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Implications for Adoption and Implementation of Effective Sexual Health Education Programs

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Sexual Health Education from the Perspective of School Staff: Implications for Adoption and Implementation of Effective Programs in Middle school by Peskin et al. highlights selected individual level variables stemming from social cognitive theory[1] as potentially important targets for facilitating the adoption and implementation of sexual health education programs in schools. The data are as expected and desired—those most likely to teach sexual health education (PE/health teachers or nurses/counselors) have higher levels of materials and policy knowledge, have a greater sense of efficacy in teaching the core skills, and perceive higher levels of administrative support than non-PE/health teachers. Though not a focus in this article, other studies have found that some of these factors (e.g., perceived administrative support) are associated with implementation quality (e.g., fidelity). There is no question that clear policies, administrative and parent support, and proper training are essential to successful implementation. Similarly, it is imperative to ensure sexual health education programs are taught by qualified teachers who are comfortable with the content, and perceive the ability to implement the interactive programs as designed. Indeed, many evidenced based programs consider these educator characteristics, among others, as "core" to the success of the programs.[2]

The study suggests these cognitive factors are relatively consistent across demographic subgroups with the exception of variations in perceived efficacy among Hispanics, supporting the practice of culturally-based standardized training approaches. As noted by the authors, trainings typically cover these cognitive factors. For example, self-efficacy in using various teaching strategies (e.g., role plays) is built through providing clear skill explanations, demonstrating the skills in context, allowing participants to practice them, and providing feedback. Similarly, most trainings address perceived barriers by engaging participants in problem solving activities or using personal testimonials.

While social cognitive theory provides one useful framework for examining individual-level factors likely to be associated with teacher adoption or implementation of sexual health education, adoption and implementation reflect a process of change, which may be better captured by a developmental model such as the Concerns Based Adoption Model (CBAM).[3,4] We used CBAM in our *Safer Choices* project to help shape our professional development activities for teachers, administrators, and staff, and to foster a climate in our intervention schools that recognized adoption and implementation as a process that evolves and needs support over time. This model may prove helpful in exploring additional individual factors that may influence adoption and implementation of sexual health

education, or shedding light on some of the cognitive factors reported in this article.

CBAM addresses both the affective dimension (or stages of concern) of adopting and implementing a new program (e.g., how teachers might feel about implementing something new and the concerns they experience in doing so) as well as a behavioral dimension (or levels of use), which captures how teachers use new programs over time. As an example, the model includes seven stages of concern that individuals typically pass through in dealing with change, which cluster into four broad categories including *awareness* (someone who isn't aware of the program or doesn't want to learn about it), *self* (concerns of how the program will affect the user), *task* (concerns that touch on the management of materials), and *impact* (concerns regarding how to make it work better for students). Teachers' concerns change over time, and professional development opportunities are essential in addressing early concerns before moving teachers to mastery. Considering the CBAM stages of concern, it is logical that non-PE/non-health teachers and staff who reported no experience teaching sexual health education had lower levels of awareness, self efficacy, and perceived support for sex education when compared to staff in other positions. They were likely at the lowest level of concern, not even aware of the programs. This is not terribly problematic unless the program includes a school-wide component that draws on teachers and staff across the school, such as that in our *Safer Choices* study, where we wanted awareness and involvement campus wide to reinforce and extend messages in the classroom curriculum.[5,6] If these teachers were asked to teach sexual health education, then they would require training to address awareness concerns that others in a different stage of concern may not need.

CBAM also addresses levels of use teachers typically pass through when using a new program—moving from various states of non-use or orientation to the program and its materials, to mechanical use (early attempts at lessons that may feel awkward) and routine use (satisfactory use). Higher levels of use typically involve teachers making refinements, collaborating with others, and even seeking more effective alternatives to the established use of the program (which is problematic for maintaining fidelity). To address changes in level of use during *Safer Choices*, we developed booster trainings each year of the intervention to support teachers' movement from mechanical to routine use, and to emphasize the need for fidelity as teachers moved toward the stage of wanting to make refinements to the curriculum.

Understanding teachers' level of use may account for data showing that more experienced teachers implement fewer lessons than less experienced teachers.[7] It also highlights the need for ongoing training rather than a single event, consistent with the conclusions of Rohrbach and colleagues[8] in their study of the dissemination of an evidenced-based drug abuse prevention program, Towards No Drug Abuse (TND).

The article by Peskin et al. represents a critical juncture in evidenced-based sexual health education research. Now that we have numerous evidenced-based programs, more focus is needed on how to help sites adopt and implement these programs with fidelity to achieve positive behavioral outcomes. Fortunately, the research and resulting literature is growing, highlighting a range of characteristics that may influence implementation including aspects of the program itself (e.g., individually focused versus environmentally focused, providing clear and explicit implementation guides); school characteristics (e.g., school size), and the larger community (e.g., community poverty level).[9-11] Rohrbach et al., 2006).This growing body of literature provides opportunities for creating guidance on ways to prepare an environment for adoption and implementation of SHE programs before introducing a new program. Notably, it also provides rich data for program developers to craft future programs that maximize likely implementation.

Finally, there are new tools available to support the successful adoption and implementation of sexual health education. Many evidenced-based programs now include adaptation guides that spell out core elements and allowable adaptations.[12] These can guide decisions about adoption (e.g., if we select this program can we maintain its core elements), and support teachers during implementation as they progress through higher levels of use (e.g., by providing guidance on elements they can refine without losing fidelity to the original program and impacting program effectiveness).

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