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ORIGINAL RESEARCH

Seven principles for integrating health equity considerations in the practice guideline enterprise

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Abstract

Background and Objectives: Health equity aims to provide all individuals with equal and fair opportunities to achieve optimal health. Practice guidelines can play a pivotal role in advancing health equity; yet, few organizations use tools to systematically integrate health equity considerations. Thus, it is important to establish a foundation for practical tools to support the systematic integration of health equity

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considerations. This manuscript proposes principles for the integration of health equity considerations in the practice guideline enterprise.

Methods: In the process of developing an equity extension for the GIN-McMaster guideline development checklist, we established a diverse advisory group of guideline developers, patients, members of the public experiencing inequities, health equity researchers, and guideline developers. We formulated the principles informed by a methodological review of guideline handbooks and iterative discussions between working group members.

Results: We identified the following seven principles for integrating health equity considerations into the practice guideline enterprise: (1) articulating health equity, (2) a priori planning for considering health equity, (3) selection and engagement of individuals with lived experiences of inequities, (4) equity in evidence synthesis, (5) developing equity-informed recommendations, (6) inclusive knowledge mobilization, and (7) evaluating the impact of health equity considerations. We elaborated on the importance of the principles using published examples and mapped them to the different phases of the guideline development process.

Conclusion: Guideline developers should adhere to these principles in the development of guidelines and health equity guideline development and appraisal tools. These principles are the foundational concepts for developing health equity extension items for the GIN-McMaster guideline development checklist.

Keywords: Guidelines; Equity; Diversity and inclusion; GIN-McMaster guideline checklist; Implementation; Health equity

1. Introduction

Health equity ensures that everyone has a fair opportunity to achieve their optimal health by recognizing and addressing the specific needs of different populations [1]. Attaining this goal requires dismantling barriers to health, which are often rooted in structural systems and power imbalances that restrict access to essential resources and opportunities [2]. Practice guidelines can play a key role in addressing and removing these barriers, thereby advancing health equity [3−6]. However, it is important to note that practice guidelines may also inadvertently perpetuate or exacerbate existing health inequities among and between different populations [4,5,7−11]. Thus, failing to prioritize health equity in guideline development undermines global health efforts, including progress toward the Sustainable Development Goals [12].

A few guideline-producing organizations and societies have explicitly adopted and implemented structured frameworks to integrate health equity considerations into their guideline development processes [13−18]. Health equity considerations entail strategies and interventions described in a practice guideline that have the potential to reduce health inequities and improve care for populations experiencing inequities [15]. However, global and consistent adoption remains limited, likely due to challenges in visualizing how to effectively integrate health equity considerations within the guideline. Contributing factors include lack of prioritization of health equity as an important component of guideline development [6], the perceived resource intensity required to implement it properly [15,19−21], fragmented guidance [15], and a lack of clear starting points or actionable steps to address the issue across different stages [22,23]. For instance, although there is plenty of guidance regarding the evidence synthesis process including searching for, collecting, and appraising evidence [15], developers often ask: *What practical steps can we take to integrate health equity considerations in the recommendations when the empirical evidence is limited?* In addition, guidance is frequently tailored to meet the needs and structures of specific institutions, limiting its adaptability for broader application. For instance, the US Preventive Services Taskforce (USPSTF) health equity framework [13] offers valuable insights in all phases of the recommendation development process but may be challenging to implement in other contexts, as its successful use relies on the infrastructure available to the USPSTF.

Unlike other areas of guideline development that have standardized methodologies, such as evidence synthesis, health equity considerations require complex value-based judgments that require consideration of ethics, governance, and social contexts [24]. In turn, these complexities demand a flexible and adaptable approach to developing health equity considerations that can be applied across diverse health-care systems and contexts. To address these challenges, we developed consensus-based principles designed to guide the integration of health equity considerations before, during, and after guideline development (ie, guideline enterprise).

2. Materials and methods

We developed these principles in the context of developing a health equity extension for the GIN-McMaster guideline development checklist [25]. It will serve as an operational tool to facilitate the implementation of principles across different guideline topics. We assembled a diverse, multidisciplinary advisory group, which included guideline developers, equity researchers, patients, members of the public, decision-makers, and researchers from various countries, genders, ethnicities, and career stages. A smaller working group—composed of O.D., A.J.D., S.S., J.P.P., P.T., H.J.S., V.W., E.A.A., J.K., J.S.L., and G.C.W.—was responsible for drafting the initial set of potential principles. We defined ‘‘principles’’ as high-level

What is new?

