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METHODOLOGY

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Bridging the gap: translating and simplifying CFIR 2.0 for French practitioners in implementation science

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Abstract

Background The Consolidated Framework for Implementation Research (CFIR) 2.0 is widely used in implementation projects but can be difficult for non-researchers to apply due to its complexity. While a French version of the original CFIR exists, CFIR 2.0 had not yet been translated. This study aimed to translate and simplify CFIR 2.0 for healthcare practitioners in French-speaking Switzerland to improve its accessibility and utility.

Method Using the Principles of Good Practice for Translation and Cultural Adaptation, the process included: (1) four independent forward translations, (2) reconciliation of simplified definitions, (3) online survey with 16 clinical nurse specialists to assess the content validity of the simplified definitions, (4) back translation, and (5) harmonization to finalize the French version. The content validity of each construct was assessed using the Content Validity Index (CVI), with further revisions based on feedback.

Results Most participants found the simplified definitions understandable, with an average score of 1.46 (where 1 is "very easy to understand" and 2 is "easy to understand"). Thirteen items with lower I-CVI scores (≤ 0.78) were revised. The overall S-CVI was 0.87, indicating high content validity. Minor discrepancies in the back translation were resolved.

Conclusions This study produced a French translation of CFIR 2.0 with simplified definitions tailored for healthcare practitioners. The high content validity and feedback underscore the need for contextually relevant adaptations to enhance the practical use of the CFIR framework. Further testing in diverse French-speaking contexts is necessary to refine the tool and broaden its applicability in real-world settings.

Keywords Implementation Science, Framework, CFIR, Cultural Adaptation

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Contributions to the literature

- This study provides a French translation and simplified definitions of the CFIR 2.0, enhancing its accessibility for French-speaking healthcare practitioners and policymakers.
- By adapting the CFIR to align with the specific cultural and organizational contexts of Swiss practitioners, the paper addresses a significant gap in the usability of implementation science frameworks.
- The findings support integrating user feedback in the translation process, demonstrating an innovative approach to contextualizing implementation science frameworks for diverse audiences.
- This research underscores the importance of linguistic and conceptual clarity in promoting the adoption of evidence-based practices in non-research settings, ultimately contributing to improved healthcare outcomes.

Background

The Consolidated Framework for Implementation Research (CFIR) is a determinant framework widely used as a comprehensive taxonomy of determinants that influence implementation outcomes [1, 2]. The CFIR was originally developed in 2009 by synthesizing constructs from 19 existing frameworks and theories across 13 scientific disciplines and was later updated in 2022 on the basis of users' feedback and literature to improve its applicability and usability [1, 2]. The CFIR stands out as one of the most frequently referenced and utilized frameworks in implementation science research, with widespread adoption since its introduction in 2009 [1, 2]. The CFIR constructs are organized into five major domains: Intervention Characteristics, Outer Setting, Inner Setting, Characteristics of Individuals, and Implementation Process [1, 2]. As implementation science is defined as the broad study of methods to promote the uptake of research findings into practice, frameworks such as the CFIR must be made accessible to frontline practitioners [3]. Indeed, the wide array of theories, models and frameworks can make it challenging for those involved in implementation projects to choose the right one and use it effectively, especially if they lack a research background or familiarity with the field [4]. While implementation scientists can be driven by scientific rigor in conducting implementation studies, healthcare practitioners can gain from improving their understanding of implementation science methods to be able to select and apply suitable frameworks, strategies, and other implementation concepts and tools, informed by the context [4, 5]. Although the CFIR offers detailed definitions for each construct, its usability for nonresearchers, such as frontline practitioners or policymakers, is often hindered by its technical language and complexity [2].

