

AFRICA DEVELOPMENT AND RESOURCES RESEARCH INSTITUTE (ADRRI) JOURNAL



ADRRI JOURNALS (www.adrri.org)

E-ISSN: 2343-6662 VOL. 27, No. 2(4), December, 2017

Renewing the Scope of Training and Transfer of Learning among Community Health Service Workers in Ghana: The Intervening Role of Experiential Training

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Available Online: 31st December, 2017

URL: <http://www.journals.adrri.org/>

[Cite Article as: Opoku, K. F. (2017). **Renewing the Scope of Training and Transfer of Learning among Community Health Service Workers in Ghana: The Intervening Role of Experiential Training** V. (2017). Africa Development and Resources Research Institute Journal, Ghana: Vol. 27, No. 2 (4), Pp. 8-24, ISSN: 2343-6662, 31st December, 2017.]

Abstract

This paper examines the extent to which Community Health Service Workers (CHSWs) can effectively transfer the skills acquired from training to the workplace in Ghana. A sample of 200 CHSWs from nine (9) Community-Based Health Planning and Services Campuses in the Amansie West District were surveyed. A modified version of the Learning Transfer System Inventory Scale (LTSIS) by Holton, Bates and Ruona (2000) was used to measure transfer of training, while the Experiential Learning Principles (ELP) of the Association for Experiential Education (2011, paragraph 4) were used to test experiential training. The data were collected using the survey questionnaire. The relationship between experiential training and transfer of training was measured using the structural equation model. The study found that Community Health Service trainees had higher propensity to transfer learning from training programmes to their workplace if the experiential method of training was adopted. It was therefore, concluded that the Ghana Community Health Service Worker can contribute more to health care delivery if their practical training was repackaged into the experiential type of training. It was recommended that management of Community Health Service Workers in Ghana must shift from the traditional abstract method of training and education where the Community Health Service Workers were less involved in the learning and teaching activity, towards the experiential training which involves a cycle of "trying" and "undergoing"

an experience by becoming aware of a problem, getting an idea, trying out a response, experiencing the consequences, and either confirming or modifying previous conceptions.

Keywords: training, transfer of training, experiential training, community health service

INTRODUCTION

One major challenge facing many employers and human resource practitioners is how to design a training programme to ensure or encourage transfer of learning (Coelho & Vilares, 2010; Goldwasser, 2001). As noted by Haskel (2001), most training programmes are built on theoretical perspectives, in which case the learner simply memorises isolated facts with little opportunity to organise the learned material in a more practical fashion (Shi, Fan, & Ren, 2008). This, according to Eaton, DesJardins and Lane (2008) does not allow the trainees to transfer what they have learnt from a training programme. In buttressing their stand, Coelho and Vilares (2010) argued that training is necessary only when it is capable of providing employees with the specific competencies they require to better perform or correct deficiencies in their work environment. The investment in training can be justified only when it is capable of fostering the initiative and creativity of trainees to transfer what they have learnt from a training programme to the workplace (Coelho & Vilares, 2010).

In contemporary business, it has become imperative for employers to understand the impact that training has on their organisations; for this is what guides their human capital investment decisions (Brown & Drusilla, 2011; Bartel, 2000). Managers can no longer approve expenditure on training without substantial justification to support their spending decisions (Eaton, DesJardins & Lane, 2008). As the investment in various training programmes continue to rise, the question that often comes to mind is, "For every dollar invested in training, how many dollars do employers get in return"? In response to this question, human resource managers are required to design training programmes that will ensure the transfer of the skills and knowledge acquired by trainees (Goldwasser, 2001). To achieve this, training programmes must be designed to suite the background characteristics and learning styles of the trainees (Forrest & Peterson, 2006). Again, the trainees must participate actively in the learning process (Coelho & Vilares, 2010). The emphasis now is on learners doing something (in the learning process) other than listening and watching (Asare-Bediako, 2013). Therefore, a major role of the trainer becomes one of designing activities and experiences that provide trainees with the opportunity to transfer the competencies learnt during the training programme (Brown & Drusilla, 2011; Coelho & Vilares, 2010; Eaton, DesJardins & Lane, 2008; Bartel, 2000).

