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Equity-focused theories, models, and frameworks in implementation science: a scoping review and critical appraisal

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Abstract

Background Implementation science theories, models and frameworks (TMFs) can guide implementation research and practice to address widening inequities in healthcare access, quality, and health outcomes. This scoping review aimed to map and critically appraise implementation science TMFs explicitly created or adapted to advance health equity.

Methods We conducted a scoping review using Joanna Briggs Institute guidance. We searched MEDLINE, CINHAL, and five implementation science and equity journals from inception to May 20, 2025. Eligible records were primary descriptions of (i) implementation science TMFs purposely built to advance health equity or (ii) equity-focused adaptations of existing implementation science TMFs. Applications of TMFs in research or practice and non-implementation science TMFs were excluded. Two reviewers independently screened titles/abstracts then full texts in Covidence with consensus adjudication. Data were charted on a standardized form, and each TMF underwent duplicate critical equity appraisal against eight a priori criteria with an equity expert providing methodological input. Findings were summarized narratively and in evidence tables.

Results From 6,012 records, 42 TMFs were included (23 adaptations of existing TMFs, 19 purpose-built), and most (69%) were published after 2020. Geographic provenance was heavily skewed with 67% originating in the United States; none originated in low-income countries. Most included TMFs aimed to orient the implementation process (45%) or assess determinants (23%). Assessment of TMFs according to eight equity criteria showed uneven coverage: 90% explicitly name health inequities; 88% suggest incorporating lay knowledge; 86% promote cultural responsiveness; 64% emphasize two-way learning and relationship building, and 60% consider structural determinants. However, only 45% propose concrete community co-ownership mechanisms; 40% outline strategies to mitigate inequities; and 40% offer processes addressing structural barriers. Seven TMFs (17%) covered all eight equity criteria.

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Conclusions Equity-focused TMFs are proliferating, but most originate in high-income countries and few provide concrete guidance for addressing structural determinants of health inequities. Before use, researchers and practitioners should critically appraise candidate TMFs with communities and equity experts, co-adapt them to local contexts, and, where necessary, extend them to strengthen underdeveloped domains such as structural change and community co-ownership.

Registration N/A.

Keywords Theories, Models, Frameworks, Health equity, Community engagement, Implementation research, Implementation practice, Knowledge translation

Contributions to the literature

- This review maps and critical appraises 42 equity-focused implementation science theories, models and frameworks (TMFs).
- Most TMFs originated in high-income countries, and many publications did not report whether communities, people with lived and living experience, or equity-related experts contributed to their development. Although several equity attributes were commonly addressed, fewer than half explicitly included community co-creation or co-ownership, responses to structural barriers, or equity-focused implementation strategies.
- Researchers and communities should critically assess whether candidate TMFs address their equity priorities and, where gaps remain, adapt existing TMFs or develop new ones with meaningful community and equity expertise.

Introduction

There is a pressing need to address issues of health equity and social justice [1–3]. Ensuring access to high-quality, evidence-informed healthcare for all people, regardless of income, race, gender, ethnicity or other social determinants of health, is a critical piece in addressing health inequities [1, 4]. Implementation science offers valuable tools to address gaps in access to care; however, it can also have the unintended consequence of amplifying inequities when its guiding theories, models, and frameworks (TMFs) overlook the legacies of colonialism, power asymmetries, and Indigenous ways of knowing [3, 5]. There is a critical need to ensure that evidence-based interventions are effective for specific populations that experience health inequities, and that key groups in particular community members are fully engaged in all stages and have ownership over and leadership in implementation efforts [3, 5].

Recent scholarship has called for implementation science to place greater emphasis on equity and, where relevant, to support locally defined decolonial aims [2, 3, 5]. Strengthening TMFs in these directions requires explicit attention to the historical and sociopolitical forces shaping health and social systems and to locally grounded ways of knowing, values, priorities, and governance [5]. Equity-focused and decolonial approaches are related but not interchangeable; attention to selected equity attributes is not sufficient to establish that a TMF or its use is decolonial. We posit that implementation science TMFs, used since the discipline's inception, are the linchpin: they translate values into methods, dictate whose evidence counts and is prioritized, and shape which strategies are judged rigorous [6]. A prior synthesis published in 2023 [7] catalogued 15 equity-focused implementation science TMFs but did not appraise content, scope, or readiness for use, and dozens of additional equity-focused TMFs have emerged since then. A review by McKenzie et al. published in 2025 also described six implementation science TMFs that were adapted with an equity focus, however, this review did not consider other TMFs that were designed specifically with equity in mind and also did not critically appraise how these TMFs met their goal of equity-focused implementation science [8].

This scoping review therefore pursues two aims: (i) map the rapidly expanding landscape of equity-focused implementation science TMFs and (ii) critically examine the extent to which their published descriptions explicitly incorporate eight selected equity-related attributes. We examine whether these publications explicitly address structural oppression, cultural responsiveness, community co-creation, and guidance for strategy selection in settings affected by resource constraints. We also consider how researchers, practitioners, policymakers and communities might assess, adapt, combine, or set aside these tools in relation to locally defined priorities.

Methods

We performed a scoping review following the Joanna Briggs Institute methodology [9]. Results are reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) [10].

Study team composition

Our team includes a diverse group of researchers with experience in community engagement, implementation

science, global health and health equity. All authors are currently based at institutions in high-income countries. Some team members have lived or worked in low- and middle-income countries and in communities affected by structural inequities; however, we do not consider these experiences substitutes for community authority, Indigenous governance, or lived and living experience. Community members and representatives from all populations addressed by the included TMFs did not govern this review or define its appraisal criteria. The appraisal therefore reflects a situated academic interpretation informed by the published literature and the expertise represented within the team (see supplementary file for positionality statements).

In accordance with JBI guidelines, the review began with a three-step search. In the first step, initial searches of Medline, Cumulative Index to Nursing and Allied Health Literature and Google Scholar were conducted to identify relevant articles and determine keywords. In step two, a medical librarian along with LC developed a search strategy for the databases as well as relevant implementation science, health service and health equity journals (*BMC Health Services Research*, *Implementation Science*, *Implementation Science Communications*, *Implementation Research and Practice*, and *International Journal for Equity in Health*). See supplementary file for search strategies. These searches were conducted with no time limitation on May 20, 2025. Afterwards, in step three, references within systematic and scoping reviews of TMFs (identified in step two) as well as references of all retained articles, were also hand searched.

Selection criteria

We defined implementation science theories, models, and frameworks (TMFs) as structured, generalizable tools that specify constructs and relationships to (a) provide deeper understanding or explanation of implementation or (b) guide implementation processes, determinant assessment, strategy selection/adaptation or evaluation [11]. For the purpose of this review, we focused on TMFs that were intended to be used across multiple studies or settings (i.e., not study-specific program theories or logic models). Equity is defined by the World Health Organization as "the absence of unfair, avoidable, or remediable differences among groups of people." [12] As such, for this review, equity-focused TMFs were those that explicitly incorporate equity constructs (e.g., justice, structural oppression, intersectionality, cultural safety, global health considerations) or provide concrete guidance to address inequities during implementation [6,7].

Articles were eligible if they (i) described or developed a purpose-built, equity-focused implementation TMF or adapted an existing implementation TMF to embed equity considerations (e.g., adding domains, measures, or procedures that address inequities); (ii) provided enough operational detail to enable use or adaptation (constructs, definitions, relationships, steps, tools/checklists); (iii) were empirical studies, methodological papers, commentaries or concept/method notes (peer- or editor-reviewed) and (iv) pertained to health, public health, or health-adjacent services and systems (e.g., digital health, community health, policy implementation). We included publications in English or French because these were the languages that the author team had sufficient knowledge of to screen and assess the articles. No date restrictions were applied.

We excluded records that applied a TMF in a primary study without proposing a new TMF or an equity-focused adaptation; that reviewed or compared multiple TMFs; or that presented intervention-specific program theories or site-specific logic models without intent for general use. We also excluded articles that described disparities without operationalizing equity within the TMF (e.g., only recommending "consider equity" without constructs or additional guidance), were outside the scope of implementation science (e.g., knowledge translation or behavioural medicine absent implementation processes), or lacked sufficient information to extract the TMF's structure on full-text review. We also focused on TMFs that were developed for use in implementation science work generally or for healthcare specific use but included articles that were meant to be used in community organizations that provided health services or those that were meant to be used in the field of public health.

Selection process

Using Covidence (Veritas Health Innovation, Australia), references were deduplicated and each article was screened first by title and abstract and then by full text independently by two reviewers (LC, SD, RS, CW, MNA, SS, or GF). Any disagreements were resolved through consensus discussions or through the engagement of a third reviewer.

Data extraction

Data extraction was completed using a table developed by the study team. LC extracted all articles, and these were then independently verified by one of SD, RS or CW. Any disagreements were resolved through consensus discussions or through engagement of a third reviewer. In addition to the information extracted from individual articles, RS also used Scopus to gather citation counts of all included TMFs and gathered data on whether the publications were open access. The citation counts were done on July 17 and 18, 2025.

Critical appraisal of included TMFs along equity criteria

To guide the critical appraisal of included TMFs, eight equity criteria were drawn from the SELECT-IT meta framework's four equity attributes [6]. To ensure coverage, relevant literature [4, 5, 13] and our team with diverse experience in equity and implementation science reviewed the criteria and assured completeness. These criteria as well as the guiding questions are presented in Table 1. The eight criteria span a wide range of considerations, from whether the TMF explicitly addresses structural inequities to whether it includes mechanisms for engaging communities as co-creators of knowledge. We did not expect every TMF to explicitly address all eight criteria, and the criteria were used as analytic prompts rather than as universal or equally weighted standards of TMF quality. Their relevance depends on each TMF's intended purpose and context. A criterion coded as absent indicates that it was not explicit in the publication; it does not establish that the attribute was absent from TMF development or subsequent use. Framework-level totals should therefore not be interpreted as rankings of overall quality, equity, or contextual suitability. In addition to these eight questions, information was also collected about the teams creating these TMFs when available, recognizing the importance of having diverse expertise including those with lived and living experience at the table during equity-focused implementation science work. Critical appraisal was initially conducted using the eight criteria by LC and then independently verified by SD, RS or CW.

Data analysis

We synthesized extracted data descriptively, reporting counts and proportions for TMF provenance, publication year, intended populations, purpose, and implementation phase of use. For the eight equity criteria, each TMF received binary codes (present/absent) based on explicit statements, constructs, or procedures. We then calculated criterion-level coverage (percentage of TMFs meeting each criterion) and framework-level totals (0–8). Findings are presented narratively and in evidence tables, including TMF type (adaptation vs. purpose-built). ChatGPT 5 (OpenAI, 2025) was used to enhance the coherence and readability of some sections of this manuscript. The authors have reviewed all generated text and take full responsibility for the contents of this article.