Key findings

- We outline seven guiding principles that are applicable across all phases of the guideline enterprise.
- Examples from published guidelines are provided to demonstrate practical implementation of these principles.

What is added to what is known?

- The principles described herein could be tailored to meet the needs and structures of specific institutions, enabling widespread applicability.

What is the implication and what should change now?

- Guideline organizations and societies should adopt these guiding principles to support the systematic integration of health equity considerations in all phases of the guideline enterprise.
- Operational tools are needed to facilitate the implementation of these principles across diverse healthcare systems.

statements that inform and shape decision-making, helping to ensure consistency and integrity in incorporating health equity considerations in guideline development processes. However, they are not sufficient alone to integrate health equity considerations. These principles should serve as a foundation for guideline development, reporting, and appraisal tools (eg, health equity extension of the GIN-McMaster guideline development checklist).

From September 2023 to March 2024, we employed a consensus-based approach in a series of biweekly teleconferences, focusing on identifying and drafting the principles to ensure systematic integration of health equity considerations in guideline development. We proposed principles and discussed them individually, adding new items or explanations as appropriate. The preliminary set of principles were informed by findings from a methodological review of guideline development handbooks on health equity considerations [26] and supplemented by relevant peer-reviewed literature on health equity considerations in guidelines [13−16] and input from various interest-holders [27] included in our advisory board. Through an iterative process involving multiple rounds of discussion, the group refined and revised the principles until reaching consensus on the final set.

For the methodological survey of guideline handbooks (published separately in JCE), we compiled a list of guideline organizations and societies using different sources and retrieved their methodological guidance documents on guideline development. The details of the search are published on Open Science Framework [26].

No reporting guideline was used to guide the reporting of this work, as none were deemed applicable.

3. Results

Based on our findings from the systematic search of guidance on health equity consideration across different stages and through discussions with our interest-holders, we identified 10 preliminary themes. Through iterative discussions, we were able to achieve consensus on seven main themes that warranted distinct principles. These seven principles include the following: (i) articulating health equity; (ii) a priori planning; (iii) selection and engagement; (iv) equity in evidence synthesis; (v) developing equity-informed recommendations; (vi) inclusive knowledge mobilization; and (vii) evaluation and impact. The principles are explained, and their potential impact is described below. Refer to Table 1 for definitions and examples of each principle. Figure illustrates where the principles apply in the guideline enterprise.

3.1. Principles for integrating health equity considerations in the guideline enterprise

3.1.1. Articulating health equity

Principle 1: Health equity is a multifaceted and complex concept that encompasses a broad range of interacting factors and dimensions that may be context-specific and unique to different experiences of health inequities [36]. Consider for instance, the history of racial discrimination in the United States, which is one of the main drivers of health inequities, often referred as racial health inequities [37]. The US guidelines that do not consider the racial systemic and structural barriers resulting in policies and practices, including health-care delivery, would likely fail to improve racial health equity [38].

Clearly specifying how health equity is articulated in the guideline process and context establishes the foundation for how it is operationalized [4], which, in turn, shapes the scope of the guideline [14], recommendation formulation [39], implementation [40,41], and impact assessment [42]. Thus, it should be conducted as early as possible. The priority populations should also be explicitly linked within this articulation because the guideline recommendations would need to align with the interests and specific needs of those populations which may differ from other populations [43]. Health equity could be articulated in different areas of the guideline document, such as the scope or in a distinct section.