The argument that trainees must participate actively in the learning process is based on the premises that employees are adults whose learning style differs from the learning style of children (Forrest & Peterson, 2006). As noted by Knowles (1980), there are significant differences in the learning characteristics between children (subject centeredness) and adults (problem centeredness). In support of Knowles's (1980) proposition that learning shifts from subject centeredness (childhood) to problem centeredness (adulthood), Kolb (1984), developed

what he called the experiential learning cycle, arguing that adult learning is more effective when learners are more directly involved rather than passively receiving knowledge transmitted by trainers. Kolb (1984, p. 38) defined “adult experiential learning as the process whereby knowledge is created through the transformation of experience”. For Kolb (1984), experiential learning is built upon the central notion that experience plays a critical role in the learning process (Kolb, 1984). Consequently, experiential learning has often been described as learning through action, learning by doing, learning through experience, and learning through discovery and exploration, and learning based on the unique and distinctive characteristics of adults as learners (Aik & Tway, 2006). According to followers of the experiential learning, as people grow and mature, they tend to rely on past experiences, want to decide when to learn, feel the need to manage their own learning, and wish to schedule learning as they determine the need for learning (Noe, 2010). Thus, to accomplish the adult employee’s desire to learn and acquire skills, facilitators need a training model that is practical and self-directing (O’Bannon & Cara, 2008).

This paper used three learning concepts; experiential learning, transfer of learning and adult learning as the framework for designing an integrative training programme by which community health service workers in Ghana can transfer the knowledge acquired from training to the workplace. In order to strengthen efficiency and effectiveness in quality health service delivery by the Community Health Workers in Ghana, a training scheme, involving 28 weeks was launched. The training, which is mostly organised through workshops, conferences and seminars, goes through five phases before the Community Health Workers is awarded a certificate to commence work (Nyonator, Awoonor-Williams, Phillips, Tanya & Miller, 2011). A new training scheme was launched in 2005, in which case the community health service worker is required to go to a training school for two years within which there is a compulsory practical training during each vacation (Ministry of Health, 2014).

While it is the believe of the author that without such learning opportunities the health care worker, particularly those in rural or remote areas in Ghana will experience a decline in their knowledge and skills, a number of studies have found that the finest way to increase the amount of learning taking place in the adult employee is self-directed learning grounded in experience, otherwise called the experiential learning (Yates, Wilson & Kendra, 2015; O’Bannon & Cara, 2008; Clardy, 2004; Knowles, 1980). The purpose of this paper, therefore, is to determine needs which are currently not being met by existing training programmes, and how these could be met more effectively, through experiential training that would make it possible for the community health worker to transfer the skills, knowledge and abilities acquired through training to the workplace.

Snapshot of the Community Health Service (CHS) in Ghana

In her attempt to achieve the Millennium Development Goals (MDGs) 4, 5 and 6, the Government of Ghana decided to expand healthcare delivery throughout the country. From the year 2000 up-to 2014, the Government introduced more than three healthcare interventions to improve the delivery of primary healthcare services to its citizens, thereby shifting from direct doctor-patient care to community-level primary care. These included the Community-based

Health Planning and Services (CHPS) that placed community nurses in mobilised communities for providing preventive and curative primary health care services; the Health Extension Worker (HEW) programme that aimed at training a lower cadre of health workers for assisting health professionals; and the Health Promotion Assistant (HPA) programme that oriented graduates of hygiene schools to provide free basic health screening, health education and health information across the country (Ministry of Health, 2014). In each case, the main objective was to increase access to and use of health services in remote communities which, comparatively, were afflicted by high maternal and child mortality, diarrhea, malnutrition, HIV/AIDS, malaria, and other endemic diseases (Russell, 2008).