Results

Search results

We identified a total of 6,839 articles from databases and the five included journals. An additional four articles were located from hand-searching references. After duplicates were removed, 6,012 articles were screened by title and abstract, and 218 articles were retained for full text screening. The primary reasons for exclusion at this stage were: not describing a TMF ($n=65$), not

Table 1 Guiding equity criteria for the appraisal of TMFs

Criterion*	Guiding question	What we looked for
1. Explicit equity focus	Does the TMF explicitly identify, measure, or respond to equity issues (e.g., justice, disparities in access or uptake)?	Explicit mention of addressing health equity or health disparities in the TMF purpose.
2. Implementation strategies for mitigating inequities	Does it articulate implementation strategies for mitigating those inequities within implementation processes?	Provide concrete implementation strategies (e.g., tailored outreach, community health worker roles, flexible scheduling, fee waivers) linked to health inequities as part of implementation.
3. Cultural responsiveness	Is implementation responsive to local values, norms, and traditions?	Describes processes to elicit local values and adapt implementation process to fit these including modifying language/materials/workflows, employing cultural brokers and documenting assessments of fit.
4. Two-way learning and relationship building	Does the TMF foster trust, mutual respect, and cultural safety through two-way learning and relationship-building?	Provide explicit guidance on community engagement including but not limited to bi-directional learning, ongoing relationship building, psychological/cultural safety practices and agreements for communication and conflict resolution.
5. Recognition of structural determinants	Does the TMF consider structural/systemic barriers beyond individual control?	Provide guidance on how to explore and document systemic issues including social, political and economic systems that influence health outcomes by impacting who has access to power and resources as part of implementation context.
6. Strategies for structural and systems change	Are there provisions to adapt implementation to those structural/systemic influences?	Provide guidance on strategies either novel or adapted tied to structural and systemic barriers (e.g., policy navigation, task-shifting, legal workarounds) with rationale.
7. Integration of community and experiential knowledge	Does the TMF integrate non-academic/lay knowledge (e.g., lived experience, Indigenous practices)?	Explicitly acknowledges the importance of inclusion of those with lived and living experience and includes methods to elicit and embed their knowledge in the implementation process.
8. Co-creation and co-ownership	Does it propose methods for engaging communities as co-creators/co-owners of knowledge and solutions?	Includes mention of co-creation or co-ownership within the implementation process including but not limited to shared governance, decision rights, data/benefit ownership, co-lead authorship, budgets/time for co-design and stewardship.

*Criterion adapted from SELECT-IT Framework [6]

implementation science ($n = 36$) and study applying TMF ($N = 27$). No articles were excluded for having insufficient data to extract. A total of 43 articles describing 42 TMFs were included in our review. The PRISMA-ScR flow diagram is presented in Fig. 1.

Characteristics of equity-focused TMFs

As presented in Table 2, the majority of TMFs identified ($n = 23$, 55%) were adaptations of existing TMFs. The Consolidated Framework for Implementation Research (CFIR) [14] had the most, with six adaptations (14%), followed by the Practical Robust Implementation and Sustainability Model (PRISM) and Reach, Effectiveness, Adoption, Implementation, Maintenance (RE-AIM) Frameworks [15] with four (10%). Some of the adapted TMFs changed the original by providing supplements or extensions. For example, Shelton et al. proposed an extension to the RE-AIM framework which increases its focus on sustainability including its impact on health equity over time [16]. Similarly, Rodrigues et al. provided a supplement for the CFIR to include intersectionality considerations [17]. Others provided additions that were integrated into the original to increase focus on equity such as the Framework for Reporting Adaptations and Modifications-Enhanced (FRAME) adapted for digital health equity [18]. Some provided significant adaptations to the original such as the Health Equity Implementation framework (HEIF) [19] which combined both the Integrated – Promoting Action on Research Implementation in Health Services (I-PARIHS) [20] and a healthcare disparities framework [21].

As presented in Table 3, we also identified 19 purpose-built TMFs (45%). These were elaborated with the specific objective of meeting the needs of equity-deserving populations during implementation. Some of these still built on existing TMFs such as the Im4Equity which combined and then modified four existing TMFs to create the Im4Equity [22]. In contrast, the Transcreation Framework for Community-engaged Behavioral Interventions to Reduce Health Disparities (Transcreation framework) built upon the author's earlier work to create a TMF to guide development and testing of behavioural interventions [23].

Across all included TMFs, twenty-eight (67%) had a first author who was based in the United States, 12 (29%) were from other high-income countries and only two (5%) were from middle-income countries (Colombia and India). None were developed in a low-income country. The vast majority of TMFs were published within the last five years with only nine (21%) published prior to 2020 (Fig. 2) and 19 (45%) had been cited fewer than ten times, which may indicate a low adoption of these specific

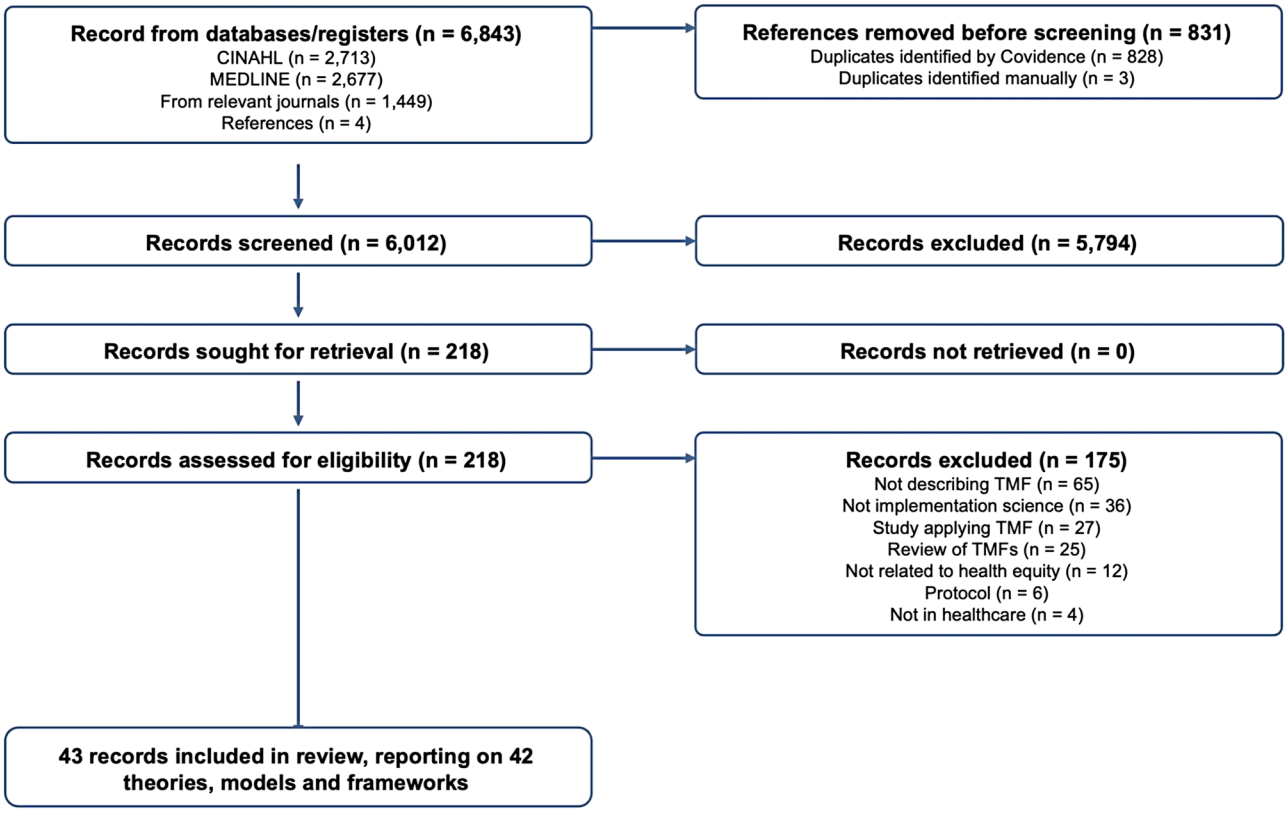


Fig. 1 PRISMA Flow Diagram

Table 2 Equity-focused adaptations of existing implementation science TMFs ($N = 23$)

First author (year)	Title	Country	Aim	Intended population	Primary purpose	Secondary purpose(s)	Number citations (Scopus, July 17–18 2025)	Article access
Consolidated Framework for Implementation Research (CFIR)[14]								
Senier (2019)[37]	Expanded CFIR framework	United States	Guide promotion of genomic medicine and broaden reach of care to diverse populations	Genomic medicine*	Guiding the implementation process	Guiding identification of determinants	11	Open
Stamatakis (2020)[56]	Measurement tool to assess local public health implementation climate and capacity	United States	To assess capacity for equity-oriented practice and capacity for effective change towards health equity in public health departments	Populations served by public health departments	Guiding identification of determinants	N/A	8	Open
Damschroder (2022)[34¶]	Updated CFIR	United States	Revised the CFIR to address critiques including centering innovation recipients and adding some equity considerations	No specific population	Guiding identification of determinants	Guiding the implementation process	1504	Open
Petrovskis (2023)[57]	Data for addressing social determinants of health (DASH) model	United States	To explicate implementation factors, process and gaps for data driven decision making in local health departments to address social determinants of health	Populations served by local health departments	Guiding identification of determinants	Guiding the implementation process	1	Restricted
Rodrigues (2023)[17]	Intersectionality supplemented CFIR	Canada	To support incorporation of intersectionality into implementation science projects	No specific population	Guiding identification of determinants	N/A	11	Open
Jacobs (2024)[41]	Integrated CFIR and culturally responsive evaluation (CRE)	United States	Integrated the CFIR into CRE approach to address key cultural considerations and collection of importance evidence for translation	Communities with populations at risk for diabetes	Guiding the evaluation and causal explanation	Guiding identification of determinants	5	Open
Theoretical Domains Framework (TDF)[58]								
Etherington (2020)[45]	Intersectionality supplemented TDF	Canada	To support incorporation of intersectionality into implementation science projects	No specific population	Guiding the identification of determinants	N/A	54	Open
Proctor et al.'s Framework[59]								
Bauman (2020)[60]	Equity considerations for Proctor et al.‡	United States	To provide guidance on how to apply existing implementation science frameworks to inequities in healthcare	No specific population	Guiding the evaluation and causal explanation	Guiding identification of determinants Guiding the implementation process	292	Open
Practical Robust Implementation and Sustainability Model (PRISM)[4] **and Reach**, **Effectiveness**, **Adoption**, **Implementation**, **Maintenance (RE-AIM) Frameworks**[61]								

Table 2 (continued)

