Balancing Fidelity and Adaptation: Implementing Evidence-Based Chronic Disease Prevention Programs

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Objectives: To describe adaptations that community-based organizations (CBOs) made to evidence-based chronic disease prevention intervention programs and to discuss reasons for those adaptations. Design: The process evaluation used project report forms, interviews, and focus groups to obtain information from organizational staff. Setting: Programs were conducted in community-based organizations (n = 12) in rural southwest Georgia including churches, worksites, community coalitions, a senior center, and a clinical patient setting. Participants: Site coordinators (n = 15), organizational leaders (n = 7), and project committee members (n = 25) involved in program implementation at 12 funded organizations. Intervention: The Emory Cancer Prevention and Control Research Network awarded mini grants to rural CBOs to implement one of 5 evidence-based nutrition or physical activity programs. These sites received funding and technical assistance from Emory and agreed to conduct all required elements of the selected evidence-based program. Main Outcome Measures: Program implementation and context were explored, including completion of core elements, program adaptation, and reasons for adaptation that occurred at sites implementing evidence-based chronic disease prevention programs. Results: Five major types of adaptations were observed: changing educational materials, intended audience, and program delivery; adding new activities; and deleting core elements. Sites had intentional or unintentional reasons for making program adaptations including enhancing engagement in the program, reaching specific audiences, increasing program fit, and reinforcing program messages. Reasons for not completing core elements (program deletions) included various types of “turbulence” or competing demands (eg, leadership/staff transitions and time constraints).

Conclusions: The types of adaptations and reasons described in this evaluation support the idea that adaptation is a natural element of implementing evidence-based interventions. Building this understanding into dissemination strategies may help researchers and funders better reach communities with evidence-based interventions that are a relevant fit, while striving for fidelity.

KEY WORDS: adaptation, dissemination, evidence-based interventions, fidelity, implementation research

There is growing emphasis on translation of evidence-based interventions or strategies into public health practice. Substantive resources are devoted to developing and testing interventions using rigorous research designs. However, many of the resulting evidence-based interventions (EBIs) that were proven effective never make it into practice settings.1,2 Even

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when these EBIs are adopted outside of research settings, they may not be implemented according to the original program design. The degree to which program components are implemented as intended by program developers is known as fidelity. Core elements are the essential program components that are believed to make an evidence-based program effective and that should be kept intact to maintain intervention effectiveness. Programs that are implemented with high fidelity are more likely to have outcomes comparable to the original study. However, adaptation of EBIs often occurs to improve the fit (or compatibility) of a program to a new setting or to increase the cultural appropriateness of a program. Not surprisingly, tensions have arisen around balancing the importance of fidelity to ensure outcomes and adaptation to improve fit within a local context. Some researchers suggest that adaptation is inevitable to meet the needs of a specific context while others believe that an adapted program will be less effective than the original program and will compromise the core elements and underlying logic of a program.

Recently, more research has focused on the practice of adapting interventions, which includes modifying program contents and modes of delivery to better accommodate the needs of the intended group. Implementation with high fidelity may be difficult for practitioners to achieve due to lack of materials or guidance from developers, program complexity, poor fit between the program and the intended population and context, lack of training, administrative turnover, lack of staff buy-in, limited resources, or limited organizational or community support. Efforts that aim to promote evidence-based programs have recommended extensive training and technical assistance (TA) to assist practitioners to adapt with fidelity, meaning to make changes without detracting from the core elements. In addition, some researchers have developed guidance for adaptation of specific EBIs.

Only a few studies, mainly in school settings, have examined the reasons for adaptation. More research is needed to understand the reasons for adaptation of EBIs in community-based organizations (CBOs). Understanding how organizations typically adapt interventions and the reasons for these adaptations may help intervention developers to design more generalizable interventions with higher levels of external validity. In addition, understanding how and why adaptation occurs within various contexts will aid in efforts to develop TA and training programs that translate research into practice. The purpose of this article is to report on the adaptations of EBIs made to evidence-based chronic disease and cancer prevention programs, as well as reasons for those adaptations.