One of the most recent and critical community health worker interventions was the implementation of the One-Million Community Health Workers (1MCHWs) programme that aimed at hiring, training, equipping and deploying 83,000 Community Health Workers in Ghana (Ministry of Health, 2014). The idea was to bring health services to the door-steps of the people of Ghana. Through a collaborative effort of the Ministry of Health (MOH), the Ghana Health Service (GHS) and the One-Million Community Health Workers system (1MCHWs), a pilot study of the programme was launched in six districts in the Ashanti Region. The districts were: 1) Amansie West, 2) Bosome Freho, 3) Sekyere Kumawu, 4) Sekyere Central, 5) Amansie Central, and 6) Ejura Sekyereduamasi. In collaboration with Non-governmental organisations, the Ghana Health Service (GHS) trained and deployed 1,000 Community Health Workers (CHWs) in 2015 to cover a total population of approximately 564,658 citizens in the six districts. Included in the plan was an estimated 15,157 CHWs by 2016 (serving 60% of the rural population), 27,845 CHWs by 2019 (achieving 100% rural coverage) and 31,707 CHWs by 2025 (achieving 100% nationwide coverage) (Ministry of Health, 2014). The Community Health Worker programme replaced the Village Health Workers (VHWs) project which was abandoned due to inadequate resources for training, monitoring and supervising (Bosu, Laryea-Adjei & McIntyre, 2003). According to the Ghana Ministry of Health (2014), the Community Health Workers programme was created to provide more professionals, and potentially more acceptable and effective services than the Village Health Workers.

Concept of training

Training is a planned effort by a company to facilitate employees' learning of job-related competencies that are critical for successful job performance in the immediate term or near future (Jehanzeb & Bashir, 2013; Armstrong, 2009; Vemic, 2007). There are two major types of training: on-the-job training and off-the-job training (Ongori & Ozonzo, 2011). On-the-job training (OJT) allows the trainee to acquire skills by actually doing the job (Dessler, 2005). It is a method of training where the learner develops skills in the real work situation by using the machinery and the materials involved in performing the job (Ongori & Ozonzo, 2011). On-the-job training is normally handled by experienced colleagues, supervisors, managers, and mentors who are usually mandated to provide training programmes for developing the specific knowledge or expertise of employees (Obisi, 2011). Most frequently, there are three incentives for embarking on this type of training: a favourable relationship between training costs and

benefits; the responsibility to train just-in-time; and the expectation of a positive transfer of what was learned to the employees' work situation (Sims, 2006).

Alternatively, employees may be engaged in off-the-job training. This may be necessary if the outside training can provide expertise, equipment, or sharing of experiences that are not available within the organisation (Jacobs, 2003). Off-the-job training programmes may be developed and conducted by in-house trainers or consultants hired for the task (Sims, 2006). Training instructions may be delivered through lecture, vestibule training, role playing, case study, discussion and simulation, and the environment can be designed or controlled to minimize intermittent distractions from employers, thereby creating a climate conducive for learners (Obisi, 2011; Gambin, Hasluck & Hogarth, 2010). A major disadvantage of off-the-job training is that training effectiveness is constrained because of the possibility of inadequate transfer of learning from the training environment to workplace environment (Sims, 2006; Jacobs, 2003).

The goal of training is to assist trainees to master the knowledge and skills learnt during training programmes and to apply them to their day-to-day activities (Jacobs, 2003). Training also moulds employees' attitudes and help them contribute meaningfully to the organisation (Olaniyan & Ojo, 2008). Training enables employees to develop and rise within the organisation, thereby increasing their market value, earning power and job security (Mamoria, 1995). It also introduces them to important business decisions (Vemic, 2007). According to Obisi (2011), training prepares employees to use new technologies, function in new work systems, such as virtual teams, and encourages them to communicate and cooperate with peers, customers, and all other stakeholders from different cultural backgrounds (Obisi, 2011). Training has a considerable benefit to the organisation as well. According to the American Society for Training and Development (ASTD), investment in employee training enhances a company's financial performance.

Designing and implementing training for employees, however, represent an investment in people that is associated with cost. In other words, training has a considerable influence on company finances because of the several potential costs that are incurred before, during and after such training programmes (Lerman, 2013). Some leading companies have made significant investments in their existing employees. In 1995, for instance, \$7.7 billion was spent on the wages and salaries of in-house company trainers and \$2.8 billion on tuition reimbursement in the United States of America (Frazis, Gittleman, Horrigan, Joyce, 1998). Training has both direct and indirect cost to the employer. The direct cost of training usually includes instructor salary, materials, travel, per diem and follow-up supervision (Gomez-Mejia, Balkin, & Cardy, 2007; Goldwasser, 2001). The indirect costs are associated with the lost productivity during training time (Mohrenweiser & Zwick, 2009).