First author (year)	Title	Country	Aim	Intended population	Primary purpose	Secondary purpose(s)	Number citations (Scopus, July 17–18 2025)	Article access
Shelton (2020)[16]	Extension of RE-AIM for sustainability	United States	Expand on RE-AIM to focus on sustainability to ensure health impact and health equity sustained over time	No specific population	Guiding the evaluation and causal explanation	Guiding the implementation process	290	Yes
KlepacPogrmilovic (2021)[39]	ProPRISM	Australia	To integrate principles of proportional universalism into PRISM	No specific population	Guiding identification of determinants	Guiding implementation process Guiding the evaluation and causal explanation	7	Open
Fort (2023)[46]	Equity PRISM/Re-Aim‡	United States	To provide guidance on applying PRISM and RE-AIM with equity lens	No specific population	Guiding the implementation process	Guiding identification of determinants Guiding the evaluation and causal explanation	31	Open
Jolles (2024)[30]	Updated equity PRISM/Re-Aim‡	United States	To offer guidance on the use of PRISM to align contextual needs with interventions from systems thinking perspective, use of co-creation and the use of RE-AIM in iterative cycles	No specific population	Guiding the implementation process	Guiding identification of determinants Guiding the evaluation and causal explanation Guiding the design and adaptation of strategies	19	Open
Integrated-Promoting Action on Research Implementation in Health Services (i-PARIHS) Framework [20] **and Healthcare Disparities Framework** [62]								
Woodward (2019)[19] Woodward (2021)[32]	Health equity implementation framework (HEIF)	United States	To explain factors relevant to implementation and disparities in healthcare	Vulnerable populations facing healthcare disparities	Guiding the identification of determinants	N/A	280; 157	Open; Open
Exploration, **Preparation**, **Implementation**, **Sustainment (EPIS) Framework**[63]								
Stanton (2022)[26]	EPIS power typology‡	United States	To guide the examination and distribution of power throughout implementation	Health fields characterized by inequity (i.e. HIV and mental health) *	Guiding the implementation process	Guiding identification of determinants	Not indexed on Scopus/ Google scholar	Open

Table 2 (continued)

First author (year)	Title	Country	Aim	Intended population	Primary purpose	Secondary purpose(s)	Number citations (Scopus, July 17–18 2025)	Article access
Gustavson (2023)[64]	Telehealth EPIS‡	United States	To integrate equity considerations into implementation process of telehealth	No specific population	Guiding the implementation process	Guiding identification of determinants	6§	Open
Conceptual framework of equity-focused implementation research for health programs (EquIR)[65]								
Groom (2024)[66]	Digital health EquIR (DH-EquiR)	United States	To guide equitable implementation of digital health tools	No specific population	Guiding the implementation process	Guiding identification of determinants Guiding the evaluation and causal explanation	3	Open
Gustafson (2024)[29]	Adaptation of EquiR for Aotearoa New Zealand	New Zealand	To support and facilitate equity-focused implementation research and health intervention implementation by mainstream health services	Māori and Pacific people of New Zealand*	Guiding the implementation process	Guiding identification of determinants Guiding the evaluation and causal explanation	5	Open
Translational Science Benefits Model (TSBM) [67]								
Huebschmann (2024)[68]	Refinement of TSBM‡	United States	Identifies impact of translational science; refinement adds outcomes related to representation and representativeness of outcomes	Indigenous populations in the United States*	Guiding the evaluation and causal explanation	N/A	0	Open
LaManna (2025)[69]	Updated TSBM‡	United States	Identities impact of translational science including outcomes related to health equity	No specific population	Guiding the evaluation and causal explanation	N/A	2	Open
Implementation Research Logic Model[70]								
Rodriguez-Hart (2023)[71]	Stigma reduction logic model	United States	To guide planning, implementing and evaluating impact of strategies to reduce HIV and intersectional stigma	People with HIV	Guiding the implementation process	Guiding identification of determinants Guiding the evaluation and causal explanation Guiding the design and adaptation of strategies	2	Open

Table 2 (continued)

First author (year)	Title	Country	Aim	Intended population	Primary purpose	Secondary purpose(s)	Number citations (Scopus, July 17–18 2025)	Article access
Knowledge to Action (early phases) [72]								
Kerkhoff (2022)[73]	Equity considerations for early Knowledge to Action‡	United States	To propose steps to integrate equity considerations from beginning of implementation planning	No specific population	Anticipating change and guiding inquiry	Guiding the implementation process	87	Open
Framework for Reporting Adaptations and Modifications-Enhanced (FRAME)[74]								
Kepper (2025)[18]	Framework for reporting adaptations and modifications-enhanced	United States	To track adaptations of digital health interventions and document implications for equity	No specific population	Guiding the design and adaptation of strategies	N/A	0	Open
Readiness Assessment for Pragmatic Trials (RAPT) Tool [75]								
Hikaka (2024)[50]	RAPT-Indigenous (RAPT-I)	New Zealand	To assess an intervention's 'readiness' in the context the intervention's current state and likelihood of intervention adoption if proven effective in pragmatic trials in Indigenous communities	Indigenous people	Guiding identification of determinants	Anticipating change and guiding inquiry	1	Open

Note: CFIR = Consolidated Framework for Implementation Research. Dash = Data for addressing social determinants of health. CRE = Culturally responsive evaluation. TDF = Theoretical Domains Framework. PRISM = Practical Robust Implementation and Sustainability Model. Re-Aim = Reach, Effectiveness, Adoption, Implementation, Maintenance. ProPrism = Proportional Practical Robust Implementation and Sustainability Model. i-PARIHS = Integrated-Promoting Action on Research Implementation in Health Services framework. HEIF = Health Equity Implementation Framework. EPIS = Exploration, Preparation, Implementation, Sustainment. HIV = Human Immunodeficiency Virus. EquiR = Conceptual framework of equity-focused implementation research for health programs. DH-EquiR = Digital Health Conceptual framework of equity-focused implementation research for health programs. TSBM = Translational Science Benefits Model. FRAME = Framework for Reporting Adaptation and Modifications. RAPT = Readiness Assessment for Pragmatic Trials. RAPT-I = Readiness Assessment for Pragmatic Trials Indigenous

*Authors note it could be applied more broadly

† Also combined the digital health equity framework (DHEF) in addition to EPIS

‡ Title created by study team

§ Number provided by Google Scholar as article not indexed on Scopus

¶ These TMFs were updated to include additional equity considerations (rather than adaptations)

Table 3 Purpose-built equity-focused implementation science TMFs ($N=19$)

First author (year)	Title	Country	Aim	Intended population	Primary purpose	Secondary purpose	Number citations (Scopus, July 17–18 2025)	Article access
Cabasa (2013)[76]	Cultural adaptation models (CAMs) with socioecological implementation science lens	United states	Within implementation science, CAMs can be used to adapt interventions and prepare the context of practice to facilitate adaptation	Mental health patients	Guiding the design and adaptation of strategies	Guiding the implementation process	213	Open
Maar (2015)[40]	Intervention and research readiness engagement and assessment of community health care (I-RREACH)	Canada	To collaboratively identify and address key contextual factors affecting complex health interventions through a structured, participatory, and culturally safe approach that enhances implementation success and sustainability.	Canadian indigenous communities and rural communities in Tanzania	Guiding the identification of determinants	Enhancing conceptual clarity Anticipating change and guiding inquiry	31	Open
Oetzel (2017)[24]	He Pikinga Waiora implementation framework (HPW)	New Zealand	To facilitate implementation for interventions to prevent and treat chronic conditions*	Māori and other Indigenous communities*	Guiding the implementation process	Guiding identification of determinants Guiding the evaluation and causal explanation Guiding the design and adaptation of strategies	107	Open
Napoles (2018)[23]	Transcreation framework	United States	To facilitate designing, delivering, and evaluating interventions to reach disparity populations in community settings	No specific population	Guiding the implementation process	Guiding identification of determinants Guiding the evaluation and causal explanation	86	Open
Percival (2018)[31]	Indigenous health promotion tool implementation model	Australia	To offer a theoretical model that explains how health promotion tools are implemented in Indigenous primary health care, highlighting key processes and conditions for culturally responsive, empowering implementation.	Indigenous Australians (Aboriginal and Torres Strait Islander)	Guiding the implementation process	Guiding the identification of determinants Enhancing conceptual clarity	8	Open
Ramaswamy (2018)[35]	Design focused implementation framework	India	To describe design focused implementation in low resource settings including three phases: (1) design, (2) implementation, (3) improvement	Populations in low resource environments	Guiding the implementation process	Guiding the identification of determinants	21	Open
Eslava-Schmalbach (2019)[65]	Conceptual framework of equity-focused implementation research for health programs (EquIR)	Columbia	To develop an equity-based framework for implementation research of health programs, policies and systems that could be used to improve evidence informed implementation processes	"Disadvantaged populations"; uses social determinants of health as a guide	Guiding the implementation process	Guiding identification of determinants Guiding the evaluation and causal explanation	88	Open
Eboreime (2021)[77]	Theory-design-implementation (TyDI) framework	Canada	To support program planners, policy makers and implementers to evaluate adaptation and implementation fidelity	Global health populations	Guiding evaluation and causal explanation	Guiding the implementation process	18	Restricted

Table 3 (continued)

First author (year)	Title	Country	Aim	Intended population	Primary purpose	Secondary purpose	Number citations (Scopus, July 17–18 2025)	Article access
Shelton (2021)[28]	Anti-racism lens for implementation science[†]	United States	To describe how anti-racism can be applied to elements of implementation science to advance health equity	Racialized individuals	Guiding the implementation process	Guiding identification of determinants Guiding the evaluation and causal explanation Guiding the design and adaptation of strategies	131[§]	Open
Puffer (2022)[78]	Community-embedded implementation model	United States	To provide evidence-based implementation strategies to maximize fit with communities (particularly those with fewer resources)	Mental health populations*	Guiding the design and adaptation of strategies	Guiding the implementation process	14	Restricted
Danesco (2023)[25]	Organizational practices advancing racial equity (OPARE)	Canada	To assess organizational efforts to advance racial equity, diversity and inclusion	Racialized individuals	Guiding the evaluation and causal explanation	N/A	0	Open
Kruse (2023)[47]	Community engagement for implementation science[‡]	United States	To describe the integration of community engagement principles into implementation science	Patients with cancer	Guiding the evaluation and causal explanation	Guiding the implementation process	13	Open
Alonge (2024)[27]	Global Health Equity Implementation Research Guidance [‡]	United States	To provide a systematic approach to guide implementation for achieving equity in global health	No specific population	Guiding the implementation process	Guiding identification of determinants Guiding the evaluation and causal explanation Guiding the design and adaptation of strategies	1	Open
Bradley (2024)[43]	Resistance framework	United States	To make the role of racialization and racial bias more visible in implementation research and practice, and to counteract this through strategies promoting social justice	Racialized individuals*	Guiding the implementation process	Guiding identification of determinants Guiding the evaluation and causal explanation Guiding the design and adaptation of strategies	10	Open
Jack (2024)[38]	Mutual capacity building model for adaptation (MCB-MA)	United States	To provide a clear adaptation process which emphasizes bidirectional learning and collaboration	No specific population	Guiding the design and adaptation of strategies	Guiding the implementation process	1	Open
Garcia (2024)[36]	Community engagement framework	United States	To integrate implementation across the spectrum of community engagement	Latinx population in the United States	Guiding the implementation process	N/A	1	Open

Table 3 (continued)