Adaptations in the definitions of the CFIR 2.0 constructs are needed to ensure the alignment of these definitions with the specific context of practitioners and stakeholders. This entails adapting and employing language that resonates with the organizational and cultural context in which the CFIR is utilized, enhancing its relevance and applicability for individuals involved in implementation settings [6]. Despite the widespread use of the CFIR, there have been few examples of its utilization in French-speaking contexts, likely due to the lack of development of related tools in French. Additionally, while a French translation of the CFIR exists [7], none is currently available for the CFIR 2.0.

This study aimed to develop a French translation of CFIR 2.0 within the Swiss context, along with a simplified version of its construct definitions. The Swiss context was chosen because Switzerland, and particularly its French-speaking region, presents a unique healthcare landscape characterized by a multilingual and multicultural environment. Implementation efforts in Swiss healthcare settings often require adaptations to accommodate linguistic diversity, varied healthcare governance structures, and differences in professional roles across institutions. Given these complexities, the translation and adaptation of CFIR 2.0 in Switzerland provide an opportunity to enhance its applicability in real-world clinical and policy settings, while also serving as a foundation for broader adoption in other French-speaking regions. By overcoming language barriers and simplifying complex concepts, this translation aims to facilitate the uptake of evidence-based practices and support implementation efforts in French-speaking healthcare settings.

Method

The Principles of Good Practice for the Translation and Cultural Adaptation Process for Patient-Reported Outcomes (PRO) were followed [8].

Step 1: preparation

The explanation of the CFIR 2.0 concepts [2] served as the foundation. The simplified version drew inspiration from the development of the pragmatic context assessment tool (pCAT) [9]. The authors of the CFIR 2.0 granted permission to translate CFIR 2.0 and confirmed that no existing translation was available at that time.

Step 2: forward translation

Four independent translations and adaptations were conducted and used in the context of two doctoral theses and three master's projects in nursing sciences, all of which focused on implementation in French-speaking clinical

settings. The translations were carried out by a panel consisting of six master's students, a PhD in nursing science, a postdoctoral researcher and an associate professor who were either native French speakers from Switzerland or France and had been living in French-speaking Switzerland for several years. Of the ten translators, three teach implementation science to master's students in a French-speaking context. While all the translators had some theoretical knowledge of CFIR through their academic work, most were using the CFIR card game for the first time. Their understanding of CFIR concepts allowed them to focus on conceptual rather than literal translations of the questions. The main objective of these theses and master's projects was to identify implementation determinants using the CFIR card game approach [10]. This tool was not only used for translation purposes but also played a central role in involving stakeholders and ensuring conceptual alignment. By facilitating discussion between participants, the CFIR card game helped to refine the understanding of key implementation constructs, which in turn influenced translation outcomes. The interactive nature of the game encouraged translators to go beyond direct linguistic translation and focus on capturing the conceptual essence of the questions to ensure their relevance in the target clinical contexts. As such, translation was an integral part of the wider implementation process, rather than a separate step.

Step 3: reconciliation

The translation panel reached a consensus on simplified definitions of each translated construct of the CFIR 2.0. This initial simplified version served as the basis for an online survey involving 16 clinical nurse specialists. These participants were selected based on their expertise in implementation practice and their familiarity with the CFIR framework. Their role as clinical nurse specialists, who are actively involved in evidence-based practice and implementation efforts within healthcare settings, made them well-suited to assess the content validity of the translation. To ensure a rigorous selection process, participants were recruited through professional networks, targeting those with direct experience in implementation projects. The sample size of 16 was chosen to balance feasibility with the need for diverse perspectives while maintaining methodological rigor in content validation. All participants were practicing in French-speaking Switzerland. Given the potential influence of linguistic variations on interpretation, their familiarity with different French variants was also considered. While all participants were fluent in Swiss French, some had prior exposure to other French variants (e.g., Metropolitan French, Canadian French) through their professional experiences, academic backgrounds, or collaborations. This linguistic diversity helped ensure that the translated constructs were comprehensible and applicable across various French-speaking contexts. The participants were asked to rate the understandability of each simplified definition on a Likert scale ranging from 1 (very easy to understand) to 4 (very difficult). A comment section was included where participants could suggest alternative wording or provide additional thoughts on the definitions.