### Methods

#### Description of “Prevention Programs That Work” mini-grants program

The Emory Cancer Prevention and Control Research Network of the Emory Prevention Research Center worked with community partners to conduct a mini-grants program in southwest Georgia. Members of the Emory Prevention Research Center’s community advisory board helped to prioritize behavioral risk factors; develop a mini-grants, training, and TA program; and select mini-grant recipients from CBOs. Over 2 funding cycles (2007-2009), 12 sites received up to $4000 and TA to conduct one of 5 evidence-based nutrition or physical activity interventions during a 12- to 18-month timeframe. Table 1 describes the 5 evidence-based programs implemented in the “Prevention Programs That Work” mini-grants program: Body and Soul, Treatwell 5-a-Day, Parents as Teachers-High Five Low Fat (H5LF), Little by Little, and Patient-centered Assessment and Counseling for Exercise (PACE). These programs were selected from NCI’s Research Tested Intervention Programs’ Web site. Program core elements for each EBI (Table 1) were listed for the mini-grants recipients on a fee for service agreement and on project report forms. Data reported here are from a process evaluation of the mini-grants program with a focus on adaptation. Findings from the full process evaluation for the first funding cycle are reported elsewhere.

#### Study Population and Recruitment

The 12 mini-grant recipients included 4 churches, 4 worksites, 2 community coalitions, a senior center, and a clinical patient setting (Table 1). Each grantee identified 1 or 2 site coordinators responsible for program implementation, and 15 site coordinators participated in the process evaluation. For the first funding cycle, organizational leaders such as pastors and human resource managers (n = 7) and project committee members (n = 25) also participated in data collection activities. In accordance with the protocol approved by the Emory University institutional review board, all evaluation participants provided written informed consent.

#### Data Collection Instruments and Procedures

Sources of data collection included project report forms, site coordinator and leader interviews, and focus groups. Coordinators submitted project report forms that provided details about meetings, events, policy changes, and related activities. The forms were tailored to specific EBIs and documented participation in and
### TABLE 1  ● Description of Evidence-Based Programs and Implementation Sites

<table>
<thead>
<tr>
<th>Evidence-Based Program and Behavior Topic</th>
<th>Intended Audience and/or Setting of Original Study</th>
<th>Program Core Elements</th>
<th>Number and Type of Mini-Grants Implementation Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body and Soul (nutrition)</td>
<td>African American churches</td>
<td>Project committee</td>
<td>4 predominantly African American churches</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kick-off event</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>3 churchwide nutrition events</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>1 event involving the pastor</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Church food policy change</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 motivational interviewing calls to each participant</td>
<td></td>
</tr>
<tr>
<td>Treatwell 5-a-Day (nutrition)</td>
<td>Worksites</td>
<td>Employee advisory board</td>
<td>4 worksites:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EatWell discussion series</td>
<td>● 2 health care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>At least one other activity to change individual behavior</td>
<td>● 1 industry</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family/home component of learning</td>
<td>● 1 community coalition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annual family/holiday event</td>
<td></td>
</tr>
<tr>
<td>Parents as Teachers— High Five Low Fat (nutrition)</td>
<td>Homes/Parents of children ages 0-5</td>
<td>5 home visit sessions to parents</td>
<td>2 community coalitions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Interactive group meetings by parent educators</td>
<td></td>
</tr>
<tr>
<td>Little by Little (nutrition)</td>
<td>Multiple community sites</td>
<td>Use of CD-ROM by participants</td>
<td>Senior center</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Follow-up call to check in on goals 2-4 weeks later</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2nd follow-up call within 2 months</td>
<td></td>
</tr>
<tr>
<td>Patient-centered assessment and counseling for exercise (PACE) (physical activity)</td>
<td>Primary care patients</td>
<td>Patients complete a “PACE assessment”</td>
<td>Clinical patient setting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patients receive a stage-matched, written protocol</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stage-relevant counseling</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Booster call from health educator</td>
<td></td>
</tr>
</tbody>
</table>

Completion of core elements. At the end of the project, Emory staff conducted semi-structured in-person or telephone interviews with site coordinators (both cycles) and organizational leaders (first cycle only), as well as focus group discussions with the project planning committees (first cycle only). Interview and discussion guides were tailored to the EBI being implemented but covered the same general topics. The site coordinator interviews lasted about 60 minutes and included questions about implementation, core elements/adaptation, program impact, future health promotion plans, and recommendations for Emory. The site coordinator interview guide for the second cycle was revised to focus more deeply on fidelity and adaptation. The organizational leader interviews lasted about 30 minutes and included questions about the leader’s role, the program and its fit within the organization, and future plans for health promotion. The focus group discussions lasted about 45 minutes and included questions about program staff, implementation, and future health promotion plans.

