




Guidance for Adopting and Adapting Global Health Approaches for U.S. Local Health Departments (v.1) Aug 2020

At its core, global health is defined as a bidirectional endeavor, with “a mutuality of real partnership, a pooling of experience and knowledge, and a two-way flow between developed and developing countries” (Koplan et al, 2009). There is much that other countries, including low- and middle-income countries, can teach U.S. local health departments to improve persistent health challenges. While a relatively new area of study, there are examples of the adaptation and diffusion of global ideas within U.S. communities, and through these examples and the broader examination of program adaptation, we can learn the most effective strategies to adopt and adapt global strategies for LHDs.

Introduction: This guidance was created to assist local health departments (LHDs) in adopting and adapting global health approaches. Global health offers unique examples of innovative, and often cost-effective, approaches to vexing health challenges. However, given the cultural and health system differences between the program's country of origin and the United States, some adaptation will be needed to ensure it is appropriate in a new context. This can be a challenge for LHDs, and discussions with health department leaders have indicated that uncertainty about this process can be a barrier to adopting global health approaches. Therefore, we hope to provide guidance on the most effective strategies for LHDs to adapt global health solutions so that the entire globe can be a resource for new solutions to challenging problems.

How to Use this Guidance: This guide is meant to assist LHDs through the thought process surrounding the adoption and adaptation of a global approach. We have broken down the guidance into three general steps:

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- I. Assessing the elements to adapt: Determine what elements of a global approach you can change without corrupting the effectiveness of the program
 - II. Adapting the appropriate elements of an approach: Determine the best possible methods to adapt the global approach to ensure that it will be effective in your community
 - III. Diffusing the approach into your community and communicating it effectively: How to tailor diffusion to different groups in your community and the most effective strategies to communicate the benefits of a global program to community members and stakeholders

*** Important to Note:** Much of the information in this guidance comes from general research on adapting approaches from different communities or cultures and not specifically a global approach into the United States. NACCHO is actively collecting information related to adopting and adapting global health programs to U.S. LHDs specifically, and that information will be compiled for version 2 (v.2).

Key Definitions:

- **Adoption:** Taking an approach that did not originate within the United States and bringing it into your community
- **Adaptation:** Changing certain elements to make the approach effective in your community. This must be done with caution to ensure that you do not remove elements that are critical to the approach's success
- **Global Approaches:** Programs, policies, or ideas that originated outside of the United States

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Examples: There are a number of LHDs and other public health entities in the United States that have adopted and adapted a global health approach to their communities. Click through these approaches to see how others did it:

Program	Description	Link
Bringing Global Health Home: The Case of Global to Local in King County, Washington	General overview of potential options for approaches that can be adapted from global health to be effective in local U.S. public health	https://www.globaltolocal.org/wp/wp-content/uploads/2018/05/Bringing-Global-Health-Home-.pdf
CHW model from Venezuela to Orange County, California and back	A doctor from Venezuela recognizes the value of community health workers (CHWs) to improve health outcomes for the Latinx population in Orange County, California	https://www.naccho.org/uploads/downloadable-resources/From-Venezuela-to-California.pdf
South African HIV intervention adapted for syphilis outbreak in Monongalia County, West Virginia	After learning about mobile alerts related to HIV outbreaks in South Africa, Monongalia County, West Virginia, uses the same approach when confronted with a syphilis outbreak in their county	https://www.naccho.org/uploads/downloadable-resources/West-Virginia-Syphilis-Project.pdf
Global vector control strategies in Harris County to prevent infectious mosquito-borne diseases	Approaches from Australia, India, Vietnam, Indonesia, China, Sri Lanka, Fiji, New Caledonia, Mexico, Brazil, and Columbia, provide inspiration for vector-control strategies to prevent Zika, Chikungunya, Dengue, West Nile virus, and Saint Louis encephalitis in Harris County, Texas	https://www.naccho.org/uploads/downloadable-resources/Houston-Public-Health.pdf
How Healthy is Your Main Street? Adapting an Approach from the United Kingdom	A British program to determine how healthy high streets are based on their storefronts is adapted to measure the health on U.S. main streets	https://www.naccho.org/uploads/downloadable-resources/How-Healthy-is-Your-Main-Street-UK-Project.pdf
Uganda Health Information Network	An information network for community health workers using low-cost tablet or phone and cellular networks to collect and share critical health data	https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-016-0225-1/tables/1
Bloomberg Philanthropies Maternal Health Initiative	The program trains assistant medical officers and midwives in remote areas to perform life-saving procedures including caesarean sections and upgrades isolated health centers	https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-016-0225-1/tables/2
Zimbabwe's Friendship Benches in New York City	Zimbabwe placed benches in areas where mental health services were needed and trained grandmothers to provide basic mental health services. Now New York City is trying the same approach	https://www.nytimes.com/2019/07/22/opinion/depressed-heres-a-bench-talk-to-me.html
The Cardiff Model	Created in Wales, UK, this approach uses data from ERs to determine where there are hotspots of violence (bar fights) and create policy to address and prevent it	https://www.cdc.gov/violenceprevention/publichealthisue/fundedprograms/cardiffmodel/whatis.html
Cuban Maternity Care Policy Could Improve MMR and IMR in Rural Alabama	Improved prenatal care for women with high-risk pregnancies in Cuba adapted to address the needs of similar women in rural Alabama	https://onlinelibrary.wiley.com/doi/abs/10.1002/wmh3.312