The content validity of the simplified translations was quantitatively assessed to ensure that the definitions were clear and comprehensible. For each construct, the item-level content validity index (I-CVI) was determined by calculating the proportion of participants who rated understandability as either 1 (very easy to understand) or 2 (easy to understand). The overall content validity of the entire set of constructs (S-CVI) was assessed by averaging the I-CVI scores across all the constructs. A high I-CVI and S-CVI indicate that the simplified definitions are generally understandable to the target audience. Constructs with lower I-CVI scores (≤ 0.78) were identified for further revision on the basis of participant feedback provided in the comment Sects [11, 12].

Step 4: back translation

An independent professional translator carried out the back translation of the French version of the CFIR 2.0.

Steps 5 & 6: back translation review & harmonization

Our team reviewed the back translation against the original version of the CFIR 2.0, and discrepancies justifying revisions were identified and addressed.

Results

Forward translation

The four translated versions of CFIR 2.0 were very similar, with the main differences arising in the simplified versions of the construct definitions. These differences were particularly notable in the terms "implementation and/or delivery of the innovation" and "setting."

Reconciliation

After a consensus was reached, a few terms were modified in the first forward translation, and the translation of the terms "implementation and/or delivery of the innovation" and "setting" was standardized in the simplified definitions (see Additional file 1).

The results of the online survey are detailed in Table 1. Participants in the online survey had between one and 12 years of implementation science experience as a clinical nurse specialist (CNS) or as a master's or doctoral student. Work settings included acute care hospital units and home health care services. Their experience with CFIR ranged from one to four years, gained either

Table 1 Results of the online survey

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Item 1	1	2	3	1	1	1	1	1	3	2	1	1	1	2	4	1
Item 2	1	1	1	1	1	3	1	3	3	1	1	1	1	2	1	1
Item 3	1	1	1	1	1	1	1	2	3	1	1	1	1	2	1	1
Item 4	1	1	1	1	1	1	1	3	1	1	1	1	3	2	1	1
Item 5	1	1	3	3	1	1	1	1	3	2	1	1	3	1	4	1
Item 6	1	2	3	1	1	1	1	1	3	2	1	1	2	1	1	1
Item 7	1	2	2	1	1	1	1	2	1	1	3	1	1	2	1	1
Item 8	1	1	2	1	1	1	1	1	3	1	1	1	2	2	4	1
Item 9	1	1	1	1	1	1	1	1	1	1	1	1	2	2	1	1
Item 10	1	2	2	1	2	1	1	2	2	2	1	1	1	2	4	3
Item 11	1	3	2	1	1	1	1	3	1	1	1	1	2	2	1	3
Item 12	1	3	2	1	2	1	2	3	3	1	1	1	3	2	4	3
Item 13	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Item 14	1	1	1	1	1	1	1	1	1	3	1	1	1	1	1	1
Item 15	1	1	1	1	1	1	1	1	4	2	1	1	2	1	1	1
Item 16	1	3	2	2	1	1	1	3	3	1	1	1	2	2	1	1
Item 17	1	3	2	1	1	1	1	3	2	2	1	1	2	2	1	3
Item 18	1	1	2	1	1	1	1	3	3	2	1	1	2	2	4	1
Item 19	1	1	2	1	2	1	1	3	3	2	1	1	2	2	4	3
Item 20	1	3	1	1	1	2	1	1	3	1	3	1	1	2	1	3
Item 21	1	2	1	1	2	1	1	1	2	1	3	1	1	1	3	1
Item 22	1	1	1	1	2	1	1	1	3	3	1	1	1	1	1	1
Item 23	1	1	1	1	2	1	1	1	1	2	2	1	1	2	1	1
Item 24	1	1	1	1	2	1	1	1	1	1	2	1	1	2	1	1
Item 25	1	1	2	1	2	1	1	2	1	2	1	1	1	2	1	1
Item 26	1	1	2	1	1	1	1	2	1	1	1	1	1	2	1	1
Item 27	1	1	2	1	2	1	1	1	1	1	1	1	1	2	3	1
Item 28	1	1	2	1	1	1	1	3	1	1	3	1	1	2	1	1
Item 29	1	2	2	2	1	2	1	1	3	2	1	1	2	2	4	1
Item 30	1	1	1	1	1	1	2	1	1	1	1	1	1	2	1	1
Item 31	1	1	1	1	1	1	1	2	1	1	1	1	1	2	3	1