Transfer of training

Baldwin and Ford (1988) defined transfer of training as the degree to which trainees effectively apply the knowledge, skills and attitudes gained in the training context to the job. It is also defined by Broad and Newstrom (1992) as the effective and continuing application, by trainees to their jobs, of the knowledge and skills gained in training - both on and off the job. Transfer of

training may be direct or indirect (Kraiger, 2003). Direct transfer of training means that the trainee is able to apply the knowledge and skills embedded in the training objectives to his work (Hunter-Johnson & Closson, 2011). Indirect transfer on the other hand means that the trainee may transfer to the workplace, skills or attitudes that were acquired in training, not embedded in the training objectives but as a result of the interactions and methods used (Kontoghiorghes, 2004). Thus, working in a group, promoting self-confidence, self-esteem, being responsible, reliable and punctual, are all possible skills and attitudes that may be developed indirectly through training (Kraiger, 2003). To maximize the transfer of training in any one of these forms, all stakeholders - *managers* (including executives, supervisors, team leaders, etc.), *trainers* (including all HRD related professionals) and *trainees or learners* must have a strong interest in initiating the training programme and must agree to work together to support the full application of the expected skills (Yamnull & Mclean, 2001).

Having critically analysed the literature relating to transfer of training, Baldwin and Ford (1988) developed a model that was used and continue to be used as a foundational platform for other transfer of training models (Hunter-Johnson & Closson, 2011; Dowling & Welch, 2005; Kontoghiorghes, 2002). The model was based on the assumption that, to understand the training transfer process, one need to understand all the factors affecting trainees before, during, and after training (Kontoghiorghes, 2004). The model incorporates three factors that have impact on training transfer – training inputs, training outputs and the conditions of training transfer (Baldwin & Ford, 1988). Training inputs have three elements: 1) trainee characteristics, 2) training design, and 3) workplace environment. The characteristics of a trainee’s personality directly affect the training process. As noted by Kontoghiorghes (2004), to ensure transfer of training, facilitators are encouraged to design training programmes to reflect the background characteristics of trainees (Brown & McCracken, 2009). Trainee characteristics include ability, skill, motivation, self-efficacy, perceived utility and personality (Brown & McCracken, 2009).

The next important element in the model is the design and delivery of training programmes. According to Baldwin and Ford (1988), a training programme must not only incorporate learning principles but must adhere to appropriate sequencing of relevant training materials (Grossman & Salas, 2011; Brown & McCracken, 2009). The final element of training input relates to the work environment which may or may not encourage the use of new trainee behaviors (Yamnull & Mclean, 2001). Baldwin and Ford (1988) identified the four most critical components of the work environment that impact on the trainee’s ability to transfer Knowledge and skills learnt: availability of equipment, supportive climate, opportunity and follow-ups (Kontoghiorghes, 2004).

The second major component of Baldwin and Ford’s (1988) model of training transfer, training outputs, are what the trainee has learnt and what he is able to retain after training (Kraiger, 2003). They include the knowledge, skills, attitudes and behaviours acquired during training. The final component of Baldwin and Ford’s (1988) model of training transfer, the conditions of transfer include both the generalization of knowledge and skills acquired from training and the maintenance of that learning over time (Brown & McCracken, 2009).

Experiential training

Experiential learning is a cycle of “trying” and “undergoing” an experience by becoming aware of a problem, getting an idea, trying out a response, experiencing the consequences, and either confirming or modifying previous conceptions (Asare-Bediako, 2013). The experiential learning movement was an attempt to shift from the traditional abstract education and training programmes where instructions were highly structured and students competed with one another or remain uninvolved or unmotivated in the learning and teaching activity (Obisi, 2011). Until the early 19th Century, practically all training programmes were built on theoretical perspectives which hampered the transfer of materials learnt in a more practical fashion (Mohrenweiser & Zwick, 2009). As noted by Lerman (2013), just like the traditional classroom learning situation, trainers present information and hope that trainees will later apply the knowledge (Asare-Bediako, 2013).

