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Implementing in context: Applying equity-oriented design principles in implementation research with rural and remote cancer services

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Abstract

Inequities in cancer outcomes for rural populations highlight the need for equity-oriented implementation research. Implementation science strategies that support adoption of evidence-based practices are not always applied with an understanding of diverse service contexts. This study reflects on design approaches that enable equity-oriented implementation research in rural cancer care settings, using implementation of Australian Optimal Care Pathways as an example. This was a mixed-methods discovery phase study of a broader program to improve implementation of Optimal Care Pathways in rural and remote Australian health services. An online survey and semi-structured interviews with health care professionals in three Australian states were conducted. The Theoretical Domains Framework was used as a guiding scaffold to explore determinants of implementation. The research team reflexively examined study processes to surface practical methodological considerations focused on flexibility, partnership, and rigour that could apply to broader equity-oriented implementation research. We conducted 74 interviews with health professionals providing cancer care. The number of interviews and sampling frame was expanded in response to emerging insights to reflect diversity of services in different states. Established governance structures and partnership-based recruitment enabled high engagement and collection of in-depth data. Flexible application of the Theoretical Domains Framework facilitated meaningful enquiry across different contexts. This enabled us to surface context-specific determinants that will be used to co-design implementation strategies for rural health services. Equity-oriented implementation research in rural health care settings requires design choices that accommodate contextual complexity, including latency to enable trust-building and flexibility in study design.

Background

Cancer remains a global challenge, with over 30 million new cases predicted by 2045 (International Agency for Research on Cancer, 2026). Internationally, achieving equitable cancer care is recognised as a priority, yet favourable outcomes remain disproportionate for some groups (Rodi et al., 2025). People living in rural and remote areas experience lower cancer survival, with survival decreasing as remoteness increases (Marshall et al., 2025). These inequities cannot be attributable solely to individual risk factors, but reflect longstanding structural disadvantage, including reduced access to services, workforce shortages, and fragmented care pathways (Ugalde et al., 2025). Clinical practice frameworks outlining standards for cancer care are well established, with strong evidence that implementation of structured, evidence-based care pathways significantly improves patient outcomes (Jensen et al., 2017; Møller et al., 2015; Nejati et al., 2019; Nilssen et al., 2019). In Australia, the Optimal Care Pathways (OCPs) offer nationally endorsed, cancer-specific guidance of best-practice care across the continuum of diagnosis, treatment, and follow-up (Bergin, Whitfield, et al., 2020). The OCPs cover most cancer types and several population groups.

Despite standing to benefit significantly from such guidance, uptake of the OCPs has been inconsistent in rural and remote health services (Bergin, Thomas, et al., 2020) resulting in delays in diagnosis,

treatment and lower utilisation of diagnostic and treatment services among rural patients (Baade et al., 2011; Bergin et al., 2018; Burmeister et al., 2016). The disparities in implementation in rural context highlight the limits of current, often uniform, implementation approaches to improving cancer care across a geographically dispersed population. Ensuring effective implementation of the OCPs across rural and remote cancer services requires understanding of how implementation occurs across diverse and resource-constrained rural health systems (Chaji et al., 2024).

Implementation science has made substantial progress with understanding how to support uptake of evidence-based practices in health care settings more generally (Chambers & Emmons, 2024). In cancer control, the application of implementation science methods has provided shared language to describe barriers and enablers to inform the design of implementation strategies for increasing uptake of screening and prevention interventions (Chambers et al., 2018). This application however has largely focused on describing discrete behaviours (for example, increasing rates of HPV vaccination (Waters et al., 2024)) among health care professionals with well-defined roles. Less is known about the usefulness of such frameworks to support implementation of broader care pathways, and how to adequately design implementation studies that reflect the realities of rural and remote health care, where services are characterised by smaller teams, overlapping roles and rapidly changing contexts (Chapman et al., 2025).

It is now well recognised that equity-oriented implementation studies should move beyond “one size fits all” approaches and respond to the needs of diverse service contexts, including rural communities **([BLINDED – Program Reference])**. However, while flexible and context-responsive design processes may be applied in practice, they are seldom explicitly described or justified in the literature. This can limit our understanding of how implementation research can be adapted to different contexts and constrains the ability to assess relevance and transferability. More transparent reporting of design decisions is therefore needed to support methodological rigour and advance equity-oriented implementation science.

Purpose

This paper therefore seeks to address this by describing the design principles and approaches applied to explore determinants of implementation of the OCPs in rural and remote health care settings in Australia. This study was undertaken as part of the **[BLINDED – Program name]** program, a broader collaborative which aims to understand and address inequities in cancer outcomes for people living in rural and remote areas **([BLINDED – Program Reference])**. Our manuscript focuses on describing the process of undertaking equity-oriented implementation studies, with findings regarding implementation determinants reported elsewhere.