I. ASSESSING THE ELEMENTS TO ADAPT

Levels of Adaptation: Adapting a global approach can sound like a daunting task. Where to start? Looking at program adaptation from a very broad perspective, there are a number of ways that this can be done. Here are a few ways in which a program or approach could be adapted:

- **Cultural adaptation:** Tailoring the intervention to meet the community’s worldview and lifestyle
- **Cognitive adaptation:** Changing the language, reading, or age level of the intervention
- **Affective-motivational adaptation:** Adjusting aspects related to gender, ethnic, religious, and socioeconomic background of participants
- **Environmental adaptation:** Ecological aspects of the community, for example implementing in homes instead of at a clinic
- **Program content adaptation:** Tailoring of language, visuals, examples, scenarios, and activities used during the intervention
- **Program form adaptation:** Altering program structure and goals, which have a potential to reduce program effectiveness

Each of these elements can and should be considered as you think about where changes to the original global approach need to be made. However, it is important to note that some elements of the program should not be adapted, or else you run the risk of compromising the integrity of what made the approach successful in the first place. On the next page we discuss “Stoplight Adaptations,” which reviews acceptable, cautiously acceptable, and unacceptable changes that can be made to adapt a program to another context.

Additional Resources:

[HHS’s Making Adaptations Tip Sheet](#)

[CDC’s General Adaptation Guidance: A Guide to Adapting Evidence-Based Sexual Health Curricula](#)

[Considerations When Adapting a Program](#)

[Adapting Community Interventions for Different Cultures and Communities](#)

Stoplight Adaptations: Changes You Can and Cannot Make: Adaptation is necessary in a global to local approach. The program as it exists in one country will inevitably change as it is implemented in a different country. However, not all elements are as adaptable as others, and adapting those could have a negative impact on the success of the overall program. There are three different categories of adaptations; those you can make with minimal to no negative impact, those you should make with caution, and those you should not make. The Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) have defined what they call Stoplight Adaptations:

- **Green Light Adaptations:** *Go!* These adaptations are appropriate and are encouraged so that program activities better fit the age, culture, and context of the population. In many cases these changes should be made because they ensure the program is current and relevant to the community
- **Yellow Light Adaptations:** *Caution!* These adaptations should be made with caution so that the core components are adhered to and the adaptation does not cause other issues (e.g., time constraints, competition of topics). When making yellow light adaptations, it is recommended to consult more detailed adaptation tools and/or an expert in the approach, such as the model developer (if available) before making the change
- **Red Light Adaptations:** *Stop!* These adaptations remove or alter key aspects of the program that will weaken the program's effectiveness

Examples of Green Light Adaptations:

