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Exploring the Perceived Capabilities of Health Professionals in Providing Health Education and Counseling to Their Clients: A Qualitative Study

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Abstract

Background: How health care providers perceive their capabilities affects their performance of their educational duties.
Objectives: The present study was conducted on health and treatment staff to explain the experiences of health care providers regarding their perceived capabilities in delivering health education.
Methods: The present study is a qualitative study with a conventional content analysis approach, which was conducted in different environments, including hospitals, doctors' offices, and health centers in Isfahan, Iran, using purposive sampling in 2017 - 2018. Thirty-two participants with an average experience of 8 years of work in health centers took part in this study. The data were analyzed using the MAXQDA software simultaneously with data collection.
Results: Two themes emerged: (1) the ability to gain the audience's trust, with the two main categories of personal characteristics and communication skills, and (2) professional capabilities with the two main categories of attitude to the profession and professional conversance. Some subcategories of both themes acted as both augmenting and diminishing factors affecting the perceived capabilities of the health care providers.
Conclusions: An individual has about his own personal characteristics, communication skills, and professional capabilities, which play central roles in the formation of their self-concepts. By enhancing these two factors via interventions based on the findings of such qualitative studies, the health care providers' self-concept related to health education can be improved.

Keywords: Health Care Providers, Health Education, Qualitative Study, Capabilities

1. Background

Health promotion involves the process of raising awareness, influencing attitudes, and determining the methods so that people can make conscious choices and modify their own behaviors; consequently, achieve a favorable level of physical and mental health and improve their physical and social environment (1). In this regard, the concept of health education has been developed, which is one of the key roles that health and treatment personnel can play (2). Numerous factors such as health promotion, the priority of prevention over treatment, shorter hospital stays, earlier discharge from the hospital, spending the recovery period at home, increased cases of disability and handicap, increased numbers of the elderly, and increased incidence of chronic illnesses suggest the need for client education (3). Health education increases patient satisfaction, the quality of life, participation in health care programs, and patient autonomy in performing daily activities whereas decreases patient anxiety, the incidence of complications derived from disease, and the need for the administration of opioid drugs after surgery (4).

Nurses and family health experts, who represent more than 70 percent of the health care team, play a valuable role in educating patients, because they have more access to the patient and his/her family and spend a lot of time taking care of him/her; as a result, have many opportunities to provide training and can also assess the quality of the training (5). Nohie et al. pointed out that only 26.7% of

the nurses working in the internal medicine wards of hospitals affiliated with the Tehran University of Medical Sciences trained patients based on the educational process, however, their performance was not at a favorable level in this field (6). While believing in the efficacy and benefits of educating the patients, the health and treatment staff of health centers do not unfortunately, pay fundamental and serious attention to this important and sensitive issue. Exploring and explaining health care providers' experiences regarding their capability to provide health education play a prominent role in identifying their strengths and weaknesses in this area, and subsequently the results of such studies can be used in measuring and trying to augment the strengths and eliminate the weaknesses through workshops and other educational strategies (7).

It seems that perceived capabilities is a complicated subject in health education and is related to social issues and psychological aspects. Hence, the most appropriate approach to understand the dimensions of the capabilities of health care providers is to use qualitative methods with an inductive approach (8).

2. Objectives

The present study was conducted to explain and explore the health care providers' experiences with regard to their perceived capabilities in delivering health education in health and treatment centers in Isfahan.

3. Methods

3.1. Research Design

This was a qualitative descriptive study implemented through a conventional content analysis method in 2017 - 2018.

3.2. Participants and the Research Context

The study was conducted on 32 health care providers using the purposive sampling method in various settings, including hospitals, doctors' offices, and health centers in the Isfahan province, Iran. Participants included nurses (7 individuals), midwives (4 individuals), social pathologists (3 individuals), individuals with master's degrees in health education (3 individuals), individuals with bachelor's degrees in public health (10 individuals), individuals with BAs in general psychology (3 individuals), and 2 people with PhDs in health education and health promotion. These individuals had a mean of 8 years of work experience in health centers. Inclusion criteria were having at least one year of work experience in health centers and being interested in expressing and describing experiences clearly. The exclusion criteria included unwillingness to continue to participate in the study and the inability to describe experiences clearly (Table 1).