In experiential training, the trainee is involved in the learning process by reflecting on his or her past experiences and applying what he has learnt (Cercone, 2008; Knowles, 1980). The focus of training has shifted from the trainer to the trainee (Lerman, 2013). The emphasis now is on learners doing something in the learning process other than listening and watching the trainer (Cercone, 2008). The role of the trainer has become one of designing activities and experiences, assessing what trainees know, providing suggestions for their improvement, and teaching them self-assessment skills that gives them the opportunity to transfer the competencies they have learnt from the training (Lerman, 2013; Mohrenweiser & Zwick, 2009; Gilroy & Winch, 2006; Phillips, 1996). This is what Kolb sought to achieve with his experiential learning theory. According to the theory, learning is a “holistic adaptive process that provides conceptual bridges across life situations such as school and work” (Kolb, 1984, p. 33).

Experiential learning occurs in a cycle involving four stages: Concrete Experience, Reflective Observation, Abstract Conceptualization, and Active Experimentation (Du Plooy & Guest, 1998). As submitted by Lewis and Williams (1994):

Learners have concrete experiences...on which they reflect on from a variety of perspectives. From these reflective observations, learners engage in abstract conceptualization, creating generalizations or principles that integrate their observations into theories. Learners then use these generalisations as guides to engage in further action, called active experimentation, where they test what they have learned in other more complex situations. This in turn leads to another set of concrete experiences and another round of learning at a more sophisticated level (P. 5).

In summary, trainees in experiential learning engage in experiences, reflect on them from various perspectives, form concepts that integrate their observations with theories, and use these theories to guide their future action (Gilroy & Winch, 2006).

METHODOLOGY

The study population for this study comprised all the 200 community health service workers in the Amansie West District. The District was purposively selected because it is among the first six districts in which a pilot study of the One-Million Community Health Worker Programme was carried out in Ghana. Again, the district has the highest number of Community-Based Health Planning and Services campuses, including the campuses in Kiniago, Asamang,

Adimposo, Mpraniase, Manso Nkran, Akyekyerekrom, Datano, Aboaboso and Nnipankyeremia (Yeleduor, 2012). Two variables were measured in the study: transfer of training and experiential training. Transfer of training was measured using the Learning Transfer System Inventory Scales developed by Holton, Bates and Ruona (2000). The LTSI contains eighty-nine items measuring sixteen factors in two construct domains: Training in Specific and Training in General. The Training in Specific domain contains fifty-three items measuring eleven constructs while Training in General domain consists of thirty-six items measuring five constructs. As this study sought to examine the transfer of training of specific training needs of community health workers, only the fifty-three items relating to training in specific domains were required. Experiential training on the other hand was measured on the basis of the experiential learning principles as developed by the Association for Experiential Education (2011, paragraph 4).

The study adopted a purely quantitative approach, using a closed ended survey questionnaire based on a five-point Likert scale ranging from Least Agreement to Total Agreement (Creswell, 2007; Punch, 2005). The survey questionnaire was self-administered. Because the researcher intended to observe existing patterns of behaviour between experiential training and transfer of training, why they occur, and what they imply, the descriptive and exploratory survey designs were adopted for the study (Creswell, 2007). The IBM Statistical Product and Service Solutions (SPSS) Version 18.0 was used to process the data. The structural equation modeling, using partial least squares was used to measure the relationship between experiential training and transfer of training. The Partial least squares structural modelling technique was adopted because it provides a very general and convenient framework for any statistical analysis as it combines the advantages of several traditional multivariate procedures such as the factor analysis, regression analysis, discriminant analysis and canonical correlation (Kim, 2016; Haenlein & Kaplan, 2004).

Profile of the study area

The Amansie West District is located within latitudes 6° 35 and 6° 51 North and Longitudes 1° 40 and 2° 05. It covers about 5.4 percent of the total land area of the Ashanti Region (1,364 square kilometres). The district shares boundaries with the Amansie East District in the west, Atwima Mponua District in the east, Atwima Nwabiagya District in the north and Amansie Central in the South (Ghana Statistical Service, 2012). The dominant economic activity in the district is agriculture (44.5%). This is followed by wholesale and retail trade (18.4%), manufacturing (12.2%), and community, social and personal services (9.9%). Other activities include: mining; timber processing; and small-scale processing of agricultural products (Ghana Statistical Service, 2012). The Amansie West District has both forest and savannah vegetations. A greater part of the district, particularly the south, is covered by semi-deciduous forest, while the north-eastern part, due to human activity and bushfires, is reduced to the open savannah vegetation (Guinea savannah). The guinea savannah vegetation consists of tall grasses, such as the Andropogon, Plasmidium, and Rottbela which are interspersed with short fire-resistant tree species like the Damela, Vitex and Lophira (Paulus, 2009). The forest part of the region consists of trees with thick corky barks that are generally scattered due to logging activities. Common

economic trees include Odum, Wawa, Sapele and other lesser-known species. The district has an average annual rainfall of 1,270 mm and two rainy seasons (Ayarkwa, 2009).

