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RESEARCH ARTICLE

Historical foundations and contemporary expressions of a right to health care in Circumpolar Indigenous contexts: A cross-national analysis

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Although numerous comparative Indigenous health policy analyses exist in the literature, to date, little attention has been paid to comparative analyses of Circumpolar health policy and the impact these policies may have on Indigenous peoples' rights to health. In this article, we ground our discussion of Indigenous peoples' right to access culturally appropriate and responsive health care within the context of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). Under UNDRIP, signatory states are obligated to guarantee that Indigenous peoples have access to the same services accessible to all citizens without discrimination. Signatory states must also guarantee access to services that are grounded in Indigenous cultures, medicines, and practices and must address Indigenous peoples' determinants of health at least to the same extent as their national counterparts. Our analysis finds that the implementation of this declaration varies across the Circumpolar north. The United States recognizes an obligation to provide health care for American Indian and Alaska Native people in exchange for the land that was taken from them. Other countries provide Indigenous citizens access to care in the same health care systems as other citizens. Intercultural models of care exist in Alaska and to some extent across the Canadian territories. However, aside from Sámi Norwegian National Advisory Unit on Mental Health and Substance Use in northern Norway, intercultural models are absent in Nordic countries and in Greenland. While Russia has not ratified UNDRIP, Russian policy guarantees access to health care to all citizens, although access is particularly limited in rural and remote environments, including the Russian Arctic. We conclude that Circumpolar nations should begin and/or expand commitments to culturally appropriate, self-determined, access to health care in Circumpolar contexts to reduce health inequities and adhere to obligations outlined in UNDRIP.

Keywords: Aboriginal, Inuit, Alaska Native, American Indian, Human rights, Access to care, Health care

Introduction

The Arctic region is the home of Indigenous peoples with recognized rights under international treaties and conventions (Toebes, 1999). As a result of climate change, and because it is increasingly framed globally as a resource-rich environment, the Arctic has become a globally embedded and contested space in dominant discourses. An increasing number of Arctic and non-Arctic states and non-state stakeholders are competing for a say in governance over economic and political interests in the Circumpolar north (Johannsdottir and Cook, 2017; Keil and Knecht, 2017).

At national and global levels, Circumpolar Indigenous peoples' pursuit of self-determination has largely focused on legitimizing Indigenous stewardship over sustainable resource development in their territories (Shadian, 2017). In the past decade, this focus has broadened to encompass climate change. The international movement toward recognizing Indigenous rights is often not present in these debates. When featured, the focus on rights centers on Indigenous peoples' stewardship over natural resources and their individual and collective resilience (Wexler, 2014; Teufel-Shone et al., 2016).

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Indigenous peoples' relationships to their nation-states can best be described as one of internal colonialism as a result of external intrusion (Canada, the United States, Greenland/Denmark) or internal colonial imposition (Nordic countries and Russia; Shadian, 2017, p. 45). Little attention has been paid to the past and continued contribution of colonialism in perpetuating Circumpolar Indigenous peoples' (apparent) vulnerabilities to the impacts of climate change (Cameron, 2012). These perceived vulnerabilities could also be attributed to displacement, the destruction or undermining of local traditional economies, and the marginalization and dismissal of local and Indigenous knowledge in policy decision-making (such as resource management, including hunting rights; Poppel, 2017).

At national levels, Indigenous engagement with these global debates operates in the context of severe health inequities when compared to their national counterparts (see Young, 2012, pp. 86–121, for a detailed discussion). These health inequities can be attributed in part to differential access to determinants of health such as appropriate housing, safe drinking water, economic opportunities, food security, and appropriate local infrastructure (Young et al., 2020). Providing access to health services cannot palliate social and economic marginalization, compensate for underinvestment in infrastructure, rectify racism and dismissal, nor address the imposition of national over local interests in public policy (Marmot and Wilkinson, 2006; Greenwood et al., 2015): Access to responsive and appropriate health care can at best expand life expectancy and improve quality of life. While partial, these objectives remain worthwhile, and their assurance is codified in international treaties and declarations.

This article discusses the international and national foundations of Indigenous rights to culturally appropriate health care in Circumpolar contexts. Although numerous comparative Indigenous health policy analyses exist in the literature (Lavoie, 2003, 2004; Lavoie et al., 2010a; Tenbensel et al., 2013; Lavoie, 2014; Lavoie and Dwyer, 2016; Kornelsen et al., 2017), to date, little attention has been paid to comparative analyses of Circumpolar health policy and the impact these policies may have on Indigenous peoples' rights to access culturally appropriate and responsive health care.

This work was undertaken in the context of the Fulbright Arctic Initiative program, which brought together Indigenous and non-Indigenous Arctic scholars from Canada, Denmark, Finland, Iceland, Sweden, Russia, and the United States. The authors are established scholars in their respective countries, actively engaged in Circumpolar health research in partnership with Indigenous communities and organizations. Our collective purpose is to highlight areas where Circumpolar health and policy developments hold promise for improving the health and well-being of Indigenous peoples.

The method we chose is to review published and gray literature, including legislation, policies, and government reports for each state under study, and related policy studies that might shed light on the implementation of such policy. Policy document analysis is a widely accepted method for tracking policy implementation (see e.g., Lavoie et al., 2013; Jones et al., 2017; Munthe-Kaas et al., 2019; Steinmann et al., 2020). We searched for documents publicly available online. We based this choice on trends in governments' transparency and in their use of the internet as key vehicle for sharing policy documents.

Our chosen approach draws on obligations included in the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), which require states to be transparent in their actions. By definition, transparency requires the publication of findings. We admit that some policies and analyses may not be published but argue that in such cases, the lack of transparency is not in compliance with the principles expressed by UNDRIP.

We tried to assess the extent to which Indigenous nations were engaged in cocreating or were at least consulted in the drafting of the policies we reviewed. In all cases, however, we assume that the final document reflects a national policy position. We did not attempt to document whether a policy document reflects Indigenous perspectives. We instead assessed the policy's alignment with UNDRIP.

The international foundation for a right to health

Although some authors trace the origin of the right to health to more recent documents (Tobin, 2012), the Constitution of the World Health Organization (1946) entrenched a list of inalienable rights, including,

> *The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.*

Toebes has argued that the concept of a *right to health* is problematic, as health cannot be guaranteed. Accordingly, the right to health is at times conflated in the literature with the right to health care, that is, to medical care and/or to health protection (Toebes, 1999).

International covenants have tended to focus on health protection and access to care. For example, the United Nations' Universal Declaration of Human Rights reiterated a right to health, including well-being, stating:

> *(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control (UN, 1948).*

For this article, we reviewed relevant international provisions on the right to health in international covenants and resolutions. A summary is provided in Appendix A. Key themes highlighted in these declarations include the following:

- The Universal Declaration of Human Rights (UN, 1948) and the International Covenant on Economic, Social and Cultural Rights (UN,

1966) establish a right to standards of living (determinants of health and well-being) necessary to achieve the highest attainable physical and mental health;
- The International Convention on the Elimination of All Forms of Racial Discrimination (United Nations, 1965) establishes a right to public health, medical care, social security, and social services devoid of discrimination and racism;
- The International Labour Office's Convention No. 169 Concerning Indigenous and Tribal Peoples in Independent Countries (International Labour Office, 1991) establishes a right to participate individually and collectively in the planning and implementation of health care; and
- The Convention on the Elimination of All Forms of Discrimination Against Women (UN, 1979) establishes a right for women living in rural environment to access care.

States' obligation to realize a right to health requires the adoption of national health plans, effective accountability measures, the collection of appropriate data, the development and assessment of appropriate benchmarks, the facilitation of effective participatory strategies, multisectoral and interdisciplinary initiatives, and targeted policies for vulnerable populations (Tobin, 2012, p. 224). Oversight by human rights monitoring bodies further ensures some accountability.

International treaties and other instruments have emerged addressing Indigenous peoples' right to health, and several specifically address racism (see Appendix B for details). For Indigenous peoples, access to effective and responsive care has historically been challenged by ethnocentrism, prejudice, and racism (see, e.g., Bhopal, 1998; Hansen et al., 2010; Billie and Smylie, 2015; Gair et al., 2015; Leyland et al., 2016; Paradies, 2016; Browne, 2017). In addition, Circumpolar Indigenous communities often face challenges in access to care, such as the scarcity and attrition of professionals, inappropriate communications, and high costs associated with travel to specialized care (Young and Chatwood, 2011; Young, 2012). The UN Combat Racism Conference of 1983 explicitly recognized that Indigenous peoples are covered in existing international instruments (World Conference to Combat Racism and Racial Discrimination, 1983). However, of these, only UNDRIP explicitly recognizes Indigenous peoples' right to access "programmes for monitoring, maintaining and restoring the health of indigenous peoples" managed by Indigenous peoples (UN, 2007).