#### Data Analysis

Project report forms were summarized into tables documenting what activities sites conducted to complete the program core elements. All interviews and focus groups were audio-recorded, transcribed verbatim, and analyzed using standard qualitative data analysis procedures. The research team used an iterative process to develop a master coding structure to code data from multiple sources. The codebook contained 9 primary upper-level codes: staff and organization, program implementation, participants, adaptation, materials, resources, TA, maintenance, and concurrent programs. After the full team coded 4 transcripts to develop the coding structure and a common understanding of codes, 2 analysts independently coded the remaining transcripts and resolved any discrepancies through discussions. After coding was complete, the codes were entered into QSR (Qualitative Solutions & Research Pty Ltd, Doncaster, Victoria) NUD*IST (Non-numerical Unstructured Data Indexing Searching and Theorizing) Version 6.0.
Reports consisting of all passages with relevant code(s) about adaptation were generated. The team focused on codes related to context and implementation, including adaptation. A primary reviewer analyzed each report to identify themes, which were organized into matrices with themes and data sources. A second reviewer analyzed the coded transcripts and matrices, and the 2 analysts discussed discrepancies and reached consensus. Major themes were identified by looking at which recurred multiple times across sites.

Results

Types of Adaptation

Across the sites, major themes emerged about the types of adaptations made to the original evidence-based interventions. Table 2 includes a list of common types of adaptations, examples of adaptation within each type, reasons for making the adaptation, and illustrative quotes. Five major types of adaptations were observed: changing educational materials, intended audience, and program delivery; adding new activities; and deleting core elements.

Changes to educational materials

All sites made changes to educational materials, which included updating content, customizing with local information, and adding items to supplement program materials. For example, one site supplemented existing program educational materials with the Internet resources:

I thought it was just really neat that the information that we were able to find on the [Fruits & Veggies More Matters] web site supplemented the topic that we were on at the time.

—Site coordinator

Changes to intended audiences

Adaptations related to the program audience often involved shifting, expanding, or narrowing the original primary audience of the intervention. Shifting the audience refers to changing the audience to a new population that is different than the original audience. One site, motivated by recent chronic illnesses and deaths of coalition partners, took an innovative approach by refocusing the Treatwell worksite program, which originally focused on employees, to a nontraditional workforce consisting of their small paid staff plus their volunteer board of directors and coalition board members.

Expanding the audience refers to including the original intended audience while also reaching beyond that audience. The outreach mission of churches prompted several churches to expand the audience to invite the broader community for Body and Soul events, in addition to their own congregations (the original audience).

[W]e let them know that it wasn’t for . . . only our church, but also a community. We wanted to get more people involved, . . . we had seen the need that there were more people than [us] that would benefit from what we were doing.

—Planning committee member

Narrowing the audience involved focusing on a specific subset of the original audience. Rather than reaching a general population of mothers as in the original Parents as Teachers H5LF program, one mini-grant site focused on the population they already served—pregnant teens and teen mothers.

Changes to program delivery

There were a wide range of program delivery adaptations including modifying the characteristics of the program provider, order or length of activities, and communication channels. For example, in the PACE program, the program provider that delivered the counseling was a physician or nurse in a primary care setting. In the mini-grant site, certified diabetes educators delivered the counseling protocol in a diabetes care management setting.

Several sites that conducted the Treatwell 5-a-Day program modified the order or length of the discussion series. Two sites changed the discussion order to fit their local needs (eg, scheduling speakers and addressing topics to fit recent events). Some sites slightly varied the discussion session length based on the time period feasible for their site’s work environment. The original program discussions lasted 20 to 60 minutes. However, 2 sites had 15- to 20-minute sessions to accommodate a limited lunch period.