- Updating and/or customizing statistics or information as it is relevant to the community
 - Ensure your resources are reliable, up-to-date, and medically accurate
- Making activities more interactive, appealing to different learning styles
 - Keeping the information and/or skill-building content the same
- Tailoring learning activities and instructional methods to culture, developmental stage, gender, and/or sexual orientation
 - Making the words, images, and scenarios inclusive of all participants to increase engagement and effectiveness

Examples of Yellow Light Adaptations:

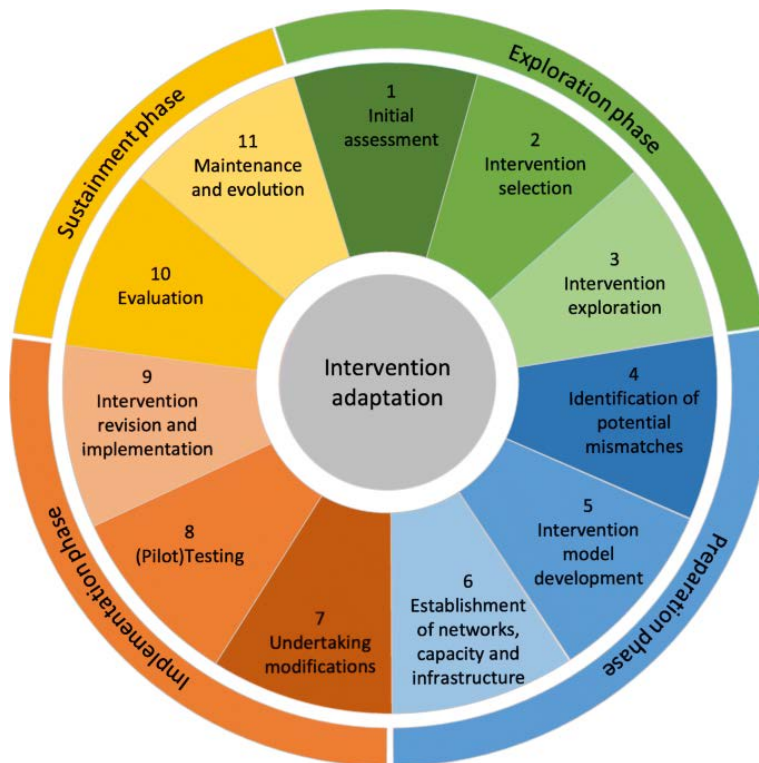
- Changing session order or sequence of activities
 - Curricula tend to build upon previous activities and lessons. Be careful not to undermine this logical progression and decrease understanding or skill-building
- Adding activities to reinforce learning or to address additional risk and protective factors
 - Added activities should reinforce the approach's key positive health behaviors. Adding too many activities could dilute the core messages, make the program too long, and create retention problems
- Replacing videos with other videos or activities or using supplemental videos to replace a lecture
 - Caution must be taken in replacing or supplementing videos to ensure the same content and prevention messages from the original lesson are addressed
- Implementing program with a different population or in a different setting
 - Ensure that any changes made to curricula based on group size, setting, or culture are done appropriately for the population while also considering the original content and purpose of the activities

Examples of Red Light Adaptations:

- Shortening a program
- Reducing or eliminating activities
- Contradicting, competing with, or diluting the program's goals

II. ADAPTING THE APPROPRIATE ELEMENTS OF AN APPROACH

Effectively Adapting Interventions or Approaches: There are a number of studies indicating the most effective methods for adapting an intervention or approach for your community. [A scoping study of frameworks for adapting public health evidence-based interventions](#) and [Adapting evidence-informed complex population health interventions for new contexts: a systematic review of guidance](#) are both meta-analyses that reviewed available methods in the literature, and were consistent in several steps that are key to effective adaptation.