In this article, we recognize the importance of all international instruments cited above and chose to ground our discussion of Indigenous peoples' right to access culturally appropriate and responsive health care as articulated in UNDRIP (UN, 2007). UNDRIP has created an opportunity to define, legitimize, and advance a broader range of Indigenous rights. In this article, we focus on UNDRIP's Articles 24 and 29, which are focused on the health of Indigenous nations:

> 24.1. 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**.
>
> 24.2. 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 realization of this right.**
>
> 29.3. States shall also take effective measures to ensure, as needed, that programmes for monitoring, maintaining, and restoring the health of indigenous peoples, **as developed and implemented by the peoples affected by such materials**, are duly implemented (UN, 2007, pp. 9, 21, emphasis added).

To date, seven of the eight[1] Circumpolar countries have endorsed UNDRIP, Russia being the exception.[2]

We recognize that national legislative and policy frameworks already exist in some Circumpolar countries to frame Indigenous rights in relation to health care. We also recognize that non-signatory countries may draw from UNDRIP to inform their own policy development. For example, Russia recognizes the rights of Indigenous peoples "in accordance with generally recognized principles and norms of international law" (Constituteproject.org, 2014, Article 69). However, this qualification lacks the guarantees we believe are warranted to fully operationalize the spirit of UNDRIP.

1. Circumpolar countries include Canada, Denmark, Finland, Greenland, Iceland, Norway, Russia, Sweden, and the United States. Our article focuses on eight of these countries since Iceland does not have an Indigenous population as defined by the United Nations (United Nations Permanent Forum on Indigenous Issues, n.d.).

2. Official versions of the declaration are available in Arabic, Chinese, English, French, Spanish, and Russian. In addition, unofficial versions have emerged in Danish, Finnish, Kalaallisut (Greenland), Innu (Labrador and northern Quebec), Karelian (Republic of Karelia, Russian Federation), Komi (northeastern European part of Russia), Livvi-Karelian (Republic of Karelia, Russian Federation, and part of Finland), Norwegian, some Sámi languages (North, Inari, Skolt, Finland), and Veps (Republic of Karelia, Leningrad, and Vologda regions of the Russian Federation). Absent from this list are Dené (Alaska), Deneh (Canada), Iñupiaq (Alaska), Yup'ik (Alaska), Inuktitut (Canada), Inuvialuktun (Canada), Sámi languages spoken in Norway and Sweden, and Swedish (United Nations Department of Economic and Social Affairs, 2008).

Table 1. United Nations Declaration on the Rights of Indigenous Peoples–informed framework for tracking progress in Circumpolar Indigenous Peoples' Right to Health (United Nations, 2007). DOI: https://doi.org/10.1525/elementa.2019.00079.t1

Right	Indicators
24.1 Obligation to guarantee access to the same services accessible to all citizens without discrimination.	1. Access guaranteed in legislation/policies
29.3 Obligation of states to implement programs monitoring, maintaining, and restoring the health of indigenous peoples, as developed and implemented by the peoples affected by such materials.	2. Systematic monitoring of socioeconomic, education, health, and other inequities in the public domain
24.1 Obligation to guarantee access to traditional medicines and to maintaining their health practices, including the conservation of their vital medicinal plants, animals, and minerals.	3. Support for traditional practices in the form of enabling policies, funding, as appropriate to the national context
24.2 Obligation to address Indigenous peoples' determinants of health at least to the same extent as national determinants of health.	4. Cocreation of programs to remedy inequities, with active engagement from Indigenous populations.

Implementation of an indigenous right to health

The UNDRIP stipulates clear obligations for nations to operationalize Indigenous peoples' rights in relation to health. These obligations provide a framework to assess nations' progress on the implementation of UNDRIP, as shown in **Table 1**.

Interestingly, UNDRIP was adopted in 2007 by Denmark, Finland, Iceland, and Sweden. At the time, Canada and the United States voted against UNDRIP, and Russia abstained. The United States eventually adopted UNDRIP in 2011 and Canada in 2015. In the Circumpolar context, Russia remains the only country which has still not ratified UNDRIP.

Circumpolar comparison

Table 2 provides an overview of Circumpolar Indigenous nations and their access to health care, as provided by the nation-state. The table highlights two important contextual factors that impact how states can respond to the obligations stated under UNDRIP. To begin, Indigenous populations vary considerably in terms of their proportion to the overall population in the jurisdiction in which they live: Nunavik Inuit represent 0.1% of the population of Québec, whereas Inuit in Nunavut constitute 85.9% of the Nunavut population. Also important is the diversity of Indigenous nations within a single jurisdiction. Noteworthy are Alaska and Circumpolar Russia, which are home to multiple and diverse nations.[3] The second factor relates to national policies regarding access to health care. Of all countries under study, only the United States does not have a universal coverage health care system: Indigenous Alaskans however benefit from such a provision. Thus, expectations within these states are framed differently than in states where universal coverage is entrenched in policy. Further, cultural diversity, population density, and national policies regarding state obligations toward citizens in relation to access to care, all shape opportunities available to nation-states in terms of compliance with UNDRIP provisions.

Table 3 provides a comparative analysis of Circumpolar countries, based on indicators identified in **Table 1**, taking into consideration the contextual factors identified above. We discuss each country's alignment with these requirements in two distinct sections. We first discuss Indigenous peoples' access to health care and then explore the adaptation of services to Indigenous cultures, including access to traditional medicine.

Equitable access to health care

In *Canada*, an Indigenous-specific right to health remains under discussion. Treaty 6, signed between the Crown and First Nations peoples in what is now Saskatchewan and eastern central Alberta, contains what is commonly referred to as the Medicine Chest Clause (Canada, 1876a), promising First Nations peoples access to a medicine chest located at the house of the Indian Agent, to be used at the discretion of that agent. Similar provisions were discussed in the negotiations of Treaties 8 and 11, but no provision was included in the final text of these Treaties (Lavoie et al., 2012). These historical treaties should be understood as limited colonial concessions made with First Nations in exchange for a peaceful settlement of land held by First Nations but needed by the colonial state to support an emerging agrarian economy. The implementation of the treaties was however haphazard. Canada has to date interpreted the Medicine Chest Clause to signify that access to medical care is to be provided at the discretion of the Crown (Canada, 1966).

Universal coverage for hospital-based care, family physician, and specialist care is guaranteed to all Canadians, including Indigenous peoples, through the Canada Health Act 1984 (Government of Canada, 1985; for a more detailed analysis, see Lavoie, 2017). In addition, First Nations and Inuit can access a complement of medication, dental care, eye care, and medical equipment funded

3. Canada recognizes 70+ different nations; Circumpolar Canada is far less diverse.

Table 2. Indigenous peoples and health care in Circumpolar countries. DOI: https://doi.org/10.1525/elementa.2019.00079.t2

Region/Country	Indigenous Population, Total Population (% of Total Population)	Indigenous Nations	Universal Coverage Health Care	Access to Care
Yukon (Canada)/Indigenous peoples	8,195; 35,111 (23.3%)	Kutchin, Hän, Kaska, Tagish, Tutchone, and Teslin	Yes	Access to health care for Indigenous peoples is currently viewed as a matter of policy, based on the Johnston appeal of 1966.
NWT (Canada)/Indigenous peoples	20,860; 41,135 (50.7%)	Deneh, TłįchǪ, Slavey, Innuvialuit, Gwich'in, Sahtu, and Métis		
Nunavut (Canada)/Inuit	30,550; 35,580 (85.9%)	Inuit		
Nunavik (QC, Canada)/Inuit	10,880; 7,965,450 (0.1%)	Although the overall province includes many nations, the Circumpolar portion of the province includes primarily Inuit.		
Labrador (Newfoundland and Labrador, Canada)/ Innu and Inuit	1,285 (Innu) and 6,450 (Inuit)/ 512,250 (1.5%)	Nunatsiavut Inuit, Innu, Nunatukavut Inuit		
Denmark/Greenlanders	Estimate, 16,470; 5,581,190 (0.30%)	Greenlandic Inuit or Kalaallit	Yes	Universal, no specific Indigenous provision
Finland/Sámi	Estimate, 9,000; 5,517,830 (0.2%)	Sámi	Yes	
Greenland	50,171; 55,877 (89.8%)	Greenlandic Inuit or Kalaallit	Yes	
Norway/Sámi	Estimate, 55,544; 5,295,619 (1.0%)	Sámi	Yes	
Russia/north, Multiple tribes	Estimate, 270,000, based on small population rule;a 146,000,000 (0.2%)	Aleuts, Alyutors, Chelkans, Chukchis, Chulyms, Chuvans, Dolgans, Enets, Siberian Yupik, Inuit, Evenks, Evens, Itelmens, Kamchadals, Kereks, Khanty, Koryaks, Kumandins, Mansi, Nanai, Negidals, Nenets, Nganasans, Nivkhs, Oroks, Orochs, Sámi, Selkups, Shors, Soyots, Taz, Telengits, Teleuts, Tofalars or Tofa, Tubalars, Tozhu, Udege, Ulchs, Veps, Yukaghirs Yakuts, Buryat, Komi and Tuvans do not have Indigenous status under Russian legislation	No	Market-driven, no specific Indigenous provision

(continued)

TABLE 2. *(continued)*

Region/Country	Indigenous Population, Total Population (% of Total Population)	Indigenous Nations	Universal Coverage Health Care	Access to Care
Sweden/Sámi	Estimate, 20,000–40,000; 10,230,185 (0.2%–0.4%)	Sámi	Yes	Universal, no specific Indigenous provision
Alaska (USA)/Indigenous peoples	737,438; 112,828 (15.3%)	229 federally recognized tribes, including Iñupiat, Yupik, Siberian Yupik, Sugpiaq, Unangax, Eyak, Tlingit, Haida, Tsimshian, and Athabascan	No	Access to free health care is considered a right for Indigenous peoples as compensation for land taken.