Sites changed the communication channels for delivering the intervention in multiple ways. For the PACE and Little by Little programs, most participants received follow-up telephone calls after the initial intervention contact as dictated in the original program. Both sites reported that for a small portion of participants, however, it was easier to reach them in person for follow-up because they were regular visitors to their sites. One of the H5LF sites decided, for dangerous neighborhoods, to meet with multiple families together at one site rather than conduct home visits with individual families. It was safer for parent educators:

. . . if it’s like a rough neighborhood, I don’t recommend for us to go by ourselves. So, if I need to go in with someone else, I’ll ask [another educator] . . . several families come together and we’ll have a pack meeting in someone’s home.

—Site coordinator
### TABLE 2  ● Types of Adaptations and Reasons for Adaptation

<table>
<thead>
<tr>
<th>Types of Adaptation</th>
<th>Example Adaptations</th>
<th>No. of Sites Adapted (Out of 12)</th>
<th>Reasons for Adaptation</th>
<th>Example Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes to educational materials</td>
<td>Added supplemental educational materials</td>
<td>12</td>
<td>Generate/maintain engagement</td>
<td>On adding materials: “You got to think about being also sensitive to the age of the parent. If you have [a parent] that’s maybe 14 . . . give them something that can be kinda fun . . .” —Site coordinator</td>
</tr>
<tr>
<td>Updated content</td>
<td></td>
<td></td>
<td>Strengthen or reinforce message</td>
<td></td>
</tr>
<tr>
<td>Customized for local audience</td>
<td></td>
<td></td>
<td>Reach specific audiences—especially hard to reach audiences</td>
<td></td>
</tr>
<tr>
<td>Changed formatting</td>
<td></td>
<td></td>
<td>Need for program materials to address local context</td>
<td></td>
</tr>
<tr>
<td>Changes to intended audience</td>
<td>Expanded audience (beyond primary audience)</td>
<td>11</td>
<td>Reach specific audiences (eg, teen moms living with their parents)</td>
<td>On expanding audience: “It was just something I wanted to see happen and I wanted to see it in the schools and the churches and in the community.”—Project committee member</td>
</tr>
<tr>
<td>Shifted primary audience (different than original intended audience)</td>
<td></td>
<td></td>
<td>Program sparked desire to reach a broad audience</td>
<td></td>
</tr>
<tr>
<td>Narrowed audience (focus on subset of original audience)</td>
<td></td>
<td></td>
<td>Strengthen or reinforce message</td>
<td></td>
</tr>
<tr>
<td>Changes to program delivery</td>
<td>Modified program provider</td>
<td>10</td>
<td>Generate/maintain engagement in the program</td>
<td>On changing communication strategy (phone to in-person follow-up): “. . . we see them a lot at the clinic . . . So some of our actual follow ups, . . . their contact was in person. I just talked to them right then and there.”—Site coordinator</td>
</tr>
<tr>
<td>Changed order or length of activities</td>
<td></td>
<td></td>
<td>Strengthen or reinforce message</td>
<td></td>
</tr>
<tr>
<td>Used different communication channels</td>
<td></td>
<td></td>
<td>Reach specific audiences</td>
<td></td>
</tr>
<tr>
<td>Adding new activities</td>
<td>Added other activities beyond core elements</td>
<td>10</td>
<td>Increase fit</td>
<td>On adding weight loss activities to a nutrition program: “. . . we also did a Biggest Loser type of program at the same time . . . I would say it was complementary . . . they’re kind of hand in hand.”—Site coordinator</td>
</tr>
<tr>
<td>Added content within core element activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated into existing infrastructure/activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deleting core elements</td>
<td>Could not complete</td>
<td>3</td>
<td>Turbulence/Barriers: Schedule/time conflicts Staff/leadership transitions Slow economy/financial difficulties</td>
<td>On time conflicts and not completing core elements: “If I hadn’t been in school and I had a little more time to focus, I probably could have done it . . .” —Site coordinator</td>
</tr>
<tr>
<td>Decided not to complete</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Another organization decided to adapt Little by Little program delivery, originally designed for a range of community settings, to better serve senior clients. Before implementation, the site acknowledged barriers such as problems hearing the CD-ROM audio and difficulty of some seniors to maneuver the computer program. Therefore, they decided to have one of the staff members manually help seniors through the computer screens while talking one-on-one instead of having the seniors listen to the audio.