[Adapting evidence-informed complex population health interventions for new contexts: a systematic review of guidance](#) provided this intervention adaptation wheel as a visual for the steps that an LHD would go through when adapting an approach. For the context of this guidance, it is assumed that the intervention itself was already decided upon, so we will skip diving deeper into the Exploration phase. An assessment of the combined steps for each of the remaining phases from the two studies is outlined below. Some steps were incorporated from *A scoping study of frameworks for adapting public health evidence-based interventions*, and those were categorized with their respective phase in the table:

Step	Description
1. Assess community	<ul style="list-style-type: none"> - Identify behavioral determinants and risk behaviors of the new target population using focus groups, interviews, needs assessments, and logic models - Assess organizational capacity to implement the program
2. Understand the intervention	<ul style="list-style-type: none"> - Understand the theory behind the programs and their core elements
3. Consult with experts	<ul style="list-style-type: none"> - Consult content experts, including original program developers, as needed - Incorporate expert advice into program
4. Consult with stakeholders	<ul style="list-style-type: none"> - Seek input from advisory boards and community planning groups where program implementation takes place - Identify stakeholder partners who can champion program adoption in new setting and ensure program fidelity
5. Identify potential mismatches and decide what needs adaptation	<ul style="list-style-type: none"> - Identify and categorize potential mismatches (e.g., among intervention goals, characteristics of the target population, implementation agency, and/or community) - Identify potential implementation barriers - Identify potential barriers to participation - Assess fidelity/adaptation concerns for the particular implementation site (i.e., determine what core components are especially needed to maintain and address fidelity) - Theater test selected approach using new target population and other stakeholders to generate adaptations - Determine how original and new target population/setting differ in terms of risk and protective factors
6. Adapt the original program	<ul style="list-style-type: none"> - Develop adaptation plan - Adapt the original program contents through collaborative efforts, potentially creating a mock-up version of the adapted material where appropriate - Make cultural adaptations continuously through pilot testing - Core components responsible for change should not be modified
7. Train staff	<ul style="list-style-type: none"> - Select and train staff to ensure quality implementation
8. Test the adapted materials	<ul style="list-style-type: none"> - Pretest adapted materials with stakeholder groups - Conduct readability tests - Modify approach further if necessary
9. Implement	<ul style="list-style-type: none"> - Develop implementation plan based on results generated in previous steps - Identify implementers, behaviors, and outcomes - Develop scope, sequence, and instructions - Execute adapted approach
10. Evaluate	<ul style="list-style-type: none"> - Document the adaptation process and evaluate the process and outcomes of the adapted intervention as implemented - Write evaluation questions; choose indicators, measures, and the evaluation design; plan data collection, analysis, and reporting - Employ empowerment evaluation approach framework to improve program implementation
11. Maintenance and evolution	<ul style="list-style-type: none"> - Establish a wide-scale dissemination of the adapted intervention, given the intervention is successful and is embraced by the community - Develop training systems to widen the dissemination (e.g., train future implementers in the adapted version of the intervention) - Implement an ongoing re-assessment

Consider these as your basic steps for effective adaptation. While all may not be necessary for each individual circumstance, each are important and should be considered as you go through the process of adapting a global approach to address the needs of your local community.

Additional Resources:

[A scoping study of frameworks for adapting public health evidence-based interventions](#)

[Adapting evidence-informed complex population health interventions for new contexts: a systematic review of guidance](#)

[A systematic review of adaptations of evidence-based public health interventions globally](#)

Method for Program Adaptation Through Community Engagement (M-PACE):

While the steps listed above are a good general guide, those who are specifically interested in community engagement with their adaptation process may be interested in working through a specifically designed approach for this very situation. The creators of the [M-PACE method](#) provide a five-step process to ensure the effectiveness of adaptations that focus specifically on community engagement:

Step	Description
1. Convene an adaptation steering committee	<ul style="list-style-type: none"> - The committee should have between 10-12 members - The steering committee should consist of researchers, implementers or practitioners, and community members who would personally benefit from the program - At least one member of the steering committee should be well educated on the theory of the approach and its execution in its original context
2. Implement the unadapted program to generate recommendations for program change	<ul style="list-style-type: none"> - The steering committee should be very familiar with the unadapted program before they implement - Carry out the unadapted program under the same conditions that the adapted program would be carried out - Ideally, the full unadapted program will be carried out, but it is possible for only portions to be sampled. - However, note that feedback will then only apply to the portions sampled and not the entire program
3. Systematically obtain evaluations of program components	<ul style="list-style-type: none"> - Participant and facilitator surveys/interviews: Should be conducted immediately following each participant experience - Participant and facilitator focus groups: Should be done after the entire program has been completed
4. Summarize stakeholder feedback	<ul style="list-style-type: none"> - Compiling weekly feedback should be done by steering committee members - Compile into categories and themes and keep accurate records through either recordings or transcriptions
5. Adjudicate program feedback to select program modifications	<ul style="list-style-type: none"> - This will be done by the steering committee - Suggested changes should be considered by their <i>importance, feasibility, and congruence</i> <ul style="list-style-type: none"> - Importance: The degree to which it is perceived to be a change that could improve program effectiveness and reach in the new target population, and address the concerns of multiple participants - Feasibility: The ability to effectively modify based on feedback from participants, representatives of the host site, and program instructors - Congruence: How the modifications are working with, working against, or not interfering with the core components of the initial approach or program

The ability to do this effectively is based on time and resources. Therefore, while it may not be possible to follow this model exactly, best efforts must be made to address core components of the model to effectively adapt global approaches to work within local communities if you want to focus on a community engagement approach.

Additional Resources:

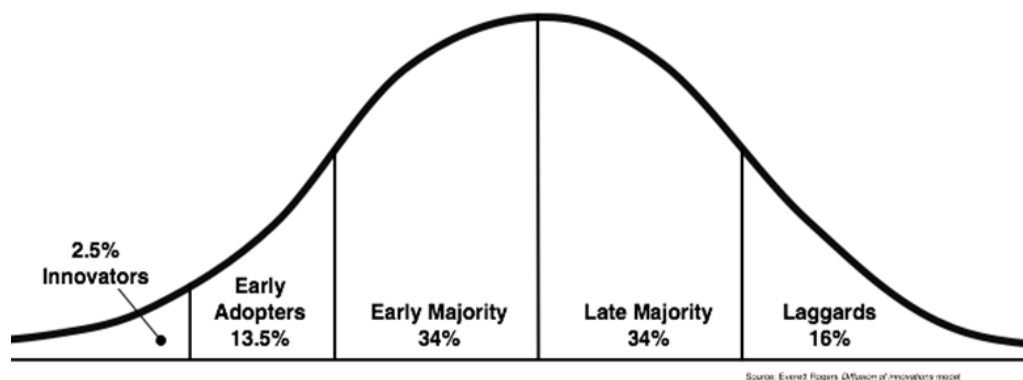
[Tailoring Evidence-Based Interventions for New Populations: A Method for Program Adaptation Through Community Engagement](#)

[WHO Community Engagement Module](#)

[CDC Community Engagement Training Module](#)

III. DIFFUSING THE APPROACH INTO YOUR COMMUNITY AND COMMUNICATING IT EFFECTIVELY

Diffusion of Innovation: Once the intervention has been selected and adaptations have been made, it is time to diffuse the intervention throughout the community. The Diffusion of Innovation Theory was developed by E.M. Rogers in 1962 and is a cornerstone of social science theories. It explains the process that innovations go through after introduction, indicating the different categories of people who will ultimately adopt the new innovation. Each category in the curve has their own specific strategies for how to approach them most effectively to encourage innovation to the adopting of a new approach:



Those of you who have already adopted and adapted a global health approach, you would be considered an **Innovator**. *Innovators are those who need little pushing to adopt new and innovative approaches and are considered adventuresome and interested in new ideas.*

The next group to adopt a new approach would be **Early Adopters**. *These are people who represent opinion leaders and embrace change opportunities. They are already aware of the need to change and so are very comfortable adopting new ideas.* What they really need is instruction on how to carry out what they are already interested in doing, rather than convincing that the change needs to be made.

Those who are in the **Early Majority** are rarely leaders, but they do adopt new ideas before the average person. That said, they typically need to see evidence that the innovation works before they are willing to adopt it. Strategies to appeal to this population include success stories and evidence of the innovation's effectiveness.