Table 1. The Demographic Characteristics of the Participants

Variable	No. (%)
Gender	
Female	17 (53)
Male	15 (47)
University major	
Public health	10 (31)
Midwifery	4 (13)
Nursing	7 (22)
Health education	5 (16)
Social pathology	3 (9)
General psychology	3 (9)
Educational attainment level	
Bachelor's degree	27 (85)
Master's degree	3 (9)
Ph.D.	2 (6)
Place of work	
Hospital	7 (22)
A doctor's office or personal office	4 (13)
Health centers	15 (47)
Counselling centers for behavioral disorders	6 (18)

3.3. Ethical Considerations

The study was started after obtaining approval from the Ethics Committee of the Isfahan University of Medical Sciences (No.IR.MUI.REC.1396.3.420). Explanations about the goals, significance, and research methodology, were explained to the participants. Written informed consent was also obtained from all participants. Although initial consents were obtained, the participants were asked about their permission and the convenience of participating in the study during the interviews. The decisions on the time and place of the interviews were made with the allowance of the participants. Participants were assured that they could freely abandon the study at any stage.

3.4. Data Collection

Data were collected using semi-structured, in-depth, individual interviews and four focus group sessions. Data were collected through voice recording.

3.5. Interviews

Interviews began with individuals introducing themselves and explaining a history of the duration and location of the services they provided. First, they were asked the factors to which they contribute to and facilitate effective health education and which factors can hinder it. They were then asked to speak freely about their experiences in delivering health education. Given what the participants said, the participants were encouraged to provide more information and clarification using expressions such as "Can you explain more?" or "How did you hold that training session?" The duration of each interview varied from 20 to 60 minutes, which was dependent on the participants' viewpoints, the circumstances, and the discussion process. Interviews were continued until no new data could be obtained.

3.6. Focus Groups

To enrich the data, focused group discussions were held. Each focused group consisted of 5 - 7 participants and the discussions were conducted in different places based on accessibility and convenience of the location. Two focused group discussions were conducted in the counseling rooms of health centers and two were conducted in the nurses' break room in the hospital. Each focus group discussion lasted roughly 45 - 60 minutes. In all focus group discussions, in order to start the mutual discussion among the participants, the same general questions were asked about their attitudes and their experiences regarding the provision of health education (e.g., "Please talk about the successful experiences you have had in delivering health education to your clients." and "Please talk about health education experiences that had not been successful."). Subsequently, explorations were used to further the discussion of the subject. Different explorations were used in different groups depending on the responses given by the participants.

3.7. Data Analysis

The process of analysis was conducted simultaneously with data collection and was performed through conventional qualitative content analysis, which was carried out in three stages: Preparation, organization, and reporting (9). In the preparation phase, each audio file was considered a unit of analysis. First, the audio files of each interview were immediately transcribed verbatim. The audio files were listened to on several occasions, and the transcriptions were repeatedly read to help the researcher gain a comprehensive understanding of the data. In order to organize the data, initial coding was used. Thus, using the inductive approach, the analysis process was continued by breaking the text down line by line and extracting the units of meaning and performing the initial coding. Then, the coded data were written in the code sheet for further referrals. Grouping began after the first few interviews. The codes were placed in categories based on their similarities and differences. By repeating the mentioned process for each interview, some new topics were added until the final pattern emerged. The merging and comparison of groups reduced the number of categories. Subcategories were formed on the basis of similar characteristics and the names of the categories were indicative of their contents (10). Data were analyzed by the MAXQDA software.

3.8. Scientific Accuracy of the Findings

Spending enough time to collect the data and being in continuous and long-term contact with the participants caused the collection of in-depth data and the gaining of the trust of the participants. The maximum diversity of the participants was achieved in sampling in terms of age, gender, occupation, place of service, and the number of years of work experience. To ensure that each code was placed in its own specific category, specialists reviewed and revised the coding. To ensure that the analysis accurately reflects the experiences of the participants, data control and check were performed with the help of the participants.