3.1.2. A priori planning

Principle 2: Guideline developers should establish a clear, a priori plan at the project planning stage for how

Table 1. Seven principles to integrate health equity considerations in the guideline enterprise

Principle	Definition	Example from guidelines
1. Articulating health equity	Explicitly framing health equity within the specific contexts and realities relevant to the condition that the guideline seeks to address.	The US Preventive Services Task Force guidelines for interventions for high body mass index in children and adolescents articulates health equity by acknowledging the structural and systemic racism in place that manifests as policies and practices, including health-care delivery, and lead to health inequities. Furthermore, they explicitly commit to helping reverse the negative impacts of these barriers on health throughout their guideline recommendations [28].
2. *A priori* planning	Planning and considering the process and financial, human and structural resources needed to optimally integrate health equity in the guideline process. This includes identifying priority populations, detailing the process for their recruitment, and specifying how to ensure meaningful engagement.	The WHO's guidelines on HIV prevention and treatment guidelines are an update of the consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, identified as (1) men who have sex with men; (2) people who inject drugs; (3) people in prisons and other closed settings; (4) sex workers; and (5) trans and gender diverse people [29]. The WHO developed a strategy to actively involve representatives from marginalized groups, selected for their ability to represent their communities and provide valuable input.
3. Selection and engagement	Using different approaches to identify and select diverse individuals for the guideline either as members of the guideline development group or an external advisory group, such as an equity oversight committee. These individuals should be actively and meaningfully engaged at various stages of the guideline development process that impact the final guideline product.	**Guideline development group selection stage:** In the development of the Canadian preventive care recommendations for promoting health equity, the guideline developers posted a public call to recruit guideline panel members and specified experience in primary care and in promotion of health equity in clinical practice as criteria for membership selection. In addition, they explicitly welcomed racialized women in the call and others who are typically underrepresented in clinical practice guideline panels [30]. **Guideline development group engagement stage:** The fourth SAEM GRACE-4 writing team included individuals with lived experience. The individuals were invited to all meetings and contributed to our deliberations and discussions, including the strength and direction of GRACE-4 recommendations and the EtD framework judgments. They provided insights on values and preferences for clinical outcomes, reviewed and interpreted evidence reviews in PICO equity-deserving subgroups, and provided contextualized understanding during the EtD framework discussions based on lived experiences [31].
4. Equity in evidence synthesis	Ensuring the consideration of equity when defining the key guideline questions the recommendations should answer and deciding on the evidence to include, appraise and synthesize to inform them.	**Guideline scope and questions stage:** The Canadian homelessness guidelines stated that evidence indicates a shift in demographic of homeless Canadians from mostly middle-aged single men to higher proportions of women, youth, Indigenous people, immigrants, and older adults [32]. In turn, the guideline was designed to address the impact of the identified priority interventions on the previously mentioned populations. **Evidence identification, appraisal, synthesis stage:** In addition to conducting reviews on the effectiveness of the priority interventions and their cost-effectiveness, the technical team conducted 3 systematic reviews to collect contextual and population-specific evidence for the populations prioritized through our Delphi process (women, youth, refugees, and migrants) [32]. In addition, they conducted 1 qualitative literature review to capture patient values and preferences, focused on the experiences of people who are homeless in engaging with our selected interventions.

(*Continued*)

Table 1. Continued

Principle	Definition	Example from guidelines
5. Developing equity-informed recommendations	Considering health equity throughout the evidence to decision process to formulate recommendations, associated remarks and other actionable statements ie, implementation or subgroup considerations. All statements must be clearly articulated, align with the values of priority populations, and be comprehensible.	The NICE guideline for integrated health and social care for people experiencing homelessness highlights that information resources are often overly complex and predominantly in English, limiting accessibility [33]. To address this, the guideline development committee recommended providing translation services and offering materials in various languages and formats, such as Easy Read [34], when accessing health and social care. Recognizing the overrepresentation of migrants, people with learning disabilities, brain injuries, and autism in homeless populations, the committee emphasized the importance of tailoring communication to individual needs, especially for those with speech, language, and communication difficulties.
6. Inclusive knowledge mobilization	Codeveloping dissemination strategies with representatives of populations experiencing inequities to ensure guidelines and recommendations are accessible and relevant to both these populations and their healthcare providers.	The CAN-PCC team are conducting educational programs focused on health-care providers, webinars, conference presentations, outreach visits to different clinical networks, working with local opinion leaders, and knowledge mobilization of the recommendation map by including it in the Public Health Ontario CME website [35] (protocol in review). They have also established activities for the public and patients with PCC, including videos, online resource sheets, translated online resource sheets, dissemination of plain language recommendations, social media posts, and conducted in-person outreach visits [35].
7. Evaluation and impact	Implementing strategies to assess the process and impact of incorporating health equity into guideline development, with findings used to inform future updates.	The CAN-PCC guideline team have adopted the RE-AIM and PRISM frameworks to evaluate the overall public health impact of the PCC educational knowledge mobilization activities, the PCC clinical pathway and the use of the CAN-PCC guidelines especially for the following populations: Indigenous peoples, elderly, children, rural populations, Immigrant, Refugee population and their caregivers [35] (protocol in review).

