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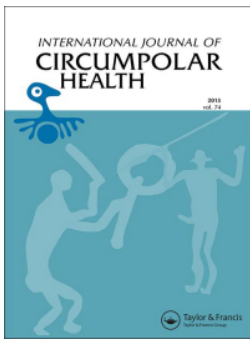
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





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Cultural competence and safety in Circumpolar countries: an analysis of discourses in healthcare

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ABSTRACT

Circumpolar Indigenous populations continue to experience dramatic health inequities when compared to their national counterparts. The objectives of this study are first, to explore the space given in the existing literature to the concepts of cultural safety and cultural competence, as it relates to Indigenous peoples in Circumpolar contexts; and second, to document where innovations have emerged. We conducted a review of the English, Danish, Norwegian, Russian and Swedish Circumpolar health literature focusing on Indigenous populations. We include research related to Alaska (USA); the Yukon, the Northwest Territories, Nunavik and Labrador (Canada); Greenland; Sápmi (northmost part of Sweden, Norway, and Finland); and arctic Russia. Our results show that the concepts of cultural safety and cultural competence (cultural humility in Nunavut) are widely discussed in the Canadian literature. In Alaska, the term relationship-centred care has emerged, and is defined broadly to encompass clinician-patient relationships and structural barriers to care. We found no evidence that similar concepts are used to inform service delivery in Greenland, Nordic countries and Russia. While we recognise that healthcare innovations are often localised, and that there is often a lapse before localised innovations find their way into the literature, we conclude that the general lack of attention to culturally safe care for Sámi and Greenlandic Inuit is somewhat surprising given Nordic countries' concern for the welfare of their citizens. We see this as an important gap, and out of step with commitments made under United Nations Declarations on the Rights of Indigenous Peoples. We call for the integration of cultural safety (and its variants) as a lens to inform the development of health programs aiming to improve Indigenous in Circumpolar countries.

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Highlights



- Circumpolar Indigenous populations experience dramatic health inequities compared to their national counterparts.
- Cultural safe care ensures better communications between service providers and users.
- These concepts have currency in Alaska, Canada and Norway.
- All Circumpolar countries should implement cultural safe care to improve Indigenous health.

Introduction

In recent decades, research exploring health inequities affecting Indigenous and minority populations has drawn attention to cross-cultural communication,

misunderstandings, and experiences of interpersonal and systemic racism in healthcare settings – and to their contribution to poorer health outcomes in these populations. As a result, a number of key concepts such as cultural competence and cultural safety have emerged, with the aim of sensitising healthcare providers and systems to the needs of their minority service users.

The purpose of this article is first, to explore the space given in the existing literature to the concepts of cultural safety and cultural competence, as it relates to Indigenous peoples in Circumpolar contexts; and second, to document where innovations have emerged. Our study initially attempted to identify whether and how the concepts of cultural competence and cultural safety were used in Circumpolar countries, to then focus on their use, where applicable, in relation to

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Circumpolar Indigenous populations. We began with English search terms, cultural* safe*, cultural competence*, cultural humility, cultural* responsive*, cultural relevant*, and focused document retrieval to studies and reports related to Indigenous populations in the countries under study. We noticed that the literature located was primarily published in English, in Canada and the USA. We noted that in Alaska, the terms relationship-centred care, used by the Nuka model of care, had more currency. Translations of the concepts (for example, *kulturkompetanse*, *kulturell kompetanse* in Norwegian, or *kulturkompetens*, *kulturell kompetens* in Swedish) yielded no document. We then decided to look at how each country discusses addressing the cultural needs of Indigenous patients in the clinical encounter, if at all.

We begin this paper by first discussing the concepts of cultural safety and cultural competence at greater length. We then focus on defining the Indigenous Circumpolar north, and describing access to health services in each jurisdiction represented, and the existing literature related to concepts of cultural competence and safety in each jurisdiction. We conclude with recommendations for the inclusion of cultural safety as lens to inform practices, principles and policies with Indigenous communities in the Circumpolar north. This work is being pursued in the context of the Fulbright Arctic Initiative programme. The authors are established scholars in their respective countries, actively engaged in Circumpolar health research in partnership with Indigenous communities and organisations. Our collective purpose is to highlight areas where Circumpolar health and policy developments hold promises for improving the health and wellbeing of Indigenous peoples.

We believe that this paper is timely. Health outcomes among Indigenous populations living in Circumpolar regions remain far poorer when compared to other Indigenous and non-Indigenous populations globally [1]. Recognising that health disparities are multi-dimensional, we focus on constraints associated with healthcare system design and service delivery, which might be more readily addressed. We draw on the *United Nations Declaration of on the Rights of Indigenous Peoples* (UNDRIP) as an overall framework for this paper. UNDRIP, Article 24, states that:

- (1) Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals.
Indigenous individuals also have the right to

access, without any discrimination, to all social and health services.

- (2) Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. **States shall take the necessary steps with a view to achieving progressively the full realisation of this right** [2, p.9, emphasis added].

In this paper, we acknowledge that operationalising Article 24 of UNDRIP requires state-supported multi-level interventions. We focus on one such concept: health systems reframing services through the lens of cultural competence and cultural safety, where service users are Indigenous peoples. A total of 143 countries have endorsed UNDRIP, including seven of the eight Arctic Council member states, Russia being the exception. Non-ratified international documents have influenced Russian legislation and function of governmental authorities: since 1993, the Russian Constitution guarantees the rights of Indigenous peoples “in accordance with generally recognized principles and norms of international law” [3, article 69]. The Arctic Council is a high-level intergovernmental forum created to provide a means for promoting cooperation, coordination and interaction among the Arctic States, with the involvement of the Arctic Indigenous communities and other Arctic inhabitants. Arctic member states include Canada, the Kingdom of Denmark (including Greenland and the Faroe Islands), Finland, Iceland, Norway, Russia, Sweden and the USA. Our article focuses on only seven of the member states, since Iceland does not have an Indigenous population as defined by the United Nations [4].