4. Results

The two themes that emerged included the ability to win the trust of the audience and professional capabilities. In some cases, the subcategories of these two themes can act as both augmenting and diminishing factors affecting individuals' understanding of their own abilities (Table 2).

4.1. Ability to Win the Audience's Trust

The ability to win the trust of the audience with the two categories of individual characteristics and healthcare communication skills played a prominent role in the ability of health care providers to provide successful health education.

4.1.1. Individual Characteristics

Individual characteristics of the health care providers are characterized by the subcategories of having a charming personality, appearance and the way the person dresses, social and economic status similarity, and being at the appropriate age and marital status.

Lack of popularity and charm of the educator makes it difficult for the clients to accept him/her and can disrupt the mutual relationship and trust. A participant said that "if I attend an educational session and the educator is

Table 2. The Perceived Abilities of Health Care Providers Regarding the Delivery of Health Education

Theme	Main Categories	Subcategories Augmenting the Capabilities	Subcategories Diminishing the Perceived Capabilities
Ability to win the audience's trust			
	Individual characteristics	Appearance; being the appropriate age; similarity of marital status; similarity of the socioeconomic status	Lack of charm; not being the same gender
	Communication skills	Humorous communication; management of ongoing communication; ability to manage the costs; positive attention to the audience; verbal and non-verbal communication	Inability to manage time
Professional capabilities			
	Attitude to the profession	Effectiveness of education; being interested in the education process	The educator and the audience's lack of interest in the education process
	Professional excellence and conversance	Academic mastery; practical experience; creativity and innovation in education	

not charming or I have a negative prior mental image of him/her, I might not listen to him/her at all... I am physically present at the session, but the education he/she is offering does not influence me" (male, B.Sc. in public health).

Based on the findings, the educator's appearance and how he/she dresses in accordance with the setting in which education is offered can affect the success of health education. "When I want to go to a girls' school, if I wear a light-colored headdress, it will attract the attention of the children, then I'd rather wear a bright colored dress", a participant said. "For example, I went to a seminar, for training, my audience said we did not expect you to be so veiled and modestly clad, we thought that because this lady belongs to that particular environment, she should have a certain appearance... It was very interesting to me because they showed a positive reaction" (female, B.Sc. in public health).

The similarity of the marital status of the educator is a factor that attracts the target audience and builds trust. A participant said, "For example, when you talk to a married woman to tell her about issues related to raising the kids and try to educate her, she asks you, lady, do you have children and if you say you are single, then she says that you do not know what problems we have... When you say yea, I myself have this problem with my kid and I've done this to solve it, then you see that they accept what you say" (female, B.Sc. in public health).

Being of the appropriate age can lead to proper communication and can build mutual trust. A contributing participant stated: "The education style is different in schools and kids like to be noisy, and if you want to be involved, you should be patient with their noise and hustle and bustle and wear a bright-colored dress. In addition, the educator should be a young person... and audience-centeredness here is essential" (female, M.Sc. in health education).

Being in different genders can affect the relationship between the educator and the client in the Iranian culture. Most health care staff agreed that female educators should not be assigned to male audiences. A female nurse said, "When I train a patient, if he is a young man, he tries to mock my training..., especially if he is poorly educated".

The similarity of the socioeconomic status of the educator with the clients leads to trust in the mutual relationship. A health care provider who serves at an urban health center said, "Clients who are more like me in terms of the socioeconomic class pay better attention to what I say and follow it" (female, B.Sc. in public health).

4.1.2. Communication Skills

Communication skills emerged with the four main categories of the humorous communication, the management of ongoing communication, positive attention, and verbal and non-verbal communication skills.

4.1.2.1. Humorous Communication

Humorous communication is one of the most important psychological characteristics of educators that wins the trust of the audience.