Methods

This study formed the initial discovery phase within the **[BLINDED – Program name]** program and sought to explore implementation determinants to inform the co-design of a context-specific OCP implementation support for rural cancer care settings. This manuscript outlines the application of several design principles (summarised in Table 1) surfaced collectively by the operational team

(**[BLINDED – Operational Team Initials]**) during conduct of the research and iterated by the broader study team.

Table 1
Design principles according to study process and their application to support equity-oriented implementation research

Study process	Design principles	Application for equity-oriented implementation studies in rural and remote health care settings
Program governance	Time as essential to trust-building and partnerships	-Plan for latency as a methodological requirement. The term latency describes the time required for trust-building, shared understanding, and relationship formation that underpins meaningful engagement in equity-oriented implementation research -Explicitly resource partnership development and building governance structures -Avoid assuming health service partners' readiness for research participation -Allow time to understand and listen to communities, including formal training (e.g. local cultural awareness) -Build in formal milestones that reflect time to build partnerships
Study design	Flexibility in study design and recognition of heterogeneous service boundaries	-Choose study designs that enable built-in flexibility to answer research questions -Avoid imposing uniform timelines, structure or quota sampling -Treat variation in service boundaries as expected input
Theoretical approach	Frameworks used as guidance not boundaries	-Use determinant frameworks as scaffolds not boundaries -Avoid overly narrow specification of target behaviours and roles
Sampling	Broad inclusion of 'implementation agents' and scope of practice	-Sampling strategies should reflect how care is delivered and coordinated rather than formally defined clinical roles -Consider the inclusion of indirect implementation agents to understand the full care pathway -Ensure flexibility within sampling frames to allow adaptation as context-specific understanding of 'implementation agents' increases
Recruitment processes	Application of different recruitment strategies and processes	-Adapt recruitment strategies to workforce pressures -Recognize the need for relationship-based recruitment strategies

Study process	Design principles	Application for equity-oriented implementation studies in rural and remote health care settings
		-Anticipate uneven and diverse participation across services as a structural feature
Data collection	Iterative and adaptive enquiry	-Provide training and build in opportunities for ongoing reflection and adaptation during data collection
Data analyses	Balance of rigour and adaptability	-Allow time for additional layers of coding where insufficient granularity is observed -Use analytic reflexivity (i.e. critical reflection) to revisit and refine coding structures
Consumer involvement	Consumer perspectives embedded throughout study processes	-Recognise that consumer input provides information on other dimensions of care that may not be captured via health professional data collection -Allow consumer input to inform design decisions including sampling, interview guides and analytic focus
Interpretation of results	Equity-oriented and strength-based stance	-Allow time for sense checking with consumers, partners and health care professionals -Explicitly reflect on how determinants are situated with the system, organisational and structural context -Use strengths-based framing to identify areas for leveraging

Application of design principles to this study and benefits

Program governance

This study was embedded within the broader **[BLINDED – Program name]** program, bringing together researchers, clinicians, health services, and consumers to generate evidence for equitable implementation of best-practice cancer care in rural and remote settings. **[BLINDED – Program name]** is also supported by a National Consumer Program, co-led by individuals with lived experience of cancer in rural and remote Australia, enabling participation in governance, agenda-setting, and co-investigation. Embedding the study within **[BLINDED – Program name]** facilitated alignment with service priorities and sustained engagement through established governance structures prior to, and alongside, data collection.

Benefits

This research leveraged established relationships and structures which were built over years to support achievement of recruitment targets within a relatively short six-month data collection period. This

demonstrates how upfront investment in partnerships and recognising latency as a methodological requirement, rather than a research inefficiency, is critical to enhance feasibility and quality of future studies.

Study design

A mixed-methods design was employed to understand determinants influencing implementation of the diagnosis and treatment components of OCPs across rural and remote health services. This included a 10-minute online quantitative survey followed by a 45–60-minute semi-structured qualitative interview with health care professionals providing cancer care in rural and remote areas across Victoria, South Australia and Queensland.

Benefits

The mixed-methods design enabled flexibility in sequencing and timing of data collection enabling greater flexibility. Learning across this period enabled variation across jurisdictions, service types, and professional roles, to better explore context-specific implementation challenges.