#### Adding new activities

Three of the 4 churches held additional physical activity events that went beyond or outside the Body and Soul nutrition program. At one site that heavily adapted the program, the leadership and key volunteers strongly prioritized physical activity and obesity as priority needs for their congregation. At that site, many activities were added beyond nutrition promotion such as exercise classes, weigh-ins, and a Biggest Loser contest. One of the focus group participants
referred to it as the “Body and Soul exercise program,” although it is a nutrition program. Other sites added minor activities without detracting from the nutrition focus but explained further:

Because of the nutrition part of it, people began to feel better and they had more energy. So they were able to do more physical activities and wanted to do more as far as looking at weight loss . . .

—Site coordinator

On the contrary, some sites added activities that supplemented the original program’s behavioral goal and stayed within the scope of core elements. Several sites added interactive demonstrations or activities to support the curriculum.

Deletion of core elements

Adaptation can also include deletion or incomplete delivery of core elements. Three of the 12 sites did not complete all program core elements. Those activities that were not completed included the last churchwide events at 2 churches and the annual family event at one of the worksites. The worksite’s program was negatively affected by financial issues, which made a social event less appropriate to conduct in that context.

They thought that if we had some type of [party or family] event, [employees] would be saying, “Now you’re asking me to take unemployment weeks, but . . . you’re having an event.

—Site coordinator

Reasons for Adaptations

Sites had intentional and/or unintentional reasons for making program adaptations, including enhancing engagement in the program, reaching specific audiences, increasing program fit, and reinforcing program messages. Reasons for not completing core elements (program deletions) included various types of “turbulence” or competing demands (eg, leadership/staff transitions and time constraints). Table 2 lists the types of adaptations and reasons why sites made those adaptations.

Enhance engagement

Multiple sites adapted programs to enhance engagement of volunteers and participants. To obtain initial buy-in among church leaders and congregation members, one site added an extra event to engage leaders prior to the program’s launch. They also anticipated difficulty retaining key volunteers and added small stipends to retain volunteers over time. Another site said they added more visually appealing educational materials to capture participants’ attention.

. . . if I hand out something in black and white with lots of words on it verses something that’s bright and colorful and is easy to read, they’re going to pay more attention to that because it’s in color and it’s more concise“

—Site coordinator

Reach specific audiences

Several organizations targeted events to specific populations. One group organized events for children, which helped parents become more interested in participating.

. . . [child-oriented events] played a great impact as far as getting those parents involved because the average parent is going to want to know what . . . their kids are getting involved in . . . the kids were actually helping to solicit the parents to come in that way . . .

—Site coordinator

Increase program fit to organization

Some sites integrated program components into pre-existing activities to increase fit into the organization’s infrastructure and mission. Multiple sites inserted program content into regularly held health fairs, holiday events, classes, and gatherings.

[There are] other events that we already have annually and that we just incorporated with the program, we just thought it would just be a good idea just to bring them, you know, merge the two together.

—Site coordinator

Because of the outreach nature of the community coalition worksite, what started out as a worksite program for their own staff and volunteers morphed into a community-wide campaign. For example, they incorporated Treatwell program information at programs for youth, low-income families, and clients of other partnering agencies. The family newsletters originally sent to employees’ homes turned into a regular monthly feature section of the rural county newspaper. The program turned into a county health initiative because it fits the outreach mission of the coalition. The coalition later leveraged this project and obtained additional external funding.

This project seems to have opened the door for a brand new issue [obesity] that our county had not talked about . . . all of a sudden the light went on . . . [the coalition] said we need to add this to our benchmarks as a group and start working on this.

—Site coordinator

Reinforce Messages

Some activities were added or modified to reinforce the messages of the program with practical skill
applications. For instance, the senior center with the Little by Little CD-ROM held events to strengthen the nutrition educational content:

The cooking demonstrations, we added once again also as incentive. But also, you know, to just kind of spruce it up a little bit. Because with them, they really enjoy events.

—Site coordinator

**Turbulence**

The 3 sites that did not complete all core elements reported different competing demands, schedule or time conflicts, or other contextual barriers within the organization. Specific examples of turbulence that prevented completion of the programs were financial difficulties and staff or leadership transitions.

The third [event], we actually had planned it. [The coordinator] had surgery . . . the other reason we didn’t do it before is because vacations . . . and we had another program that was already lined up for that Saturday, so that, we just been having a lot of bad timing.