Intimate and humorous (fun) communication with the audience creates trust. A social pathologist said, "We had a case that was a lout and a hooligan. I tried to become friend with him and told him "bring your things. I like to see them; he brought his knives and his daggers and we became friends and this led to his listening to me and he quitted his addiction... You have to communicate with drug addicts using their own language and be friend with them"

(male, B.A. in general psychology).

Additionally, establishing informal and humorous communication with the audience in training sessions can contribute to putting both sides at ease, improving the relationship and building mutual trust. A participant said, "First I started greeting them, introducing myself, and asked them to introduce themselves, because I felt if I greeted them both my worry and stress would be reduced and I would be able to attract their attention, and so they would pay attention to what I had to say".

4.1.2.2. Management of Ongoing Communication

Ongoing communication emerged with the two subcategories of time management and management of costs. Effective time management plays an important role in maintaining ongoing communication with the audience and leads to the emotional involvement of the educator. A participant who had visited a school to deliver health education said in this regard, "Because I did not have enough time, I was not able to establish a deep relationship. If I had visited from the beginning of the semester, I would have become familiar with the personalities of the students. ...Individuals have different dispositions. If I had more time, the education I offered would definitely be much more effective" (female, B.Sc. in public health).

One of the factors that causes inadequate communication with the audience or interruption in it is high costs. Participants pointed to managing and reducing it at subsequent sessions as an incentive for participation. This leads to the step by step progression of the treatment process and helps with the establishment of ongoing communication. A participant said, "I charge the highest for the first session, because in terms of time I spend more time for the first session. In fact, the treatment process is based on the first session. And in the following sessions, I charge less, because I spend less time on it... And this is actually a reward for the patient to continue with the treatment sessions" (female, B.Sc. in midwifery).

4.1.2.3. Positive Attention to the Audience

Positive Attention is shown by accepting another person as he/she is. The participants emphasized the importance of not letting with their judgments and mindsets about their clients interfere with their relationships with their clients and the importance of communicating with clients without prejudice and bias. "Various people come into your office... You encounter a person who has done something wrong in terms of the social conventions, my relationship here is not judgmental, because the client has visited to get advice and help. I put myself in the client's shoes... I have no right to judge" (female, B.A. in general psychology).

About the importance of communicating with respect and kindness with the clients, another participant said: "Older women have a lower mood because of menopausal issues... When they enter the office, I rise to show my respect... Maybe I do not do the same for a teenage patient. If I want to examine her (the old patient), I will help her and take her hand, because the examination bed is difficult for the elderly to climb and there is likely to be a fall and bone fracture" (B.Sc. in midwifery).

4.1.2.4.Verbal and Non-Verbal Communication Skills

Being a native of the region and being familiar with the language and culture of the region is necessary for verbal and non-verbal communication. One of the participants said, "I grew up in another area, and when I came here I tried to learn about the culture of the region in the first few months, because some of the words that we use in education may be offensive to people in this area" (female, B.Sc. in public health). Another participant said, "We tried to talk to them wherever we could speak with their own language, for example, if they were of the Lur ethnicity, we talked to them in Lurish... In one instance, no one referred to one of our colleagues who spoke Persian. They said we don't like it that he/she speaks Persian" (male, B.Sc. in public health).

Body language plays an important role in effective nonverbal communication. "An educator works with a cell phone while educating and does not know that this is a barrier to communication... From the viewpoint of the client, this is means ignoring the client" (female, B.Sc. in public health).

A nurse in charge of education in a hospital said, "The nurse responsible for the follow-up program of the patients should have strong communication skills, as he/she may be treated badly, their social skills should be strong and they should know how to talk" (female, nurse).

4.2. Professional Capabilities

Professional ability emerged with the two categories of attitude to the profession and professional excellence.

4.2.1. Attitude to the Profession

Health care providers' attitudes to education emerged as having the two subcategories of effectiveness of education and interest in the education process.