Introducing the concepts of cultural competence and cultural safety

Cultural competence first emerged as a concept in the field of social work in the early 1990s, and has since gained currency in other domains, including healthcare [5]. Cultural competence focuses on organisations and professionals adopting

procedures and activities to be used in acquiring culturally-relevant insights into the problems of minority clients and the means of applying such insights to the development of intervention strategies that are culturally appropriate to clients [6, p. 4].

Some have framed cultural competence as a form of “ethnocultural matching” which may be enacted through the governance of the organisation, the identity of the practitioners, and the type of services

provided [7]. Examples of this include the creation of parallel Indigenous controlled health services [8–12], or the development and implementation of initiatives designed with and for Indigenous population groups [13–15]. Cultural competence focuses on improving providers' awareness of patients' culture, in the hope to improve the effectiveness of communications in the clinical encounter. It is silent on issues of systemic racism and power relations.

The concept of cultural safety emerged in 1992, following pressures from Māori service users and service providers to improve the responsiveness of services to Māori, in the hope of improving health outcomes. To Ramsden, a Māori nurse-scholar from Aotearoa/New Zealand largely credited with the creation of the concept, "cultural safety" is part of a continuum that begins with cultural awareness, moves to cultural competence, and ends with cultural safety as a more in-depth commitment to providing better care for minority service users [16]. Ramsden saw cultural competence as insufficient and somewhat misguided, promoting a scripted approach rather than an approach to care that is centred on patients as actors within their own historical, socio-political and economic contexts [17]. Cultural safety was then defined as

the effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on her own cultural identity and recognizes the impact of the nurses' culture on own nursing practice [18].

The concept became a required part of nursing and midwifery education in Aotearoa in 1992. Wood and Schwass added guidelines to support its operationalisation in practice, instructing providers to avoid the culturally unsafe 3Ds: Diminish, Demean, Disempower, and focus instead on the 3Rs: Recognise, Respect, Rights [19]. While cultural competence has at times been operationalised as learning about a catalogue of beliefs or attention to language skills, cultural safety was intended to challenge the power imbalance and inequitable social relationships often grounded in systemic racism that exist in cross-cultural clinical encounters [20,21]. These imbalances exist where providers steeped in non-Indigenous cultures interact with Indigenous service users and their families, whose cultural practices and knowledge have been ignored, trivialised, and undermined through historic and ongoing colonialism. The concept focuses on the relationship between the service user and the provider, while also privileging health system and policy responses to counter systemic racism and other forms of discrimination.

The concepts of cultural safety and cultural competence might be seen as complementary, focusing on different dimensions of care: cultural safety focuses on a whole system's approach, whereas cultural competence could be seen as related to the provider's skillset or the way in which healthcare is understood and implemented. The contours of these concepts are blurred, making a sharp differentiation difficult when assessing interventions. This blurriness may also lead to confusion between cultural and clinical competence [22,23]. Critiques of the concepts have argued that they lack intellectual consistency [20,24]. The authors also noted that cultural safety underestimates the impact of systems, the broader social-ecological environment, power relations, and social determinants of health that shape the clinical encounter.

Both cultural competence and cultural safety tend to conceptualise service users as a generic cultural "other" to the provider [25], and underestimate heterogeneity within cultures, and resulting complexities [7]. Their relevance might also be underestimated when patients and providers share a culture, but may not share the same class, education, and other privileges. Despite these shortcomings, cultural competence and cultural safety are aspirational ideals, and could lead to better understanding between service providers and users, more relevant care plans, enhanced adherence, and better outcomes [26].

More recently, the concept of relationship-centred care has emerged, primarily in relation to the Alaska-based and Indigenous-driven Nuka system of care [discussed below, 27,28]. Relationship-centred care is founded on 4 principles: "(1) that relationships in health care ought to include the personhood of the participants, (2) that affect and emotion are important components of these relationships, (3) that all health care relationships occur in the context of reciprocal influence, and (4) that the formation and maintenance of genuine relationships in health care is morally valuable" [29, p. 1]. This approach highlights service user-clinician (based on respect, recognition of cultural differences), clinician-clinician (case management, continuity of care) and clinician-community (community engagement, address determinants of health, engagement with policy), and clinician relationship with self (self-awareness) relationships. Although relationship-centred care was created as a critique of patient-centred care which at times focuses on a patient with little consideration for their social-economic and cultural context [30], the concept is multi-dimensional, and addresses some of the shortcomings expressed in relation to cultural competence and cultural safety [29]. This model of care is imbedded in an Indigenous-centric organisation, the

Southcentral Foundation, which actively works to redress systemic exclusion and discrimination, to address power relations in the clinical encounter by framing patients as “customer-owners”, and to create a safe care environment for Indigenous patients and their family. The Foundation does not frame its approaches along the language of cultural safety [31], and does not explicitly acknowledge the role of historical trauma in reproducing inequities.

Culturally safe or culturally competent movements have emerged in parts of Europe, Oceania, and North America [32]. In Europe, including Scandinavian countries, the focus appears to have been primarily on strategies to meet the needs of migrants and newcomers: the needs of Indigenous populations within these countries appears to have been largely overlooked, at least in the literature.

Healthcare among Indigenous peoples around the Circumpolar north

In this article, we define the Circumpolar north to include the US state of Alaska; Canada’s three territories (the Yukon, the Northwest Territories, and Nunavut), the northern part of the province of Quebec known as Nunavik, and Labrador, the northern most part of the province of Newfoundland and Labrador; Greenland, which is an autonomous constituent country within the Kingdom of Denmark; Sápmi, the cultural region traditionally inhabited by the Sámi people, located in the northmost part of Sweden, Norway, and Finland; and arctic Russia. Although important similarities exist, important differences also exist across Circumpolar jurisdictions, as summarised in Table 1.

We assume that health policies informed by discourses of cultural competence and cultural safety are essential to ensure the fulfilment of Arctic states’ health-related responsibilities towards Indigenous populations. We acknowledge that organising health-care delivery in Circumpolar communities is complex, as a result of political history, geography, climate, and low population density [1]. In some jurisdictions, policies implemented in rural and remote regions were originally developed with urban contexts in mind [47]. This poses challenges to the creation of adapted system designs, and perpetuates health inequities for Indigenous and non-Indigenous residents of these regions. Indigenous peoples living in Circumpolar rural and remote communities face additional challenges seeking specialised care only available in larger urban centres (Anchorage, Edmonton, Winnipeg, Ottawa, Montreal, St Johns, and Copenhagen come to mind), where linguistic, cultural, and contextual

misunderstandings can compromise the quality of care they receive [1].