Theoretical approach

We used the Theoretical Domains Framework (TDF), an integrative framework encompassing 14 domains and 84 constructs, to capture factors associated with implementation of evidence-based practices in a range of health care settings (Cahill et al., 2021; Cane et al., 2012). The TDF was selected for its comprehensiveness and its capacity to theorise behavioural determinants influencing implementation across complex health system environments. The quantitative survey captured participants' demographics and professional characteristics and four TDF constructs: knowledge, skills, beliefs about consequences, and beliefs about capabilities, as these domains were considered most amenable to quantitative assessment and suitable for structured survey measurement. The interview guide was designed to broadly capture each of the remaining TDF constructs. Interview prompts were used flexibly, and target actions were deliberately kept broad to reflect the diversity of implementation agents involved in delivering the OCPs.

Benefits

The TDF was used primarily as a guiding structure and provided a common shared language for describing implementation determinants across diverse professional roles involved in cancer care. During the interviews, we found it most useful to treat domains as prompts for enquiry rather than fixed analytic containers. This flexible approach allowed participants to articulate determinants that cut across roles, settings, and system levels within rural and remote health services.

Sampling and recruitment processes

We used a purposive sampling strategy to recruit health care professionals and stakeholders directly or indirectly involved in cancer diagnosis and treatment for people living in rural and remote areas (defined as a Modified Monash [MM] category 3–7) (Department of Health, 2025). Our sampling approach sought to capture diversity across professional roles, disciplines, and service types including medical specialists, general practitioners, nurses, care coordinators, allied health professionals, social workers, health service managers, and professionals involved in governance, technology, systems, or advocacy relevant to cancer care delivery. This was facilitated through established **[BLINDED – Program name]** partner health services, supplemented by investigator networks and peer nomination. We kept the recruitment processes intentionally flexible, including extended recruitment windows and accommodation of participants' preferred modes of communication and engagement (including multiple face-to-face visits by the **[BLINDED – Program name]** program leads (**[BLINDED – Program Leads' Initials]**) and relevant trusted contacts). Throughout this engagement process, detailed information emerged surrounding how cancer care was organised and delivered across rural and remote service structures. Specifically, diagnostic, treatment and care coordination was often located in regional centres (MM 2), and individuals often had multiple roles or contributed indirectly to diagnosis and treatment pathways. An expansion to the sampling frame (MM 2–7, inclusive of regional sites) was therefore undertaken to ensure that care pathways were appropriately captured.

Benefits

The extended timeframes, multiple contact modes, and reliance on trusted relationships yielded 74 interviews with rural and remote health care professionals. Critically, the decision to expand the sampling frame mid-study (informed by emerging insights about how care was organized), resulted in 17% of participants being recruited from regional hub services (MM 2) that would have been excluded under the original protocol. While the number of interviews (N = 74) could be considered resource-intensive and larger than typical qualitative implementation studies, this was considered necessary to capture the complexity of distributed rural care systems and the diversity of professional roles across the three states. The extended engagement also appeared to enhance data depth and contextual insight (with average interview times spanning 45 minutes). For studies with more constrained resources, careful scoping is required and may involve prioritising key stakeholder groups, focusing on fewer sites, or adopting more targeted sampling strategies. However, such trade-offs should also be made explicitly and informed by engagement with key stakeholders within the rural health care systems.

Data collection

Four authors (**[BLINDED – Four Authors' Initials]**) conducted, video-recorded and transcribed the interviews using Microsoft Teams software. They also undertook consumer (patient and carer) interviews in parallel. Quantitative survey responses were used to tailor interview guides for each participant, such as participants' knowledge of the OCPs and whether they were directly or indirectly involved (e.g. more supportive role) in the delivery of cancer care. The interviewers maintained an

iterative approach with regular debriefs between interviews for reflection and refinement of the interview guide.

Benefit

Through iterative reflections, we were better equipped to capture important context-specific determinants and divergent perspectives across rural and remote settings.

Data analyses

We used NVivo software for data analysis and management (Lumivero, version 15.0.0) (Lumivero, 2025). Using a deductive analysis approach, an initial coding framework was developed based on the 14 TDF domains to identify determinants influencing implementation of OCPs across diverse professional roles and service contexts (Cahill et al., 2021; Cane et al., 2012). The codebook also captured the three primary elements of cancer care provision under investigation (i.e. diagnosis, treatment, multidisciplinary meetings), health service structure for each state (i.e. Victoria, South Australia and Queensland), broader system level factors (e.g. data sharing between states), and, in response to themes emerging from the consumer interviews, patient access (e.g. patient-related barriers or facilitators to accessing cancer care). During analysis, some TDF domains proved insufficiently granular for the realities of rural service delivery, so a secondary inductive approach was applied to better disaggregate some domains (e.g., 'Environmental context and resources').

