

Towards a decolonising implementation science: principles from Indigenous leadership



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Implementation science is a diverse and evolving field that draws on multiple epistemologies and methods. However, the dominant foundations of implementation science remain settler colonial, biomedical, and positivist. In Indigenous and other marginalised settings, these foundations can result in poor epistemological, ethical, and practical fit. We argue that a paradigm shift that is grounded in Indigenous values, sovereignty, relationality, and epistemologies is needed. We propose seven guiding principles for a decolonising implementation science. Drawing from emerging scholarship and innovative Indigenous-led frameworks from the USA, Aotearoa New Zealand, and Australia, these principles centre sovereignty, strengths-based approaches, and relational accountability. These principles also offer a roadmap to redefine rigour, expand what counts as evidence, and ensure genuine community control over the research process. Although born from Indigenous experience, these principles provide a framework for transforming implementation science to be more just, equitable, and effective for marginalised communities globally.

Introduction

The *Lancet Global Health's* 2025 call to action asserted that recent disruptions in global health funding create a key opportunity for implementation science to help decolonise global health.¹ We use decolonisation to mean the active and ongoing process of identifying and dismantling the enduring logics, power structures, and epistemologies of colonialism.² Implementation science is a diverse and evolving field that incorporates a wide range of epistemologies and methods (including those grounded in Indigenous knowledge, participatory approaches, and systems thinking),^{3,4} yet its foundations are anchored in settler colonial, biomedical, and positivist traditions. The field of implementation science often favours particular study designs (eg, randomised controlled trials), emphasises fidelity to designated evidence-based interventions, and presumes top-down adaptation or scale-up from central sources to local communities.⁵ In Indigenous and other colonised or marginalised communities, the application of these theories can result in poor epistemological, ethical, and practical fit,⁶ risking reproducing colonial structures and, ultimately, reinforcing the same health inequities that implementation science aims to reduce.⁷

For implementation science to catalyse decolonisation in global health, we argue that implementation science would first benefit from a paradigm shift grounded in and guided by Indigenous values, sovereignty, relationality, and epistemologies. We introduce seven principles derived from Indigenous knowledge systems and histories of successful research partnership with Indigenous communities, which offer a roadmap to expand the foundation of implementation science—including its theories, models, frameworks, methods, strategies, and outcomes—to advance global health equity and justice for all people. Although centred in Indigenous priorities and leadership, these principles are broadly transferable and offer a decolonising orientation that honours local knowledge, governance, and power relations.

Current landscape and limitations of the foundations of implementation science

We conducted a targeted literature search of PubMed, Google Scholar, and Elicit to identify sources related to Indigenous approaches to implementation science from database inception to July 14, 2025. Search terms included “Indigenous”, “implementation science”, “decolonizing”, “theoretical framework”, and related concepts. The search had no restrictions based on publication date, language, or study design.

As argued by Linda Tuhiwai Smith, settler colonial and biomedical research traditions have a long history of colonising knowledge through the imposition of settler worldviews and classifications that erase Indigenous voices and solutions.⁸ The foundations of implementation science were largely developed within well-resourced settler health systems (eg, systems established by colonial powers that remain on Indigenous lands, such as in the USA, Canada, Australia, and Aotearoa New Zealand), and reflect those traditions.⁹ Common features of foundational approaches complicate their application and limit their relevance in Indigenous and other marginalised communities. We summarise these issues in panel 1, which was developed from a synthesis of the literature cited in this paper and the collective experience of the author team. These foundational approaches systematically favour knowledge generated by academics and other experts who are socially and geographically distant from the implementation context, deeming it evidence-based practice. This is prioritised over practice-based evidence: the knowledge that communities have developed from generations of pragmatic experimentation.¹⁰ This epistemic hierarchy elevates settler colonial and biomedical knowledge above thousands of years of wisdom, and treats the core evidence of an intervention as a transportable object that is able to be separated from its original creators and the relational context—the connections between people, land, and community—in which it was created. In contrast, Indigenous ways of knowing (as documented across

Lancet Glob Health 2026;
14: e296–301

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Panel 1: Contrasting foundational and Indigenous approaches in implementation science