Nunavut and Greenland have relatively small populations, which are primarily Indigenous. Their health systems are designed to serve all residents. Parallel Indigenous-centric services do not exist in Greenland and Nunavut: such an approach would be impractical, and undesirable. Challenges with providing culturally appropriate care however remain: the majority of the care continues to be delivered by non-Indigenous providers trained in southern Canada or Denmark, with a limited awareness of how their own culture shapes their practice.

Countries where the Indigenous population is proportionally relatively small and arguably more vulnerable to policy shifts with little opportunity for meaningful Indigenous engagement (Finland, Norway, Russia, and Sweden) have few specific provisions to ensure that services are culturally appropriate [10,48–55]. However, some progress has been made in these countries that address the implementation of culturally safe services. For example, Norway created SANKS a Sámi-centric mental health service in 2001, located in the Sámi core areas [10,56], and are now in the process of expanding those services to other health domains [57]. Furthermore, those services are theoretically open for access to all Sámi in Norway, as well as Sámi in (some) healthcare regions in Sweden and Finland. Sweden and Finland have entered into border-crossing agreements with Norway to amend shortcomings in their own systems, opening up for referring some of their Sámi mental healthcare service users to the Norwegian Sámi-centric services [58,59].

Articles 41 and 72 of the Russian Federation’s Constitution provide a framework for health related rights for Russian citizens, and obligates the federal and regional governments to design and finance target programs “for health protection and health services; facilitating health safety, physical culture and sport promotion, environmental and sanitary-epidemiological well-being” [3]. Article 69 guarantees these rights for Indigenous small populations [3]. The Russian Federation adopted the Federal law “Guarantees of the Rights of Indigenous Peoples in the Russian Federation” in 1999. Although the law includes important guarantees [60], it also narrowly defines Indigenous populations as only those which are small in numbers [numbering less than 50,000 based on these criteria, 61, p.15], who have preserved their traditional way of life. Articles 8.9 endorses free medical services to all Indigenous peoples, including annual medical examination in municipal entities and other measures. In practice, these provisions were

Table 1. Circumpolar Indigenous contexts [33–46]

Jurisdiction	Indigenous population, total population (% of total population)	Indigenous nations	Access to Indigenous-centric services
Alaska, USA	737,438, 112,828 (15.3%)	228 federally recognised tribes, including Iñupiat, Yupik, Siberian Yupik, Sugpiaq, Unangax, Eyak, Tlingit, Haida, Tsimshian, and Athabaskan	<ul style="list-style-type: none"> Alaska Native peoples may access healthcare through tribal, private, or military healthcare systems (dependent on military service history and Indigenous status) The Alaska Tribal Health System and Alaska Native Tribal Health Consortium provide Indigenous-centric PHC, secondary and tertiary care.
Yukon, Canada	8,195; 35,111 (23.3%)	Kutchin, Hän, Kaska, Tagish, Tutchone and Teslin	<ul style="list-style-type: none"> Indigenous peoples access the same publicly funded services as other provincial/territorial residents.
Northwest Territories, Canada	20,860, 41,135 (50.7%)	Deneh, Tłı̨chǫ, Slavey, Inuvialuit, Gwich'in, Sahtu, Métis	<ul style="list-style-type: none"> PHC, secondary and tertiary care are provided at no cost to the individual.
Nunavut, Canada	30,550, 35,580 (85.9%)	Inuit	<ul style="list-style-type: none"> Some Indigenous nations offer culturally-defined prevention-oriented services to their members (Yukon and NWT).
Nunavik, province of Quebec, Canada	10,880, 7,965,450 (0.1%)	Although the overall province includes many nations, the circumpolar portion of the province includes primarily Inuit.	<ul style="list-style-type: none"> In Quebec and Labrador, Indigenous communities manage their own community-based PHC services and hospitals.
Labrador province of Newfoundland & Labrador, Canada	1,285 (Innu) and 6,450 (Inuit)/512,250 (1.5%)	Nunatsiavut Inuit, Innu, Nunatukavut Inuit	
Greenland, autonomous constituent country of Denmark	50,171; 55,877 (89.8%)	Greenlandic Inuit or Kalaallit	<ul style="list-style-type: none"> Greenlandic Inuit access the same services as any other resident. There is no cost to access services. Services vary depending on place. For example, access to hospitals is limited to major cities and larger towns in Greenland. In remote settlements health stations are provided with severely limited services and trained staff.
Denmark	Estimated 16,470; 5,581,190 (0.30%)	Greenlandic Inuit or Kalaallit	Sámi access the same services as their national counterpart.
Sweden	Estimated 20,000–40,000; 10,230,185 (0.2–0.4%)	Sámi	Sámi access the same services as their national counterpart.
Finland	Estimated 9,000; 5,517,830 (0.2%)	Sámi	Sámi access the same services as their national counterpart.
Norway	Estimated 55,544; 5,295,619 (1.0%)	Sámi	Sámi access the same services as their national counterpart. Limited to the Saami Norwegian National Advisory unit on Mental Health and Substance Use (SANKS)
Russia (Regions of Muymansk Oblast, Kareliya Republic, Arkhangelsk Oblast, Nenets Autonomous Okrug (AO), Komi Republic, Yamalo Nenets AO, Khanty-Mansi AO, Taymyr AO, Evenki AO, Sakha Republic, Magadan Oblast, Koryak AO, Chukotka AO)	Estimated 270,000; 146,000,000 (0.2%)	Aleuts, Alyutors, Cheikans, Chukchis, Chuvans, Dolgans, Enets, Siberian Yupik, Inuit, Evenks, Evens, Itelmens, Kamchadals, Kereks, Khanty, Koryaks, Kumandins, Mansi, Nanai, Negidals, Nenets, Nganasans, Nivkhs, Orochs, Orochs, Sámi, Selkups, Shors, Soyots, Taz, Telengits, Teleuts, Tofalars or Tofa, Tubalars, Tozhu, Udege, Ulchs, Veps, Yukaghirs Yakuts, Buryat, Komi and Tuvans	<ul style="list-style-type: none"> Indigenous-centric health services do not exist in Russia. Some efforts are directed to mobile medical complexes and centres and increased opportunities for air ambulance flights to remote places of indigenous peoples' residence as well as training doctors and nurses of indigenous heritage.
		do not have Indigenous status under Russian legislation	

implemented in the context of limited medical staff and insufficient financing. Interpersonal and systemic racism in healthcare settings also exist with examples of low-qualified medical personnel and an inappropriate attitude of staff towards Indigenous patients [62]. For these reasons Indigenous peoples may not trust medical specialists and authorities, consider doctor appointments impractical and trust in home treatment or learn about treatment methods via television [63].