People who are in the **Late Majority** are skeptical of change and will only adopt an innovation after it has been tried by the majority. Strategies to appeal to this population include information on how many other people have tried the innovation and have adopted it successfully.

Finally, there are **Laggards**. *These people are bound by tradition and very conservative. They are very skeptical of change and are the hardest group to bring on board.* Strategies to appeal to this population include statistics, fear appeals, and pressure from people in the other adopter groups.

There are **five main factors that influence adoption of an innovation**, and each of these factors is at play to a different extent in the five adopter categories. They are:

1. **Relative advantage:** The degree to which an innovation is seen as better than the idea, program, or product it replaces
2. **Compatibility:** How consistent the innovation is with the values, experiences, and needs of the potential adopters
3. **Complexity:** How difficult the innovation is to understand and/or use
4. **Trialability:** The extent to which the innovation can be tested or experimented with before a commitment to adopt is made
5. **Observability:** The extent to which the innovation provides tangible results

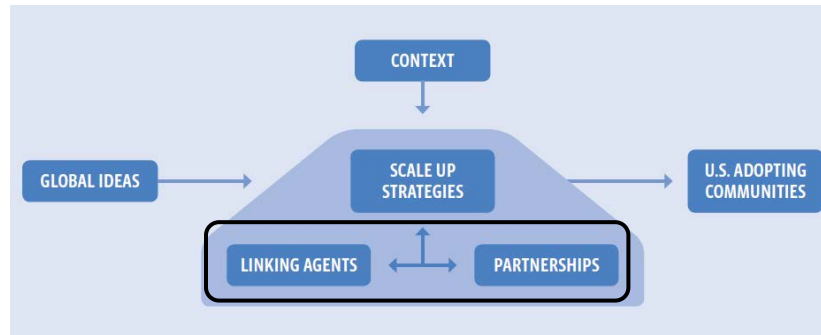
Through conversations with LHD leaders, they indicated that compatibility was one of the biggest challenges they anticipate—other decision-makers or community members may not see how a global approach can fit into their values and current experience. Therefore, while all five factors are important, being able to effectively communicate the compatibility of the core components of the program to the needs and experiences of your community will be crucial.

Additional Resources:

[Boston University School of Public Health Overview of Behavioral Change Models](#)

[Applying Diffusion of Innovation Theory to Intervention Development](#)

Designing for Diffusion: This theory was developed specifically for global ideas and is defined as “the taking of strategic steps early in the process of creating and refining an innovation, such as an evidence-based health intervention, to increase its chances of being noticed, positively perceived, accessed and tried, and then adopted, implemented and sustained in particular practice settings” (Dearing et al., 2019) Below are the six components that make up the model:



Source: A Model for Introducing Global Ideas to the U.S.

The **global idea** above is the approach that you as an LHD are adapting. To **scale up** the approach (or bring the approach to more people) linking agents and partnerships are a crucial element. In the displayed graphic, NACCHO would be considered a **linking agent**, and the mentorship between either the originator or the global approach of an LHD that has already adapted it, a **partnership**. Ultimately, the outcome of Dearing et al.’s (2019) model leads to **U.S. communities adopting** global approaches on a broader scale. Covering all elements of the model is **context**, which includes a variety of facilitating, reinforcing, and hindering factors.

Costs and benefits: These can be monetary and/or non-monetary and is one of the most common ways in which potential adopters approach decision-making

Compatibility: The extent to which the approach aligns with existing values, past experiences, and needs of potential adopters

Dearing et al. (2019) notes eight separate attributes that were of noted importance in this process: Cost and Benefits, Effectiveness, External Validity, Compatibility, Simplicity, Trialability, Observability, and Stigma. The researchers determined that when diffusing global health solutions in the United States, there was a consistent appreciation for the importance of a positive **cost-benefit analysis** and **compatibility** (shown again to be one of the more important aspects of the adaptation process).

Also deemed important were trialability, simplicity, and observability. External validity and stigma were rarely raised in the researchers’ interviews and were deemed tertiary to the other elements. Therefore, it is important to focus heavily on the

cost-benefit analysis of a global approach, which is no different than a health department looking at any new intervention. And again, this model shows the importance of compatibility and demonstrating that while its origins may be different, the global program, approach, or policy still aligns with the community’s goals and values.