Denmark and Sweden, 1751; United States of America, 1868, 1904a, 1904b, 1921, 1924, 1971, 1975, 1992; Canada, 1876a, 1876b, 1966, 1974, 1982b, 1985; Foighel, 1979; Health Canada, 1979; Government of Canada, 1985; Canada and Nunavut Tapariit Kanatami, 1993; Case and Voluck, 2002; Aaen-Larsen, 2004; Koivurova, 2008; Greenland, 2009; United States of American Office of the Legislative Counsel, 2010; Constituteproject.org, 2014; Statistics Canada, 2016a, 2016b; Statistics Denmark, 2018; Statistics Greenland, 2018; The Inuit of Labrador, Her Majesty the Queen in Right of Newfoundland and Labrador, Her Majesty the Queen in Right of Canada, 2018; U.S. Census Bureau, 2018; Arctic Council, 2019; Russian Federation Federal State Statistics Service, 2019; Statistics Finland, 2019; Statistics Sweden, 2019; Statistisk sentralbyra, 2019; Sweden, 2019; United Nations Regional Information Centre for Western Europe, 2019; Det Gronlandske Hus, n.d.).

[a]Guarantees extend only to small-numbered Indigenous peoples with population of less than 50,000 members (Xanthaki, 2004).

through the noninsured health benefits program (Health Canada [FNIHB], 2013). These additional benefits are provided by the federal government on "humanitarian grounds" (Marchildon et al., 2017). In the fall of 2019, the governments of British Columbia, the Northwest Territories, and the federal government tabled legislation committing to the implementation of UNDRIP (CBC North, 2019; Government of British Columbia, 2019; Government of Canada, 2019).

As shown in **Table 3**, Canada already complies with key UNDRIP health care–related provisions, with the exception of providing substantial support to traditional healing practices. Although Indigenous ceremonies were banned for the better part of the 20th century, these bans have been rescinded (Mitchell et al., 2019), yet the displacement many Indigenous nations experienced as a result of colonial encroachment through farming and extractive activities undermines access to food security and medicine. These pressures are more readily felt by nations whose territory is south of the 60th parallel. Circumpolar Indigenous communities have experienced these pressures to a lesser extent, although pressures appear to be growing (Markowitz, 2020).

Of all countries under study, the *United States* is the only one that recognizes a right to health care for American Indian and Alaskan Native peoples, provided with no fee at the point of service (Pfefferbaum et al., 1995). This recognized right contrasts with provisions for all other U.S. citizens whose access to care varies with private insurance coverage. The Snyder Act (United States of America, 1921) provides a basic authorization for Indian health care in the United States by authorizing the federal government to deliver programs, including health, with responsibilities vested in the Bureau of Indian Affairs under the supervision of the Secretary of the Interior. The Act did not specify an entitlement to specific benefits or services. To date, this entitlement has been interpreted as access to the full continuum of care (family physicians, specialists, hospital, public health, etc.). In the continental United States, under-resourcing and structural issues (small dispersed populations, diseconomies of scale) have resulted in chronic staff shortages within the Indian Health Service, barriers to accessing quality care, and poorer outcomes for Indigenous peoples (Levinson, 2016). The Public Law 93–638 Indian Self-Determination and Education Assistance Act, enacted in 1975, and amended several times, authorizes tribes "to contract with the Federal government to operate programs serving their tribal members and other eligible persons" (Department of the Interior Bureau of Indian Affairs and Department of Health and Human Services Indian Health Service, 1996). Substantial 1988 amendments, refined by 1994 and 2000 legislation, further allowed tribal self-governance, which has resulted in over 50% of federal Indian programs governed by tribal entities instead of federal agencies (Strommer and Osborne, 2015). Examples of health care programs that have taken advantage of this law include the Southcentral Foundation and the Alaska Native Tribal Health Consortium, which are both Alaska Native governed. These

Table 3. Circumpolar countries' legislative and policy alignment with United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). DOI: https://doi.org/10.1525/elementa.2019.00079.t3

	UNDRIP Provisions, Indicators			
Region/Country	**Access guaranteed in legislation/ policies**	**Systematic monitoring of socioeconomic, education, health, and other inequities, in the public domain**	**Support for traditional practices in the form of enabling policies, funding**	**Cocreation of programs to remedy inequities**
Yukon (Canada)/ Indigenous peoples	√	√	Existing legislation to respect traditional healing	Some, limited
Northwest Territories (Canada)/Indigenous peoples	√	√	No[a]	√
Nunavut (Canada)/Inuit	√	√	No[a]	√
Nunavik (QC, Canada)/ Cree and Inuit	√	√	Decisions on programming are at the discretion of the Nunavik and Cree health boards for community-based services only	Extensive, primary, and secondary health care
Labrador (Newfoundland and Labrador, Canada)/ Innu and Inuit	√	√	Decisions on programming are at the discretion of Labrador Inuit Association for community-based services only	Extensive, primary prevention services only
Denmark/Greenlanders	√	No	No	Limited to counseling services
Greenland	√	No	No	No
Finland/Sámi	√	No	No	Limited to Sámi-centric mental health services in northern Norway
Norway/Sámi	√	Yearly Statistics Norway report on Sāmi health using geographical proxy for identity.	No	
Sweden/Sámi	√	No	No	
Russia/north, Multiple tribes	√	No	No	No
Alaska (USA)/Indigenous peoples	√	Yes	No barriers are entrenched in policies	Extensive, primary, secondary, and tertiary health care

Â Denmark and Sweden, 1751; United States of America, 1868, 1904a, 1904b, 1921, 1924, 1971, 1975, 1992; Canada, 1974, 1982a, 1985, 2004; Foighel, 1979; Health Canada, 1979; Government of Canada, 1985; Canada and Nunavut Tapariit Kanatami, 1993; Case and Voluck, 2002; Yukon, 2002; Aaen-Larsen, 2004; Koivurova, 2008; Greenland, 2009; United States of American Office of the Legislative Counsel, 2010; Lavoie et al., 2012; Constituteproject.org, 2014; Statistics Canada, 2016a, 2016b; Nunavik Board of Health and Social Services, 2018; Sønstebø, 2018; Statistics Denmark, 2018; Statistics Greenland, 2018; The Inuit of Labrador, Her Majesty the Queen in Right of Newfoundland and Labrador, Her Majesty the Queen in Right of Canada, 2018; U.S. Census Bureau, 2018; Arctic Council, 2019; Cree Board of Health and Social Services of the James Bay, 2019; Russian Federation Federal State Statistics Service, 2019; Statistics Finland, 2019; Statistics Sweden, 2019; Statistisk sentralbyra, 2019; Sweden, 2019; United Nations Regional Information Centre for Western Europe, 2019; Det Gronlandske Hus, n.d.

[a]The Northwest Territories and Nunavut do not have Indigenous-centric policies; however, since Indigenous populations constitute the majority of these territories' population, and since the territories' legislative assembly include a majority of seats held by Indigenous candidates, it is often assumed that policies represent the interest and wishes of Indigenous residents.

entities jointly own and operate the Alaska Native Medical Center, which offers comprehensive medical services, including specialty care, primary care, dental, behavioral health, and pharmacy services, using a framework that integrates key Indigenous values in program planning and everyday delivery of services (Alaska Native Medical Center, 2020).

Nordic countries have adopted universal coverage provisions for all citizens, including Indigenous Sámi, thereby guaranteeing a right to health care for all. Of all the countries under study, health inequities between Indigenous peoples and their national counterparts appear to be less pronounced in Sweden, Norway, and Finland, although credible research on disparities in these regions is scant.[4]

There are considerable disparities when comparing Greenlandic Indigenous peoples' (Kalaallit) health to that of Danes. The relationship between Kalaallit and Danes is arguably somewhat different than that between Sámi and their national counterparts: *Greenland* was colonized by, and remains a part of, The Kingdom of Denmark. Different from most other Indigenous populations in the Arctic, Kalaallit are a majority in their own country, with approximately 90% of Greenland residents being Indigenous to Greenland. Greenland acquired home rule in 1979 and self-rule in 2009. The elected Parliament has all Indigenous leaders and health care has been the responsibility of the Inuit Government of Greenland since 1992. Greenlandic movements toward self-governance and home rule (Foighel, 1979) have highlighted striking differences in power between Kalaallit and Danes living in Greenland (Gad, 2013), which remain today.

The *Russian* government guarantees access to health care and emergency medical treatment for unemployed and socially vulnerable categories of citizens (Popovich et al., 2011; Constituteproject.org, 2014). Like the United States, access depends on a mix of private insurance and personal resources (Popovich et al., 2011), although affordability of insurance is not addressed (Vorobyev et al., 2012). Barriers to accessing care are related to substantial inequities in the distribution of health workers and hospitals across the Russian Federation. Access is particularly limited for all Russians in rural and remote environments, including Indigenous peoples in the Russian Arctic.