First author (year)	Title	Country	Aim	Intended population	Primary purpose	Secondary purpose	Number citations (Scopus, July 17–18 2025)	Article access
Stockton (2024)[33]	Framework for collaborative adaptation of service models for child and family health in diverse settings (CASCADES)	Australia	To guide the co-design and adaptation of specialist child and family health service models for diverse settings	Children vulnerable to health disparities	Guiding the implementation process	Guiding identification of determinants Guiding the design and adaptation of strategies	2	Open
Bouckley (2025)[44]	Health system reform implementation framework to promote heath equity‡	Australia	To support implementation of health equity promoting policies and initiatives	No specific population	Guiding the implementation process	Guiding identification of determinants	0	Open
Perez (2025)[22]	Im4Equity	United States	To facilitate the identification of determinants including equity focused determinants in diverse settings	No specific population	Guiding the identification of determinants	N/A	0	Open

Note: CAM = Cultural Adaptation Models. OPARE = Organizational Practices Advancing Racial Equity. MCB-MA = Mutual capacity building model for adaptation. CASCADES = Collaborative Adaptation of Service Models for Child and Family Health in Diverse Settings. I-RREACH = Intervention and Research Readiness Engagement and Assessment of Community Health Care). TyDi = Theory-Design-Implementation. EquIR = Conceptual framework of equity-focused implementation research for health programs

*Authors note it could be applied more broadly

† Not described explicitly as a TMF or tool by author but judged by our team to meet the criteria of a TMF as described by Fontaine et al.[8]

‡ Title created by study team

§ Number provided by Google Scholar as article not indexed on Scop

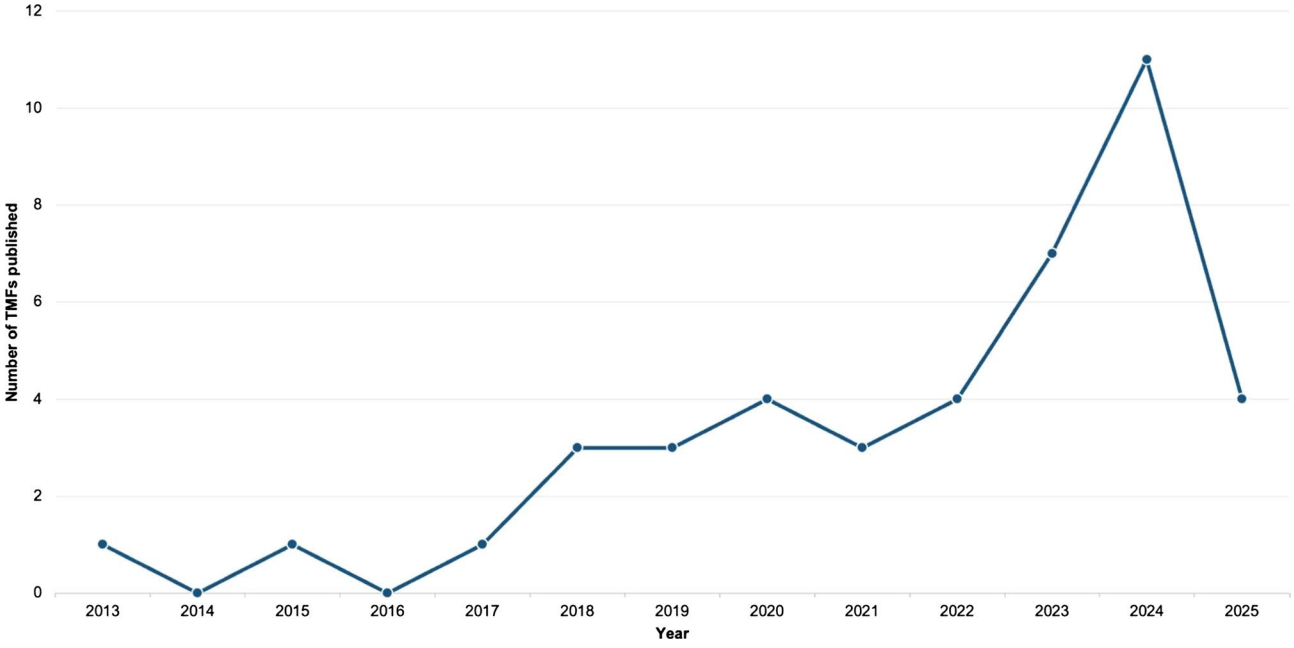


Fig. 2 Equity-focused TMFs by Publication Date

TMFs to date. Nearly all TMFs ($n = 39$, 93%) were published in open access journals.

Just over half (57%) of included TMFs were developed for use with a specific population. For example, six (14%) were developed for use with Indigenous populations such as the Kaupapa Māori-centred He Pikinga Waiora (HPW) Implementation Framework which was developed for use with Māori people [24]. Similarly, three were developed to be used with racialized individuals more broadly such as the Organizational Practices Advancing Racial Equity framework (OPARE) [25]. In contrast, some did not focus specifically on equity deserving groups, but rather people living with specific conditions such as the Stigma Reduction Logic Model which provides guidance for the planning, implementing and evaluation of strategies for addressing Human Immunodeficiency Virus (HIV) related stigma [26]. Others focused generally on those experiencing healthcare disparities or on implementation in low resource environments or identified no specific population ($n = 18$, 43%).

Most ($n = 32$, 76%) of the TMFs could be used throughout the implementation process. Six (14%) specifically focused on the early phases of implementation, one (2%) on the implementation phase itself, and three (7%) on the sustainment phase once an intervention had been implemented. A majority had a primary purpose of guiding the implementation process ($n = 19$, 45%). Other purposes included guiding the identification of determinants ($n = 10$, 23%), guiding evaluation and providing causal explanations ($n = 8$, 19%), guiding the design and adaptation of strategies ($n = 4$, 10%), or anticipating change and guiding inquiry ($n = 1$, 2%). However, nearly all included TMFs had multiple uses. For example, the model described by Alonge was primarily aimed at guiding the implementation process but also included considerations for guiding the identification of determinants, designing and adapting strategies, and guiding evaluation [27]. Similarly the Transcreation framework provided guidance for the entire implementation process as well as guidance for the identification of determinants and implementation outcome evaluation [23].

Importantly, many of the teams developing TMFs did not explicitly report who was involved in the creation and adaption of them. Only eleven (26%) explicitly reported including team members with expertise in health equity or related concepts and only nine (21%) reported engaging with members of the community or those with lived and living experience when developing the TMF (see Fig. 3). Because development teams were rarely described in detail, we could not determine whether, and with what authority, equity experts, community members, or people with lived and living experience participated. This limited reporting prevents assessment of the relational grounding and legitimacy of TMF development and should not be interpreted as evidence that these groups were necessarily excluded. Greater transparency regarding who shaped the TMF, how decisions were shared, and whose knowledge informed development is therefore needed.

Critical appraisal of TMFs along the equity criteria

Of the 42 implementation science TMFs appraised, only seven (17%) explicitly addressed all eight equity criteria:

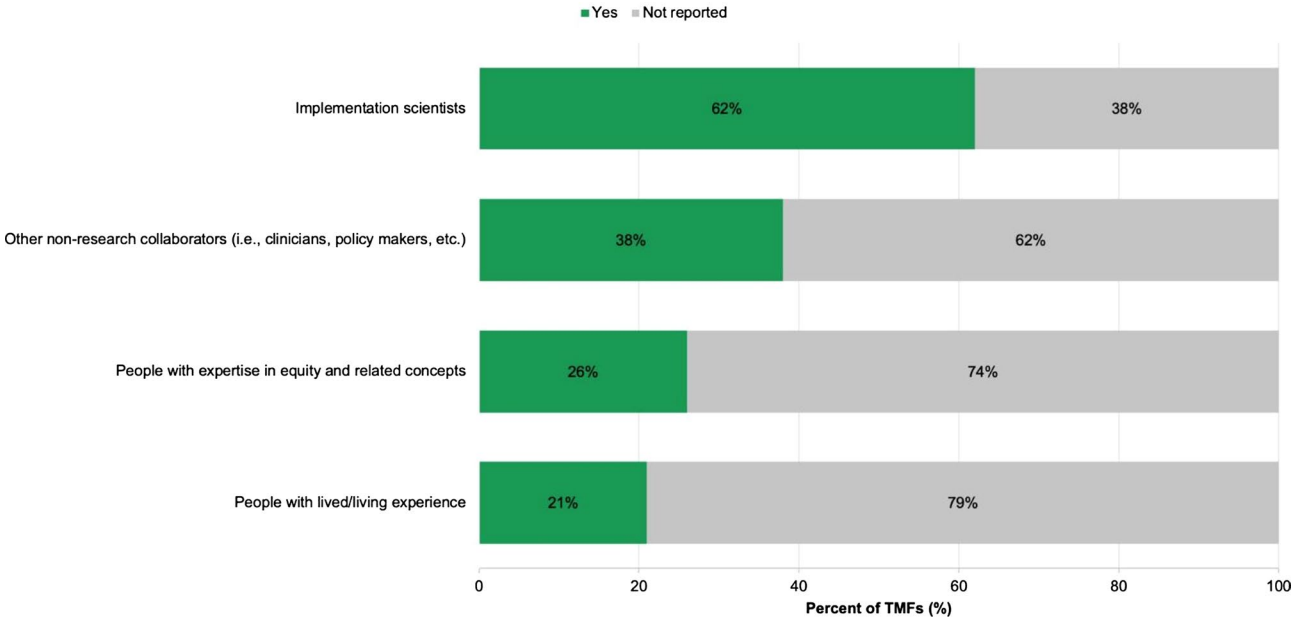


Fig. 3 TMF Development Team Composition

Alonge's Global Health Equity Implementation Research Guidance (2024) [27], Shelton's Anti-Racism Lens (2021) [28], the HPW Implementation Framework (2017) [24], Gustafson's Adapted Conceptual Framework of Equity-Focused Implementation Research for Health Programs (EquiR) (2024) [29], Stanton's Exploration, Preparation, Implementation and Sustainment (EPIS) Power Typology (2022) [26], Jolles' adaptation of PRISM /RE-AIM (2024) [30] and Percival's Indigenous Health-Promotion Implementation Model (2018) [31]. Table 4; Fig. 4 presents the assessment of each TMF along the equity criteria.

Criterion 1: Explicit health equity focus

Explicit recognition of health inequities was near-universal, with 38 TMFs (90%) meeting criterion 1. For example, the HEIF was explicitly developed to assess factors relevant to health disparities and equitable implementation [19, 32]. Similarly, the Collaborative Adaptation of Service Models for Child and Family Health in Diverse Settings (CASCADES) framework was developed to provide guidance for adapting child and family service models to various settings to address inequities [33]. Those that did not meet this criterion but were included in this review included the revised CFIR which was updated by Damschroder et al. in 2022 to include some equity considerations but does explicitly address these throughout [34]. The Design-Focused Implementation Framework also did not meet this criterion because it provided guidance for ensuring implementation in low resource settings but did not explicitly address health inequities arising from the lack of resources [35].