—Organizational leader

**Discussion**

The findings of this process evaluation demonstrate that adaptations to evidence-based interventions are common. Mini-grant recipients described adaptations to intended audience, program materials, and program delivery. These findings are not unusual. Prior studies have documented that adaptation is common in translation of EBIs from research to practice. Others have noted that adaptation may involve modifications of program content and/or delivery (eg, characteristics of deliverer, channel, or location). Similar to these other examples, the southwest Georgia sites made adaptations that were both intentional and unintentional. The intentional adaptations were decided on before implementation or during the implementation phase.

On the basis of observations from the current study, adaptation can be thought of as a continuum rather than a discrete action. Much of the prior work on reasons for adapting intervention has been based in school settings. The rationale for changing school-based programs is often to better fit English proficiency or cultural background of the audience, simplify the program components, supplement materials, use more interactive learning techniques, or conform to time limitations. The current study is one of the first to examine reasons for adapting EBIs in community-based settings.

**Intentional and unintentional adaptations**

Similar to these other examples, the southwest Georgia sites made adaptations that were both intentional and unintentional. The intentional adaptations were decided on before implementation or during the implementation phase. For example, organizations with a community outreach mission such as churches and coalitions often intentionally expanded program activities to invite those outside the original intended audience to enhance program reach. Another site intentionally decided not to hold an annual family event because it would be inappropriate in the context of financial hardship in that worksite.

However, other adaptations happened unintentionally before or during the course of implementation. Those that occurred out of necessity were often related to turbulence in the organizational setting. Some organizations intended to complete the core elements but could not because of unforeseen circumstances with work, schedules, family, or other personal situations. Two of the smaller church sites in rural counties did not complete core elements because of unplanned turbulence. While the deletions could be related to rurality or lack of resources, further study would be needed to fully understand how organizational and community context could affect program implementation.

On the basis of observations from the current study, adaptation can be thought of as a continuum rather than a discrete action. Researchers often recommend a planned adaptation process to guide intentional changes in a systematic process to increase fit with the organization or community while retaining the theory of change.

**Continuum of adaptation**

On the basis of observations from the current study, adaptation can be thought of as a continuum rather than a discrete action. Lara et al discusses different levels of fidelity, including minor and major adaptation.
The Figure illustrates a continuum of fidelity and adaptation, including examples of adaptations made among the 12 sites and where they may fall on a continuum from major to minor adaption. The figure suggests an inverse relationship in which fidelity to the original program may decrease as adaptation increases. As modifications become increasingly major, such as changes in intervention delivery, expanding the audience, shifting the behavioral focus, and dropping core elements, the underlying logic of the program may be altered so significantly that the program no longer leads to the desired outcomes. Without additional research or evaluation, it is difficult to know which types of adaptations and how much adapting can be accommodated before the changes fundamentally alter how a program works. The more adaptation made to a program, therefore, the greater the need for a more rigorous outcome evaluation to test the potential effects of the adapted program.

**Limitations**

This process evaluation of the mini-grants program was limited to 5 EBIs implemented in 12 CBOs in southwest Georgia, and findings may not be generalizable to other EBIs and settings. Most of the data were provided by self-report and potentially limited by social desirability. A key limitation of this evaluation is that the design did not allow for assessing the impact of the adaptations on behavioral outcomes but rather focused only on process measures.

**Implications for future research and practice**

This study is unique in its evaluation of program implementation at a variety of sites in a single, rural region. These findings can guide development of more formal training and TA processes for CBOs to strategically adapt EBIs to increase fit and relevance to the organizational context and how it shapes the need for adaptation.

The overall picture obtained from the mini-grants recipients described in this study is that adaptation is a common and natural element of implementing EBIs in community settings. The tension between fidelity and adaptation might well be reframed as a natural process of program evolution; albeit one that warrants continuous monitoring and evaluation. Better understanding the reasons for adaptation and the types of adaptations, combined with a concerted effort to build these into dissemination strategies, will help researchers and funders better disseminate EBIs to communities. This approach could also speed up the process of moving research to implementation, while helping to ensure that interventions that worked in a research setting continue to create the type of change desired when disseminated to community settings.

**REFERENCES**