“In-between” jurisdictions such as the state of Alaska, the Yukon and the Northwest Territories (NWT), where Indigenous peoples constitute between 20–50% of the population, have adopted mixed responses to healthcare system designs [64–67]. The NWT has maintained a unique system for all, and adopted some policy-specific provisions to address specific issues [66]. In the Yukon, some parallel services (First Nation on-reserve services, focused on prevention) have emerged, creating opportunities to reframe health services through an Indigenous lens. Such parallel systems might create opportunities to shift the core values of the overall healthcare systems. This shift is evident in the Yukon, but is also evident in the NWT, where a parallel system has not emerged.

Alaska has three parallel healthcare systems; the private sector, the military, and Indigenous systems [41]. In rural and remote regions of Alaska, tribal health services are often the only providers available, and serve all members of the community [41]. In these areas, the point of contact with primary care for residents is often a Community Health Aide or Community Health Practitioner who is usually an individual from the community whose work is integrated within a broader tribal health system where physicians and mid-level providers may often not be Indigenous [68]. While translation services are likely to be prioritised when needed, a complementary commitment to cultural competency and cultural safety may still be helpful in these contexts where healthcare, in theory, is designed for a population that is predominantly Indigenous, but often relies on providers who are not.

Circumpolar cultural competence and cultural safety discourses across jurisdictions

In the **Canadian** context, discourses have shifted away from cultural competence to cultural safety [7]. Cultural competence-based approaches have been seen as essentializing and codifying cultures, reinforcing stereotypes rather than challenging them. The National Aboriginal Health Organization has advocated for the recognition of diversity among Canadian Indigenous populations, for an acknowledgement of the power

differential that exists in the provider-patient relationship, and for raising awareness of cultural, social and historical issues in organisations and institutions [24]. More recently, Browne, Varcoe and colleagues [69,70] have advocated to include trauma- and violence-informed care to cultural safety-informed programs, recognising that the colonial project is on-going and that Indigenous patients remain largely “disadvantaged by systemic inequities [and] experience varying forms of violence that have traumatic impacts on an ongoing basis” [70, p. 5]. This might include, for examples, racial profiling by the justice system, discrimination in employment opportunities and when trying to secure safe housing, increased vigilance by child welfare agencies, and differential access to health care options based on assumptions.

The Canadian National Collaborating Centre for Aboriginal Health commissioned an environmental scan of cultural safety intervention in First Nations, Métis and Inuit public health. The scan focuses on core competencies expected of the Public Health Agency of Canada, Indigenous health professional associations, and of universities [25]. Crawford has developed a series of modules focused on Inuit mental health and safety [71], including one on cultural safety [72] and another on trauma- and violence-informed care [73]. In Nunavut, the term cultural humility is preferred. Resources have been created to support health care providers, including a mandatory course [74]; a smartphone application called HEALTH NU designed to improve cultural competence among Nunavut’s health care practitioners, [with all components identified and written by community members, 75]; a set of online modules for healthcare practitioners working with Inuit children [76]; as well as an emerging body of literature and resources to support further development [77–81]. Finally, Section 6 of the Nunavut Public Health Act outlines specifically how the public health system of Nunavut is to be based on Inuit Societal values [82].

Neither the language of cultural safety nor cultural competency appears prevalent in **Alaska**. The US Department of Health and Human Services Office of Minority Health has released the report *Setting the agenda for research on cultural competence in healthcare*, defining cultural competence as; “to encompass both interpersonal and organizational interventions and strategies that seek to facilitate the achievement of clinical and public health goals when those differences come into play” [83, p. 3]. Part of this may be reflective of different understandings of the term “cultural competence”, which, in the US context, encompasses a broader range of activities than a clinical encounter,

and may extend to community-based development and implementation of initiatives. Darroch et al. provide evidence that interventions that may be framed as “cultural safety” in a Canadian context, are understood as “culturally competent”, “culturally responsive”, or “culturally relevant” in a US context, lending credence to earlier comments that the contours of these concepts remain blurred [84]. In Alaska, the Nuka system of care uses the language of relationship-centred care: “Southcentral Foundation’s Nuka System of Care (Nuka) is a relationship-based, customer-owned approach to transforming healthcare, improving outcomes and reducing costs” [27,28,85,86]. As adopted by the Southcentral Foundation, relationship-centred care is more or less inclusive of cultural competence and cultural safety.

Patient legislation underpinning the universal healthcare systems in **Finland** [87], **Sweden** [88] and **Norway** [89] acknowledge the rights of users’ access to care regardless of ethnic background. Also, in Norway, Sámi service users within certain defined Sámi administrative areas have the right to access healthcare in their own language [90], and some regional healthcare authorities in Sámi areas of Sweden and Finland have entered into agreements with their Norwegian counterparts, to address their own lack of health services in Sámi language and/or cultural competence. However, the simultaneous existence of universal healthcare systems and acknowledgement of status as Indigenous peoples (for Sámi) does not necessarily translate into adapted health services. In the Swedish case, the United Nations rapporteur on the right of everyone to the highest attainable health status, Paul Hunt, reported in 2007 *“regret[ting] that he found little, if any, evidence that Sweden has translated the special status of the Sami into meaningful, practical measures in the health context”* [55]. We noted little progress since. Instead, Norway has been leading developments of health policy specifically addressing Sámi needs – starting with the “Plan for health and social services for the Sámi population in Norway” [91]. A body of literature has emerged, focusing on how Sámi people, as well as their therapists and caregivers, understand and cooperate towards improving Sámi health [92–96]. Furthermore, a new wave of research has taken a critical stance towards previous policy and (Sámi) healthcare research, criticising it for lacking perspectives of diversity and complexity, resulting in risk of spreading essentialist understandings of Sámi culture and patients by, for example, reducing Sámi culture as uniquely centred around reindeer herding thereby perpetuating stereotypes [56,97]. To some extent, this body of work mimics international developments, in the sense that there have been two main

waves of research, i.e: first the call for cultural competence, followed by a critical reaction and a call for more nuances. A new study by Mehus and colleagues [98] documenting culturally unsafe encounters Sámi have with health care in Norway signals that the concept of cultural safety is getting traction.