Access to culturally appropriate and adapted care

UNDRIP's Article 24 goes beyond a generic right to health, adding specific rights relevant to Indigenous peoples. Signatory states are thus obligated to guarantee that Indigenous peoples have access to the same services accessible to all citizens without discrimination. Signatory states must also guarantee access to services that are grounded in Indigenous cultures, medicines, and practices and must address determinants of health that negatively impact Indigenous health, at least to the same extent as is possible at the national scale. These provisions, which are intended to progressively achieve "equal right to the enjoyment of the highest attainable standard of physical and mental health" (UN, 2007, p. 9), are supported by the literature. Considerable attention has been paid in recent years to cultural assumptions embedded in the delivery of biomedical health care. The deleterious impact of biomedical hegemony has resulted in a silencing of alternative knowledge (Flesch, 2007; Hardon and Pool, 2016). A vast literature has emerged to

- conceptualize culturally appropriate care (e.g., see Ramsden, 1990; McCormick, 1996; Anderson et al., 2003; Wilson, 2008; Baba, 2013; Kirmayer, 2013; Crawford, n.d.),
- document existing models (Johnson, 2006; Mignone et al., 2007; Salaverry, 2010; Scaioli, 2010; Wetterhall et al., 2011; Kirmayer and Ban, 2013; Haynes et al., 2014; Carrie et al., 2015; Marsh et al., 2015; Browne et al., 2016; Lavoie et al., 2016; Menendez, 2016; Pelcastre-Villafuerte et al., 2017; Sandes et al., 2018), and
- evaluate the impact of innovations on outcomes (Mignone et al., 2007; Lavoie et al., 2010b; Mignone et al., 2011; Mignone and Gómez Vargas, 2015; Browne et al., 2016; Browne et al., 2018; Cueva et al., 2018a, 2018b).

Intercultural models building on Indigenous peoples' health knowledge and practices have not emerged uniformly across Circumpolar countries (see **Table 3**). Intercultural models of care exist in Alaska: These emerged not only from legislative and policy commitments but also from Indigenous innovations in the development of these models (Gottlieb, 2013; Southcentral Foundation, 2019). Canada's territories have developed a single territorial health care system, supplemented by policies addressing key issues of relevance to Indigenous citizens. For example, the Yukon Health Act of 2002 acknowledges the importance of respecting traditional healing practices (2002): This policy commitment has however not necessarily resulted in access to these treatment modalities in territorial hospitals. Such access is being promoted by the research community (Redvers et al., 2019). Land-based healing and wellness programs exist across all territories as a result of community initiatives that have emerged ad hoc and are funded through a patchwork of largely short-term pathways (Redvers, 2016). These modalities exist largely in parallel to the main health care system, which remains largely informed by a biomedical paradigm. In Nunavut, there is substantial writing documenting Inuit health-promoting practices (Briggs et al., 2000; Ootoova et al., 2000; Bennet and Rowley, 2004; Pudlat, 2011; Tagalik, 2018); however, to date, although Nunavut has made some attempts to embed Inuit values into the health care system,

4. The SAMINOR survey remains, to date, the only reputable source of research documenting inequities between Sámi living in northern Norway and other Norwegians (SAMINOR, 2014; Broderstad et al., 2019).

discussions of embedding Indigenous practices have not yet emerged.

Evidence of intercultural care models in Nordic countries is scant: Such models exist only in Norway, and even then, only for mental health services (Lavoie, 2014; Dagsvold et al., 2015). The Greenlandic health care system remains primarily structured like the Danish health care system, with little adaptation to Greenlandic Indigenous cultures and values, beyond language. We are not aware of intercultural models of care in Arctic Russia, although certain regions (Yamal, for example) take efforts to make health care available and Indigenous-centered. What Indigenous-centered care means in this context, however, may or may not align with a North American concept of Indigenous-centered care (Markin and Silin, 2016). Further research is required to unpack the meaning of Indigenous-centered care in the Russian context.

Discussion

In the celebrations that followed the adoption of UNDRIP in 2007, Victoria Tauli-Corpuz, then chairperson of the UN Permanent Forum on Indigenous Issues, noted in her remarks on the passage of the declaration, "This is a Declaration which sets the minimum international standards for the protection and promotion of the rights of Indigenous peoples. Therefore, existing and future laws, policies and programs on Indigenous peoples will have to be redesigned and shaped to be consistent with this standard" (UN Permanent Forum on Indigenous Issues, 2007).

The declaration nevertheless generated staunch criticisms: Speaking of Sweden and drawing on Brunsson (2006), Mörkenstam refers to UNDRIP as a system of "organised hypocrisy," where "organization meets some demands by the way of talk, others by decisions, and yet others by action" (2019, p. 1719). Others have argued that UNDRIP focuses on deficits rather than strengths (Craft et al., 2018). A recurrent criticism is that key concepts embedded in UNDRIP are based on western epistemologies rather than Indigenous philosophies. We agree that UNDRIP has numerous and concerning limitations. The four provisions we focused on, however, provide a basic framework that can help track progress across Circumpolar states.

Our analysis suggests that countries with a history of colonialism from external intrusion (Canada, the United States, both notably late to ratify UNDRIP) are showing some progress in implementing UNDRIP-compliant policies and processes. Most of this progress occurred before Canada and the United States ratified UNDRIP. Both countries have sizable Indigenous populations living in the Arctic, and these nations/tribes have been actively engaged in the pursuit of self-determination for decades. Inequities have been painstakingly recorded, if not effectively addressed.

In contrast, Nordic countries adopted UNDRIP at the onset. Interestingly, these countries show little progress in implementing UNDRIP in the health care and delivery context. These countries' relationship to Indigenous citizens is best qualified as internal colonial imposition. Across Nordic countries, Sámi populations are small, making the implementation of programs paralleling what the state offers difficult to operationalize. Still Nordic countries have, to date, refused to monitor inequities in health outcomes for minority ethnic populations, including Sámi, on the individual level. We acknowledge that Norway reports on Sāmi health inequities, yearly, using a geographical proxy (Sámi municipalities, i.e., comparing health outcomes from communities with a higher proportion of Sámi, vs. other communities). Whether these reports accurately reflect Sāmi's reality is questionable.

In this analysis, Greenland and Russia are outliers. As discussed, Greenland is an independent country colonized by Denmark. Its population is primarily Indigenous, although most professional positions remain held by Danes, and the health care systems itself was and remains modeled on the Danish system. Accommodations beyond language are not apparent. Any critique of this situation is however double-edged: The Greenlandic government, which is Indigenous-led, has been setting health policies for Greenland since 1992.

Russia is an entirely different case. For decades, the Arctic did not feature in Russian policy. Recent interest is centered on resource extraction and Indigenous rights. Mokhorov argues that the Constitution guarantees a complement of Indigenous rights. He also explains that "branch laws" of both federal and regional levels further secure certain rights of Indigenous peoples for traditional uses of natural resources and to engage in traditional economic activities (Mokhorov et al., 2019). We found no evidence of inequity monitoring. Admittedly, the Russian social contract is vastly different from that of other countries under study: Although the Constitution guarantees coverage of health care for Russians, the system remains fragmented and insufficiently funded. Access to care, therefore, depends largely on location rather than entitlement (Popovich et al., 2011). We took this into consideration in our analysis. It remains, however, that Russia's definition of Indigenous peoples includes nations with less than 50,000 members only. Therefore, while guarantees exist, they selectively apply to some. Larger groups are assumed to be "Russian" rather than Indigenous. This distinction suggests a continued and unquestioned colonial agenda.

Conclusions

We acknowledge that considerable challenges remain in ensuring adequate access to effective and culturally appropriate health care, especially in remote communities. We also acknowledge that no single solution exists for addressing health inequities across Circumpolar countries. However, we assert that Indigenous peoples must be fully engaged in the creation, implementation, and continual assessment and improvement of health care services for Indigenous peoples. As local communities and populations must be involved, the definition of culturally appropriate care will differ from one country to the next and between Indigenous nations. Nevertheless, it is our collective recommendation that Circumpolar nations begin and/or expand commitments to culturally appropriate, self-determined, access to health care in Circumpolar contexts to reduce health inequities and adhere to their obligations outlined in UNDRIP.

Appendix A

Table A1. International covenants, conferences and their relevance to the right to health. DOI: https://doi.org/10.1525/elementa.2019.00079.tA1

			Ratified								
Covenant	**Document**	**Right to Health**	**# Countries**	**Canada**	**Denmark**	**Finland**	**Greenland**	**Iceland**	**Norway**	**Russia**	**Sweden**	**United States**
Universal Declaration of Human Rights (United Nations, 1948)	Universal Declaration	(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control.	50	√	√	√	√	√	√	√	√	√
International Convention on the Elimination of All Forms of Racial Discrimination 1965 (United Nations, 1965)	UN Human Rights Treaty	*Article 5* In compliance with the fundamental obligations laid down in Article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, color, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: (d) Other civil rights, in particular: . . . (iv) The right to public health, medical care, social security, and social services	166	√	√	√	√	√	√	√	√	√
International Covenant on Economic, Social and Cultural Rights (United Nations, 1966)	UN Human Rights Treaty	1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment, and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions that would assure to all medical service and medical attention in the event of sickness.	146	√	√	√	√	√	√	√	√	√
Alma-Ata Declaration 1978 (World Health Organization, 1978)	Unilateral Declaration	**I** The Conference strongly reaffirms that health, which is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector. **II** The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially, and economically unacceptable and is, therefore, of common concern to all countries.	N/A	UN Resolution, ratification not applicable.								