Criterion 2: Implementation strategies for mitigating inequities

Just under half of the TMFs ($n = 17$, 40%) provided specific implementation strategies for addressing inequities which may be attributed to the fact that relatively few of the identified TMFs were conceptualized as strategy frameworks. For example, the Community Engagement Framework aimed to integrate implementation science with community engagement and so did not provide specific implementation strategies [36]. In contrast, Senier et al. in their expanded CFIR framework note specific strategies such as engaging consumers and tailoring to context as well as providing potential partners such as professional societies and patient advocacy groups [37]. Others focused on the adaptation of strategies. For example, the Mutual Capacity-Building Model for Adaptation (MCB-MA) [38] was developed to facilitate bi-directional learning between high- and low-income countries. In contrast, the FRAME for digital health equity provides a template for reporting adaptations during implementation including specific prompts to capture equity considerations [18].

Criterion 3: Cultural responsiveness

Thirty-six (86%) TMFs met the criterion of promoting responsiveness to local values, norms and traditions. For example, the adapted EquiR outlines elements for equitable implementation, many of which acknowledge the importance of including and being responsive to local needs [29]. Similarly, the Transcreation Framework includes multiple steps to ensure that implementation is responsive to community needs [23]. In contrast,

Table 4 Scoring of included TMFs according to equity criteria

Author (year)	Title	Equity Criteria								Total
		Criterion 1: Does the TMF explicitly identify, measure, or respond to equity issues (e.g., justice, disparities in access or uptake)?	Criterion 2: Does it articulate strategies for mitigating those inequalities within implementation processes?	Criterion 3: Is there an emphasis on ensuring that implementation efforts are responsive to local values, norms, and traditions?	Criterion 4: Does the TMF foster trust, mutual respect and cultural safety through two-way learning and relationship-building?	Criterion 5: Does the TMF consider how structural or systemic barriers and contextual constraints beyond individual control shape or constrain implementation processes and outcomes?	Criterion 6: Are there provisions for adapting implementation efforts to address these wider structural and systemic influences?	Criterion 7: Does the TMF include or encourage the integration of non-academic or lay knowledge (e.g., lived experiences, indigenous practices)?	Criterion 8: Does it propose methods for engaging communities and stakeholders as co-creators or co-owners of knowledge and solutions?	
Oetzel 2017[24]	He Pikinga Waiora implementation framework	✓	✓	✓	✓	✓	✓	✓	✓	8
Percival 2018[31]	Indigenous health promotion tool implementation model	✓	✓	✓	✓	✓	✓	✓	✓	8
Shelton 2021[28]	Anti-racism lens for implementation science†	✓	✓	✓	✓	✓	✓	✓	✓	8
Stanton 2022[26]	EPIS power typology‡	✓	✓	✓	✓	✓	✓	✓	✓	8
Alonge 2024[27]	Global Health Equity Implementation Research Guidance †	✓	✓	✓	✓	✓	✓	✓	✓	8
Gustafson 2024[29]	Adaptation of EquiR for Aotearoa New Zealand	✓	✓	✓	✓	✓	✓	✓	✓	8
Jolles 2024[30]	Updated equity PRISM/Re-Aim†	✓	✓	✓	✓	✓	✓	✓	✓	8
Fort 2023[46]	Equity PRISM/Re-Aim†	✓	✗	✓	✓	✓	✓	✓	✓	7
Gustavson 2023[64]	Telehealth EPIS†	✓	✓	✓	✓	✓	✓	✓	✗	7
Bradley 2024[43]	Resistance framework	✓	✓	✓	✓	✓	✓	✓	✗	7
Hikaka 2024[50]	RAPT-Indigenous (RAPT-I)	✓	✗	✓	✓	✓	✓	✓	✓	7
Jack 2024[38]	Mutual capacity building model for adaptation (MCB-MA)	✓	✗	✓	✓	✓	✓	✓	✓	7

Table 4 (continued)

Author (year)	Title	Equity Criteria								Total
		Criterion 1: Does the TMF explicitly identify, measure, or respond to equity issues (e.g., justice, disparities in access or uptake)?	Criterion 2: Does it articulate strategies for mitigating those inequalities within implementation processes?	Criterion 3: Is there an emphasis on ensuring that implementation efforts are responsive to local values, norms, and traditions?	Criterion 4: Does the TMF foster trust, mutual respect and cultural safety through two-way learning and relationship-building?	Criterion 5: Does the TMF consider how structural or systemic barriers and contextual constraints beyond individual control shape or constrain implementation processes and outcomes?	Criterion 6: Are there provisions for adapting implementation efforts to address these wider structural and systemic influences?	Criterion 7: Does the TMF include or encourage the integration of non-academic or lay knowledge (e.g., lived experiences, indigenous practices)?	Criterion 8: Does it propose methods for engaging communities and stakeholders as co-creators or co-owners of knowledge and solutions?	
Bouckley 2025[44]	Health system reform implementation framework to promote heath equity†	✓	✓	✓	✓	✓	✓	✓	✗	7
Maar 2015[40]	Intervention and research readiness engagement and assessment of community health care (I-RREACH)	✓	✗	✓	✓	✓	✗	✓	✓	6
Napoles 2018[23]	Transcreation framework	✓	✓	✓	✓	✗	✗	✓	✓	6
Shelton 2020[16]	Extension of RE-AIM for sustainability	✓	✗	✓	✓	✓	✓	✓	✗	6
Puffer 2022[78]	Community-embedded implementation model	✓	✓	✓	✓	✗	✗	✓	✓	6
Danesco 2023[25]	Organizational practices advancing racial equity (OPARE)	✓	✗	✓	✓	✓	✗	✓	✓	6
Garcia 2024[36]	Community engagement framework	✓	✓	✓	✓	✗	✗	✓	✓	6
Cabasa 2013[76]	Cultural adaptation models (CAMs) with socioecological implementation science lens	✓	✗	✓	✗	✓	✓	✓	✗	5
Senier 2019[37]	Expanded CFIR framework	✓	✓	✗	✗	✓	✓	✓	✗	5

Table 4 (continued)

Author (year)	Title	Equity Criteria								Total
		Criterion 1: Does the TMF explicitly identify, measure, or respond to equity issues (e.g., justice, disparities in access or uptake)?	Criterion 2: Does it articulate strategies for mitigating those inequalities within implementation processes?	Criterion 3: Is there an emphasis on ensuring that implementation efforts are responsive to local values, norms, and traditions?	Criterion 4: Does the TMF foster trust, mutual respect and cultural safety through two-way learning and relationship-building?	Criterion 5: Does the TMF consider how structural or systemic barriers and contextual constraints beyond individual control shape or constrain implementation processes and outcomes?	Criterion 6: Are there provisions for adapting implementation efforts to address these wider structural and systemic influences?	Criterion 7: Does the TMF include or encourage the integration of non-academic or lay knowledge (e.g., lived experiences, indigenous practices)?	Criterion 8: Does it propose methods for engaging communities and stakeholders as co-creators or co-owners of knowledge and solutions?	
Baumann 2020[60]	Equity considerations for Proctor et al. †	✓	✓	✓	✓	✗	✗	✓	✗	5
Woodward 2019[19]/Woodward 2021[32]	Health equity implementation framework (HEIF)	✓	✗	✓	✓	✓	✓	✗	✗	5
Kerkhoff 2022[73]	Equity considerations for early Knowledge to Action†	✓	✗	✓	✓	✓	✗	✓	✗	5
Kruse 2023[47]	Community engagement for implementation science†	✓	✗	✓	✓	✗	✗	✓	✓	5
Stockton 2024[33]	Framework for collaborative adaptation of service models for child and family health in diverse settings (CASCADES)	✓	✗	✓	✓	✗	✗	✓	✓	5
Perez 2025[22]	Im4Equity	✓	✗	✓	✓	✓	✗	✓	✗	5
Etherington 2020[45]	Intersectionality supplemented TDF	✓	✗	✓	✗	✓	✗	✓	✗	4
Rodrigues 2023[17]	Intersectionality supplemented CFIR	✓	✗	✓	✗	✓	✗	✓	✗	4
Huebschmann 2024[68]	Refinement of TSBM†	✓	✗	✓	✓	✗	✗	✓	✗	4

Table 4 (continued)

Author (year)	Title	Equity Criteria								Total
		Criterion 1: Does the TMF explicitly identify, measure, or respond to equity issues (e.g., justice, disparities in access or uptake)?	Criterion 2: Does it articulate strategies for mitigating those inequalities within implementation processes?	Criterion 3: Is there an emphasis on ensuring that implementation efforts are responsive to local values, norms, and traditions?	Criterion 4: Does the TMF foster trust, mutual respect and cultural safety through two-way learning and relationship-building?	Criterion 5: Does the TMF consider how structural or systemic barriers and contextual constraints beyond individual control shape or constrain implementation processes and outcomes?	Criterion 6: Are there provisions for adapting implementation efforts to address these wider structural and systemic influences?	Criterion 7: Does the TMF include or encourage the integration of non-academic or lay knowledge (e.g., lived experiences, indigenous practices)?	Criterion 8: Does it propose methods for engaging communities and stakeholders as co-creators or co-owners of knowledge and solutions?	
Jacobs 2024[41]	Integrated CFIR and culturally responsive evaluation (CRE)	✓	✗	✓	✓	✗	✗	✓	✗	4
Kepper 2025[18]	Framework for reporting adaptations and modifications-enhanced	✓	✓	✓	✗	✗	✗	✓	✗	4
LaManna 2025[69]	Updated TSBM†	✓	✗	✗	✗	✓	✗	✓	✓	4
Ramaswamy 2018[35]	Design focused implementation framework	✗	✗	✓	✗	✗	✗	✓	✓	3
Eslava Schmalbach 2019[65]	Conceptual framework of equity-focused implementation research for health programs (EquIR)	✓	✗	✓	✗	✗	✗	✓	✗	3
Rodriguez-Hart 2022[71]	Stigma reduction logic model	✗	✗	✓	✗	✓	✗	✓	✗	3
Groom 2024[66]	Digital health EquIR (DH-EquiR)	✓	✓	✗	✗	✗	✗	✓	✗	3
Stamatakis 2020[56]	Measurement tool to assess local public health implementation climate and capacity	✓	✗	✗	✗	✗	✗	✓	✗	2
Eboreime 2021[77]	Theory-design-implementation (TyDI) framework	✗	✗	✓	✗	✗	✗	✗	✗	1

Table 4 (continued)

Author (year)	Title	Equity Criteria								Total
		Criterion 1: Does the TMF explicitly identify, measure, or respond to equity issues (e.g., justice, disparities in access or uptake)?	Criterion 2: Does it articulate strategies for mitigating those inequalities within implementation processes?	Criterion 3: Is there an emphasis on ensuring that implementation efforts are responsive to local values, norms, and traditions?	Criterion 4: Does the TMF foster trust, mutual respect and cultural safety through two-way learning and relationship-building?	Criterion 5: Does the TMF consider how structural or systemic barriers and contextual constraints beyond individual control shape or constrain implementation processes and outcomes?	Criterion 6: Are there provisions for adapting implementation efforts to address these wider structural and systemic influences?	Criterion 7: Does the TMF include or encourage the integration of non-academic or lay knowledge (e.g., lived experiences, indigenous practices)?	Criterion 8: Does it propose methods for engaging communities and stakeholders as co-creators or co-owners of knowledge and solutions?	
KlepacPogrmilovic 2021[39]	ProPRISM	✓	✗	✗	✗	✗	✗	✗	✗	1
Damschroder 2022[34]	Updated CFIR	✗	✗	✓	✗	✗	✗	✗	✗	1
Petrovskis 2023[57]	Data for addressing social determinants of health (DASH) model	✓	✗	✗	✗	✗	✗	✗	✗	1
N (%) meeting criterion		38 (90%)	17 (40%)	36 (86%)	27 (64%)	25 (60%)	17 (40%)	37 (88%)	19 (45%)	