In **Greenland**, a land colonised by the Danish and still part of the Kingdom of Denmark, visibility of concepts of cultural safety and cultural competency in the health literature is severely limited [99]. Historically, the healthcare system in Greenland offered healthcare in Danish, with interpretation in Greenlandic. There is a small, but growing Kalaallit, Inughuit and Tunumiit (Greenlandic Inuit) healthcare provider network. Models of healthcare delivery and prevention have largely been based on European models imported from Denmark, and adaptations have been largely limited to the translation of material into Greenlandic [100]. However, there is an emerging discourse focusing on the promotion of nursing education and training among Greenlandic Inuit. The concept of “double cuturedness” is used within the nursing literature to describe nurses who are Greenlandic Inuit, trained in a Danish medical system and navigating a European model of healthcare delivery. As Inuit Greenlanders, there is an assumed intuitive knowledge of how to actually work with their patients in a way that is culturally competent and safe [101,102]. Current research in Greenland also speaks to the desire on the part of Greenlandic Inuit to be actively involved in their healthcare and engaged with their healthcare providers as equal partners in the medical decisions and the healing process [103].

In the **Russian Federation**, Indigenous-centric services do not exist, although adapted services have emerged in selected regions, based on local policies [104]. The language of cultural safety is not visible in Russian health research literature.

Conclusions

Our review of the Circumpolar health research literature shows that the concept of cultural safety remains largely circumscribed to the Canadian context, and in Alaska as relationship-centred care. We also note an uptake of the concept (using slightly different terminology) in the Circumpolar North, with the development of Inuit-centric tools. In the Canadian context, the role of historical trauma in reproducing inequities is increasingly acknowledged in discussions of cultural safety. This is less evident in Alaska. The gaps in the Circumpolar health and healthcare literature suggests that Nordic countries and Russian researchers and

practitioners have not yet begun to consider the role of culture, racism, and ongoing histories of oppression and discrimination in healthcare, in relation to Indigenous populations.

We acknowledge that this article is based on a review of the published literature and policy documents. While our team includes researchers fluent in English, Danish, Norwegian, Russian and Swedish (as well as other) languages, we recognise that healthcare innovations are often localised, and that there is often a lapse between localised innovations finding their way into the literature. We also acknowledge that access to healthcare in Russia remains a major concern that is likely to overshadow any concern for cultural safety.

We conclude that the general lack of attention to culturally safe care for Sámi and Greenlandic Inuit is somewhat surprising given Nordic countries' concern for the welfare of their citizens. We see this as an important gap, and out of step with commitments made under UNDRIP. The lack of and overall limited attention to cultural safety across all Circumpolar contexts is problematic: we call for the integration of cultural safety as a lens to inform the development of health programs aiming to improve Indigenous in Circumpolar countries.

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References

- [1] Young TK. Circumpolar health atlas. Toronto: University of Toronto Press; 2012.
- [2] United Nations. United nations declaration on the rights of indigenous peoples. Internet Geneva. 2007.
- [3] Constituteproject.org. Russian federation's constitution of 1993 with amendments through 2014. Austin: University of Texas at Austin; 2014.
- [4] United Nations Permanent Forum on Indigenous Issues. Who are indigenous peoples? Geneva: United Nations; n.d.
- [5] Gallegos JS, Tindall C, Gallegos SA. The need for advancement in the conceptualization of cultural competence. *Adv Social Work*. 2008;9(1):51–62.
- [6] Gallegos JS. The ethnic competence model for social work education. In: White BW, editor. *Color in ta white society*. Silver spring MD. National Association of Social Workers; 1982.
- [7] Kirmayer LJ. Cultural competence and evidence-based practice in mental health: epistemic communities and the politics of pluralism. *Soc Sci Med*. 2012;75(2):249–256.
- [8] Lavoie JG, O'Neil JD, Reading J. Community healing and Aboriginal self-government. In: Belanger YD, editor. *Aboriginal Self-Government in Canada: current trends and issues*. Third Edition ed. Saskatoon: Purich Publishing; 2009. p. 172–205.
- [9] Lavoie JG, Kornelsen D, Wylie L, et al. Responding to health inequities: indigenous health system innovations. *Glob Health Epidemiol Genom*. 2016;1(e14):1–10.
- [10] Lavoie JG. Policy and practice options for equitable access to primary healthcare for indigenous peoples in British Columbia and Norway. *Int Indig Policy J*. 2014;5(1):1–17. [9]
- [11] Hiratsuka VY, Beans JA, Robinson RF, et al. Self-determination in health research: an Alaska native example of tribal ownership and research regulation. *Int J Environ Res Public Health*. 2017;14(11):1324.
- [12] Lavoie JG, Dwyer J. Implementing Indigenous community control in health care: lessons from Canada. *Aust Health Rev*. 2015.
- [13] Cueva K, Cueva M, Revels L, et al. A framework for culturally relevant online learning: lessons from Alaska's tribal health workers. *J Cancer Educ*. 2018;33(5):1102–1109.
- [14] Cueva K, Revels L, Cueva M, et al. Culturally-relevant online cancer education modules empower Alaska's community health aides/practitioners to disseminate cancer information and reduce cancer risk. *J Cancer Educ*. 2018;33(5):1102–1109.
- [15] Cueva K, Ingemann C, Zaitseva L, et al. Community health workers as a sustainable health care innovation: introducing a conceptual model. *Elementa*. 2021;9(1):00008.
- [16] Ramsden IM. Cultural safety. *NZNursJ*. 1990;83(11):18–19.
- [17] Ramsden IM. Cultural safety and nursing education in Aotearoa and Te Waipounamu. Wellington: Victoria University of Wellington; 2002.
- [18] Nursing Council of New Zealand. Standards for registration of comprehensive nurses from poly-technic courses. Glossary. Wellington: Nursing Council of New Zealand; 1992.
- [19] Wood PJ, Schwass M. Cultural safety: a framework for changing attitudes. *NursPraxNZ*. 1993;8(1):4–15.
- [20] Curtis E, Jones R, Tipene-Leach D, et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *Int J Equity Health*. 2019;18(1):174.
- [21] Browne AJ, Varcoe C, Ward C. San'yas Indigenous cultural safety training as an educational intervention: promoting anti-racism and equity in health systems, policies and practices. *Int Indig Policy J*. 2021;12(3):1–23.
- [22] Wetterhall S, Burrus B, Shugars D, et al. Cultural context in the effort to improve oral health among Alaska Native people: the dental health aide therapist model. *Am J Public Health*. 2011;101(10):1836–1840.
- [23] Clifford A, McCalman J, Bainbridge R, et al. Interventions to improve cultural competency in health care for Indigenous peoples of Australia, New Zealand, Canada and the USA: a systematic review. *Int J Qual Health Care*. 2015;27(2):89–98.