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Item 32	1	1	1	1	1	1	1	1	1	1	1	1	1	2	1	3
Item 33	1	1	1	1	1	1	1	1	2	4	3	1	1	2	3	3
Item 34	1	1	1	1	1	1	1	1	1	4	1	1	1	2	1	1
Item 35	1	1	1	1	1	1	1	1	2	4	3	1	1	2	3	3
Item 36	1	1	1	1	1	1	2	2	3	1	1	1	2	1	4	1
Item 37	1	1	1	1	1	1	2	2	1	1	1	1	2	1	4	1
Item 38	1	1	1	1	1	1	2	2	3	4	1	1	2	1	4	1
Item 39	1	1	2	1	1	1	2	2	3	1	1	1	2	1	4	1
Item 40	1	1	2	1	1	1	2	2	2	1	1	1	2	1	4	1
Item 41	1	1	1	1	1	1	2	3	2	4	1	1	1	1	4	1
Item 42	1	1	1	1	1	1	2	2	2	2	1	1	1	1	4	3
Item 43	1	1	1	1	1	1	2	2	1	1	1	1	1	1	4	1
Item 44	1	1	1	1	1	1	2	2	1	1	1	1	1	1	3	1
Item 45	1	1	2	1	1	1	1	1	1	1	1	1	1	2	1	1
Item 46	1	1	1	1	1	1	1	1	1	1	1	1	1	2	4	1
Item 47	1	1	2	1	1	1	1	3	3	1	1	1	3	2	4	1
Item 48	1	2	2	1	1	1	1	1	2	1	1	1	1	2	4	1
Item 49	1	1	1	1	1	1	2	1	4	3	1	1	3	2	4	1
Item 50	1	2	1	1	1	1	2	1	2	1	1	1	1	2	3	1
Item 51	1	2	1	1	2	1	1	1	2	1	1	1	1	2	1	1
Item 52	1	1	1	1	1	1	1	1	2	1	1	1	1	2	1	1
Item 53	1	1	1	1	1	1	1	1	1	3	1	1	3	2	1	1
Item 54	1	1	1	1	2	2	1	2	1	3	1	1	2	2	1	3
Item 55	1	1	2	1	1	2	1	2	1	2	1	1	3	2	1	1
Item 56	1	1	2	1	1	1	1	1	3	1	3	1	1	2	3	3
Item 57	1	1	1	1	1	1	1	3	3	1	3	1	2	2	1	3
Item 58	1	1	1	1	1	1	1	3	3	1	3	1	2	2	3	3
Item 59	1	2	1	1	1	1	1	1	2	3	1	1	2	2	1	3
Item 60	1	3	3	1	1	1	2	1	3	4	1	1	2	2	1	3
Item 61	1	2	3	1	1	1	2	2	3	3	1	1	3	2	1	3
Item 62	1	1	1	1	1	1	1	3	1	1	1	1	2	2	1	1

Legend: 1 "Very easy to understand"/2 "Easy to understand"/3 "Difficult to understand"/4 "Very difficult to understand"

through their master's studies and projects or as supervisors of master's research. For most participants, the items were "very easy" or "easy to understand". Only three participants rated some items as "very difficult to understand". The total average score was 1.46. The lower number agreement was for item 12: "The Inner Setting is networked with external entities, including referral networks, academic affiliations, and professional organization networks".

