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Implementation Lessons: The Importance of Assessing Organizational "Fit" and External Factors When Implementing Evidence-Based Teen Pregnancy Prevention Programs

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A B S T R A C T

In recent years, the demand for evidence-based teen pregnancy prevention programs has increased, but practitioners often struggle to replicate and implement them as designed in real-world community settings. The purpose of this article is to describe the barriers and facilitators encountered during pilot year attempts to implement an evidence-based teen pregnancy prevention program within three types of organizations: (1) small community-based organizations; (2) a school-based organization; and (3) a large decentralized city-sponsored summer youth program. We frame our discussion of these experiences within the context of a systemic, multilevel framework for implementation consisting of (1) core implementation components; (2) organizational components; and (3) external factors. This article explores the organizational and external implementation factors we experienced during the implementation process, describes our lessons learned throughout this process, and offers strategies for other practitioners to proactively address these factors from the start of program planning. These findings may provide useful insight for other organizations looking to implement multi-session, group-level interventions with fidelity.

IMPLICATIONS AND CONTRIBUTION

This paper describes lessons learned during pilot implementation of an evidence-based teen pregnancy prevention program within three different types of organizations. It describes organizational and external barriers and facilitators, and provides practical recommendations. These findings may be useful for organizations that want to implement multi-session, group-level interventions with fidelity.

Teen pregnancy and childbearing can have immediate and long-lasting consequences for the young parent, their child, and society at large: teen mothers are much less likely to obtain a high school diploma [1]; children of teen mothers are at increased risk of behavioral problems, dropping out of high school, incarceration during adolescence, and becoming teen parents themselves [1]. In 2008, the national public cost of teen childbearing was estimated at $10.9 billion [2].

To help address this issue, in 2010, the Office of Adolescent Health (OAH) began to provide organizations with funding to implement and rigorously evaluate evidence-based teen pregnancy prevention (TPP) programs [3]. However, programs that have

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demonstrated effectiveness may fail to reproduce improved participant outcomes if they are not implemented as intended [4]. Quality implementation of evidence-based programs (EBPs) is essential not only to provide the greatest benefit to participants but also to ensure that limited public resources are maximized, and evaluation findings accurately inform policy, research, and programming decisions [5].

Replication and implementation of EBPs in the real-world context of community-based settings can be challenging [6]. As community providers have worked to implement EBPs with fidelity, a body of literature has developed around the study of the "translation" of research into practice and the role of implementation as potentially the "missing link" between the two [7]. In their meta-analysis of 500 implementation studies, Duklak and Dupre [7] find support for their hypothesis that effective implementation is associated with better outcomes. Implementation science outlines many models, theories, and frameworks of implementation; these models have progressively become multilevel systemic frameworks of factors that impact implementation [8]. In their seminal synthesis of implementation studies, Fixsen et al. [9] suggest that there are three levels of implementation (Figure 1): core implementation components, organizational components, and external factors. Core implementation components are key implementation drivers that support high-fidelity behaviors of program providers/staff such as training, coaching, and fidelity monitoring. Organizational components ensure the availability and integrity of core implementation components and include staff selection, administrative support, and program evaluation. External factors refer to the social, political, and economic context in which an organization works to implement a program, such as federal and state laws, local ordinances, funding priorities, and community resources. Fixsen et al. [9] contend that all three levels are interrelated and that "sustainable high fidelity practices best will be achieved when strong core implementation components are well-supported by strong organizational structures and cultures in an enabling mix of external influences" (p. 59).

Although core implementation components have been clearly articulated [10], Fixsen et al. [9] state in their summary of areas for future implementation research that "research related to organizational and socio-political factors that directly influence implementation efforts can help define hospitable practices and environments in which the probability of successful implementation and sustainability is increased" (p. 75). Rosenheck [11] views the "organizational process as a largely unaddressed barrier and as a potential bridge between research and practice" (p. 1607). Fixsen et al. [9] further contend that there is limited information available about practical approaches to working within the organizational and external implementation levels, and "[t]hus, organizational and systems intervention strategies and skills represent a critical research and practice area for national implementation of successful practices and programs" (p. 66).

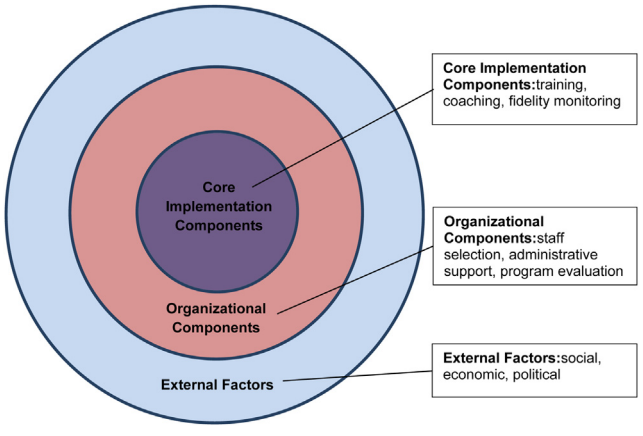

Figure 1. Multilevel influences on successful implementation [9].

Although numerous impact studies of TPP EBPs exist [12], there are fewer implementation studies [13]. Some researchers have provided tools, models, or strategies for improving TPP EBP implementation [13–17]. One such tool, *Promoting Science-Based Approaches to Teen Pregnancy Prevention Using Getting to Outcomes* (PSBA-GTO), was specifically developed for the implementation of evidence-based TPP programs and outlines a 10-step process for program planning, implementation, and evaluation: (1) needs and resource assessment; (2) goal and objective setting; (3) identification of best practices; (4) assessing fit; (5) assessing capacity and readiness; (6) program planning; (7) implementation and process evaluation; (8) outcome evaluation; (9) continuous quality improvement; and (10) sustainability [17].

Other researchers have articulated specific challenges in implementing TPP EBPs with fidelity. In keeping with the language of the Fixsen et al. model [9], researchers describe challenges with core implementation components, such as inadequate staff training [18,19]; organizational components, such as staff turnover [19,20], lack of staff buy-in [18], lack of resources [17,19], lack of general organizational capacity [21], an absence of accountability within community partnerships [22], and concern that sex education programming will impact an organizations' ability to secure funding [19,20]; and external factors, such as low parental involvement [23] and community opinions against comprehensive sex education for adolescents [18–20].

Program background

In 2010, the Louisiana Public Health Institute (LPHI) received a 5-year grant from OAH to replicate and rigorously evaluate the effectiveness of *Becoming a Responsible Teen* (BART), an evidence-based sexual education curriculum. The Policy & Research Group (PRG), an independent research firm, was contracted by LPHI to conduct the rigorous evaluation.

BART is a group-level behavioral skills training sexual education intervention that aims to reduce HIV risk for African-American adolescents [24]. Implementation fidelity requirements for BART mandate that the intervention be delivered to youth 14–18 years of age in small gender-specific groups of between 5 and 15 persons. BART is intended to be delivered in eight 2-hour sessions over the course of 8 weeks; each session should be facilitated by a team of two health educators, one male and one female [25]. LPHI renamed the program for their implementation setting to 4Real Health.

Organizational structure. During the grant proposal-writing process, LPHI formed partnerships with three different types of organizations to implement the program: (1) two small community-based organizations (CBOs); (2) a school-based CBO; and (3) a large decentralized city-sponsored summer youth program. Based on the information that was available about the program at that time, leadership of these four organizations felt confident that they could meet implementation requirements. In the planning and pilot year, LPHI's initial model (Figure 2) was to