "I think lack of planning and allocation of time to teaching and educational processes by the trainer is a serious damage to proper implementation of the activities of trainers at schools".

**Poor administrative system:** The poor administrative system category included the subcategories "economic problems of school health education", "lack of inter-sectoral and extra-sectoral collaboration", "authorities' negligence of education", and "administrative problems of education".

Poor monitoring of the health center over schools health education, lack of lesson plan and health education courses in some majors of medical sciences, little attention to school health education and health trainers' problems by the authorities,

inconsistent educational subjects at schools and organizations related to the school health, inconformity of the trainer's gender and culture, lack of workforce and regular attendance of health trainers at schools, cultural problems and absence of cooperation and coordination between the health and education ministries, poor collaboration between the health trainers and school authorities, and poor cooperation between schools, and other organizations related to the students' health were the codes extracted from the poor administrative system category.

One trainer mentioned (participant 6): "We need to plan and invite parents in order to perform the activities better, but unfortunately, no specific budget is allocated to health education".

Another trainer said (participant 5): "There is a poor supervision over the health trainers' activities at schools and assessment is not done or performed poorly, which is indicative of the negligence of authorities and experts toward health activities at schools".

The trainers asserted the presentation of equal and consistent education at schools and organizations, and enforcing facilitative and motivating regulations and rules like increasing the economic welfare could improve the implementation of health education promotion programs.

One trainer mentioned (participant 6): "Lack of cooperation on the part of education department and ministry of health is the major problem that needs to be solved radically".

Another trainer declared (participant 4): "Negative attitude, poor cooperation of managers, and teachers with health trainers... are the principal problems that must be solved principally".

## Discussion

There are barriers to health education at schools. The findings of the present study reported barriers of health education from the perspective of school health trainers. One of the barriers to health education at schools was the shortage of educational facilities like space and equipment. The results of this study were in line with those of Kubo *et al.* in Brazil and Kranz *et al.* in North Carolina regarding the teachers' opinions about challenges of oral health at schools [15, 24]. It is clear that educational materials and equipment are vital sources that promote the quality of education, reinforce learning and motivate students, combine theory and practice, and generate variation in classroom. Due to lack of up-to-date educational facilities at Iranian schools, the trainers do not have sufficient access to appropriate educational technologies, thereby reducing the efficiency of health education. Precise identification of facilities required for health education at schools and employment of the educational facilities of other organizations can enhance the efficacy of education. It can be argued

that the majority of schools in Iran do not pay heed to psychology of colors, which consequently reduce the psychological security of students. A lively educational environment and colored classrooms and halls using the psychology of colors generate a happy environment, promote the students' motivation, and prevent depression in students and other school personnel.

Lack of attention to students' characteristics and poor educational planning were other challenges of health education. Hendrickson *et al.* reported that complex educational content not only diminished the value of education, but also limited the educational activities of students and their families [25].

Zarezadeh *et al.* reported repetitive and complicated trainings, dispersed educational subjects and resources, subjective educational topics, lack of needs assessment, inapplicability of educational materials, lack of classifying the learners based on their attributes, characteristics and conditions, and ignoring the motivation, interest, and age of learners as challenges of the health education [26].

The high quality, attractive, and appropriate educational content were designed by the specialists and adjusted to the features of students and their cultural and social texture enhance the efficacy of education [15].

Unfortunately, the trainings presented at Iranian schools are usually general and contents are not designed according to the learners' needs. Lack of adequate experience about the advantages of health behaviors and needs and failure to comprehend the severity of diseases bring about poor cooperation of students with health trainers and make them disregard the health issues. The sensitivity and perceived self-efficacy should be included in the school health education in order to prevent diseases in students. Theoretical models of disease prevention such as health belief model are also recommended to be used in health education programs. It should be pointed out that only some schools in Iran have health trainers, where the proportion of trainer to student is very low. Therefore, the trainer cannot have a good relationship with all students and pay enough attention to their personal characteristics. In many cases, students have no relationship with the health trainer and do not discuss their health problems. Hence, it is necessary to increase the number of health trainers at schools to design appropriate health education programs based on the needs of the students.