The content validity of the entire set of constructs (S-CVI) was 0.87. Thirteen items had an I-CVI lower than 0.78 (Table 2). On the basis of the participants' feedback, these 13 items were reformulated (see Additional file 2). As the word implementation can be translated in

Table 2 Content validity

Items	Average Score	Number Agreement	I-CVI	Items	Average Score	Number Agreement	I-CVI
Item 1	1.63	13	0.81	Item 32	1.19	15	0.94
Item 2	1.44	13	0.81	Item 33	1.69	12	0.75
Item 3	1.25	15	0.94	Item 34	1.25	15	0.94
Item 4	1.31	14	0.88	Item 35	1.69	12	0.75
Item 5	1.75	11	0.69	Item 36	1.50	14	0.88
Item 6	1.44	14	0.88	Item 37	1.38	15	0.94
Item 7	1.38	15	0.94	Item 38	1.69	13	0.81
Item 8	1.50	14	0.88	Item 39	1.56	14	0.88
Item 9	1.13	16	1.00	Item 40	1.50	15	0.94
Item 10	1.75	14	0.88	Item 41	1.63	13	0.81
Item 11	1.56	13	0.81	Item 42	1.56	14	0.88
Item 12	2.06	10	0.63	Item 43	1.31	15	0.94
Item 13	1.00	16	1.00	Item 44	1.25	15	0.94
Item 14	1.13	15	0.94	Item 45	1.13	16	1.00
Item 15	1.31	15	0.94	Item 46	1.25	15	0.94
Item 16	1.63	13	0.81	Item 47	1.69	12	0.75
Item 17	1.69	13	0.81	Item 48	1.44	15	0.94
Item 18	1.69	13	0.81	Item 49	1.75	12	0.75
Item 19	1.88	12	0.75	Item 50	1.38	15	0.94
Item 20	1.63	12	0.75	Item 51	1.25	16	1.00
Item 21	1.44	14	0.88	Item 52	1.13	16	1.00
Item 22	1.31	14	0.88	Item 53	1.31	14	0.88
Item 23	1.25	16	1.00	Item 54	1.56	14	0.88
Item 24	1.19	16	1.00	Item 55	1.44	15	0.94
Item 25	1.31	16	1.00	Item 56	1.63	12	0.75
Item 26	1.19	16	1.00	Item 57	1.63	12	0.75
Item 27	1.31	15	0.94	Item 58	1.75	11	0.69
Item 28	1.38	14	0.88	Item 59	1.50	14	0.88
Item 29	1.75	14	0.88	Item 60	1.88	11	0.69
Item 30	1.13	16	1.00	Item 61	1.88	11	0.69
Item 31	1.25	15	0.94	Item 62	1.25	15	0.94

S-CVI/Ave	0.87
Total Agreement	10
S-CVI/UA	0.16

Legend: I-CVI: Item-level Content Validity Index, S-CVI: Scale-level Content Validity Index, S-CVI/Ave, scale-level content validity index, averaging calculation method, S-CVI/UA, scale-level content validity index, universal agreement calculation method

several ways in French, participants were asked to choose between the terms "mise en œuvre" and "implantation" to facilitate understanding of the simplified version. Twelve out of 16 participants (75%) selected the term "implantation." A suggestion made by several participants was to include a glossary with definitions and alternative terms in the simplified version. On the basis of the results of this survey, a simplified version was adapted.

Back translation

The back translation is available in Additional file 3.

Back translation review & harmonization

The comparison between the original version and the back translation revealed three types of minor discrepancies: (1) the use of different vocabularies with the same meaning, (2) the use of different grammatical forms that did not affect the meaning, and (3) the use of terms with slightly different meanings but better suited to French. The results of this comparison are available in Additional file 3. As these results did not lead to any major changes, the research team made the final decisions regarding the refined translation. Although participant feedback played a key role in identifying difficult concepts and suggesting terminological adjustments, no further testing was carried out with participants after the revisions.