FINDINGS

Measurement model evaluation

This section of the study focused on the suitability of the indicators used to measure the variables in the study. A number of variables were measured: Trainee Readiness (TR), Motivation to Transfer (MT), Positive Personal Outcomes (PPO), Negative Personal Outcomes (NPO), Personal Capacity to Transfer (PCT), Peer Support (PS), Supervisor Support (SS), Perceived Content Validity (PCV), Transfer Design (TD), Opportunity to use Newly Acquired Skill (ONAS) and Experiential Training (ET). An indicator is considered reliable when its outer loading is higher than 0.7. Almost all the indicators used for measuring the eleven variables had an outer loading well above 0.7 as in column 2 of Table 1. An indicator that loaded below the minimum threshold was removed from the model. The remaining indicators were retained at a significant level of $p < 0.05$. Also, the reliability of each construct was assessed by observing the composite reliabilities of the constructs used in the model. The composite reliability of each construct was well above the minimum value of 0.7, ranging from 0.824 to 0.935, thereby confirming the reliability of the constructs, as in column 3 of Table 1.

Table 1: Construct Reliability and Validity

Construct	Cronbach Alpha	Composite Reliability	AVE
Experiential Training (ET)	0.922	0.935	0.589
Motivation to Transfer (MT)	0.761	0.862	0.676
Negative Personal Outcomes (NPO)	0.889	0.913	0.602
Opportunity to use Newly Acquired Skill (ONAS)	0.802	0.871	0.628
Peer Support (PS)	0.743	0.854	0.663
Perceived Content Validity (PCV)	0.667	0.857	0.750
Personal Capacity to Transfer (PCT)	0.846	0.886	0.565
Positive Personal Outcomes (PPO)	0.810	0.887	0.724
Supervisor Support (SS)	0.574	0.824	0.701
Trainee Readiness (TR)	0.778	0.847	0.582
Transfer Design (TD)	0.741	0.853	0.659

Convergent validity was also assessed by observing the Average Variance Extracted (AVE) for each construct. According to Hair, Ringle and Sarstedt (2013), the minimum value of the Average Variance Extracted of all the latent variables used in a study should not be less than 0.5. Thus, the requirements of convergent validity have been fulfilled in this study as the Average Variance Extracted for each latent variable was above the cutoff point of 0.5. The results are presented in column 4 of Table 1. Again, the Average Variance Extracted of each construct (latent variable) was higher than the squared value of the correlation between the

constructs, thereby suggesting that the requirement of discriminant validity is achieved. The results are presented in Table 2.

Table 2: Fornell-Larcker Criterion

	ETA	MTV	NPO	OYU	PS	PCV	PCFT	PPO	SS	TR	TD
ETA	0.768										
MTV	0.569	0.822									
NPO	0.549	0.538	0.776								
OYU	0.326	0.445	0.456	0.793							
PS	0.538	0.497	0.680	0.387	0.814						
PCV	0.506	0.463	0.650	0.346	0.709	0.866					
PCFT	0.602	0.669	0.429	0.489	0.401	0.398	0.752				
PPO	0.598	0.691	0.651	0.466	0.559	0.557	0.630	0.851			
SS	0.630	0.537	0.635	0.372	0.713	0.659	0.455	0.562	0.837		
TR	0.287	0.457	0.295	0.253	0.346	0.266	0.391	0.401	0.266	0.763	
TD	0.337	0.421	0.436	0.614	0.422	0.405	0.463	0.509	0.370	0.323	0.812

Again, Table 2 shows that the cross loading of each indicator is higher on the construct it is measuring than on any other construct it is not measuring.

Finally, the Heterotrait-Monotrait Ratio (HTMT), another means of determining the discriminant validity of a PLS-SEM model is presented in table 3. According to Henseler, Ringle and Sarstedt (2015), a latent construct has discriminant validity when its HTMT ratio is below 0.825.