CAN-PCC, Canadian guidelines for post-COVID-19 condition; EtD, evidence-to-decision; GRACE, Guidelines for reasonable and appropriate care in the emergency department; PRISM, practical, implementation, and sustainability model; RE-AIM, reach, effectiveness, adoption, implementation, and maintenance; SAEM, Society for Academic Emergency Medicine; WHO, World Health Organization; PICO, Population, Intervention, Comparator, Outcome; NICE, National Institute for Health and Care Excellence.

the guideline development team will integrate health equity considerations in the guideline enterprise. This principle is cross-cutting with the subsequent principles. A key aspect of preplanning is determining how to identify, recruit, and prepare individuals from populations experiencing health inequities or their caregivers to actively engage them in the guideline development process. The plan should allocate resources appropriately—including financial resources, human involvement, and time—to ensure that the individuals are well prepared and fairly compensated for their contributions.

In addition, evidence synthesis approaches should be planned to identify health equity–relevant evidence that will be used to inform decisions, while considering the trade-offs and challenges of different empirical approaches. Collaborations with relevant community partners should also be planned to understand their needs for implementation and dissemination and take that into account as early as possible in the development of the guideline. Any changes to what was planned should ideally be reported and justified.

A priori planning generally enhances the transparency of the guideline by setting clear goals and strategies for development upfront [44]. In the context of health equity considerations, preplanning ensures that the guideline team is equipped with the necessary tools to integrate health equity considerations throughout the guideline development process to meet the timeline [45]. For instance, planning to engage diverse perspectives from the outset of the guideline project can ensure guideline developers to have sufficient time and resources to determine which priority individuals they should include, how to include them, and what resources are needed to ensure meaningful engagement. Similarly, a priori planning for health equity considerations in evidence synthesis is essential to contemplate the appropriate methods to identify health equity evidence while considering the trade-offs and challenges of different

empirical approaches. This approach also promotes transparency and prevents cherry picking of data that could occur later in the process, balancing diverse evidence with scientific rigor.

3.1.3. Selection and engagement

Principle 3: Selection and engagement of relevant individuals in the guideline process should come hand in hand as one without the other will jeopardize the impact meaningful involvement can have on the guideline process. Thus, guideline developers should use inclusive approaches to identifying, selecting and engaging relevant individuals including those experiencing inequities in the guideline development process [46]. This involvement could be as part of the guideline development group (GDG) [47–49] or through external mechanisms [50–54] such as in the "equity oversight committee" [35].

The use of these approaches would require guideline developers to assign roles and responsibilities to members of the different groups including patient partners, transparently documenting expected level of engagement and adjusting and tailoring logistics and processes to effectively collect and integrate feedback [44,55]. This includes considering any special needs of those involved such as disabilities and social determinants of health that can create barriers to participation (eg, time zones, internet access, and transportation) and being aware of power dynamics that could hinder meaningful engagement (eg, using small group discussions to collect feedback). Financial compensation is often critical for patient partners and members of the public to feel valued and recognized for their contributions.

The impact of this principle on the guideline development process is multifold. First, it ensures that different perspectives are considered and most importantly those affected by the health inequities are actively involved in the process and their management [56]. The inclusion of patient or public partners in the GDG or other committees within the guideline enterprise will ensure they have the opportunity to engage in all guideline activities (eg, identifying the target audiences of the guideline, the formulation of the recommendation questions, and the development of the recommendations [53]) and incorporate their insights from the beginning of the guideline effort. This would not only improve the inclusivity of the guidelines, but it can avoid issuing guideline recommendations that reinforce existing health inequities. Second, their lived experience provides expert evidence [57] and enriches empirical evidence (eg, on contextual information). More importantly, the lived experiences form the basis for the legitimate (nonconflicting) interests of these individuals that will inform their judgments throughout the process [58]. Third, their involvement would ground the research and product of the guideline in community needs [59,60].