Additional Resources:

[A Model for Introducing Global Ideas to the U.S.](#)

[CDC Cost-Benefit Analysis Tool](#)

[Duke University Cost-Benefit Analysis Tool](#)

[Academic Resource Providing Formulaic Approaches to Cost-Benefit Analysis](#)

[The Secret to Successful Health Partnerships](#)

Tools and Resources:

- **Adaptation**
 - [Considerations When Adapting a Program](#)
 - [HHS's Making Adaptations Tip Sheet](#)
 - [CDC's General Adaptation Guidance: A Guide to Adapting Evidence-Based Sexual Health Curricula](#)
 - [A scoping study of frameworks for adapting public health evidence-based interventions](#)
 - [Adapting evidence-informed complex population health interventions for new contexts: a systematic review of guidance](#)
 - [A systematic review of adaptations of evidence-based public health interventions globally](#)
 - [Adapting Community Interventions for Different Cultures and Communities](#)

- **Community Engagement**
 - [WHO Community Engagement Training Module](#)
 - [CDC Community Engagement Training Module](#)
 - [Tailoring Evidence-Based Interventions for New Populations: A Method for Program Adaptation Through Community Engagement](#)

- **Understanding the Diffusion of Innovation Theory**
 - [Boston University School of Public Health Overview of Behavioral Change Models](#)
 - [Applying Diffusion of Innovation Theory to Intervention Development](#)

- **Cost Benefit Analysis**
 - [CDC Cost-Benefit Analysis Tool](#)
 - [Duke University Cost-Benefit Analysis Tool](#)
 - [Academic Resource Providing Formulaic Approaches to Cost-Benefit Analysis](#)

- **Effective Partnerships**
 - [The Secret to Successful Health Partnerships](#)

- **NACCHO Global-Local White Papers**
 - [Lessons from the World: Applying Global Thinking to Local Public Health](#)
 - [From Global to Local: Bringing International Lessons to U.S. Local Public Health Practice](#)

- **Additional Global-Local Resources**
 - [A Model for Introducing Global Ideas to the U.S.](#)
 - [Landscape Assessment: Bringing Health to Local Communities—Strategies from Global Health](#)
 - [The Task Force on Global Advantage Report](#)

- **RWJF Global Ideas for U.S. Solutions Blog Series**
 - [Health Equity: What We're Learning from the World](#)
 - [Global Approaches to Curb the Health Impact from Climate Change](#)

- [Global Approaches to Well-Being: What We Are Learning](#)
- [Creative Communities are Addressing Social Isolation](#)
- [Advancing Well-Being in an Inequitable World](#)
- [Four Ways to Build Inclusive, Healthy Places for All](#)
- [A Successful Model that Predicts and Prevents Violence](#)
- [Can a Trash Can Reveal a Community's Values](#)
- [How Lessons from Abroad Are Uplifting Youth in the United States](#)
- [What if All Children Could Attend Preschool?](#)

Continuing Our Understanding: The challenges of adopting and adapting global approaches within a U.S. LHD context should not be understated. However, they are not impossible to overcome, as evidenced by the effective global approaches already in place within U.S. communities. There is less research on how LHDs adapt global approaches specifically, and NACCHO is particularly keen on understanding this better. Through our conversations with LHD leaders, adjusting to the U.S. health care system and communicating the approach effectively with other stakeholders (particularly those who are skeptical of something that originated outside the United States) were two key areas they were the most concerned about when thinking about adopting and adapting a global approach.

- 1. Adjusting to the U.S. Health Care System:** During focus group discussions, many participants were concerned at how global approaches would fit into the U.S. health care system, which is often very different from the countries where these approaches originate.

“I think something that is a challenge is that the way other countries are set up is very different from how our health system is set up ... So, if you go out and get a screening and they find something, there is a system to take care of you; here, there’s not. So getting past the public health space and into the health system space, there’s a huge chasm, where in other countries, that chasm doesn’t exist. So they can actually focus on the public health prevention strategy.” — Urban local health department official

This is an area that is less discussed in the academic research on the topic, but is a crucial sticking point for many LHDs interested in adapting a global approach.