		III Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace. **IV** The people have the right and duty to participate individually and collectively in the planning and implementation of their health care. **V** Governments have a responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations, and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice. **VI** Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.										
Convention on the Elimination of All Forms of Discrimination Against Women (United Nations, 1979)	UN Human Rights Treaty	***Article 10.*** States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women: Article 10(h): (h) Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning. Article 12.1 1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

(continued)

TABLE A1. *(continued)*

Covenant	Document	Right to Health	Ratified								
			# Countries	Canada	Denmark	Finland	Greenland	Iceland	Norway	Russia	Sweden	United States
		Article 14 1. States Parties shall take into account the particular problems faced by rural women and the significant roles that rural women play in the economic survival of their families, including their work in the non-monetized sectors of the economy, and shall take all appropriate measures to ensure the application of the provisions of the present Convention to women in rural areas.										
		2. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right: (b) To have access to adequate health care facilities, including information, counseling, and services in family planning;										

Appendix B

Table B1. International covenants, conferences and their relevance to Indigenous health. DOI: https://doi.org/10.1525/elementa.2019.00079.tB1

			Ratified								
Covenant	**Document**	**Relevance**	**# Countries**	**Canada**	**Denmark**	**Finland**	**Greenland**	**Iceland**	**Norway**	**Russia**	**Sweden**	**United States**
International Labour Organization Convention No. 107 on the Protection and Integration of Indigenous Tribal and Semi-Tribal Populations in Independent Countries 1957 (Office of the United Nations High Commissioner for Human Rights, 2006)	Legally binding agreement for signatories	·Intro: Recognition of the existence and significance of indigenous people ·2. Promotion of integrative policies (assimilation) ·3. Equal rights between indigenous and non-indigenous ·12. No forced removal from territory unless for health ·19, 20: Adequate services for social security and health, based on studies of social, economic, and cultural conditions	27	·Neither ratified nor denounced. ·Assimilationist								
UN Combat Racism Conference 1978 (World Conference against Racism; World Conference to Combat Racism and Racial Discrimination, 1978)	Adopted by UN	·21. The right of indigenous peoples to maintain their traditional structure of economy and culture, including their own language, and also recognizes the special relationship of indigenous peoples to their land and stresses that their land, land rights, and natural resources should not be taken away from them; ·A8. Recognize the following rights of indigenous peoples: (a) To call themselves by their proper name and to express freely their ethnic, cultural, and other characteristics; (b) To have an official status and to form their own representative organizations; (c) To carry on within their areas of settlement their traditional structure of economy and way of life; this should in no way affect their right to participate freely on an equal basis in the economic, social, and political development of the country; (d) To maintain and use their own language; (e) To receive education and information in their own language. ·A9. Funds should be made available by the authorities for investments, the uses of which are to be determined with the participation of the indigenous peoples themselves, in the economic life of the areas concerned, as well as in all spheres of cultural activity. ·A10. The Conference urges States to allow indigenous peoples within their territories to develop cultural and social links with their own kith and kin everywhere, with strict respect for the sovereignty, territorial integrity and political independence, and non-interference in the internal affairs of those countries in which the indigenous peoples live. ·A11. The Conference further urges States to facilitate and support the establishment of representative international organizations for indigenous peoples, through which they can share experiences and promote common interests.	N/A	UN Resolution, ratification not applicable.							

(continued)

TABLE B1. *(continued)*

Covenant	Document	Relevance	Ratified								
			# Countries	Canada	Denmark	Finland	Greenland	Iceland	Norway	Russia	Sweden	United States
UN Combat Racism Conference 1983 (World Conference to Combat Racism and Racial Discrimination, 1983)	Adopted by UN	Recognizes that indigenous peoples are covered in existing international instruments, 22. The rights of indigenous populations to maintain their traditional economic, social, and cultural structures, to pursue their own economic, social, and cultural development and to use and further develop their own language, their special relationship to their land and its natural resources should not be taken away from them; 35. Indigenous populations should be free to manage their own affairs to the fullest practicable extent and should be consulted in all matters concerning their interests and welfare, wherever possible through formal consultative arrangements. Special measures should be taken to remedy past dispossession, dispersal, and systematic discrimination. 36. Funds should be made available by the national authorities for investments, the uses of which are to be determined with the participation of the indigenous populations themselves, in the economic life of the areas concerned, as well as in all spheres of cultural activity. 37. Governments should allow indigenous populations within their territories to develop cultural and social links with related or similar populations, taking into account the important role of international organizations or associations of indigenous populations, and with due respect for the sovereignty, territorial integrity, and political independence of those countries in which indigenous populations live. 38. The Conference further urges States to facilitate and support the establishment of representative nongovernmental international organizations for indigenous populations through which they can share experiences and promote common interests. The Sub-Commission on Prevention of Discrimination and Protection of Minorities should ensure that the urgent work being carried out by its Working Group on Indigenous Populations is continued so that the complex issues involved can be analyzed and appropriate measures taken at the international and national levels. 39. In view of the vulnerability of Indigenous populations to discrimination and violations of their human rights, and of the gravity of the threat faced by Indigenous populations in some parts of the world, Governments should pay close attention to situations in which the rights of Indigenous populations may be violated or denied, in order to prevent such violations, which should be widely publicized as soon as they are detected.	N/A	UN Resolution, ratification not applicable.								
ILO Convention No. 169 Concerning Indigenous and Tribal Peoples in Independent Countries 1989 (International Labour Office, 1991)	Legally binding agreement for signatories	Article 25.2. Health services shall, to the extent possible, be community-based. These services shall be planned and administered in cooperation with the peoples concerned and take into account their economic, geographic, social, and	17		√	√			√			

		cultural conditions as well as their traditional preventive care, healing practices, and medicines.										
Declaration on the Rights of Indigenous Peoples 2007 Working Group on Indigenous Populations (United Nations, 2007)	Declaration	*Article 21.*1. Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health, and social security. 2. States shall take effective measures and, where appropriate, special measures to ensure continuous improvement of their economic and social conditions. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children, and persons with disabilities. *Article 23.* Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing, and other economic and social programs affecting them and, as far as possible, to administer such programs through their own institutions. *Article 29*, 1. Indigenous peoples have the right to the conservation and protection of the environment and the productive capacity of their lands or territories and resources. States shall establish and implement assistance programs for indigenous peoples for such conservation and protection, without discrimination. 2. States shall take effective measures to ensure that no storage or disposal of hazardous materials shall take place in the lands or territories of indigenous peoples without their free, prior, and informed consent. 3. States shall also take effective measures to ensure, as needed, that programs for monitoring, maintaining, and restoring the health of indigenous peoples, as developed and implemented by the peoples affected by such materials, are duly implemented.	143	√[a]	√	√[b]	√	√	√		√	√[c]

[a]Canada initially refused to ratify because of the Declaration's language over self-determination and the lack of clarity over the word Indigenous. Canada ratified the declaration in 2016.

[b]Finland signed the declaration despite long-standing disputes between Sami Reindeer owners and Forest Administration.

[c]The United States initially refused to ratify because of the Declaration's language over self-determination and the lack of clarity over the word Indigenous. The United States ratified the declaration in 2010.

Data accessibility statement

All data are cited and contained in the article.

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- Contributed to analysis and interpretation of data: All.
- Drafted and/or revised the article: All.
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References

Aaen-Larsen, B. 2004. Health care in the circumpolar world: Greenland. *International Journal of Circumpolar Health* **63**(Suppl 2): 49–53. DOI: http://dx.doi.org/10.3402/ijch.v63i0.17785.

Alaska Native Medical Center. 2020. Anchorage, AK: Alaska Native Medical Center. Available at https://anmc.org/.

Anderson, J, Perry, J, Blue, C, Browne, A, Henderson, A, Khan, KB, Kirkham, SR, Lynam, J, Semeniuk, P, Smye, V. 2003. "Rewriting" cultural safety within the postcolonial and postnational feminist project, toward new epistemologies of healing. *Advances in Nursing Science* **26**(3): 196–214.

Arctic Council. 2019. Russian Association of Indigenous Peoples of the North (RAIPON). Tromsø, Norway: Arctic Council Secretariat. Available at https://arctic-council.org/index.php/en/about-us/permanent-participants/raipon.

Baba, L. 2013. *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, Canada: National Collaborating Centre for Aboriginal Health. Available at https://www.ccnsa-nccah.ca/docs/emerging/RPT-CulturalSafetyPublicHealth-Baba-EN.pdf.

Bennet, J, Rowley, S. 2004. Introduction, in Bennet, J, Rowley, S eds., *Uqalurait: An oral history of Nunavut*. Montreal, Canada: McGill Queen's University Press: xxv–xxx.

