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Why We Fail to Replicate Pilot Results

Adopting Realistic Expectations

Rogers and colleagues show us that translation of a successful research project into a broader public health program is difficult and complex *(1)*. Failure of the resource mothers' program to achieve the same positive results in reducing low birth weight and small gestational age infants as in the pilot project raises interesting issues. Despite the intent of the agency to replicate the pilot project, program implementation changed key elements.

Demonstration projects have been used successfully to design systems and programs for replication into larger arenas. In the Improved Pregnancy Outcome and Improved Child Health Projects, States identified and designed statewide maternal and child health programs. Expansion of direct, observed therapy for tuberculosis treatment *(2)* and the adoption of multi-faceted approaches to providing immunizations were successfully translated from pilot projects.

The study published in this issue compels us to consider carefully why scale up sometimes fails. Careful attention to today's hostile environment permits us to use the pilot results for program implementation yet avoid unrealistic expectations. Progress must not be undermined by undetected mines in an unexpected minefield: diluted resources and funding fluctuations, intrusion of outside priorities, loss of leadership or "champion," declining time and capacity to encourage and maintain community support, less local support on behavioral issues and for social services than for clinical ones, and finally, slippage from the research design and from careful record keeping.

Our tools are getting better. Public health planning and evaluation has made great strides in the past 8–10 years, driven by the development and dissemination of the Health Objectives for the Nation for 1990 and the year 2000. Planning tools such as the Assessment Protocol For Excellence in Public Health (APEX) and The Planned Approach To Community Health (PATCH) provide States and localities a way to design programs based on specific needs. Our information systems, while far from adequate, are much improved. We continue to develop and refine public health data sets.

Leadership training sponsored by the Centers for Disease Control and Prevention improves the decision making skills of public health leaders. The exhortation of the Institute of Medicine's report, "The Future of Public Health," to work more closely with schools of public health, has enhanced our evaluation capacity.

Despite progress, we continue to encounter barriers in the struggle to determine effective interventions for troublesome public health problems. The dilemma of where to spend our money only can worsen as we face greater demands on limited local, State, and Federal resources. We cannot ignore the importance of research-based successful interventions.

Perhaps our chances for successful translation from pilot to program can be improved by adopting realistic expectations and considering the following suggestions:

- Ensure that the research surrounding our interventions is sound and that the data are valid and reliable. This will require vigilant attention to data collection.
- Assure early buy-in from agency officials, community providers and, most importantly, recipients.
- Adopt an ongoing epidemiologic approach to program management for continuous evaluation and quality improvement.
- Remember that a single intervention is not likely to alleviate a major health problem, as it is only one of many interventions and should be judged accordingly.

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References

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