Some questions to consider:

- What elements of the U.S. health care system (if any) did you engage in while adapting this approach to your LHD?
- What did you have to change about the global approach to accommodate the differences in the health care systems?

- 2. Communicating Effectively with Other Stakeholders:** The other main concern voiced by LHDs during NACCHO’s discussions with department leaders was the need to convince other decision-makers that a global approach could be effective. Many were open to global approaches themselves, but balked at the idea of convincing boards, community members, and even other staff members of their health department.

“When I want to implement something new, I have to go to my governing board, and I’m from a rural area and we don’t really have a whole lot of diversity on our board. And I think that it would be hard for me to be able to relay to them that it would work in our community. If they can’t relate to it, it’s harder for them to approve it and for a lot of things that I have to implement, I have to get approval from them, so I think that would be a barrier.” — Rural Michigan health department official

Understanding the best strategies and approaches for communicating the benefits of a global approach to stakeholders is a crucial element to both implementing the approach to start and increasing the likelihood of its success. While the Diffusion of Innovation model provides us with a framework to share new approaches with others, it doesn’t specifically address the challenges of the innovation being from

outside the United States. Therefore, NACCHO is eager to learn more about effective strategies for communicating global approaches specifically.

Some questions to consider:

- How did you communicate this approach with members and decision-makers of your LHD?
- How did you communicate this approach to stakeholders outside of your LHD?
- How did you communicate this approach to members of your community?

We intend to collect additional information from LHDs who have adopted and adapted a global health approach for their communities and add that information into the second version of this guidance (v.2). There is much more that we can learn on this, so multiple iterations of this guidance are anticipated as NACCHO continues to learn more about how LHDs effectively adopt and adapt global approaches. We welcome your feedback.

Five Key Takeaways:

- 1. There are different levels of adaptations:** While it is important to adapt global approaches to address system or cultural differences, you do not want to make changes that will render the successful elements of the global approach ineffective. Consider the Stoplight Adaptation resources when thinking about what you can and cannot adapt to ensure that while you are adjusting the program for your community, you are not changing what originally made the program effective in the first place.
- 2. Adaptation is a long and involved process that requires input from multiple sources:** Adapting a successful program is not a simple or quick endeavor and trying to make it so will limit your ability to be successful. Include multiple stakeholders (including members of the community) to ensure that you are making thoughtful decisions in your adaptation process.
- 3. How you communicate the new approach will depend on the characteristics of those you are trying to reach:** Different elements will be important to different people, and the messaging you use on early adopters will be very different from the messaging that will be effective for the late majority or laggards. A positive cost-benefit analysis and compatibility of the key elements of the global approach are a good place to start with diffusing the global approach across your community.
- 4. More information is needed on adjusting global approaches to work within the U.S. health care system:** The U.S. health care system is unique, with specific challenges related both to clinical care and social acceptance of health approaches. Many LHDs mentioned that this was an area of concern for them as they thought through adapting and adopting global health approaches to their communities. As we get more experience, a better understanding of how to adapt global approaches most effectively within the U.S. health care system would be an extremely useful resource for LHDs interested in adopting a global approach.
- 5. More information is needed on how to effectively communicate the benefits of global approaches to stakeholders and community members:** While it is clear that this is important and there are general guidelines that have been outlined in previous research, there is less information on effective strategies to do so when the innovation is from out the United States. NACCHO is keen to gather more information on this to share in our next version of this guidance.

Conclusion: Following focus group discussion around global health, we came to the conclusion that while many LHDs had not yet considered the option of using global health approaches to address challenges in their own communities, they were open to the idea and saw the benefit of global approaches. Global health provides opportunities to find solutions to vexing programs in an innovative and cost-effective way. There is a lot that the world can teach local health departments, and it is crucial that we tap into this incredible resource of ideas and approaches, so that we can continue to improve the health of our local communities.

References

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