It is important to note that the accountability of the guideline developers at every stage of the guideline development process is important to maintain integrity and trustworthiness in the guideline enterprise. This is particularly important when involving individuals with lived experience of inequities, as it requires a commitment to ensuring meaningful engagement and creating an empowering environment, which are essential for building their trust in the process and the science. Establishing roles (eg, requesting focused feedback) and expectations (eg, regarding time

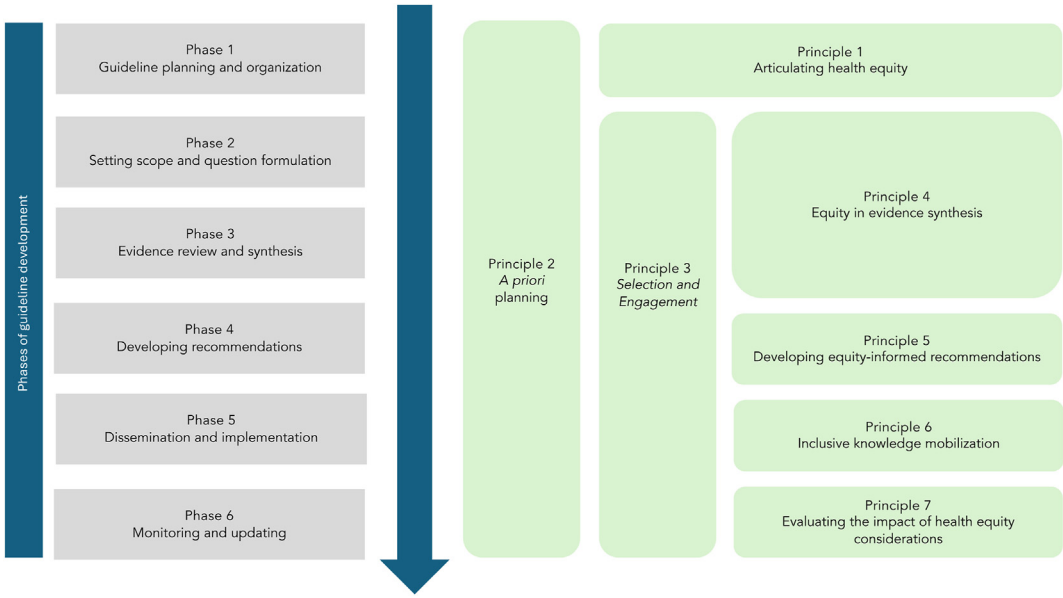

Figure. Guideline enterprise phases for applying the 7 principles to integrate health equity considerations.

commitment, travel, online meetings, and review of material) may help mitigate any concerns.

3.1.4. Equity in evidence synthesis

Principle 4: A guideline that prioritizes health equity should apply a health equity lens in all stages of the guideline development process. An important step is when planning the scope, prioritizing questions, and identifying, appraising and synthesizing relevant evidence.

First, it is important to consider equity when setting the guideline scope (ie, deciding which health issue the guideline should address), deciding on the type of guideline questions to generate (eg, such as formal guideline questions or good practice statements), and constructing them (i.e., Population, Intervention, Comparator, Outcome elements) [14]. This ensures that the guideline is responsive to the needs of those disproportionately affected by the condition. Also, applying a health equity lens at the level of the guideline questions results in recommendations that can directly respond to the needs of those experiencing inequities.

Second, an equity lens should be applied when selecting the types of evidence to assess within the evidence to decision process (eg, efficacy and harms, values and preferences, cost-effectiveness, and acceptability), the type (quantitative vs qualitative data) and source of research evidence informing their judgments (eg, databases, national registries, gray literature, and non-English sources), and where to search for the evidence [61]. Incorporating diverse evidence sources, including gray literature and non-English studies, ensures a more comprehensive understanding of the issue at hand and avoids biases inherent in narrowly focused searches and eligibility criteria. The selection of these criteria may differ depending on the type of decision being made. Generally, the more criteria considered, the more comprehensive the judgment of potential impact on health equity [62].

Third, once the evidence is retrieved and appraised, guideline developers should consider the best way to summarize the evidence for populations experiencing inequities, so that they are clearly described in the guidelines. The World Health Organization frequently dedicates a section in the guideline to discuss the findings for priority populations [63–65]. This approach helps make health equity data visible for users of the guideline and provides valuable resource for authors of future studies and guideline updates.