Following harmonization, a French translation of CFIR 2.0 and a simplified version of the construct definitions were developed (see Additional files 4 and 5).

Discussion

The study aimed to translate and adapt the CFIR 2.0 into French and develop simplified definitions of its constructs to enhance its usability for healthcare practitioners. The results provide valuable insights into applying implementation science frameworks and emphasize the importance of contextually relevant adaptations.

The overall content validity of the simplified translations was high (0.87), indicating that most of the constructs were perceived as clear and easily understandable. This suggests that the initial efforts to simplify and adapt the CFIR 2.0 definitions made the framework more accessible to practitioners. However, 13 constructs were more challenging to understand. These results are consistent with the German translation, where extensive cognitive debriefing led to the revision of 11 items [5]. Common suggestions included providing examples, clarifying terms that were considered too technical, and using simpler language and terminology that felt more intuitive and contextually appropriate [5].

Notably, the use of conceptual frameworks in implementation research is not yet systematic. Moreover, their application in French-speaking contexts remains rare, especially in publications in French. Thus, ensuring that implementation science frameworks are not only translated accurately but also simplified and contextualized appropriately is crucial for their effective use in practice. Involving potential users in creating an assessment tool is an essential step, as shown by the tool for analyzing equity or scaling up, for example [13]. The simplified version of CFIR 2.0 was tested via the approach of the CFIR card game [10], which involves engaging teams of healthcare professionals to analyze implementation factors across several implementation projects. This approach had several benefits and offered valuable lessons regarding the direct use of CFIR with professionals unfamiliar with its constructs. The CFIR card game provided a playful and interactive method for teams to reflect on the CFIR constructs. However, even the simplified constructs required further adaptation to the specific context, the innovation being implemented, and the individuals involved. Without this adaptation, using CFIR with teams can become more of a barrier than a pragmatic and useful tool. This underscores the importance of tailoring the constructs to ensure their relevance and applicability, thereby enhancing the effectiveness of CFIR 2.0 in real-world settings. By addressing healthcare practitioners' specific needs and preferences, this approach can enhance their engagement with the framework and improve the likelihood of successful implementation of evidence-based practices. Such tailoring aligns with the broader goal of making implementation science more accessible and practical for frontline practitioners.

Beyond linguistic simplification, our findings highlight the need for deeper cultural adaptation of CFIR 2.0 constructs. While our translation aimed to preserve the conceptual integrity of the original framework, it is essential to recognize that the theoretical foundations of CFIR—rooted in Western implementation science—may not always align with how implementation processes are understood and operationalized across different French-speaking healthcare systems [14–16]. Implementation science is predominantly developed in Anglo-American contexts, where conceptual frameworks are shaped by specific governance structures, professional hierarchies, and healthcare delivery models [17]. In contrast, French-speaking healthcare systems—whether in Africa, North America or Europe—may have different institutional dynamics, decision-making processes, and sociocultural factors influencing implementation efforts. These differences may impact how CFIR constructs, such as Leadership Engagement or Relative Advantage, are perceived and applied in practice. Thus, future adaptations should not only refine language but also critically examine whether certain CFIR constructs need theoretical recalibration to better reflect the realities of French-speaking implementation contexts. In this sense, some adaptations have already begun in Mali and Burkina Faso. This could involve refining conceptual definitions, incorporating region-specific examples, or reconsidering the relationships between constructs based on how implementation is operationalized in different settings. For instance, collective decision-making models, which are more prominent in some French-speaking healthcare systems, might require nuanced interpretations of constructs related to leadership and organizational readiness.