Potential issues with foundational approaches to implementation science

- Emphasis on evidence-based practice over practice-based evidence
- Externally driven and deficit-oriented
- Equity emphasised only recently
- Technical and jargon-heavy
- Poor alignment with Indigenous ways of knowing
- Insufficient attention to social determinants

Alternative Indigenous approaches to implementation science

- Affirming and valuing local practice-based evidence and traditional knowledge
- Community driven and strengths-based, with a focus on Indigenous leadership
- Equity and sovereignty embedded as core guiding principles
- Accessible and community-centred, with the use of shared terminology
- Integrating and building on Indigenous research methods, ontologies, and epistemologies
- Holistic frameworks addressing upstream social determinants of implementation success

Native American, Alaska Native, First Nations, Māori, and Australian Aboriginal communities) emphasise that knowledge is inseparable from its context, creators, and relationships, all of which are essential for meaning and usefulness.¹¹ Especially in Indigenous communities, the pressure to implement an intervention often comes from outside of local practice settings and stems from the priorities of national funders, health systems, or academic researchers rather than from the communities.¹² Implementation research efforts are also often deficit-oriented and focused on overcoming contextual weaknesses and local barriers to implementation, rather than building on community strengths. Furthermore, the theories, models, and frameworks (hereafter, frameworks) that are central to these mainstream approaches tend to be technical and jargon-heavy, which creates barriers to practical application by implementers and community partners in real-world settings.¹³ Despite the turn towards health equity and recognition of the importance of context in recent years, this focus often layers these considerations onto existing frameworks that are not originally designed to address them.¹⁴ As a result, dominant frameworks continue to focus on narrow barriers that are centred around providers or organisations, and largely overlook or underemphasise the more profound social determinants of implementation: the structural, historical, economic, and cultural forces (eg, racism, biases, and chronic underfunding of health systems) that hinder

implementation success. In Indigenous communities, these forces are understood through the lens of the Indigenous determinants of health, which encompass not only the harms of historical trauma from attempted genocide and forced relocation but also the healing power of cultural continuity and sovereignty.¹⁵ Therefore, there is a pressing need to expand the foundations of implementation science in ways that respect and uplift Indigenous sovereignty and culture, incorporate Indigenous ways of knowing and doing, and recognise the inherent strengths of Indigenous communities through strengths-based, participatory, and relational approaches.

Principles for a decolonising implementation science

We introduce seven guiding principles to operationalise this decolonial agenda. Drawing from a synthesis of emerging scholarship¹⁶ and an analysis of existing Indigenous-led frameworks identified through our targeted search, these principles offer a coherent and actionable framework for reorienting implementation science towards the remediation of the historical and ongoing suppression of Indigenous and other non-hegemonic knowledge systems.¹⁷ These principles detail how implementation science can be reimaged within non-hegemonic and Indigenous ontologies and epistemologies; that is, from within communities' distinct ways of gathering and holding knowledge. This reimagining is not an anti-science perspective; rather, we advocate for expanding the boundaries of knowledge. In practice, this reimagining means transforming implementation science theories to centre the structural and historical determinants of both health and implementation success; redesigning implementation strategies to value approaches that are unique to each community; and expanding implementation outcomes to reflect Indigenous and other diverse marginalised worldviews. Although these principles are born from Indigenous experience, they can help correct colonial legacies and foster more ethical and effective implementation science engagement with communities that have been marginalised by the settler colonial and biomedical research enterprise (panel 2).

Indigenous innovation and principles in action

A growing movement of innovation led by Indigenous researchers is already reshaping implementation science, rooted in the foundations of community-based participatory research, tribal participatory research, and community-led research.²⁴ Scholars and communities are developing new models grounded in Indigenous knowledge systems that centre sovereignty and relational accountability. Panel 3 shows how our seven principles could be applied and refined in practice across diverse settings, with a hypothetical case study outlining this application across the lifecycle of a project.