3.1.5. Developing equity informed recommendations

Principle 5: Health equity considerations should be reflected when drawing conclusions from the evidence assessments and developing the recommendations. This requires the consideration of health equity within the framework used to organize and structure the evidence to inform decisions (eg, Grading of Recommendations, Assessment, Development and Evaluation (GRADE) evidence-to-decision framework) [66]. The criteria considered in the framework should align with the type of evidence sought during the evidence review.

As part of the process, guideline developers should consider assessing the evidence in a way to determine if different population-specific recommendations are needed [14]. In addition, guideline developers should examine if the evidence dictates the development of recommendation remarks, implementation strategies, subgroup considerations, or identifies future research priorities [62,67]. Finally, the syntax of all statement produced from the guideline should be reviewed for inclusivity and ensure that it aligns and resonates with the populations of interest.

Developing equity informed recommendations results in actionable statements that are more likely to account for barriers that may prevent certain groups from accessing or adhering to interventions—such as economic, geographic, or social factors and directly improve health equity. In some cases, guideline developers may issue different types of actionable statements—such as good practice statements addressing human rights issues [68,69]—to ensure that population needs are addressed. Furthermore, by using inclusive language (guided by engaging with individuals with lived experiences of inequities), the guideline recommendations can reduce bias, stigma, and improve uptake [70].

3.1.6. Inclusive knowledge mobilization

Principle 6: Inclusive knowledge mobilization involves developing strategies to improve the awareness of the guideline to populations experiencing inequities and their providers. However, populations experiencing inequities may be difficult to reach partly due to social needs and determinants of health. Therefore, guideline developers should try to identify these barriers and develop strategies to account for them to reach their populations of interest effectively [71].

Engaging individuals with lived experiences presents an additional benefit as they can help with identifying these barriers [72]. For instance, the Canadian homelessness guidelines employed the GRADE F.A.C.E (feasibility, acceptability, cost, and equity) tool [54], which was used to identify barriers among both practitioners and individuals with lived experiences of inequities. The process revealed that even with well-developed equity-oriented recommendations, many of the people experiencing homelessness were very skeptical these recommendations would be used by real-world practitioners and agencies. Nevertheless, persons facing precarious housing did see some hope for the youth and women experiencing homelessness [73].

To effectively reach priority populations, feasible and effective knowledge mobilization strategies are needed to ensure that the recommendations are understood and adopted by the intended audiences [74]. Without such focused efforts, the impact of the guideline is limited. In addition, tailoring knowledge mobilization strategies will help populations experiencing inequities feel valued and would

encourage future engagement and trust in research [75]. In addition, guideline developers could collaborate with community partners who represent populations experiencing inequities to help identify and codevelop knowledge mobilization strategies through a variety of accessible formats (eg, plain language summaries, webinars, and educational videos).

3.1.7. Evaluation and impact

Principle 7: Integrating health equity considerations in the guideline development process is evolving as we develop more understanding about cocreation and codevelopment with people with lived experiences of inequities and new practice and novel methodological approaches continue to emerge. Developing formal evaluation strategies to assess the impact of these considerations in the guideline development process, the impact of the equity-informed guideline recommendations and their uptake among populations experiencing inequities, is urgently needed [15]. When evaluating the impact of the recommendations, one should not only measure the effectiveness of the recommendations in improving health outcomes but also how well underlying barriers to recommendation impact, such as access to care and other social determinants of health, were addressed in relation to these outcomes [76,77]. The findings from these assessments should inform the timing and direction of future updates.

Evaluating all these aspects of guideline development may help ensure that guidelines are responsive to emerging evidence and societal changes identify areas for improvement. By embedding regular feedback loops for these assessments, developers can monitor the guidelines' effectiveness in addressing health inequities and the needs of populations experiencing inequities. Future guideline updates can then address any residual or disproportionate burden of disease that remains. Ultimately, this approach ensures that the guidelines remain responsive to emerging evidence and societal changes, maintaining their relevance and adaptability in the face of new challenges and evolving contexts. In turn, guideline developers may need to revisit how they articulated health equity in the guideline.