Table 3: Heterotrait-Monotrait Ratio (HTMT) of constructs in the study

Constructs	ETA	MTV	NPO	OYU	PS	PCV	PCFT	PPO	SS	TR	TD
ETA											
MTV	0.672										
NPO	0.602	0.659									
OYU	0.379	0.573	0.538								
PS	0.646	0.667	0.835	0.500							
PCV	0.642	0.652	0.841	0.482	1.015						
PCFT	0.676	0.834	0.485	0.590	0.498	0.524					
PPO	0.689	0.882	0.767	0.578	0.724	0.760	0.756				
SS	0.862	0.815	0.887	0.552	1.101	1.069	0.647	0.824			
TR	0.303	0.573	0.330	0.316	0.431	0.354	0.466	0.482	0.381		
TD	0.404	0.575	0.529	0.790	0.564	0.568	0.582	0.651	0.570	0.394	

As presented in Table 3, the HTMT ratios of most of the constructs used in the model were well below the threshold of 0.825, indicating that a greater proportion of the constructs in the study have discriminant validity.

Structural model evaluation

R² is the coefficient of determination, and is evaluated in the structural model for this study. Table 4 presents the results of the R² values. The R² value for the endogenous construct, Experiential Training, is 0.557. This satisfies the minimum threshold value of 0.1. To know whether the indicators of the endogenous construct (reflective measurement model) can be predicted accurately, the author used predictive relevance (Q²). The results indicate that the model is highly predictive, as the value of predictive relevance is above the threshold of zero (Kim, 2016). Additionally, the results show that the endogenous construct (Experiential Training) has a Q² value of 0.531 which met the general requirement that Q² should be greater than 0 (Haenlein & Kaplan, 2004).

Table 4: Structural Model Results

R² = 0.557

R²Adjusted = 0.531

Path	Path Coefficients	F squared	T Stats	P Values
Motivation to transfer -> Experiential training approach	0.066	0.004	0.903	0.367
Negative personal outcomes -> Experiential training approach	0.109	0.010	1.057	0.291
Opportunity to use newly acquired skills -> Experiential training approach	-0.085	0.009	1.009	0.313
Peer support -> Experiential training approach	0.061	0.003	0.744	0.457
Perceived content validity -> Experiential training approach	0.005	0.000	0.065	0.949
Personal capacity for transfer -> Experiential training approach	0.331	0.113	4.227	0.000
Positive personal Outcomes -> Experiential training approach	0.135	0.015	1.389	0.166
Supervisor support -> Experiential training approach	0.307	0.084	3.600	0.000
Trainee readiness -> Experiential training approach	-0.028	0.001	0.518	0.604
Transfer design -> Experiential training approach	-0.039	0.002	0.507	0.613

DISCUSSIONS

The general objective of this study was to determine the relationship between experiential training and transfer of training among community health service workers in Ghana. Ten elements were used to measure transfer of training: Motivation to Transfer, Positive Personal

Outcomes, Negative Personal Outcomes, Personal Capacity to Transfer, Peer Support, Supervisor Support, Perceived Content Validity, Opportunity to use Newly Acquired Skills, Trainee Readiness and Training Transfer Design. There was therefore the need to test the correlation among these variables and experiential training. The significant structural relationship among the research variables, the standardized path coefficients and P values are presented in Table 4. The data shows that Experiential Training has a positive effect on Motivation to Transfer (path correlation = 0.066; $p = 0.367$), Positive Personal Outcomes (path correlation = 0.135; $p = 0.166$), Negative Personal Outcomes (path correlation = 0.109; 0.291), Personal Capacity to Transfer (path correlation = 0.331; $p = 0.000$), Peer Support (path correlation = 0.061; 0.457), Supervisor Support (path correlation = 0.307; 0.000) and Perceived Content Validity (path correlation = 0.005; 0.949).