Bhopal, R. 1998. Spectre of racism in health and health care: Lessons from history and the United States. *British Medical Journal* **316**: 1970–1973.

Billie, A, Smylie, J. 2015. *First Peoples, second class treatment: The role of racism in the health and well-being of Indigenous peoples in Canada*. Toronto, Canada: The Wellesley Institute.

Briggs, J, Ekho, N, Ottokie, U. 2000. *Childrearing practices*. Iqaluit, Canada: Nunavut Arctic College (Interviewing Inuit Elders).

Broderstad, AR, Hansen, S, Melhus, M. 2019. The second clinical survey of the population-based study on health and living conditions in regions with Sami and Norwegian populations—The SAMINOR 2 Clinical Survey: Performing indigenous health research in a multiethnic landscape. *Scandinavian Journal of Public Health*. DOI: http://dx.doi.org/10.1177/1403494819845574.

Browne, AJ. 2017. Moving beyond description: Closing the health equity gap by redressing racism impacting Indigenous populations. *Social Science & Medicine* **184**: 23–26. DOI: http://dx.doi.org/10.1016/j.socscimed.2017.04.045.

Browne, AJ, Varcoe, C, Ford-Gilboe, M, Wathen, N, Smye, V, Jackson, BE, Wallace, B, Pauly, BB, Herbert, CP, Lavoie, JG, Wong, ST, Garneau, AB. 2018. Disruption as opportunity: Impacts of an organizational-level health equity intervention in primary care clinics. *International Journal for Equity in Health* **17**(1): 154. DOI: http://dx.doi.org/10.1186/s12939-018-0820-2.

Browne, AJ, Varcoe, C, Lavoie, J, Smye, V, Wong, ST, Krause, M, Tu, D, Godwin, O, Khan, K, Fridkin, A. 2016. Enhancing health care equity with Indigenous populations: Evidence-based strategies from an ethnographic study. *BMC Health Services Research* **16**(1): 544. DOI: http://dx.doi.org/10.1186/s12913-016-1707-9.

Brunsson, N. 2006. *The organization of hypocrisy. Talk, decisions and actions in organizations*. Malmö, Sweden: Liber.

Cameron, ES. 2012. Securing Indigenous politics: A critique of the vulnerability and adaptation approach to the human dimensions of climate change in the Canadian Arctic. *Global Environmental Change: Human and Policy Dimensions* **22**(1): 103–114. DOI: http://dx.doi.org/10.1016/j.gloenvcha.2011.11.004.

Canada. 1876a. Copy of Treaty No. 6 between Her Majesty the Queen and the Plain and Wood Cree Indians and other Tribes of Indians at Fort Carlton, Fort Pitt and Battle River with Adhesions, Roger Duhamel, F. R.S.C., 1964. Ottawa. Cat. No.: R33-0664, IAND Publication No. QS-0574-000-EE-A-1. Available at http://www.ainc-inac.gc.ca/pr/trts/trty6_e.html. Accessed 29 November 2020.

Canada. 1876b. The Indian Act 1876 [Assented to 12th April, 1876.]. Ottawa, Canada. Available at https://www.aadnc-aandc.gc.ca/DAM/DAM-INTER-HQ/STAGING/texte-text/1876c18_1100100010253_eng.pdf. Accessed 4 August 2020.

Canada. 1966. Regina v. Johnston, 56 D.L.R. (2d) 749 Saskatchewan Court of Appeal, Culliton C.J.S., Woods, Brownridge, Maguire and Hall JJ.A., 17 March 1966. Regina, Canada: Saskatchewan Court of Appeal.

Canada. 1974. The James Bay and Northern Quebec Agreement (JBNQA). Ottawa, Canada: Government of Canada. Available at http://www.gcc.ca/pdf/LEG000000006.pdf. Accessed 29 November 2020.

Canada. 1982a. Canadian charter of rights and freedoms. Ottawa, Canada: Government of Canada. Available at https://laws-lois.justice.gc.ca/eng/const/page-15.html. Accessed 29 November 2020.

Canada. 1982b. The Constitution Act, 1982. Available at http://laws.justice.gc.ca/en/const/annex_e.html#II. Accessed 1 February 2007.

Canada. 1985. Indian Act (R.S., 1985, c. I-5). Ottawa, Canada: Government of Canada.

Canada. 2004. Canada Health Act. Available at http://www.hc-sc.gc.ca/hcs-sss/medi-assur/cha-lcs/overview-apercu-eng.php. Accessed 29 November 2020.

Canada, Nunavut Tapariit Kanatami. 1993. The Nunavut Land Claims Agreement. Available at http://www.ainc-inac.gc.ca/pr/agr/nunavut/index_e.html. Accessed 29 November 2020.

Carrie, H, Mackey, TK, Laird, SN. 2015. Integrating traditional indigenous medicine and western biomedicine into health systems: A review of Nicaraguan health policies and miskitu health services. *International Journal for Equity in Health* **14**: 129. DOI: http://dx.doi.org/10.1186/s12939-015-0260-1.

Case, DS, Voluck, DA. 2002. *Alaska natives and American laws*. Second edition. Fairbanks, AK: University of Alaska.

CBC North. 2019. *What does 'implementing UNDRIP' actually mean?* Yellowknife, Canada: CBC North. Available at https://www.cbc.ca/news/canada/north/implementing-undrip-bc-nwt-1.5344825.

Constituteproject.org. 2014. Russian Federation's Constitution of 1993 with Amendments through 2014. Austin, TX: University of Texas at Austin. Available at https://www.constituteproject.org/constitution/Russia_2014.pdf?lang=en.

Craft, A, Gunn, BL, Knockwood, C, Christie, G, Askew, H, Henderson, JY, Borrows, J, Nichols, J, Wilkins, K, Chartrand, L, Fitzgerald, OE, Hamilton, R, Beaton, R, Morales, S, Lightfoot, S. 2018. UNDRIP implementation: More reflections on the braiding of international, domestic and indigenous laws. Waterloo, Canada: Centre for International Governance Innovation. Available at https://www.cigionline.org/publications/undrip-implementation-more-reflections-braiding-international-domestic-and-indigenous.

Crawford, A. n.d. Cultural safety and Inuit mental health and wellbeing. Palo Alto, CA: ISSUU. Available at https://issuu.com/amjlvc/docs/3_cultural_safety?embed_cta=read_more&embed_context=embed&embed_domain=www.inuitstorybones.ca&embed_id=0%252F7568966.

Cree Board of Health and Social Services of the James Bay. 2019. aashikum pipunh tipaachimuusinihiikin [Annual Report]. Chisasibi, Canada: Cree Board of Health and Social Services of the James Bay. Available at https://www.creehealth.org/sites/default/files/CBHSSJB%20Annual%20Report%202018-2019.pdf. Accessed 29 November 2020.

Cueva, K, Cueva, M, Revels, L, Lanier, AP, Dignan, M, Viswanath K, Fung, TF, Geller AC. 2018a. A framework for culturally relevant online learning: Lessons from Alaska's Tribal health workers. *Journal of Cancer Education* **34**(4): 647–653. DOI: http://dx.doi.org/10.1007/s13187-018-1350-8.

Cueva, K, Revels, L, Cueva, M, Lanier, AP, Dignan, M, Viswanath K, Fung, TF, Geller AC. 2018b. Culturally-relevant online cancer education modules empower Alaska's community health aides/practitioners to disseminate cancer information and reduce cancer risk. *Journal of Cancer Education* **33**(5): 1102–1109. DOI: http://dx.doi.org/10.1007/s13187-017-1217-4.

Dagsvold, I, Møllersen, S, Stordahl, V. 2015. 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. *International Journal of Circumpolar Health* **74**. DOI: http://dx.doi.org/10.3402/ijch.v74.26952.

Denmark, Sweden. 1751. Stromsad Treaty, Lapp Codicil. Stromstad. Available at https://www.arcticcentre.org/loader.aspx?id=1796863c-4dc1-4118-8c8b-2bfdf3eccdf8, http://tesi.cab.unipd.it/59515/1/Irene_De_Faccio_2018.pdf. Accessed 4 August 2020.

Department of the Interior Bureau of Indian Affairs, Department of Health and Human Services Indian Health Service. 1996. Public law 93–638 Indian self-determination and education assistance act, as amended, regulations final rule. Washington, DC: Government of the United States. Available at https://www.bie.edu/cs/groups/xbie/documents/document/idc2-087684.pdf. Accessed 4 August 2020.

Det Gronlandske Hus. n.d. Om os. Copenhagen, Denmark: Det Gronlandske Hus. Available at https://www.sumut.dk/da/om-os/. Accessed 4 August 2020.

Flesch, H. 2007. Silent voices: Women, complementary medicine, and the co-optation of change. *Complementary Therapies in Clinical Practice* **13**(3): 166–173. DOI: http://dx.doi.org/10.1016/j.ctcp.2007.03.005.

Foighel, I. 1979. Home rule in Greenland 1979. *Nordisk Tidsskrift Int'l Ret* **4**(1–9): 4–14.

Gad, UP. 2013. Greenland: A post-Danish sovereign nation state in the making. *Cooperation and Conflict* **49**(1): 98–118. DOI: http://dx.doi.org/10.1177/0010836713514151.