He Pikinga Waiora (Aotearoa New Zealand)

This framework for implementation of chronic disease interventions exemplifies how to build frameworks from within specific Indigenous epistemologies. Grounded in Kaupapa Māori (Māori philosophy), He Pikinga Waiora (Enhancing Wellbeing) integrates four core elements: cultural-centredness, community engagement, systems thinking, and integrated knowledge translation.²⁶ He Pikinga Waiora explicitly operationalises Principle 1 (sovereignty) through its foundation in Māori self-determination (tino rangatiratanga). The focus of He Pikinga Waiora on cultural-centredness and deep community engagement directly aligns with Principle 2 (strengths-based framing) and Principle 4 (Indigenous methods and strategies). In practice, research teams have used co-design approaches to adapt intervention delivery

mechanisms with Māori partners (eg, defining target audiences, venues, and workforce roles). Evaluations have noted subsequent improvements in bodyweight and quality of life.²⁶

Indigenous Systems Alignment Framework (USA)

This emerging framework shows how Indigenous communities can adapt and indigenise mainstream systems-level models. Developed from a practice-based study with US tribal partners, the framework reinterprets the core components of the Georgia Health Policy Center's Framework for Aligning Systems—purpose, governance, data, and finance—with Indigenous worldviews.²⁹ The framework exemplifies Principle 1 (sovereignty) by centring tribal governance, Principle 4 (Indigenous methods and strategies) by operationalising

Panel 2: Principles for a decolonising implementation science

Principle 1: sovereignty

Central to a decolonising implementation science is explicit recognition of all communities' inherent right to self-determination. Engagement needs to be grounded in the political and legal realities of sovereignty, treaties, and trust responsibilities. Indigenous and other marginalised communities should retain ultimate authority over all aspects of the research process, including the collection, analysis, interpretation, and dissemination of their data.¹⁸ We note that academic freedom should not supersede sovereignty, but needs to be exercised in respectful relationship with it.

Principle 2: strengths-based framing

A decolonising implementation science should elevate community strengths, resilience, and inherent capacities through local leadership and participation. This approach counters deficit-oriented narratives that have long pathologised Indigenous and other marginalised people and instead recognises culture and ceremony as powerful protective buffers against historical trauma.¹⁹ This framing also recognises structural strengths. For example, many Indigenous nations and communities take a holistic view of health and offer integrated public health, health-care, traditional care, and social services.

Principle 3: social and Indigenous determinants

A decolonising implementation science needs to acknowledge the profound impact of historical trauma, systemic racism, colonisation, culture, language, and land connection on the implementation of services in Indigenous and other communities. Implementation frameworks should be expanded to integrate these determinants as core analytic components, aligning with concepts such as the Indigenist Ecological Systems Model.²⁰ This expansion also facilitates the development of new implementation theories, models, and frameworks that are rooted within Indigenous and other non-hegemonic ontologies.

Principle 4: Indigenous methods and strategies

A decolonising implementation science explicitly values local ways of knowing and doing, promoting cultural congruence

and respect by building upon existing effective practices and healing traditions (eg, methods centred around leadership by respected community knowledge holders).²¹ Relational and culturally embedded methods and strategies, shared decision making, and trauma-informed and culturally integrated implementation should be elevated.²² The use of Indigenous and other non-settler languages during the research process is another powerful decolonising strategy.

Principle 5: community definitions of success

A decolonising implementation science will create opportunities to understand implementation success from diverse ontological perspectives and approaches to evaluation. For example, what does sustainability mean when viewed through an intergenerational lens? Can we expand fidelity to include cultural congruence and cultural safety? Redefining outcomes in this way ensures that results reflect what matters the most to Indigenous communities.

Principle 6: sustainability and building capacity

This principle extends beyond implementation research methods to include building community expertise in areas such as financial management, data sovereignty, evidence dissemination, programme scale-up, and policy advocacy. Building relationships between research teams and community members that are grounded in respect, trust, and reciprocity is crucial.

Principle 7: diversity

Indigenous and other marginalised people represent a plurality of cultures, identities, and experiences. A decolonising implementation science needs to recognise common histories of colonisation and use an intersectional lens to account for the diversity within and across communities. This approach avoids universalising experiences across communities and perpetuating intracommunity inequities.²³

Panel 3: Applying the principles of a decolonising implementation science

This hypothetical case study shows how the seven principles could translate across the lifecycle of a single project.