- [24] Brascoupé S, Waters C. Cultural safety: exploring the applicability of the concept of cultural safety to aboriginal health and community wellness. *Int J Aboriginal Health*. 2009;5(2):6–41.
- [25] Baba L. Cultural safety in first nations, inuit and métis public health: environmental scan of cultural competency and safety in education, training and health services. Prince George[BC]: National Collaborating Centre for Aboriginal Health; 2013.
- [26] Brach C, Fraser I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Med Care Res Rev*. 2000;57(Suppl 1):181–217.
- [27] Gottlieb K. The nuka system of care: improving health through ownership and relationships. *Int J Circumpolar Health*. 2013;72(1):21118.
- [28] Southcentral Foundation. Nuka system of care. Anchorage[Alaska]: Southcentral Foundation;; 2019.
- [29] Beach MC, Inui T. Relationship-centered care: a constructive reframing. *J Gen Int Med*. 2006;21(Suppl 1): S3–S8.
- [30] Tanenbaum SJ. What is patient-centered care? A typology of models and missions. *Health Care Anal*. 2015;23(3):272–287.
- [31] Southcentral Foundation. Southcentral foundation: about anchorage: Southcentral foundation; 2022 [updated 2022. Available from: <https://www.southcentralfoundation.com/about-us/>].
- [32] Johnstone MJ, Kanitsaki O. Health care provider and consumer understandings of cultural safety and cultural competency in health care: an Australian study. *J Cult Divers*. 2007;14(2):96–105.
- [33] Anderson K. Alaska. In: Young K, Marchildon G, editors. A comparative review of circumpolar health systems. Circumpolar health supplements. Oulu[Finland]: International Association of Circumpolar Health Publishers; 2012. p. 31–40.
- [34] Popovich L, Potapchik E, Shishkin S, et al. Russian federation: health system review. London[UK]: European Observatory on Health Systems and Policies; 2011.
- [35] Statistics Canada. Aboriginal peoples highlight tables, 2016 census. Ottawa: Statistics Canada; 2016.
- [36] Statistics Canada. Inuit population by residence inside or outside Inuit Nunangat, 2016. Ottawa: Statistics Canada; 2016.
- [37] Statistics Denmark. People born in Greenland and living in Denmark 1. January by time and parents place of birth. 2018.
- [38] Statistics Finland. Finland's preliminary population figure 5,518,393 at the end of March. Helsinki[Finland]: Työpajankatu; 2019.
- [39] Statistisk sentralbyrå. Statistics Norway. Oslo[Norway]: Statistisk sentralbyrå; 2019.
- [40] USA Census Bureau. QuickFacts Alaska. Washington: US Department of Commerce; 2017.
- [41] USA Section of Health Planning & Systems Development. Division of public health, department of health and social services. health care in Alaska: 2014 update. Fairbanks: Alaska Health Care Commission; 2014.
- [42] World Population Review. Sweden Population 2019. Walnut CA: World Population Review; 2019.
- [43] Det Gronlandske Hus. Om os. Copenhagen: Det Gronlandske Hus; n.d.
- [44] Russian Federation Federal State Statistics Service. Russia in figures. Moscow[Russia]: Russian Federation Federal State Statistics Service; 2019.
- [45] Statistics Greenland. Greenland in figures 2018. Nuuk: Statistics Greenland; 2018.
- [46] Statistics Sweden. Population in the country, counties and municipalities on 31 december 2018 and population change in 2018. Stockholm[Sweden]: Statistics Sweden; 2019.
- [47] Lavoie JG, Boyer Y, Kornelsen D. Re-writing health policy in the north: patchy and southern-centric: health policies for northern and Indigenous Canadians. In: Schiff R, Møller H, editors. Health and healthcare in the Canadian North. Vancouver: UBC Press; 2021. p. 377–395.
- [48] Organisation for Economic Development and Co-operation. OECD reviews of health systems: russian federation 2012. Paris: Organisation for Economic Development and Co-operation; 2012.
- [49] Gaski M. Aspects of health services in Sami areas. University of Tromsø, Faculty of Health Sciences, Department of Community Medicine; 2011.
- [50] Gaski M, Melhus M, Deraas T, et al. Use of health care in the main area of Sami habitation in Norway - catching up with national expenditure rates. *Rural Remote Health*. 2011;11(2):1655.
- [51] Swedish Institute. Sami in Sweden. Stockholm: Swedish Institute; 2013.
- [52] Arberdsdepartementet. Samepolitikken - hovedinnhold i St.meld. nr. Vol. 28. 2007-2008. Oslo; 2008 .
- [53] Norwegian Ministry of Labour and Social Inclusion. Summary of Sami Policy. Oslo; 2008 . Report No.: White Paper No. 28 (2007-08).
- [54] Nyntti K. The Nordic Sami parliaments. In: Aikio P, Scheinin M, editors. Operationalizing the right of Indigenous peoples to self-determination. Gezeliusgatan[Finland]: Institute for Human Rights, Abo Akademi University; 2000. p. 203–222.
- [55] Hunt P Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Addendum, Mission to Sweden. Geneva: United Nations Human Rights Council; 2007. Contract No.: A/HRC/4/28/Add.2 2007 Feb 28
- [56] Dagsvold I, Møllersen S, Stordahl V. What can we talk about, in which language, in what way and with whom? Sami patients' experiences of language choice and cultural norms in mental health treatment. *Int J Circumpolar Health*. 2015;74(1):26952.
- [57] Finnmarkssykehuset. Samisk helsepark [Sámi health centre]: finnmarkssykehuset [Finnmark county hospital trust]; 2019 [Available from: <https://finnmarkssykehuset.no/om-oss/samisk-helsepark#tidsplan>].
- [58] Lapin sairaanhoitopiirin, Helse Finnmark HF SNK-PHoR. Yhteistyösopimus erikoissairaanhoidosta Lapin sairaanhoitopiirin (LSHP) ja Helse Finnmark HF:n välillä - Samarbeidsavtale om spesialisthelsetjenester mellom Lapin sairaanhoitopiiri (LSHP) og Helse Finnmark HF [Agreement of cooperation on specialized health