Gair, S, Miles, D, Savage, D, Zuchowski, I. 2015. Racism unmasked: The experiences of Aboriginal and Torres Strait Islander students in social work field placements. *Australian Social Work* **68**(1): 32–48. DOI: http://dx.doi.org/10.1080/0312407X.2014.928335.

Gottlieb, K. 2013. The Nuka system of care: Improving health through ownership and relationships. *International Journal of Circumpolar Health* **72**(1): 21118. DOI: http://dx.doi.org/10.3402/ijch.v72i0.21118.

Government of British Columbia. 2019. A new path forward. Victoria, Canada: Government of British Columbia. Available at https://declaration.gov.bc.ca/. Accessed 4 August 2020.

Government of Canada. 1985. Canada Health Act. Ottawa, Canada: Government of Canada.

Government of Canada. 2019. First Session, Forty-second Parliament, 64-65-66-67-68 Elizabeth II, 2015-2016-2017-2018-2019 House of Commons of Canada Bill C-92: An Act respecting First Nations, Inuit and Métis children, youth and families, First Reading, February 28, 2019. Ottawa, Canada: House of Commons of Canada. Available at https://www.parl.ca/DocumentViewer/en/42-1/bill/C-92/first-reading. Accessed 4 August 2020.

Greenland. 2009. Act no. 473 of 12 June 2009 Act on Greenland self-government. Available at https://naalakkersuisut.gl//~/media/Nanoq/Files/Attached%20Files/Engelske-tekster/Act%20on%20Greenland.pdf. Accessed 4 August 2020.

Greenwood, M, de Leeuw, S, Lindsay, NM, Reading, C. 2015. *Determinants of indigenous peoples' health in Canada: Beyond the social*. Toronto, Canada: Canadian Scholars' Press.

Hansen, KL, Melhus, M, Lund, E. 2010. Ethnicity, self-reported health, discrimination and socio-economic status: A study of Sami and non-Sami Norwegian populations. *International Journal of Circumpolar Health* **69**(2): 111–128. DOI: https://doi.org/10.3402/ijch.v69i2.17438.

Hardon, A, Pool, R. 2016. Anthropologists in global health experiments. *Medical Anthropology* **35**(5): 447–451. DOI: http://dx.doi.org/10.1080/01459740.2016.1177046.

Haynes, E, Taylor, KP, Durey, A, Bessarab, D, Thompson, SC. 2014. Examining the potential contribution of social theory to developing and supporting Australian Indigenous-mainstream health service partnerships. *International Journal for Equity in Health* **13**(1): 75. DOI: http://dx.doi.org/10.1186/s12939-014-0075-5.

Health Canada. 1979. Indian Health Policy 1979. Canada: Health Canada Medical Services Branch. Available at http://caid.ca/IndHeaPol1979.pdf. Accessed 30 March 2021.

Health Canada (FNIHB). 2013. Non-insured health benefits, Annual Report 2012/2013. Ottawa, Canada. Available at http://publications.gc.ca/collections/collection_2014/sc-hc/H33-1-2-2013-eng.pdf. Accessed 21 September 2020.

International Labour Office. 1991. Convention (No. 169) concerning Indigenous and Tribal Peoples in Independent Countries adopted on 27 June 1989 by the General Conference on the International Labour Organisation at its seventy-sixth session. 2003. Available at 193.194.138.190/html/menu3/b/62.htm. Accessed 6 October 2003.

The Inuit of Labrador, Her Majesty the Queen in Right of Newfoundland and Labrador, Her Majesty the Queen in Right of Canada. 2018. Labrador Inuit land claims agreement act. Available at https://www.assembly.nl.ca/legislation/sr/statutes/l03-1.htm. Accessed 1 May 2008.

Johannsdottir, L, Cook, D. 2017. Discourse analysis of the 2013–2016 Arctic Circle Assembly programmes. *Polar Record* **53**(270): 276–279. DOI: http://dx.doi.org/10.1017/S0032247417000109.

Johnson LM. 2006. Gitksan medicinal plants—Cultural choice and efficacy. *Journal of Ethnobiology & Ethnomedicine* **2**: 29.

Jones, CM, Clavier, C, Potvin, L. 2017. Are national policies on global health in fact national policies on global health governance? A comparison of policy designs from Norway and Switzerland. *BMJ Global Health* **2**(2): e000120. DOI: http://dx.doi.org/10.1136/bmjgh-2016-000120.

Keil, K, Knecht, S. 2017. *Governing Arctic change, global perspectives*. London, UK: Springer Nature.

Kirmayer, L. 2013. Embracing uncertainty as a path to competence: Cultural safety, empathy, and alterity in clinical training. *Culture, Medicine and Psychiatry* **37**(2): 365–372. DOI: http://dx.doi.org/ http://dx.doi.org/10.1007/s11013-013-9314-2.

Kirmayer, L, Ban, L. 2013. Cultural psychiatry: Research strategies and future directions. *Advances in Psychosomatic Medicine* **33**: 97–114. DOI: http://dx.doi.org/ http://dx.doi.org/10.1159/000348742.

Koivurova, T. 2008. The Draft Nordic Saami Convention: Nations working together. *International Community Law Review* **10**: 279–293.

Kornelsen, D, Boyer, Y, Lavoie, JG, Dwyer, J. 2017. Reciprocal accountability and fiduciary duty: Implications for indigenous health in Canada, New Zealand and Australia. *Australian Indigenous Law Review* **19**(2): 17–33.

Lavoie, JG. 2003. Indigenous primary health care services in Australia, Canada and New Zealand: Policy and Financing Issues. Winnipeg, Canada: University of Manitoba Centre for Aboriginal Health Research.

Lavoie, JG. 2004. Governed by contracts: The development of Indigenous primary health services in Canada, Australia and New Zealand. *Journal of Aboriginal Health* **1**(1): 6–24.

Lavoie, JG. 2014. Policy and practice options for equitable access to primary healthcare for indigenous peoples in British Columbia and Norway. *International Indigenous Policy Journal* **5**(1): 1–17.

Lavoie, JG. 2017. Medicare and the Care of First Nations, Métis and Inuit. *Journal of Health Economics, Policy and Law* **13**(3–4): 280–298. DOI: http://dx.doi.org/10.1017/S1744133117000391.

Lavoie, JG, Boulton, AF, Dwyer, J. 2010a. Analysing contractual environments: Lessons from indigenous health in Canada, Australia and New Zealand. *Public Administration* **88**(3): 665–679.

Lavoie, JG, Dwyer, J. 2016. Implementing Indigenous community control in health care: Lessons from Canada. *Australian Health Review* **40**: 453–458. DOI: http://dx.doi.org/10.1071/AH14101.

Lavoie, JG, Forget, EL, Prakash, T, Dahl, M, Martens, PJ, O'Neil, JD. 2010b. Have investments in on-reserve health services and initiatives promoting community control improved First Nations' health in Manitoba? *Social Science & Medicine* **71**(4): 717–724. DOI: http://dx.doi.org/10.1016/j.socscimed.2010.04.037.

Lavoie, JG, Gervais, L, Toner, J, Bergeron, O, Thomas, G. 2012. *Looking for aboriginal health in legislation and policies, 1970 to 2008: The policy synthesis project*. Prince George, Canada: National Collaborating Centre for Aboriginal Health. Available at https://www.ccnsa-nccah.ca/docs/context/RPT-LookingHealthLegislationPolicies-EN.pdf.

Lavoie, JG, Gervais, L, Toner, J, Bergeron, O, Thomas, G. 2013. *Aboriginal health policies in Canada: The policy synthesis project*. Prince George, Canada. Available at http://www.nccah-ccnsa.ca/docs/Looking%20for%20Aboriginal%20Health%20in%20Legislation%20and%20Policies%20-%20June%202011.pdf.

Lavoie, JG, Kornelsen, D, Wylie, L, Mignone, J, Dwyer, J, Boyer, Y, Boulton, A, O'Donnell, K. 2016. Responding to health inequities: Indigenous health system innovations. *Global Health, Epidemiology and Genomics* **1**(e14): 1–10. DOI: http://dx.doi.org/10.1017/gheg.2016.12.

Levinson, DR. 2016. Indian Health Service Hospitals: *Longstanding challenges warrant focused attention to support quality care*. Washington, DC: Department of Health and Human Services, Office of Inspector General. Available at https://oig.hhs.gov/oei/reports/oei-06-14-00011.asp.

Leyland, A, Smylie, J, Cole, M, Kitty, D, Crowshoe, L, McKinney, V, Green, M, Funnell, S, Brascoupé, S, Dallaire, J, Safarov, A. 2016. Health and health care implications of systematic racism on indigenous people in Canada: Indigenous health working group, fact sheet. Toronto, Canada: Indigenous Health Working Group of the College of Family Physicians of Canada and Indigenous Physicians Association of Canada.

Marchildon, GP, Beck, C, Katapally, TR, Abonyi, S, Dosman, J, Episkenew, J-A. 2017. Bifurcation of health policy regimes: A study of sleep apnea care and benefits coverage in Saskatchewan. *Healthcare Policy* **12**(4): 69–85. DOI: http://dx.doi.org/10.12927/hcpol.2017.25097.