1. Context and governance

A tribal health department initiated a project in partnership with a university research team to strengthen diabetes care in their community. Diabetes was identified as a key health concern through the tribe's recent community health assessment. Grounded in Principle 1 (sovereignty), the tribal council passed a research agreement, governed by tribal law, that established full tribal ownership and decision-making authority over project aims, data, and dissemination. The university's role was to support—rather than direct—the tribe's vision. The agreement operationalised CARE Principles for Indigenous Data Governance,²⁵ required tribal institutional review board approval for all activities, and specified memorandums of understanding that strictly limited external data access to the specific study timeframe and analytic goals.

2. Design and methods

The project centred Principle 4 (Indigenous methods and strategies) by combining local knowledge systems with clinical guidelines. This co-design process is consistent with the approach described in the He Pikinga Waiora framework.²⁶ Through community design workshops, the research team and community collaborators mapped cultural assets—such as language, kinship roles, and food sovereignty—to diabetes care choices (Principle 2: strengths-based framing). The design also acknowledged Indigenous determinants of implementation (Principle 3: social and Indigenous determinants), recognising historical trauma as a potential barrier to engagement and leveraging community strengths (eg, strong trust networks) to facilitate participation. The team also facilitated cross-sector alignment between the clinic, public health, and social services, which was an approach that was supported by the Indigenous Systems Alignment model.²⁷

3. Implementation and adaptation

Implementation was guided by a relational approach that prioritised process over pace (Principle 4: Indigenous methods and strategies). To ensure long-term sustainability and capacity building (Principle 6: sustainability and building capacity), the project resulted in tangible, reciprocal benefits, including certifying and paying local community members to serve as health coaches. This practice of centring reciprocity and building relationships aligns with the process foundations of the Model of Engaging with Communities Collaboratively.²⁸ Furthermore, youth (aged 16–24 years) were engaged as paid facilitators who supported outreach, session logistics, and intergenerational activities that linked older adults living with diabetes (including tribal Elders [as defined by the community]) with health coaches and services. This intergenerational model strengthened connection and mutual support (eg, reducing isolation among older adults and supporting youth mentorship and cultural continuity). People living with diabetes and caregivers were also engaged through community design workshops and a community advisory group that guided adaptation and evaluation.

4. Measurement and outcomes

Data collection combined clinical metrics with Indigenous methods (Principle 4: Indigenous methods and strategies), such as using talking circles and digital storytelling to gather qualitative feedback on the programme's cultural safety and relevance. In line with Principle 5 (community definitions of success), the team tracked clinical measures (eg, glycated haemoglobin) alongside indicators such as relational trust, workforce retention, and cultural safety. These measures ensured that the programme was responsive to the community's internal diversity, including those experiencing poverty or living in rural areas (Principle 7: diversity). After 1 year, the tribal council reviewed all findings and approved dissemination with a community-authored narrative that provided essential context.

accountability to communities as a non-transactional obligation that extends beyond professional roles, and Principle 3 (social and Indigenous determinants) by prioritising integrated tribal data systems and data sovereignty to overcome fragmentation and support self-governed decision making.²⁷

Model of Engaging with Communities Collaboratively (Australia)

Developed with extensive Indigenous input and applied in partnership with Indigenous communities in Australia, this model integrates cultural adaptation and implementation science with a community-based participatory research and co-design approach. The model operationalises Principle 4 (Indigenous methods and strategies) via five process foundations—relationship building, mutual respect, mutual trust, mutual benefit, and empowerment—and advances Principle 1 (sovereignty) and Principle 2 (strengths-based framing) by beginning with community-identified concerns and solutions, ensuring shared decision making throughout, and requiring community approval of all knowledge dissemination. The cyclical and collaborative process is explicitly designed to shift research from being done on Indigenous people to being done with and by Indigenous people, thereby reflecting Principle 6 (sustainability and building capacity). Research teams are encouraged to maintain cultural advisory groups, document adaptations, pilot with local implementers, and formalise a dissemination approval step that requires community sign-off before presentations or publications.²⁸