4.2.1.1. Effectiveness of Education

This category shows that when the educator has a positive attitude towards the effectiveness of education, he/she

feels higher responsibility for conducting health education. In fact, the educator's attitude toward education determines the educational method and process and the outcome of education and communication with the audience. About the impact of offering education and counseling services to a mother who had postpartum depression and committed suicide, a participant mentioned that "If counseling services were provided at our center and she was referred to a specialist, this would not happen" (B.Sc. in midwifery). Moreover, another participant expressed satisfaction with the education he had provided thus, "I am proud of myself because I see that addicts who refer for counseling and training along with the treatment process they become healthy" (male, B.Sc. in general social pathology).

4.2.1.2. The Educator's Interest in the Training Process

The interest of the educator in educating the clients, especially in their field of study, promotes or facilitates an effective education. A participant stated: "I studied social pathology, because I like my major. Now that I work at the central office, I go to addiction treatment centers and educate addicts" (male, B.A. in social pathology).

"As a health educator, I say that the educator's interest in the education process and the subject he/she wants to teach is important," said one of the participants on the impact of educator's interest in the education process on the outcome of education. "If what I want to compulsorily teach the learner or the educator, it won't be effective to a large extent" (female, nurse).

The participants expressed that the effectiveness of education depends on the interest of both the audience and the educators reciprocally. "As long as I feel forced to do it, I just go into the class, and I wait for the time to pass, I just want to do some semblance of a job and perform the duty that I have been assigned and I don't care whether it has a positive impact on the audience or not", said a participant (female, B.Sc. in public health).

The interest in the subject of education makes it feel elective and voluntary, which is one of the principles of lasting and fruitful health education. Teaching topics, which the participants need and are interested in, will lead to their voluntary and willing participation. A participant said, "When it is compulsory for the participants to take part in the session for any reason, the attitude does not change or it may even result in reverse outcome" (female, Ph.D. in health education and health promotion).

4.2.2. Professional Excellence and Conversance

This category emerged with the three sub-categories of creative education, and the educator's academic and practical mastery of the subject of education.

4.2.2.1. Creativity and Innovation in Education

Creative education refers to the creativity of the ideas that the educator uses when working with the target group to deliver a more effective and lasting education. In this regard, the participants mentioned creativity in congruent education and the follow-up program. For example, a participant stated: "We write down the names and telephone numbers of all patients with hypertension. Every three months, we ask them to gather in the hospital hall. Then, two or three of the patients who have been trained by ourselves speak on the podium. For example, one of them says, 'I have had hypertension for two or three years, and when I take these drugs, my blood pressure is adjusted', or a diabetic patient says, 'Since I have followed my diet and injected insulin regularly, I have foot ulcers no longer.' Hearing about the problem and its solutions from their peers is more effective. This was my idea, i.e. this was my educational creativity. In this way, we only work with a limited number of people and they reeducate others (male, nurse)". Another participant said, "I prepared my own checklists for the follow-up program so that the follow-up nurse knows what questions to ask the patient during a phone call, because it is not arbitrary and nothing is forgotten" (female, nurse).

4.2.2.2. Educator's Academic Mastery

Having sufficient knowledge and studying in the field of the service that the educator offers is an important factor in health education, as mentioned by the participants. A participant said, "The level of awareness of health care providers is important so that they do not misinform the patient. We told them that if you do not know the answer to a question, do not reply, refer to the book or, for example, ask the head nurse or give the patient a phone number [to ask later] or you yourself call the patient later" (female, nurse in charge of health education).

Based on the findings, having sufficient scientific knowledge increases both the speed of service delivery and the accuracy of the work. For example, a participant said, "Since I study regularly and have mastery over the science, I simultaneously train and deliver a service like putting an IUD in place. Others may not be able to do the work for the patient in 15 minutes" (B.Sc. in midwifery).

4.2.2.3. Having Practical Experience

This category refers to the educator's having work experience and making use of practical methods for educating clients. Having work experience will improve the education of the various aspects related to the subject. "I thought it was good that I had a lot of experience with people who had the disease, because they asked a lot of different questions," one of the participants said about an educa-

tional experience delivered to caregivers to Alzheimer patients at the Municipality's Cultural Center (female, Ph.D. in health education and health promotion).