Using cognitive debriefing (e.g., probing techniques [6]) during CFIR card game sessions can provide further insights into whether practitioners find the translated constructs conceptually meaningful within their specific contexts. Continued collaboration with healthcare professionals and implementation scientists from diverse French-speaking regions will be essential to refining not only the language but also the theoretical applicability of CFIR 2.0 in these settings. This process could also serve as a foundation for adapting other implementation frameworks beyond CFIR.

Limitations

Applying the principles of good practice for the translation ensured a rigorous and systematic approach to the translation and adaptation of CFIR 2.0 in French. By involving healthcare practitioners in the evaluation of simplified constructs, this study prioritized the end-users' perspectives. This process helped maintain the conceptual integrity [18] of the CFIR 2.0 while making it accessible to a French-speaking audience. The simplified version of the CFIR 2.0 also allows for continuous refinement and ensures that the framework remains relevant across various implementation settings and projects. Indeed, a primary limitation is the inherent variability of implementation projects and their contexts. This variability necessitates continuous adaptations of the translated CFIR constructs, suggesting that having a single, static translation may not be sufficient. Placeholders such as [intervention] were included in brackets to address this limitation to indicate that specific terms should be replaced with the intervention relevant to each project.

This study involved advanced practice nurses who were already familiar with implementation science. This knowledge may have influenced their ability to understand and evaluate the simplified CFIR constructs, potentially skewing the results toward higher content validity scores. Future studies should aim to include a broader range of healthcare practitioners, including those with less exposure to implementation science.

Additionally, the diversity within healthcare systems, cultural nuances, and organizational structures across different French-speaking regions may affect the applicability of the translation. These regional differences underscore the need for localized adaptations and highlight the challenge of creating a universally applicable translation. Therefore, it is now essential to operationalize CFIR 2.0 in French by developing practical resources—such as qualitative interview guides or quantitative questionnaires—while simultaneously ensuring that the theoretical foundation of the framework remains relevant across varied contexts.

Conclusions

This translation and simplification of the CFIR 2.0 mark a significant step toward making implementation science frameworks more accessible to French-speaking healthcare practitioners. The high content validity of the simplified CFIR 2.0 constructs and the constructive feedback from practitioners highlight the success of our initial adaptation efforts. By continuing to refine and test these adaptations, we can enhance the practical utility of implementation science frameworks and support the effective translation of research into practice in French-speaking healthcare contexts.

Abbreviations

CFIR	Consolidated Framework for Implementation Research
CVI	Content validity index
I-CVI	Item-level Content Validity Index
pCAT	Pragmatic Context Assessment Tool
PRO	Patient-Reported Outcomes
S-CVI	Scale-level Content Validity Index

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s43058-025-00719-8.

Supplementary Material 1.

Supplementary Material 2.

Supplementary Material 3.

Supplementary Material 4.

Supplementary Material 5.

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Authors' contributions

JP, SP and CM led the translation process. SP and JP wrote the manuscript. CM and VR reviewed the manuscript. All the authors approved the final manuscript.

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Data availability

All data generated or analyzed during this study are included in this published article [and its supplementary information files].

Declarations

Ethics approval and consent to participate

Not applicable.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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References