† Title created by study team

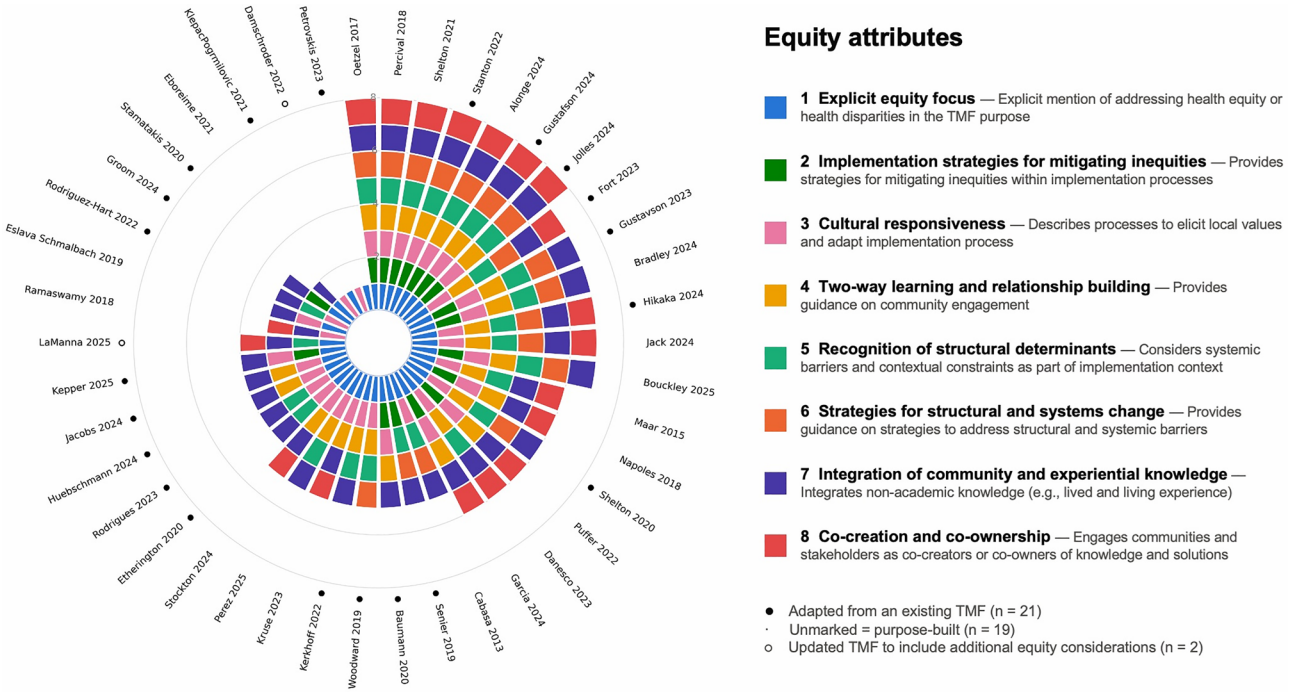


Fig. 4 Equity attributes of included TMFs

ProPrism integrates proportional universalism into the PRISM framework, which addresses equity by increasing the intensity and scale to meet needs rather than adjusting programming to local values, norms and traditions [39]. As such, while it does provide some guidance on integrating equity, it was judged to not have met this criterion.

Criterion 4: Two-way learning and relationship building

Twenty-seven (64%) TMFs recognized the need for two-way learning and relationship building to foster trust, mutual respect and cultural safety within implementation. Many of these TMFs did this by emphasizing community engagement. For example, the Intervention and Research Readiness Engagement and Assessment of Community Healthcare (I-RREACH) tool uses a participatory and culturally safe approach to identify and address factors influencing implementation in Indigenous communities [40]. Similarly, the Integrated CFIR and Culturally Responsive Evaluation (CRE) approach highlights engaging stakeholders to ensure evaluations meet community and health equity goals [41].

Criterion 5: Recognition of structural determinants

Twenty-five (60%) TMFs acknowledged systemic or structural roots of inequities. For example, Jolles et al. in their update of the equity-focused PRISM/RE-AIM include assessing structural inequities when assessing determinants [30]. Bradley et al. also acknowledges systemic inequities in their resistance framework which builds on Black radical tradition including Critical Race Theory [42] to integrate a resistance lens that acknowledges influence of power and social justice in implementation science [43]. In contrast, other included TMFs in the review focused on addressing inequities without consideration of how they came to be and are perpetuated through systems that individuals work and live within and thus did not meet this criterion.

Criterion 6: Strategies for structural and systems change

Of the TMFs that acknowledged systemic roots of inequities, many lacked suggestions on how these could be addressed through implementation processes ($n = 17$, 40%). The framework proposed by Bouckley et al. highlights power systems and provides strategies that address systemic barriers across different system levels (i.e., national, state, community, etc.) and so was judged to meet this criterion [44]. Shelton's anti-racism lens explicitly addresses structural barriers tied to racism and integrates it through every stage of implementation including providing implementation strategies and so also was judged to have met this criterion [28].

Criterion 7: Integration of community and experiential knowledge

Nearly all the included TMFs ($n = 37$, 88%) promote integration of community and lay knowledge. For example, the intersectional supplement for the TDF discusses the importance of involving community members when assessing determinants [45]. Similarly, Fort et al.

discusses including community knowledge and expertise extensively in their equity-focused PRISM/RE-AIM [46].

Criterion 8: Co-creation and co-ownership

Despite many TMFs advocating for including non-academic and lay knowledge throughout implementation efforts as described in criterion seven, only 19 (45%) of TMFs recommended engaging community as co-creators and co-owners. Some positive examples include those described by Maar and Percival who designed equity-focused TMFs specific to Indigenous communities and note the importance of including Indigenous people as co-creators [31, 40]. Similarly, Kruse et al. discuss embedding community co-creation into implementation science in their TMF [47].

Discussion

This scoping review and critical appraisal shows rapid proliferation of equity-focused implementation science TMFs but unevenness in their development and how they consider and address equity. In just five years, the number of equity-focused TMFs has expanded sharply, yet only 7 of 42 explicitly addressed all eight equity criteria. Most TMFs explicitly name equity considerations, and many promote cultural responsiveness, but fewer provide explicit guidance for responding to structural determinants, sharing decision authority, or supporting ongoing community co-ownership. Below, we discuss five themes that, taken together, point to where the field is advancing and where there are gaps and opportunities for continued development.

Equity-focused TMFs are proliferating, but the publications identified were concentrated in a small set of institutional and geographic locations. Two-thirds had a first author affiliated with an institution in the United States; none had a first author affiliated with a country classified as low-income. Fewer than one quarter explicitly reported including people with equity-related expertise or lived and living experience in TMF development. First-author affiliation does not establish where the conceptual work originated, who governed its development, or whose knowledge informed it. Nevertheless, this concentration raises concern that assumptions associated with high-income academic and health systems may be treated as broadly transferable. Future TMF development and reporting should support transparent leadership, authorship, governance, and resourcing by communities experiencing inequities, Indigenous rights holders, and researchers and practitioners in low- and middle-income countries.

Most TMFs do the declarative work of equity but less than half tell implementers what to do differently through concrete strategies to mitigate inequities, processes to address structural barriers, or emphasising co-creation and co-ownership approaches. In other words, equity is visible in the framing stage but diluted in the operational stage [13]. This gap likely reflects that many of these TMFs were designed to extend existing, non-equity TMFs rather than to rebuild them on an equity logic, and that the evidence base on equity-specific implementation strategies (e.g., community benefit agreements, data sovereignty arrangements, compensation and decision rights for community partners, strategies for working under colonial legal regimes) is still surprisingly small [48]. For users, this means these TMFs can help make inequities legible, but they will often need to be paired with strategy taxonomies, community-engagement standards, or Indigenous data governance tools to become actionable.

Third, a majority of TMFs now name structural, systemic, or colonial drivers of inequity (60%), which is a marked shift from pre-2020 implementation science but only 40% translate this recognition into methods that actually help teams work on those structures, for example, by specifying system-level actors and pathways for policy change. The result is what we might call a "structural light" equity focus: TMFs that situate inequities in racism, coloniality, or political economy, but then drop back to individual- or organizational-level levers or strategies (training, tailoring, communication). The TMFs that did best on our appraisal such as the HPW framework, the anti-racism lens, the EPIS power typology, the adapted EquIR by Gustafson et al., and Bouckley's reform framework were precisely those that kept structural analysis visible across all phases, and paired that analysis with concrete practices (shared governance, partnership agreements, staged relational work, explicit attention to power and benefit flows). These should be the exemplars that future TMFs build on.

Finally, limited explicit guidance for community leadership, shared governance, and co-ownership is an important limitation for TMFs claiming to advance equity. Meaningful engagement requires more than consultation: it may include sustained relationships, decision authority, control over resources and data, and shared ownership of knowledge and benefits [24]. Community, experiential, and Indigenous knowledge can challenge dominant epistemologies and strengthen the local legitimacy of implementation; however, co-creation alone should not be treated as evidence of decolonial practice [5, 49]. Its equity implications depend on who defines the problem, controls resources and data, interprets findings, holds decision authority, and benefits from the work [5, 24]. Several TMFs developed in relation to Indigenous communities explicitly emphasized self-determination and data-sovereignty principles and addressed more of the appraisal criteria [40, 50, 51]. These approaches should be engaged within their specific legal, cultural, political, and relational contexts rather than detached and generalized

as transferable components. Where work involves Indigenous Peoples, decisions about whether and how TMFs are used should remain subject to Indigenous leadership and governance.

While there is space for further work to refine TMFs to better address some of the limitations discussed, it is also important to consider the results of our appraisal in the context of the purposes of the TMFs. For example, a framework that aims to guide the identification of barriers and facilitators using a health equity lens would not necessarily be expected to also provide guidance on strategies to address health inequities. It is nonetheless critical for users of these TMFs to critically analyse gaps in how equity is considered, analysed and addressed to ensure that the TMFs chosen meets their needs and those of the population they are working with.

In cases where implementation researchers find that existing TMFs do not meet their needs, they could consider combining multiple TMFs that serve different purposes or address different equity criteria. In some cases, particularly in specific settings, it may also be necessary to adapt or develop new TMFs. If teams chose this approach, it is essential they engage equity experts and relevant communities in the development. In a 2026 review, Kennedy et al. detailed several methods to adapt and apply equity-focused implementation science TMFs which could inform this work when necessary [52]. Authors should also thoughtfully evaluate whether their new or adapted TMFs include the described equity attributes giving due consideration to each and explaining any exclusions.