- services between Lapin sairaanhoitopiiri (LSHP) and Helse Finnmark HF] 2007.
- [59] Jämtland Härjedalen R, Finnmarkssykehuset HF Överenskommelse om sjukvård och samarbete mellan Region Jämtland Härjedalen och Finnmarkssykehuset HF (FIN) - Avtale om helsehjelp og samarbeid mellom Region Jämtland Härjedalen og Finnmarkssykehuset HF (FIN) [Agreement on health care and cooperation between Region Jämtland Härjedalen and Finnmarkssykehuset HF (FIN)]. 2015.
- [60] Xanthaki A. Indigenous rights in the Russian federation: the case of numerically small peoples of the Russian North, Siberia, and far East. *Hum Rights Q.* 2004;26(1):74–105.
- [61] Rohr J. Indigenous peoples in the Russian federation. Copenhagen[Denmark]: International Work Group for Indigenous Affairs; 2014.
- [62] Khaknazarov SK. Здоровье народов Севера в контексте социологических исследований [Health of the people of the north in a context of sociological researches]. *Soc Issues Public Health.* 2013;3(31):1–12.
- [63] Kirko VI, Kopitsa AS, Upatov AV. Оценка Уровня Качества И Полноты Оказания Медицинской Помощи На Территории Таймырского Долгано-Ненецкого И Эвенкийского Муниципальных Районов Красноярского Края [Estimation of a level of quality and completeness of delivery of medical aid on the territory of Taimyr Dolgano-Nenets and Evenki municipal districts of the Krasnoyarsk Territory. *Mod Probl Sci Educ.* 2013;2:57–59.
- [64] Norris T, Vines PL, Hoffel EM. The American Indian and Alaska native population: 2010, 2010 census briefs. Washington: USA Census Bureau US Department of Commerce; 2010.
- [65] Zuckerman S, Haley J, Roubidoux Y, et al. Health service access, use, and insurance coverage among American Indians/Alaska natives and whites: what role does the Indian health service play? *Am J Public Health.* 2004;94(1):53–59.
- [66] Lavoie JG, Gervais L, Toner J, et al. Looking for Aboriginal health in legislation and policies, 1970 to 2008: the policy synthesis project. Prince George[BC]: National Collaborating Centre for Aboriginal Health; 2012.
- [67] Kirmayer LJ, Fletcher C, Watt R. Locating the ecocentric self: inuit concepts of mental health and illness. In: Kirmayer LJ, Valaskakis GG, editors. *Healing traditions: the mental health of aboriginal peoples in Canada.* Vancouver: UBC Press; 2008. p. 289–314.
- [68] Golnick C, Asay E, Provost E, et al. Innovative primary care delivery in rural Alaska: a review of patient encounters seen by community health aides. *Int J Circumpolar Health.* 2012;71(1):18543.
- [69] Browne AJ, Varcoe CM, Wong ST, et al. Closing the health equity gap: evidence-based strategies for primary health care organizations. *Int J Equity Health.* 2012;11(1):59.
- [70] Browne AJ, Varcoe C, Lavoie JG, et al. Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. *BMC Health Serv Res.* 2016;16(544):16.
- [71] Crawford A. Resilience through story: inuit story bones game. Palo Alto California: ISSUU; n.d.
- [72] Crawford A. Cultural safety and Inuit mental health and wellbeing. Palo Alto[CA]: ISSUU; n.d.
- [73] Crawford A. Trauma-informed care and Inuit mental health and wellbeing. Palo Alto [CA]: ISSUU; n.d.
- [74] Nunavut Department of Executive and Intergovernmental Affairs. Indigenous cultural competence in health and social services. Iqaluit: Nunavut Department of Executive and Intergovernmental Affairs;; n.d.
- [75] Pinguuq Association. Release – health NU. Lindsay ON: Pinguuq Association; 2017.
- [76] Children's Hospital of Eastern Ontario CHEO. Qikiqtaaluk Cultural Competency Ottawa: Children's Hospital of Eastern Ontario; 2014 [Available from: <https://www.cheo.on.ca/en/Nunavut-Program-Modules>].
- [77] Healey G. A Critical Examination of health system governance in Nunavut. Commentary. *Can Med Assoc J Blog.* 2016 2016 Jun 11.
- [78] Healey G. Exploring the development of a health care model based on Inuit wellness concepts as part of self-determination and improving wellness in Northern communities. In: Piggot T, Arya N, editors. *Under-served: health determinants of Indigenous, inner-city and migrant populations in Canada.* Toronto: Canadian Scholar Press; 2018.
- [79] Tagalik S. Inuit knowledge systems, elders, and determinants of health: harmony, balance, and the role of holistic thinking. In: Greenwood M, de Leeuw S, Lindsay NM, editors. *Determinants of Indigenous peoples' health: beyond the social.* 2nd ed. Toronto: Canadian Scholars' Press; 2018. p. 93–110.
- [80] Christensen J. Indigenous housing and health in the Canadian North. *Revisiting Cultural Safety Health Place.* 2016(40):83–90.
- [81] Inuuqatigiit. Inuit Cultural Online Resource Ottawa: Inuuqatigiit; 2015 [Available from: <http://icor.ottawainuitchildrens.com/>].
- [82] Nunavut. Chapter 13, public health act. Iqaluit: Government of Nunavut; 2016. [Assented to Nov 8].
- [83] USA Department of Health and Human Services Office of Minority Health, Agency for Healthcare Research and Quality. Setting the agenda for research on cultural competence in health care. Washington: U.S. Department of Health and Human Services Office of Minority Health and Agency for Healthcare Research and Quality Contract No. 00T061242; 2004.
- [84] Darroch F, Giles A, Sanderson P, et al. The USA does CAIR about cultural safety: examining cultural safety within indigenous health contexts in Canada and the USA. *J Transcult Nurs.* 2017;28(3):269–277.
- [85] Driscoll DL, Hiratsuka V, Johnston JM, et al. Process and outcomes of patient-centered medical care with Alaska native people at Southcentral foundation. *Ann Fam Med.* 2013;11(Supplement 1):S41–9.
- [86] Johnston JM, Smith JJ, Hiratsuka VY, et al. Tribal implementation of a patient-centred medical home model in Alaska accompanied by decreased hospital use. *Int J Circumpolar Health.* 2013;72(S2: Supplement 1):S41–9.
- [87] Finland Ministry of Social Affairs and Health Health Care Act (Helsinki: Finland Ministry of Social Affairs and Health). 2010 <https://www.finlex.fi/en/laki/kaannokset/2010/en20101326>.