The positive coefficient implies that a change in experiential training will lead to a change in each of the element of transfer of training in the same direction. For instance, an increase in experiential training will result in an increase in say motivation to transfer the skills acquired from training. Thus, in general, the use of experiential training or an improvement in it can increase the degree to which trainees effectively apply the knowledge, skills and attitudes gained during training to their workplace. This finding corroborates Yamnill and Mclean's (2001) conclusion that to maximize transfer of training, *trainers* and *trainees* must have a strong interest in initiating the training programme and must agree to work together to support the full application of the expected skills. In this way, and as submitted by Cercone, (2008) and Knowels (1980), the trainee is involved in the learning process by reflecting on his or her past experiences and applying what is he has learnt. The implication of this to management of community health service workers in Ghana is that the training programmes for the health service workers must be designed in such a way that the trainee is doing something in the learning process rather than listening and watching the trainer as in the traditional classroom learning situation.

Contrarily, the results show that Experiential Training has a negative effect on Opportunity to use Newly Acquired Skills (path correlation = - 0.085; $p = 0.313$), Trainee Readiness (path correlation = - 0.028; $p = 0.604$) and Training Transfer Design (path correlation = - 0.039; $p = 0.613$). The negative coefficient implies that a change in experiential training will lead to a change in each of those elements of transfer of training in opposite direction. In other words, there is an inverse relationship between experiential training and Opportunity to use Newly Acquired Skills, Trainee Readiness and Training Transfer Design. Thus, an increase in experiential training will result in a decrease in say the Opportunity to use Newly Acquired Skills. Thus, in general, the use of experiential training or an improvement in it can increase the degree to which trainees effectively apply the knowledge, skills and attitudes gained during training to their workplace. The managerial implication of these results is that the opportunity to use newly acquired skills, trainee readiness and training transfer design appear not to influence trainees ability to transfer the skills acquired during the experiential learning to their jobs.

Following the preceding findings, this paper concludes that if management of community health service workers in Ghana wants to effectively increase or improve the ability of their trainees to transfer the skills learnt from all training programmes, then they should adopt the experiential training approach. With the experiential training, the trainee becomes integral in the training process. The trainer is only required to design the training programme, assess what trainees know, provide suggestions for their improvement, and teach them self-assessment skills that gives them the opportunity to transfer the competencies they have learnt from the training. In this way, training becomes more practical than theoretical which often times hamper the effective transfer of the skills learnt from the training programme.

CONCLUSIONS AND RECOMMENDATIONS

This study proposed a systemic model for assessing the extent to which Community Health Service Workers (CHSWs) can effectively transfer the skills they acquire from training to their workplace in Ghana. Transferring learning to the workplace from a formal off-the-job training programme is a challenge that must be addressed in light of the huge investment that most companies make in their employees. The ability and motivation to transfer learning to one's workplace greatly depends on the level of experience gained by the facilitator of that training and the method of training used by the facilitator (Brown & McCracken, 2009; Kontoghiorghes, 2004). A good number of studies have confirmed this by indicating that the finest way to increase the amount of learning taking place in the adult employee, and his or her ability to transfer that learning, is self-directed learning grounded in experience, otherwise called the experiential learning (Yates, Wilson & Kendra, 2015; O'Bannon & Cara, 2008; Clardy, 2004; Knowles, 1980). Following these observations, it became necessary to examine the training programmes of Community Health Service Workers (CHSWs) in Ghana, and to assess the extent to which they transfer the learning acquired from their practical off-the-job training programmes at school. Having found from the study that trainees had higher propensity to transfer learning from training programmes to their workplace, using the experiential training approach, it was concluded that the Ghana Community Health Service Worker can contribute more to health care delivery if their practical training was repackaged into the experiential type of training. On the basis of this conclusion, it was recommended that management of Community Health Service Workers in Ghana must shift from the traditional abstract method of training and education where the Community Health Service Workers were less involved in the learning and teaching activity, towards the experiential training which involves a cycle of "trying" and "undergoing" an experience by becoming aware of a problem, getting an idea, trying out a response, experiencing the consequences, and either confirming or modifying previous conceptions as noted by Asare-Bediako (2013).

LIMITATIONS AND SUGGESTIONS FOR FUTURE RESEARCH

Just like all other empirical studies based on survey data, this study has some potential limitations. In the first place, all the items used to measure the variables in the study were framed into a five-point Likert-Type Scale. The author believes that measuring all constructs using one type of scale may lead to a mono-method bias which can hamper the validity of the study. Again, the sample for this study was obtained from a survey of community health

service workers in Ghana which included only health service workers. Consequently, if the sample contained staff from other industries, then the results could be generalised more vigorously.

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