However, it is also important to ensure that the field of implementation science develops tools and resources to catalogue and critically appraise the TMFs that have already been produced especially considering the rapid proliferation of equity-focused TMFs that has been noted in our review and others [52, 53]. Some available resources include the Dissemination and Implementation Models Webtool an online resource to help navigate available TMFs [54] and the SELECT-IT meta framework by Fontaine et al. which provides guidance in the selection of TMFs [6]. Using these in tandem could enable more robust empirical testing and refinement of existing TMFs and help limit unnecessary duplication of efforts. For an explicit equity lens, the Equity-in-implementation Indicators provides four indicators and methods of measurement to evaluate equity during research and implementation processes [55]. As noted previously, the majority of TMFs included in this review were published within the last five years and many have been cited only a handful of times which indicates low use. This echoes the findings of Gustafson et al. in their 2023 review of equity focused TMFs which described many TMFs but also noted that several of the TMFs they included had yet to be operationalized [7]. The rapid proliferation of equity-focused TMFs, while reflective of growing attention to equity, also risks creating a "cottage industry" of overlapping frameworks that fragment rather than consolidate evidence. Going forward, researchers should use existing TMF selection tools, alongside this and other scoping reviews, to determine whether their goals can be met by adapting or combining existing TMFs or whether a truly novel or substantially revised TMF is warranted. Evaluating and reporting on how existing TMFs perform during real-world implementation, and how they address health inequities in practice, is crucial for advancing equity-focused implementation science.

Limitations

While this review attempted to give a full overview of the literature, the use of only two databases and five journals may have led to some relevant articles being excluded. Restricting articles to only those published in French and English and those that were general or healthcare specific may have similarly led to some relevant articles not being included. Additionally, while the equity attributes were decided through consultation with diverse team members and a review of the literature, these may not be relevant to all TMFs or all communities. Furthermore, we recognize that the diversity of team members (see positionality statement) is no substitute for community authority, Indigenous governance, or lived experience. As such, it remains important to engage in critical discussions with community members and research teams when determining which TMF to use including considering the TMF's purpose and attributes and its ability to capture equity concerns.

Our eligibility and search decisions also carry epistemic implications. By requiring TMFs to be formally described, intended for use beyond a single study or setting, published in English or French, and available in peer- or editor-reviewed sources, we privileged knowledge that is written, academically disseminated, and designed for transferability. This may have excluded community-owned, oral, locally governed, non-English, grey-literature, or place-specific approaches, including approaches that intentionally resist abstraction or generalization beyond the relationships and contexts in which they were developed. The geographic concentration observed may therefore reflect both where TMFs are developed and which forms of knowledge are visible in the publication systems and databases searched. Our findings should not be interpreted as a comprehensive map of all community, Indigenous, or decolonial approaches relevant to implementation.

Conclusion

This review identified 42 TMFs intended to inform equity-focused implementation science. Many published descriptions did not explicitly address structural barriers, community leadership and co-ownership, or strategies aimed at the structural roots of inequities. These findings should be interpreted in relation to each TMF's purpose and should not be treated as a ranking of overall quality or equity. Researchers and practitioners should determine with relevant communities, Indigenous rights holders, and contextual experts whether an existing TMF should be used, adapted, combined with complementary approaches, or set aside. Where adaptation or development is undertaken, participation should extend beyond consultation to clearly specified authority over priorities, decisions, data, resources, interpretation, and benefits, as appropriate to context.

Abbreviations

TMF	Theories models and frameworks
JBI	Joanna Briggs Institute
CFIR	Consolidated Framework for Implementation Research
PRISM	Practical Robust Implementation and Sustainability Model
RE-AIM	Re-Aim = Reach, Effectiveness, Adoption, Implementation, Maintenance
FRAME	Framework for Reporting Adaptation and Modifications
HEIF	Health Equity Implementation Framework
I-PAHRIS	Integrated-Promoting Action on Research Implementation in Health Services framework
HPW	He Pikinga Waiora implementation framework
OPARE	Organizational Practices Advancing Racial Equity
HIV	Human Immunodeficiency Virus
EquiR	Conceptual framework of equity-focused implementation research for health programs
EPIS	Exploration, Preparation, Implementation, Sustainment
CASCADES	Collaborative Adaptation of Service Models for Child and Family Health in Diverse Settings
MCB-MA	Mutual capacity building model for adaptation
ProPRISM	Proportional Practical Robust Implementation and Sustainability Model
I-RREACH	Intervention and Research Readiness Engagement and Assessment of Community Health Care
CRE	Culturally responsive evaluation
TDF	Theoretical Domains Framework
DH-EquiR	Digital Health Conceptual framework of equity-focused implementation research for health programs
TSBM	Translational Science Benefits Model
RAPT	Readiness Assessment for Pragmatic Trials
RAPT-I	Readiness Assessment for Pragmatic Trials Indigenous
CAM	Cultural Adaptation Models
TyDi	Theory-Design-Implementation

Supplementary Information

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Supplementary Material 1

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Author contributions

LC, GF, SS, MNA and VW conceptualized the study and developed the methods. LC, SD, RS, GF, MNA, CW and SS screened articles. LC, SD, CW and RS performed data extraction. LC drafted the original manuscript. SD, RS, MNA, CW, SS, VW, AFC, AK, CE, RCS, JP and GF reviewed, edited, and approved the final manuscript for submission. GF supervised the study.

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Data availability

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
Not applicable.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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References

1. Baumann AA, Shelton RC, Kumanyika S, Haire-Joshu D. Advancing healthcare equity through dissemination and implementation science. Health Serv Res. 2023;58:327–44.
2. Redefining implementation science for global health decolonisation. Lancet Glob Health. 2025;13(4):e599.
3. Brownson RC, Kumanyika SK, Kreuter MW, Haire-Joshu D. Implementation science should give higher priority to health equity. Implement Sci. 2021;16(1):28.
4. McNulty M, Smith J, Villamar J, Burnett-Zeigler I, Vermeer W, Benbow N, et al. Implementation research methodologies for achieving scientific equity and health equity. Ethn Dis. 2019;29(Suppl 1):83.

5. Adsul P, Shelton RC, Oh A, Moise N, Iwelunmor J, Griffith DM. Challenges and opportunities for paving the road to global health equity through implementation science. Annu Rev Public Health. 2024;45.
6. Fontaine G, Mooney M, Porat-Dahlerbruch J, Cahir K, Ellen M, Spinewine A, et al. Advancing the selection of implementation science theories, models, and frameworks: a scoping review and the development of the SELECT-IT meta-framework. Implement Sci. 2025;20(1):24.
7. Gustafson P, Abdul Aziz Y, Lambert M, Bartholomew K, Rankin N, Fusheini A, et al. A scoping review of equity-focused implementation theories, models and frameworks in healthcare and their application in addressing ethnicity-related health inequities. Implement Sci. 2023;18(1):51.
8. Mckenzie E, Barnett P, Parker G, Pilling S. Adaptations to implementation frameworks for minority ethnic groups to improve health equity: systematic scoping review. BJPsych Open. 2025;11(5):e173.
9. Peters MD, Marnie C, Tricco AC, Pollock D, Munn Z, Alexander L, et al. Updated methodological guidance for the conduct of scoping reviews. JBI Evid Synth. 2020;18(10):2119–26.
10. Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. Ann Intern Med. 2018;169(7):467–73.
11. Nilsen P. Making sense of implementation theories, models, and frameworks. Implement Sci: Springer; 2020. pp. 53–79.
12. World Health Organization. Health Equity. 2025. https://www.who.int/health-topics/health-equity#tab=tab_1. Accessed September 11 2025.
13. Chinman M, Woodward EN, Curran GM, Hausmann LR. Harnessing implementation science to increase the impact of health equity research. Med Care. 2017;55:S16–23.
14. Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. Implement Sci. 2009;4(1):50.
15. Feldstein AC, Glasgow RE. A practical, robust implementation and sustainability model (PRISM) for integrating research findings into practice. Jt Comm J Qual Patient Saf. 2008;34(4):228–43.
16. Shelton RC, Chambers DA, Glasgow RE. An extension of RE-AIM to enhance sustainability: Addressing dynamic context and promoting health equity over time. Front Public Health. 2020;8(101616579):134.
17. Rodrigues IB, Fahim C, Garad Y, Presseau J, Hoens AM, Braimoh J, et al. Developing the intersectionality supplemented Consolidated Framework for Implementation Research (CFIR) and tools for intersectionality considerations. BMC Med Res Methodol. 2023;23(1):262.
18. Kepper MM, Walsh-Bailey C, Parrish L, Mackenzie A, Klesges LM, Allen P, et al. Adaptation of a digital health intervention for rural adults: application of the Framework for Reporting Adaptations and Modifications-Enhanced. Front Digit Health. 2025;7(101771889):1493814.
19. Woodward EN, Matthieu MM, Uchendu US, Rogal S, Kirchner JE. The health equity implementation framework: proposal and preliminary study of hepatitis C virus treatment. Implement Sci. 2019;14(1):26.
20. Harvey G, Kitson A. PARIHS revisited: from heuristic to integrated framework for the successful implementation of knowledge into practice. Implement Sci. 2015;11(1):33.
21. Kilbourne AM, Switzer G, Hyman K, Crowley-Matoka M, Fine MJ. Advancing health disparities research within the health care system: a conceptual framework. Am J Public Health. 2006;96(12):2113–21.
22. Perez LG, Merle JL, Smith JD, Dopp AR, Huebschmann AG. IM4Equity: an implementation science meta-framework for community-engaged partnerships to advance health equity. BMC Health Serv Res. 2025;25(1):437.
23. Napoles AM, Stewart AL. Transcreation: an implementation science framework for community-engaged behavioral interventions to reduce health disparities. BMC Health Serv Res. 2018;18(1):710.
24. Oetzel J, Scott N, Hudson M, Masters-Awatere B, Rarere M, Foote J, et al. Implementation framework for chronic disease intervention effectiveness in Maori and other indigenous communities. Global Health. 2017;13(1):69.
25. Danseco E, Lucente G, Kurzawa J. Organizational practices advancing racial equity (OPARE): Development of a tool using an implementation science approach. Can J Commun Ment Health. 2023;42(1):97–118.
26. Stanton MC, Ali SB, The Sustain Center T. A typology of power in implementation: Building on the exploration, preparation, implementation, sustainment (EPIS) framework to advance mental health and HIV health equity. Implement Res Pract. 2022;3.
27. Alonge O. How to leverage implementation research for equity in global health. Glob Health Res Policy. 2024;9(1):43.
28. Shelton RC, Adsul P, Oh A, Moise N, Griffith DM. Application of an antiracism lens in the field of implementation science (IS): Recommendations for reframing implementation research with a focus on justice and racial equity. Implement Res Pract. 2021;2(101774031):26334895211049482.
29. Gustafson P, Lambert M, Bartholomew K, Ratima M, Aziz YA, Kremer L, et al. Adapting an equity-focused implementation process framework with a focus on ethnic health inequities in the Aotearoa New Zealand context. Int J Equity Health. 2024;23(1):15.
30. Jolles MP, Fort MP, Glasgow RE. Aligning the planning, development, and implementation of complex interventions to local contexts with an equity focus: application of the PRISM/RE-AIM Framework. Int J Equity Health. 2024;23(1):41.
31. Percival NA, McCalman J, Armit C, O'Donoghue L, Bainbridge R, Rowley K, et al. Implementing health promotion tools in Australian Indigenous primary health care. Health Promot Int. 2018;33(1):92–106.
32. Woodward EN, Singh RS, Ndebele-Ngwenya P, Melgar Castillo A, Dickson KS, Kirchner JE. A more practical guide to incorporating health equity domains in implementation determinant frameworks. Implement Sci Commun. 2021;2(1):61.
33. Stockton DA, Fowler C, Debono D, Travaglia J. Development of a framework for the collaborative adaptation of service models for child and family health in diverse settings (CASCADES). J Child Health Care. 2024;28(2):329–47.
34. Damschroder LJ, Reardon CM, Widerquist MAO, Lowery J. The updated Consolidated Framework for Implementation Research based on user feedback. Implement Sci. 2022;17(1):75.
35. Ramaswamy R, Shidhaye R, Nanda S. Making complex interventions work in low resource settings: developing and applying a design focused implementation approach to deliver mental health through primary care in India. Int J Ment Health Syst. 2018;22.
36. García JIR, Oro V, Budd EL, Mauricio AM, Cioffi CC, Anda SD, et al. A translational case study of a multisite COVID-19 public health intervention across sequenced research trials: Embedding implementation in a community engagement phased framework. Am J Public Health. 2024;114:S396–401.
37. Senier L, McBride CM, Ramsey AT, Bonham VL, Chambers DA. Blending insights from implementation science and the social sciences to mitigate inequities in screening for hereditary cancer syndromes. Int J Environ Res Public Health. 2019;16(20).
38. Jack HE, Giusto A, Rose AL, Mwamuka R, Brown I, Bere T, et al. Mutual capacity building model for adaptation (MCB-MA): A seven-step procedure bidirectional learning and support during intervention adaptation. Glob Health Res Policy. 2024;9(1):25.
39. Klepac Pogrmilovic B, Linke S, Craike M. Blending an implementation science framework with principles of proportionate universalism to support physical activity promotion in primary healthcare while addressing health inequities. Health Res Policy Syst. 2021;19(1):6.
40. Maar M, Yeates K, Barron M, Hua D, Liu P, Moy Lum-Kwong M, et al. I-RREACH: an engagement and assessment tool for improving implementation readiness of researchers, organizations and communities in complex interventions. Implement Sci. 2015;10:64.
41. Jacobs SR, Glasgow L, Amico P, Farris KD, Rutledge G, Smith BD. Integrating the Consolidated Framework for Implementation Research (CFIR) into a culturally responsive evaluation (CRE) approach to conduct mixed-method evaluations of diabetes prevention and management programs reaching underresourced populations and communities. Prev Sci. 2024;25(Suppl 1):46–55.
42. Crenshaw K, Gotanda N, Peller G, Thomas K. Critical race theory: The key writings that formed the movement. New; 1995.
43. Bradley CD, Irie WC, Geng EH. Situating implementation science (IS) in res(IS)tance: a conceptual frame toward the integration of scholarship from the black radical tradition. Front Public Health. 2024;11(101616579):1286156.
44. Bouckley T, Peiris D, Nambiar D, Mishra S, Sood T, Purwar P, et al. Addressing health equity during design and implementation of health system reform initiatives: a scoping review and framework. Int J Equity Health. 2025;24(1):1–16.
45. Etherington C, Rodrigues IB, Giangregorio L, Graham ID, Hoens AM, Kasperavicius D, et al. Applying an intersectionality lens to the theoretical domains framework: a tool for thinking about how intersecting social identities and structures of power influence behaviour. BMC Med Res Methodol. 2020;20(1):169.
46. Fort MP, Manson SM, Glasgow RE. Applying an equity lens to assess context and implementation in public health and health services research and practice using the PRISM framework. Front Health Serv. 2023;3(991833488770667 6):1139788.