4. Discussion

4.1. Implications of using the principles in research and practice

Equity considerations are needed in the guideline development process. They are relevant to all types of guidelines, including those specifically focused on populations experiencing inequities as well as those addressing broader or general populations. We propose in this manuscript seven principles for integrating health equity considerations in the guideline enterprise. The purpose of these principles is to expand the perspective of guideline developers regarding the integration of equity considerations and to support a systematic, streamlined approach to addressing health equity throughout the guideline enterprise. The methods used to apply these principles depend on unique goals, processes, and resources of the guideline development organization.

We are currently applying these principles to guide the development of an equity extension for the GIN-McMaster guideline development checklist [25], a tool aimed to enhance health equity considerations in the planning and development of practice guidelines (paper accepted) [78]. Beyond this specific checklist, the principles can also be used to inform the development of other tools, frameworks, or processes that seek to operationalize these principles and inform the integration of health equity considerations into various stages of guideline development. To enhance the feasibility and applicability of these principles across diverse contexts, future research should explore practical strategies for their implementation, particularly in low-resource settings, such as with the use of the Adolopment approach [79].

Through the development of these principles, we have recognized significant gaps in evaluating the impact of guidelines, specifically with regards to health equity. This is a critical step to understand the "success" of building health equity considerations in guidelines. We call on researchers and guideline developers to prioritize efforts in this area through the development of robust methods and metrics to assess the impacts of guideline recommendations on health equity. We also need better training for researchers, guideline developers, and commitment to lifelong learning on how to integrate equity considerations into guideline processes across different settings and evolving needs.

5. Conclusion

This paper presents seven consensus-based principles designed to support guideline-developing organizations and societies when incorporating health equity considerations into the guideline development process. These principles serve as a template for organizations to develop tools and frameworks tailored to their setting. By applying these principles, users can transparently and systematically integrate equity considerations, fostering the development of equity-informed recommendations. Although health equity methods are still evolving, we believe that these principles provide a strong foundation applicable across various guideline development methods. However, we plan to evaluate these principles over time to ensure their ongoing relevance and effectiveness through relevant channels including the Cochrane equity thematic group and GRADE equity project group. We welcome readers to join our

initiatives and contribute to advancing health equity considerations in practice guidelines.

Ethics statement

This study was approved by the University of Ottawa Ethics Board (H-03-24-10188) and conducted in accordance with their policies and procedures.

CRediT authorship contribution statement

Omar Dewidar: Writing − original draft, Visualization, Methodology, Conceptualization. **Andrea J. Darzi:** Writing − original draft, Visualization, Methodology, Conceptualization. **Shahab Sayfi:** Writing − review & editing, Methodology. **Jordi Pardo Pardo:** Writing − review & editing, Methodology. **Vivian Welch:** Writing − review & editing, Methodology. **Grace C. Wright:** Writing − review & editing, Methodology. **Elie A. Akl:** Writing − review & editing, Methodology. **Joanne Khabsa:** Writing − review & editing, Methodology. **Jennifer S. Lin:** Writing − review & editing, Methodology. **Rebecca L. Morgan:** Writing − review & editing, Methodology. **Kevin Pottie:** Writing − review & editing, Methodology. **Janice Tufte:** Writing − review & editing, Methodology. **Jana Khawandi:** Writing − review & editing, Methodology. **Xiaoqin Wang:** Writing − review & editing, Methodology. **Oyekola Oloyede:** Writing − review & editing, Methodology. **Tamara Lotfi:** Writing − review & editing, Methodology. **Xiaomei Yao:** Writing − review & editing, Methodology. **Ana Carolina Pereira Nunes Pinto:** Writing − review & editing, Methodology. **Yuan Chi:** Writing − review & editing, Methodology. **Reem A. Mustafa:** Writing − review & editing, Methodology. **Holger J. Schünemann:** Writing − review & editing, Validation, Supervision, Methodology, Funding acquisition, Conceptualization. **Peter Tugwell:** Writing − review & editing, Validation, Supervision, Methodology, Funding acquisition, Conceptualization.

Declaration of competing interest

O.D., V.W., E.A.A, K.P., and P.T. are the coleads of the GRADE equity project group. The previously mentioned authors and J.P.P. have authored some of the guidance cited in this manuscript. A.J.D. and J.P.P. are the coleads of the equity in implementation tools category of the Cochrane equity thematic group. There are no competing interests for any other author.

Data availability

No data was used for the research described in the article.

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