1. 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. https://doi.org/10.1186/1748-5908-4-50.
2. 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. https://doi.org/10.1186/s13012-022-01245-0.
3. Moullin JC, Dickson KS, Stadnick NA, Albers B, Nilsen P, Broder-Fingert S, et al. Ten recommendations for using implementation frameworks in research and practice. Implement Sci Communications. 2020;1:42. https://doi.org/10.1186/s43058-020-00023-7.
4. Rapport F, Clay-Williams R, Churruca K, Shih P, Hogden A, Braithwaite J. The struggle of translating science into action: foundational concepts of implementation science. J Eval Clin Pract. 2018;24(1):117–26. https://doi.org/10.1111/jep.12741.
5. Albers B, Metz A, Burke K. Implementation support practitioners – a proposal for consolidating a diverse evidence base. BMC Health Serv Res. 2020;20(1):368. https://doi.org/10.1186/s12913-020-05145-1.
6. Safaeinili N, Brown-Johnson C, Shaw JG, Mahoney M, Winget M. CFIR simplified: pragmatic application of and adaptations to the consolidated framework for implementation research (CFIR) for evaluation of a patient-centered care transformation within a learning health system. Learning Health Systems. 2020;4(1): e10201. https://doi.org/10.1002/lrh2.10201.
7. Turcotte-Tremblay AM, Ridde V. Cadre théorique pour l'étude de la mise en oeuvre du FBR au Mali. Available from: https://cfirguide.org/constructs-old/construit/. Cited 2024 Oct 2.
8. Wild D, Grove A, Martin M, Eremenco S, McElroy S, Verjee-Lorenz A, et al. Principles of good practice for the translation and cultural adaptation process for patient-reported outcomes (PRO) measures: report of the ISPOR task force for translation and cultural adaptation. Value in Health: The Journal of the International Society for Pharmacoeconomics and Outcomes Research. 2005;8(2):94–104. https://doi.org/10.1111/j.1524-4733.2005.04054.x.
9. Robinson CH, Damschroder LJ. A pragmatic context assessment tool (pCAT): using a think aloud method to develop an assessment of contextual barriers to change. Implementation Science Communications. 2023;4(1):3. https://doi.org/10.1186/s43058-022-00380-5.
10. Piat M, Wainwright M, Sofouli E, Albert H, Casey R, Rivest M-P, et al. The CFIR card game: a new approach for working with implementation teams to identify challenges and strategies. Implementation Science Communications. 2021;2(1): 1. https://doi.org/10.1186/s43058-020-00099-1.
11. Polit DF, Beck CT. The content validity index: are you sure you know what's being reported? Critique and recommendations. Res Nurs Health. 2006;29(5):489–97. https://doi.org/10.1002/nur.20147.
12. Madadizadeh F, Bahariniya S. Tutorial on how to calculating content validity of scales in medical research. Perioperative Care and Operating Room Management. 2023;31: 100315. https://doi.org/10.1016/j.pcorm.2023.100315.
13. Guichard A, Hébert C, Nour K, Lafontaine G, Tardieu É, Ridde V. Adaptation et conditions d'utilisation d'un outil d'analyse des interventions au regard des inégalités sociales de santé. Santé Publique. 2018;1(HS1):121–30. https://doi.org/10.3917/spub.184.0121. S.F.S.P.
14. Ridde V, Ouedraogo S, Yaya S. Closing the diversity and inclusion gaps in francophone public health: a wake-up call. BMJ Glob Health. 2021;6(2). https://doi.org/10.1136/bmjgh-2021-005231. BMJ Publishing Group Ltd.
15. Gilmore B. Realist evaluations in low- and middle-income countries: reflections and recommendations from the experiences of a foreign researcher. BMJ Glob Health. 2019;4(5): e001638. https://doi.org/10.1136/bmjgh-2019-001638.
16. Abimbola S. The foreign gaze: essays on global health. IRD Éditions. 2024. https://doi.org/10.4000/131av.
17. Proctor EK, Bunger AC, Lengnick-Hall R, Gerke DR, Martin JK, Phillips RJ, et al. Ten years of implementation outcomes research: a scoping review. Implement Sci. 2023;18(1):31. https://doi.org/10.1186/s13012-023-01286-z.
18. Pfadenhauer LM, Mozygemba K, Gerhardus A, Hofmann B, Booth A, Lysdahl KB, et al. Context and implementation: a concept analysis towards conceptual maturity. Zeitschrift Fur Evidenz, Fortbildung Und Qualitat Im Gesundheitswesen. 2015;109(2):103–14. https://doi.org/10.1016/j.zefq.2015.01.004.

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