Community Education and Training Transfer: Meaningful Border Crossing?

LaShonda Coulbertson
University of South Florida

Rosemary Closson
University of South Florida

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Abstract: *Community Health Advisors (CHAs) bridge the health and knowledge gap in marginalized communities. A program was implemented to train CHAs to educate women about their health. The challenges of the transfer of this and similar training is often unreported. The training transfer model serves as the framework for this discussion.*

Community Lay Health Advisors (CHAs) are a vital intermediary in the healthcare system (HHS, 2007). Serving as the liaison between the grassroots community and the medical establishment, their roles are complex and typically undercompensated given the output of hours and skills required for the position. As educators of adults, CHAs bridge the health and knowledge gap in marginalized communities. In 2008, in partnership with the Florida Breast and Cervical Cancer Early Detection Program, a community lay health advisor program was implemented to educate African American and Hispanic/Latina women about the risks of breast and cervical cancer.

A 12 month statewide recruitment effort resulted in 250 CHAs recruited at the grassroots level. The six-hour training curriculum drew from the Socio-Ecological Model (SEM) (Bronfenbrenner, 1979), Social Cognitive Theory (SCT) (Bandura, 1977, 2001), and adult learning principles. SEM conceptualizes multiple systemic factors affecting individual health. The curriculum addressed the problem using a multilevel model including individual (knowledge, attitudes and skills), interpersonal (social networks), organizational (social institutions, such as churches, workplaces), and community (neighborhood) levels. The SCT, as proposed by Albert Bandura, implies a reciprocal interaction between behavior, environment and the individual, rather than a linear approach to the impact of these factors on one another. Therefore any approach to education that will ultimately impact disparities must take the reciprocal nature of these interactions into account and utilize these phenomena to design appropriate interventions. Adult learning principles meant the training was based on assumptions that the CHA trainees were self-directed and goal-oriented. Equally important was to respect the participants and to the degree possible integrate their experiences into the training.

The work of CHAs is not only to educate community members about breast and cervical cancer prevention but also to create opportunities to present these educational programs. Although CHA training curriculum was theory-based and pre and post-evaluations demonstrate increases in learners' knowledge base, transfer of training into desired behavioral outcomes was limited. Our exploratory research examines this phenomenon through the lens of training transfer (Baldwin & Ford, 1988). An examination of learner characteristics, program design, and work environment (i.e. the general community), indicate that inconsistent community engagement may be due to insufficient support post-training.

Evaluations administered to 250 CHAs post-training indicated that knowledge retention was about 90% and self-efficacy was about 99% (i.e. CHAs felt confident about their ability to present the community training). However, in a six-month follow-up evaluation administered to 60 CHAs very few had actually conducted community prevention programs. Preliminary

findings indicate a satisfaction with the training and retention of the technical information (e.g. statistics on the disparity nationally, screenings needed for early detection, barriers in the community regarding screening), but we speculate inconsistent support to integrate the new information in the community setting.

Baldwin and Ford's model (1988) of training transfer is frequently used in human resource development to theorize how learning transfer takes place but is not foreign to adult education (Caffarella, 2002). Theoretically, learner characteristics, program design, and work environment are three elements that contribute to learning and retention. Retention then becomes a key determinant of the learner's ability to generalize and maintain the desired learned behavior. Follow-up evaluations returned by eleven CHAs (out of 60) demonstrated high knowledge retention and high self-efficacy. Learner characteristics include that five were nurses and were potentially motivated to enter CHA training to enhance their knowledge on cancer prevention. This is evidenced by their request for continuing education credit. Four respondents worked in health related fields. Two learners were non-health related workers. All but one of the respondents were members of the racial and ethnic groups for which the training was focused. Sequencing of the program design was content knowledge on cancer prevention, understanding access to community resources, cultural competency, literacy, and how to present and organize an educational session. A portion of the training uses simulations to allow CHAs to practice with typical and atypical issues which may arise in an educational session.

Work environment is the final element in the transfer model. Dimensions of this element are support and opportunity to use the skill or behavior. These dimensions we believe are inconsistent in the CHA post-training. CHAs must develop opportunities to provide the cancer prevention training. Although provided with some post-training supports there is limited initiative taken by the CHAs. Belzer (2009) found that when training literacy volunteers there was limited transfer of literacy techniques from the volunteer training to the work of volunteers with their client. We continue to question how best to structure CHA programs to provide learning transfer which is a critical concern in the human resource development world. Although there is evidence of adult educators acknowledging the value of learning transfer models there is little evidence of research about learning transfer in community based health programs.

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