Benefits

The additional coding meant distinct factors, for example, service configuration, geographic isolation, workforce availability, referral pathways, and inter-service coordination; all of which carry different implications for implementation strategy design, were disaggregated within the relevant TDF domain. This approach to capture context-specific determinants and possible system connections provided a greater depth to support co-design of implementation strategies in the subsequent phase.

Consumer involvement

While the primary research question focused on health care professionals' perspectives as primary implementation agents, consumer perspectives were incorporated through parallel research with people affected by cancer and their carers (i.e. family members or friends) living in rural and remote communities. The methods for consumer interviews are not outlined here; however, findings about care navigation and access influenced sampling decisions and enabled the tailoring of the health care professionals' interview guide to explore barriers around patient access.

Benefits

This ensured implementation determinants reported from the perspective of the health care professionals were examined alongside lived experiences of consumer access and care navigation, ultimately providing a more holistic understanding of rural health care pathways.

Interpretation of results

During interpretation, we took care to avoid deficit framing of rural and remote health services, allowing determinants to be interpreted in relation to structural, organisational, and system-level conditions shaping care delivery. We incorporated consumer experiences of accessing care to support framing of barriers and enablers. Both consumer representatives and health care partners reviewed language and quotations to ensure they resonated with their experience of the rural and remote health care system.

Benefits

By situating findings within the broader operating context (rather than focusing on individuals), opportunities for structural change were identified. Further attempts to synthesise these findings in a way that reflects the complex structures of rural health services and cancer care is also progressing in subsequent co-design phases.

Discussion

In this article, we highlight some ways in which this study was designed and iterated to enable implementation research in rural and remote cancer care settings. Some design features, such as long-standing governance structures and parallel consumer research, are enabled by longer-term, programmatic initiatives like **[BLINDED – Program name]**. However, other principles, including flexible sampling, relational recruitment, iterative data collection, and reflexive analysis, can be applied within smaller, time limited projects. Further, we maintain that integration of consumer perspectives alongside implementation research is essential. This enabled us to explore access and care coordination challenges alongside implementation barriers. These design decisions move towards addressing the power dynamics inherent in research with rural and remote health services and communities, shifting knowledge production away from extractive approaches toward more collaborative processes central to equity-oriented implementation research.

We have discussed the application of these principles within formative research (i.e. barriers assessment) but argue that these principles remain relevant across the implementation research continuum, including trial-based studies where a focus on adherence to specific intervention protocols may limit flexibility. At a minimum, equity-oriented implementation studies require trusted intermediaries, flexibility in recruitment and data collection timelines, and explicit recognition of relationship building as legitimate methodological work, even when formal program infrastructure is not available. As a transdisciplinary team involving implementation science, health services and cancer care researchers and practitioners, we were challenged to treat flexibility as a marker of rigour rather than a threat to methodology quality. This enabled us to rapidly adapt and align study procedures to service needs and

participant availability without compromising analytic integrity. By applying TDF within rural and remote cancer systems, this study demonstrates its utility beyond discrete professional behaviours to understand use within distributed, resource-constrained health systems. Future efforts could extend on this by applying a systems thinking lens to support conceptualising these findings as interacting elements and feedback dynamics, although attempts to draw out links between the different domains will need to be better articulated to enable this.

We recognise that application of these design principles is often constrained by systemic challenges, including short-term funding timelines and insufficient resourcing to accommodate partnership strengthening and development of governance processes. However, explicitly naming these principles and demonstrating the methodological value of flexible, relational approaches is essential to shifting expectations around how implementation research is designed, resourced, and evaluated. By articulating these considerations alongside, yet distinct from empirical findings, our research responds to calls for more equitable implementation research (Brownson et al., 2021) by making visible the decisions required to conduct context-responsive implementation studies in rural and remote health systems.

Abbreviations

[BLINDED – Program name and abbreviation]
MM
Modified Monash
OCPs
Optimal Care Pathways
TDF
Theoretical Domains Framework

Declarations

Ethics approval and consent to participate Ethics approval was provided by Deakin University HREC (2024/HE000488) and the authors certify that all research was conducted according to the ethical standards outlined by the 1964 Declaration of Helsinki. Participants consented to be involved in the study.

Author Contribution

SLY conceptualised the manuscript and drafted the initial version of the manuscript. As the project team, SLY, AC, AA, CW, SM and AU contributed to early drafts and reflections from the study process. AU is research lead of the ECORRA program and established initial governance process with rural and remote partners. All other authors contributed to different phases of the study including supporting recruitment, undertaking recruitment and supporting planning and interpretation of data. All authors contributed to manuscript revisions and approved the final version of the manuscript.

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