In the present study, family, physical, and mental problems of the students were the most critical challenges of health education from the perspectives of the health trainers. Lack of motivation, follow-up, and support on the part of families toward school health education have been reported in other studies as well [15, 27, 28].

Attitude, knowledge, and performance of parents are the factors affecting the quality of health education programs at schools [29]. The participants of the current study declared that families were negligent of the school health education programs and did not encourage their children to perform health behaviors. Economic problems and career preoccupation probably made parents to spend a lot of time away from their family and to disregard the health issues of their children.

In presentation of school health education, the communication models in families should be analyzed, their cultural and social factors need to be recognized, families have to be familiarized with the prevention concepts, and importance of health behaviors, and required consultations about health education should be provided afterward. The health education programs are required to be presented to the parents and students simultaneously by the schools, media, and other organizations concerned with the health of students. It is noteworthy that students with no physical and mental security at schools will not be able to use the required trainings at school on time and with confidence and make appropriate behavioral decisions. Creating a friendly relationship among the trainer, students and families, recognition of physical problems, and mental disorders of students like fear of changing a behavior, creating comfort in students, and performing motivational consultations to eliminate the problems can partly affect the health education at schools.

In the opinion of the health trainers, physical and mental problems of the trainer inhibited the proper and efficient presentation of health education to students. Studies have shown that lack of motivation and interest in the trainer interferes with the health education programs [30]. The trainer is a health and behavioral model for the students. Students perceive low motivation of trainer toward health education, which influences the success of the educational programs. On the other hand, the executives need to pay heed to the problems of their personnel and adopt specific strategies like pay raise and provision of recreational facilities to make them interested in health education. The participants reported physical and mental readiness was necessary to achieve success. The people without proper physical and mental conditions face various physical diseases and fail to accomplish their objectives.

Lack of knowledge, specialized skills, and poor professional performance of trainers were other barriers to school health education, which were in line with the findings of other studies [14, 15].

In the present study, the health trainers were graduates of public health, psychology, nursing, and biology. They had received little information about school health education during their academic education, had not learned how to apply communication skills in dealing with students, and

had little knowledge about the necessity of school health education. It seems that negligence of the educational authorities in hiring expert forces at schools not only reduces the quality of education, but also minimizes the significance of school health education.

The health trainers reported that poor administrative system, inadequate monitoring and assessment, and shortage of inter-sectoral and extra-sectoral collaboration were other challenges of health education at Iranian schools. In agreement with the results of the current study, the findings of other studies indicate that more attention to treatment than health education by the authorities, inadequate health budget, low efficiency of national policies in solving health problems, and poor inter-sectoral and extra-sectoral cooperation can lead to inefficient health education programs [14, 26, 31]. Enforcing transparent rules, prioritizing the execution of health regulations, and giving more attention to health education in younger ages by the authorities, detailed description of duties and responsibilities of influential school health education authorities, considering the trainers' feedback and problems, and creating and implementing consistent and equal educational protocols facilitate the attempts of the school health trainers and direct their trainings.

## Conclusion

It can be inferred from the results of this study that there are barriers to school health education, which need to be taken into consideration. These barriers require give more attention to the health promotion programs on the part of the authorities, increase the inter-sectoral and extra-sectoral collaboration, and emphasize the close relationship of home and school. Although the findings of this study increased our knowledge of barriers to health education from the viewpoint of the school health trainers, it had some limitations; first, the challenges of health education in the opinion of the health trainers were addressed at primary schools, using content analysis, whose results cannot be generalized to other educational levels. Second, the barriers to health education were explained from the perspectives of the experienced health education trainers, which might be different in the opinion of the less experienced trainers. Third, the participants were voluntarily included in the study and the viewpoints of those, who were not willing to take part in the study might be quite different. Therefore, future studies are suggested to evaluate the barriers to health education among various populations and at different urban and rural places. Moreover, future studies are recommended to take into account the reasons for the efficacy and inefficacy of different health education programs at schools, the needs of the health trainers for more effective education, causes of lack of motivation, job burnout

and job satisfaction, and managerial strategies to enhance the motivation and interest of trainers, using qualitative and quantitative approaches. The results of the current study can be helpful for the health trainers, professionals, health policymakers, and the media to design educational interventions and policies in the domain of school health education.

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