Having more work experience leads to the delivery of more tangible education and the use of strategies that makes the subject matter more directly experienced and that leads to more lasting learning. A participant said, "I show artificial replicas of the illicit drugs to family members and parents and I really see that the information that I give them is totally new to them... Many of the clients have a lot of other things in their minds. When I talk about the signs and symptoms of addiction, many come to me and tell me about things in their families and tell me we did not know that our husbands had these symptoms of addiction" (female, social psychologist).

5. Discussion

Based on the obtained results, two themes, including the ability to win the trust of the audience and professional capabilities played major roles in the formation of the perceived capabilities of health care providers in delivering health education. The first explored theme was the ability of the health educator to win audience's trust by his/her personal characteristics and communication skills. Demographic differences such as personality traits, age, marital status, gender, and even the educator's appearance are important in establishing satisfactory communication and delivering optimal education to the clients (11). Consistent with previous studies, communication with patients should be based on the demographic characteristics of the clients and not everyone should receive the same treatment (9, 12). According to previous qualitative and quantitative studies, interventions are needed at multiple levels to address social and economic barriers (10, 13-15). The most effective intervention currently receiving particular attention in Iran's Health Care System is the education of indigenous forces for providing health services, because the health care providers are most similar to those in the region where health education services are provided in terms of socioeconomic characteristics.

Health care providers have said that friendly and humorous communication is important to the clients. When clients laugh with health professionals, their self-confidence increases. Humorous communication conveys emotional messages and leads to trust (11, 16, 17). Humorous and friendly communication with the audience will lead to empathy with the audience and wins the audience's trust.

Ongoing communication with clients always leads to a positive relationship between patients and health care providers (18). In line with previous studies, one of the barriers to ongoing communication with clients is a duty-oriented approach in the health care system. Health care personnel concern with meeting their own needs, which includes performing their duties, additionally their relationships are duty-centered. This approach makes the relationships between clients and health and treatment personnel predictable and the management of the organization supports this approach. Due to the duty-centered approach, health care providers spend less time for the clients, because the job descriptions of health and treatment personnel do not define setting time aside for the patients. This approach causes health professionals to have a busy schedule such that they do not have enough time to maintain and manage their relationships with clients; whereas, this does not require much time and many resources and having a busy schedule does not justify no performing this task (17, 19). Consistent with previous studies, continuing education using communication technologies helps maintain ongoing communication and allows health care providers to convey accurate information to the clients who have been discharged from the hospital. Continuing education provides an opportunity for health care providers to manage barriers, such as lack of time and high costs to improve the outcome of the treatment (20-22).

In the present study, the participants stressed the needs for positive attention and avoiding prejudice and bias toward the clients. To pay positive attention to the clients in communicating with them, it is necessary that they are not judged. Positive attention is a method in which the client is accepted and respected so that he/she feels safe. Therefore, the prerequisite for winning the trust of the audience is to pay them positive attention (9, 11). The prerequisite for empathizing with the patient is to pay positive attention to him/her and care for him/her. This behavior leads to an intimate and empathetic relationship. Attention and care is a patient-centered process, and is, in fact, the foundation of a relationship based on honesty, closeness, and empathy. When clients feel that their feelings are validated by the health care providers, they feel that the educator understands their conditions better and this wins their trust (11, 23, 24).

One of the most important factors in the quality of care is verbal and non-verbal communication skills among health care providers and the clients, e.g. one of the objectives of the joint commission on patient safety in 2009 was to promote effective communication between care providers and clients. Effective communication is the explicit transmission and reception of the content of the message in which information is knowingly or unknowingly created by a person and transmitted to the recipient through verbal and non-verbal patterns. When com-

municating with clients, individual differences in patients should be taken into account and nurses should use words that are understandable to the patients. The use of medical terms without explaining them makes the patients stressed and anxious (18, 25). What clients believe is that nurses and doctors are in a hurry and do not listen to them and do not explain. In line with previous research, mutual verbal communication with clients rather than unilateral communication, the use of words that are understandable to clients, and not overloading clients with information, as well as the use of memory enhancement strategies, such as written instructions and reminders, help to enhance the mutual verbal communication (26-28).