- [88] Sen A. Universal truths: human rights and the westernizing illusion. *Harv Int Rev.* Summer. 1998. 40–43.
- [89] Norway Ministry of Health and Care Services. *Lov om pasient- og brukerrettigheter.* Oslo[Norway]: Norway Ministry of Health and Care Services;; 1999.
- [90] Norway Ministry of Local Government and Modernisation. *Lov om Sametinget og andre samiske rettsforhold.* Oslo Norway: Norway Ministry of Local Government and Modernisation;; 1987.
- [91] Norway. *Norges Offentlige Utredninger 1995:6 Plan for helse- og sosialtjenester til den samiske befolkning i Norge* [Norwegian Official Report 1995:6 Plan for the health- and social services for the Sami population in Norway]. Oslo: Statens forvaltningstjeneste, seksjon statens trykking;; 1995.
- [92] Jávo C. Kulturens betydning for oppdragelse og atferdsproblemer. *Transkulturell forståelse, veiledning og behandling* [The meaning of culture for upbringing and behavioral problems. Transcultural understanding, guidance and treatment.]. Oslo[Norway]: Universitetsforlaget; 2010.
- [93] Nymo R. *Helseomsorgssystemer i samiske markebygder i Nordre Nordland og Sør-Troms. Praksiser i hverdagslivet.* En ska ikkje gje sæ over og en ska ta tida til hjelp. Universitetet i Tromsø; 2011.
- [94] Bongo BA. “Samer snakker ikke om helse og sykdom” – samisk forståelsehorisont og kommunikasjon om helse og sykdom. En kvalitativ undersøkelse i samisk kultur. Tromsø: Universitetet i Tromsø; 2012.
- [95] Møllersen S, Sexton HC, Holte A. Effects of client and therapist ethnicity and ethnic matching: a prospective naturalistic study of outpatient mental health treatment in Northern Norway. *Nord J Psychiatry.* 2009;63(3):246–255.
- [96] Nystad T, Melhus M, Lund E. Sami speakers are less satisfied with general practitioners’ services. *IntJCircumpolarHealth.* 2008;67(1):114–121.
- [97] Blix Hansen B, Hamran T, Normann HK. “The Old Sami” – who is he and how should he be cared for? A discourse analysis of Norwegian policy documents regarding care services for elderly Sami. *Acta Borealia.* 2013;30(1):75–100.
- [98] Mehus G, Bongo BA, Engnes JI, et al. Exploring why and how encounters with the Norwegian health-care system can be considered culturally unsafe by North Sami-speaking patients and relatives: a qualitative study based on 11 interviews. *Int J Circumpolar Health.* 2019;78(1):1612703.
- [99] Ellsworth L, O’Keeffe A. Circumpolar Inuit health systems. *Int J Circumpolar Health.* 2013;72.
- [100] Bjerregaard P, Mulvad G. The best of two worlds: how the Greenland Board of Nutrition has handled conflicting evidence about diet and health. *Int J Circumpolar Health.* 2012;71(1):18588.
- [101] Møller S. “Double culturedness”: the “capital” of Inuit nurses. *Int J Circumpolar Health.* 2013;72(1):21266.
- [102] Møller S. Nursing Education in Greenland. *North Rev.* 2016;43:129–133.
- [103] Aagard T. Patient involvement in healthcare professional practice – a question about Knowledge. *Int J Circumpolar Health.* 2017;76(1):1403258.
- [104] Правительство Ямало-Ненецкого автономного округа [Government of the Yamalo-Nenets autonomous district]. Государственная программа Ямало-Ненецкого автономного округа «Развитие здравоохранения на 2014 – 2020 годы» Постановление Правительство Правительства Ямало-Ненецкого Автономного Округа от 25 декабря 2013 года N 1142-П. ПОСТАНОВЛЕНИЕ 25 декабря [State program of the Yamalo-Nenets Autonomous Okrug “Health care development for 2014–2020” Resolution of the Government of the Government of the Yamal-Nenets Autonomous Okrug of December 25, 2013 N 1142-P. DECISION December 25th.]. Salekhard: Правительство Ямало-Ненецкого автономного округа [Government of the Yamalo-Nenets autonomous district]; 2013.