47. Kruse GR, Lee RM, Aschbrenner KA, Daly JG, Dargon-Hart S, Davies ME, et al. Embedding community-engaged research principles in implementation science: The implementation science center for cancer control equity. J Clin Transl Sci. 2023;7(1):e82.
48. Lovero KL, Kemp CG, Wagenaar BH, Giusto A, Greene MC, Powell BJ, Proctor EK. Application of the Expert Recommendations for Implementing Change (ERIC) compilation of strategies to health intervention implementation in low-and middle-income countries: a systematic review. Implement Sci. 2023;18(1):56.
49. Snell-Rood C, Jaramillo ET, Hamilton AB, Raskin SE, Nicosia FM, Willging C. Advancing health equity through a theoretically critical implementation science. Transl Behav Med. 2021;11(8):1617–25.
50. Hikaka J, McCreedy EM, Jutkowitz E, McCarthy EP, Baier RR. Modifications of the readiness assessment for pragmatic trials tool for appropriate use with Indigenous populations. BMC Med Res Methodol. 2024;24(1):121.
51. Canadian Insitutes of Health Research. Executive Summary: CIHR-III First Nations, Inuit and Métis Engagement Strategy (2024–2025). 2025. https://www.cihr.ca/e/54471.html. Accessed October 20 2025.
52. Kennedy LJ, MacIntyre G, Boulos L, Collins SE, Delahunty-Pike A, Gray M et al. Methods to design, adapt and apply equity-focused implementation science theories, models and frameworks in healthcare systems: a scoping review. Implement Sci Commun. 2026.
53. Wang Y, Wong EL-Y, Nilsen P, Chung VC-h, Tian Y, Yeoh E-K. A scoping review of implementation science theories, models, and frameworks—an appraisal of purpose, characteristics, usability, applicability, and testability. Implement Sci. 2023;18(1):43.
54. University of Colarado Denver. Dissemination and Implementation Models in Health. 2025. https://dissemination-implementation.org/. Accessed Novemb er 14 2025.
55. Kamarajah SK, Agbeko AE, Ghosh D, Hirschorn LR, Lawani I, Shelton R, Bhangu A. Operationalising and measuring equity in implementation science for global health. Lancet Global Health. 2026;14(2):e186–7.
56. Stamatakis KA, Baker EA, McVay A, Keedy H. Development of a measurement tool to assess local public health implementation climate and capacity for equity-oriented practice: Application to obesity prevention in a local public health system. PLoS ONE. 2020;15(9):e0237380.
57. Petrovskis A, Bekemeier B, Heitkemper E, van Draanen J. The DASH model: Data for addressing social determinants of health in local health departments. Nurs Inq. 2023;30(1):e12518.
58. Cane J, O'Connor D, Michie S. Validation of the theoretical domains framework for use in behaviour change and implementation research. Implement Sci. 2012;7(1):37.
59. Proctor E, Silmere H, Raghavan R, Hovmand P, Aarons G, Bunger A, et al. Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda. Adm Policy Ment Health. 2011;38(2):65–76.
60. Baumann AA, Cabassa LJ. Reframing implementation science to address inequities in healthcare delivery. BMC Health Serv Res. 2020;20(1):190.
61. Glasgow RE, Vogt TM, Boles SM. Evaluating the public health impact of health promotion interventions: the RE-AIM framework. Am J Public Health. 1999;89(9):1322–7.
62. Adler NE, Stewart J. Health disparities across the lifespan: meaning, methods, and mechanisms. Ann N Y Acad Sci. 2010;1186(1):5–23.
63. Aarons GA, Hurlburt M, Horwitz SM. Advancing a conceptual model of evidence-based practice implementation in public service sectors. Adm Policy Ment Health. 2011;38(1):4–23.
64. Gustavson AM, Lewinski AA, Fitzsimmons-Craft EE, Coronado GD, Linke SE, O'Malley DM, et al. Strategies to bridge equitable implementation of telehealth. Interact J Med Res. 2023;12(101598421):e40358.
65. Eslava-Schmalbach J, Garzón-Orjuela N, Elias V, Reveiz L, Tran N, Langlois EV. Conceptual framework of equity-focused implementation research for health programs (EquIR). Int J Equity Health. 2019;18(1):NPAG–NPAG.
66. Groom LL, Schoenthaler AM, Mann DM, Brody AA. Construction of the digital health equity-focused implementation research conceptual model - Bridging the divide between equity-focused digital health and implementation research. PLOS Digit Health. 2024;3(5):1–21.
67. Luke DA, Sarli CC, Suiter AM, Carothers BJ, Combs TB, Allen JL, et al. The translational science benefits model: a new framework for assessing the health and societal benefits of clinical and translational sciences. Clin Transl Sci. 2018;11(1):77–84.
68. Huebschmann AG, Brega AG, Stotz SA, Shane AL, King R, Jernigan VBB, et al. Gaps and opportunities for measuring equity with the translational science benefits model: Recommendations from the Center for American Indian and Alaska Native Diabetes translation research. J Clin Transl Sci. 2024;8(1):e206.
69. La Manna A, Heidbreder J, Casey S, Phelps K, LaBrier M, Brossart L, et al. Who benefits? Health equity and the Translational Science Benefits Model. Front Public Health. 2025;13(101616579):1565248.
70. Smith JD, Li DH, Rafferty MR. The implementation research logic model: a method for planning, executing, reporting, and synthesizing implementation projects. Implement Sci. 2020;15(1):84.
71. Rodriguez-Hart C, Mackson G, Belanger D, West N, Brock V, Phanor J, et al. Reducing intersecting stigmas in HIV service organizations: An implementation science model. J Acquir Immune Defic Syndr. 2022;90(S1):S215–25.
72. Graham ID, Logan J, Harrison MB, Straus SE, Tetroe J, Caswell W, Robinson N. Lost in knowledge translation: Time for a map? J Contin Educ Health Prof. 2006;26(1):13–24.
73. Kerkhoff AD, Farrand E, Marquez C, Cattamanchi A, Handley MA. Addressing health disparities through implementation science-a need to integrate an equity lens from the outset. Implement Sci. 2022;17(1):13.
74. Stirman SW, Miller CJ, Toder K, Calloway A. Development of a framework and coding system for modifications and adaptations of evidence-based interventions. Implement Sci. 2013;8(1):65.
75. Baier RR, Jutkowitz E, Mitchell SL, McCreedy E, Mor V. Readiness assessment for pragmatic trials (RAPT): a model to assess the readiness of an intervention for testing in a pragmatic trial. BMC Med Res Methodol. 2019;19(1):156.
76. Cabassa LJ, Baumann AA. A two-way street: bridging implementation science and cultural adaptations of mental health treatments. Implement Sci. 2013;8(101258411):90.
77. Eboreime EA, Olawepo JO, Banke-Thomas A, Abejirinde I-OO, Abimbola S. Appraising and addressing design and implementation failure in global health: A pragmatic framework. Glob Public Health. 2021;16(7):1122–30.
78. Puffer ES, Ayuku D. A community-embedded implementation model for mental-health interventions: Reaching the hardest to reach. Perspect Psychol Sci. 2022;17(5):1276–90.

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