Conclusion

Answering *The Lancet Global Health's* call to action requires a direct confrontation with colonial definitions of rigour and power. In a decolonial paradigm guided by Indigenous values and methods, rigour would be redefined—not as rigid fidelity to external models but as a focus on validity, relevance, and impact within community contexts. Community-led decision making around outcomes and relational methods would increase rigour, not dilute it. This paradigm offers a model that moves towards genuine community control over the entire research lifecycle, which includes setting research agendas, directing budget allocation, maintaining data ownership, and having final approval on what is published. These lessons are not limited to Indigenous contexts, but provide a roadmap for the entire field of global implementation science to address foundational blind spots.³⁰ The core elements outlined in this paper—including community co-design, power-sharing governance, attention to structural determinants, and culturally congruent measurement—provide a blueprint for an approach to implementation science that works to remediate historic harms and redistribute power, resources, and decision-making authority back to the communities it serves. These principles could be applied

to work with communities who have been marginalised and colonised globally.

Decolonising implementation science through an Indigenous lens will be an important part of the journey towards achieving equity and justice in global health. However, operationalising this approach would involve several changes. Funders could move towards direct payment models that allow communities to set their own research agendas and work with academic partners in ways that centre the priorities of the communities. This process should be paired with an appreciation for the time and flexibility that are needed to build trust and relational foundations for research. Academic journals and institutions could mandate transparent reporting of power-sharing processes, promote epistemic diversity by valuing and elevating Indigenous and relational methodologies, and require adherence to reporting guidelines (eg, the consolidated criteria for strengthening the reporting of health research involving Indigenous Peoples [CONSIDER] statement) to ensure ethical and comprehensive research reporting.³¹ Academic bodies could also create pathways for the participation and incentivisation of community-based authors. Implementation science training programmes could build and offer access to courses on Indigenous methodologies, relational ethics, anti-racism, and the historical and structural determinants of health. Crucially, these efforts need to be linked to Indigenous workforce development for service delivery, implementation oversight, and research leadership, which will enhance cultural alignment, promote socioeconomic development, and improve service effectiveness.³² Broadly, we call for global implementation science to embrace non-hegemonic and Indigenous epistemologies and community-driven approaches, which could transform the foundations of global health practice.

Positionality

We are a group of Indigenous and ally implementation and public health researchers based at academic institutions in the USA. Our work is shaped by our commitment to partnering with Indigenous communities to support their health and wellness priorities. We write this paper from our distinct positions. CGK (Ngāi Tahu) is a Māori and Pākehā (English and Scottish) cisgender man. Raised in the USA in a predominantly White, affluent community away from his Māori whānau (family), he is now reconnecting. CGK's work focuses on defining and building the promise of an Indigenous implementation science and the delivery of health services that honour and build from the effective and healing practices that already exist within communities. LW (Choctaw Nation of Oklahoma) is a trained social worker whose research focuses on the cultural adaptation of mental health treatments for American Indian and Alaska Native communities. LW combines community-based participatory research with implementation science to develop and disseminate interventions for depression, trauma, and substance use that are grounded in the cultural context and strengths of the communities she serves. EEH is a non-Indigenous ally and epidemiologist who uses implementation science to support suicide prevention and mental health services in partnership with Indigenous communities globally. EEH is committed to strengths-based and community-led research, and the advancement of tribal data sovereignty to ensure that communities own and control their own information. DW (Oglala Lakota) is a physician and a leading voice in public health policy and education in Indigenous communities. DW serves as the

Co-Director of the Center for Indigenous Health at Johns Hopkins University. DW's work is grounded in Lakota values and focuses on addressing health disparities by building on cultural strengths and centring the crucial importance of sovereignty and cultural continuity in health.

Contributors

CGK conceptualised the paper and wrote the initial draft of the manuscript. EEH, DW, and LW all contributed to the conceptualisation and provided critical revisions and intellectual content. All authors reviewed and approved the final manuscript for submission.

Declaration of interests

We declare no competing interests.

Acknowledgments

The authors have received funding support from the Johns Hopkins Center for Indigenous Health Willow Fund (CGK, EEH, and DW), the US National Institute of Allergy and Infectious Diseases (P30AI094189 [CGK]), the US National Institute on Drug Abuse (P50DA058619 [CGK, EEH, and DW] and R01DA057913 [CGK and EEH]), and the US National Institute of Mental Health (R01MH128518 [CGK and EEH]; R25MH084565 [LW]; and R01MH136768 [LW]).

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