Most patients admitted to intensive care units are patients who, due to physical conditions, are not able to communicate in the usual way; therefore, in such a situation, nurses take advantage of the non-verbal methods of communication, additionally the appropriate use of these methods and skills can be more effective than physical care based on the patient's conditions (29). Nurses have to use specific tools and behaviors to improve communication with clients, most notably using body language, facial expressions, eye contact, and using paper and pencil, drawing, and asking yes-no questions (29). The results of previous studies have shown that 69% of patients hospitalized in such wards use body language, 30% use lip reading and one percent make use of paper and pencil for communication, while, for nurses too, the use of body language and facial expressions have been mentioned as a fundamental element in nursing (27, 30).

The second explored theme was the professional capabilities of health educators with two sub-categories, including attitude to the profession and professional excellence. Participants believed that health educators need to be aware of the impact of health education on the health system. In line with previous studies, the attitude of health professionals toward the effectiveness and positive outcomes of health education for patients leads to feelings of responsibility for this issue (15). The accountability of health professionals to the care they provide is an important assumption in health education quality management programs (21, 31).

One of the most important factors of professional capabilities on the path to professional development and professionalism is interest in health education. Interest has an undeniable effect on the effort to improve health education services and becoming professional in this field. Interest in the academic field of study is one of the important and influential factors in becoming a professional in education and the formation of a professional commitment (14, 18). A study on the barriers to achieving professional ethics showed that inappropriate attitude toward the academic discipline leads to lack of motivation and interest (32). According to the findings, public health personnel have a negative attitude to their academic field of study in terms of the social and financial status associated with it. As a participant said, "The field that I studied has neither social prestige nor good income. I no longer have motivation to spend enough time to educate the clients". The effect of an individual's specialty on the applicability of the education and training is accounted for by the relationships among the field of study, professional knowledge and skills and the area of work of the person with the target course of study. The closer this relationship is, the more applicable the education would be (32, 33).

The Health educator's academic and practical mastery is among the important factors that affect the self-concept of the health care providers in terms of successful health education. Applying professional knowledge and skills in health education creates a sense of professional capabilities and excellence among health and treatment personnel. It is crucial to professional excellence and conversance that health and treatment personnel possess the professional knowledge and skills and know how to apply them effectively in health education in order to meet the needs of the clients (14). According to previous studies, the performance of health and treatment personnel in health education based on knowledge that originates from scientific interventions can increase the satisfaction obtained from health care (20, 34).

In addition to knowledge and skills, the participants also paid attention to work experience. Lack of work experience leads to a lack of self-esteem and self-confidence among health personnel in their ability to use their knowledge of care and academic skills in health education (35). According to previous studies, health care is a profession based on science and practice, and clinical internships play a major role in the development of health professionals' skills in the field of psychomotor learning goals. Clinical education enhances active learning and the socialization of the profession (14). Previous studies show that for some skills, which are less likely to be applicable in clinical settings, it would be better to use clinical workshops and medical moulage in order to achieve scientific and practical knowledge and the mastery to provide better services (23, 36).

Creativity is a kind of problem-solving through identifying issues, constructing hypotheses, and the continuous testing of solutions, and the creative person is much more successful in applying, localizing, and using the education in new conditions and adapting it to new problems (29). Consistent with previous studies, the use of new teaching strategies and methods, education based on problem-solving, the creation of clinical situations for understand-

ing real-life situations, and education along with practice can be seen as the ways of enhancing creativity and providing successful education. The fact that most training in the health system is offered in the classical framework raises the necessity of innovation and creativity for the successful application of the training. Communication with patients should be based on creative clinical problem solving and it is necessary to make decisions for each individual or group creatively (11, 37, 24).

5.1. Conclusions

The exploration of the experiences of health care providers regarding their perceived capabilities in health education identified their strengths and weaknesses in this field. These results are applicable in measuring and improving these capabilities in health and treatment personnel using different educational strategies.

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Footnotes

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