Markin, VV, Silin, AN. 2016. Circumpolar region amid socio-spatial transformation of a territory (case study of Yamal). *Socio-Economic Development Strategy* **6**(48): 28–52. DOI: http://dx.doi.org/10.15838/esc/2016.6.48.2

Markowitz, JN. 2020. *Perils of plenty: Arctic resource competition and the return of the great game*. Oxford, UK: Oxford University Press.

Marmot, M, Wilkinson, RG. 2006. *Social determinants of health*. Oxford, UK: Oxford University Press.

Marsh, TN, Coholic, D, Cote-Meek, S, Najavits, LM. 2015. Blending Aboriginal and Western healing methods to treat intergenerational trauma with substance use disorder in Aboriginal peoples who live in northeastern Ontario, Canada. *Harm Reduction Journal* **12**: 14. DOI: http://dx.doi.org/10.1186/s12954-015-0046-1.

McCormick, R. 1996. Culturally appropriate means and ends of counselling as described by the First Nations people of British Columbia. *International Journal for the Advancement of Counselling* **18**: 163–172.

Menendez, EL. 2016. Intercultural health: Proposals, actions and failures. *Ciencia & Saude Coletiva* **21**(1): 109–118. DOI: http://dx.doi.org/10.1590/1413-81232015211.20252015.

Mignone, J, Bartlett, J, O'Neil, J, Orchard, T. 2007. Best practices in intercultural health: Five case studies in Latin America. *Journal of Ethnobiology and Ethnomedicine* **3**: 31. DOI: http://dx.doi.org/10.1186/1746-4269-3-31.

Mignone, J, Gómez Vargas, J. 2015. Health care organizations in Colombia: An Indigenous success story within a system in crisis. *AlterNative* **11**(4): 9.

Mignone, J, Nállim, J, Gómez Vargas, H. 2011. Indigenous control over health care in the midst of neoliberal reforms in Colombia: An uneasy balance. *Studies in Political Economy* **87**: 15.

Mitchell, T, Arseneau, C, Thomas, D. 2019. Colonial trauma: Complex, continuous, collective, cumulative and compounding effects on the health of Indigenous peoples in Canada and beyond. *International Journal of Indigenous Health* **14**(5): 74–94. DOI: http://dx.doi.org/10.32799/ijih.v14i2.32958.

Mokhorov, DA, Baranova, TA, Donenko, AA. 2019. Rights of indigenous peoples of the Russian Arctic. *IOP Conference Series: Earth and Environmental Science* **302**. DOI: http://dx.doi.org/10.1088/1755-1315/302/1/012155.

Mörkenstam, U. 2019. Organised hypocrisy? The implementation of the international indigenous rights regime in Sweden. *The International Journal of Human Rights* **23**(10): 1718–1741. DOI: http://dx.doi.org/10.1080/13642987.2019.1629907.

Munthe-Kaas, H, Nokleby, H, Nguyen, L. 2019. Systematic mapping of checklists for assessing transferability. *Systematic Reviews* **8**(1): 22. DOI: http://dx.doi.org/10.1186/s13643-018-0893-4.

Nunavik Board of Health and Social Services. 2018. *Annual report 2017/2018*. Kuujjuaq, Canada: Nunavik Board of Health and Social Services. Available at

https://nrbhss.ca/sites/default/files/Annual_Report_2018_EN.pdf. Accessed 4 August 2020.

Office of the United Nations High Commissioner for Human Rights. 2006. *Status of ratifications of the principal international human rights treaties as of 02 May 2006*. Geneva, Switzerland. Available at http://www2.ohchr.org/english/bodies/docs/status.pdf. Accessed 5 February 2003.

Ootoova, I, Atagutsiak, T, Ijjangiaq, T, Pitseolak, J, Joamie, A, Papatsie, M. 2000. *Perspectives on Traditional Health*. Iqaluit, Canada: Nunavut Arctic College (Interviewing Inuit Elders).

Paradies, Y. 2016. Colonisation, racism and indigenous health. *Journal of Population Research* **33**: 83–96.

Pelcastre-Villafuerte, BE, Meneses-Navarro, S, Ruelas-Gonzalez, MG, Reyes-Morales, H, Amaya-Castellanos, A, Taboada, A. 2017. Aging in rural, indigenous communities: An intercultural and participatory healthcare approach in Mexico. *Ethnicity & Health* **22**(6): 610–630. DOI: http://dx.doi.org/10.1080/13557858.2016.1246417.

Pfefferbaum, B, Strickland, R, Rhoades, ER, Pfefferbaum, RL. 1995. Learning how to heal: An analysis of the history, policy, and framework of Indian health care. *American Indian Law Review* **20**(2): 365–397.

Popovich, L, Potapchik, E, Shishkin, S, Richardson, E, Vacroux, A, Mathivet, B, Federation, R. 2011. *Russian Federation: Health system review. London, UK: European Observatory on Health Systems and Policies*. Available at http://www.euro.who.int/__data/assets/pdf_file/0006/157092/HiT-Russia_EN_web-with-links.pdf.

Poppel, B. 2017. Well-being of circumpolar arctic peoples: The quest for continuity, in Estes, RJ, Sirgy, MJ eds., *The pursuit of human well-being international handbooks of quality-of-life*. Cham, the Netherlands: Springer: 565–605.

Pudlat, Q. 2011. *Ilagiinniq: Interviews on Inuit family values from the Qikiqtani region*. Iqaluit, Canada: Niutaq Cultural Institute and Qikiqtani Inuit Association: 73–87.

Ramsden, I. 1990. Cultural safety. *New Zealand Nursing Journal* **83**(11): 18–19.

Redvers, JM. 2016. *Land-based practice for indigenous health and wellness in Yukon, Nunavut, and the Northwest Territories*. Calgary, Canada: University of Calgary, Environmental Design. Available at https://prism.ucalgary.ca/handle/11023/2996.

Redvers, N, Marianayagam, J, Blondin, B. 2019. Improving access to Indigenous medicine for patients in hospital-based settings: A challenge for health systems in northern Canada. *International Journal of Circumpolar Health* **78**(2). DOI: http://dx.doi.org/10.1080/22423982.2019.1589208.

Russian Federation Federal State Statistics Service. 2019. Russia in figures. Moscow, Russia: Russian Federation Federal State Statistics Service. Available at http://www.gks.ru/wps/wcm/connect/rosstat_main/rosstat/en/figures/population/. Accessed 4 August 2020.

Salaverry, O. 2010. Interculturality in health. *Revista Peruana de Medicina Experimental y Salud Publica* **27**(1): 80–93.

SAMINOR. 2014. The SAMINOR study. Available at https://en.uit.no/forskning/forskningsgrupper/gruppe?p_document_id=591555. Accessed 1 July 2020.

Sandes, LFF, Freitas, DA, de Souza, M, Leite, KBS. 2018. Primary health care for South-American indigenous peoples: An integrative review of the literature [Atencion primaria en salud a indigenas de America del Sur: Revision integrativa de la bibliografia]. *Rev Panam Salud Publica* **42**: e163. DOI: http://dx.doi.org/10.26633/RPSP.2018.163.

Scaioli, I. 2010. Medicine, Culture and Power: Interpreting for Navajo people in medical settings. Available at http://lingue2.lingue.unibo.it/didattica/ inglese/rudvin/interpreting%20for%20navajo%20people%20in%20medical%20settings%20-%20scaioli.pdf%20.

Shadian, JM. 2017. Reimagining political space: The limits of Arctic Indigenous self-determination in international governance? in Keil, K, Knecht, S eds., *Governing Arctic change, global perspectives*. London, UK: Springer Nature: 43–57.

Sønstebø, A. 2018. *Samisk statistikk 2018*. Oslo, Norway: Statistisk sentralbyrå.

Southcentral Foundation. 2019. *Nuka system of care*. Anchorage, AK: Southcentral Foundation. Available at https://www.southcentralfoundation.com/nuka-system-of-care/.

Statistics Canada. 2016a. Aboriginal Peoples Highlight Tables, 2016 Census: Aboriginal identity population by both sexes, total - age, 2016 counts, Canada, provinces and territories, 2016 Census—25% Sample data. Ottawa, Canada: Statistics Canada. Available at http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/abo-aut/Table.cfm?&T=101&S=99&O=A. Accessed 4 August 2020.

Statistics Canada. 2016b. Inuit: Fact Sheet for Nunavik. Ottawa, Canada: Statistics Canada. Available at https://www150.statcan.gc.ca/n1/pub/89-656-x/89-656-x2016016-eng.htm. Accessed 4 August 2020.

Statistics Denmark. 2018. People born in Greenland and living in Denmark 1. January by time and parents place of birth. Available at https://www.statistikbanken.dk/BEF5G. Accessed 4 August 2020.

Statistics Finland. 2019. *Finland's preliminary population figure 5,518,393 at the end of March*. Helsinki, Finland: Työpajankatu. Available at http://www.stat.fi/til/vamuu/2019/03/vamuu_2019_03_2019-04-26_tie_001_en.html. Accessed 4 August 2020.

Statistics Greenland. 2018. Greenland in figures 2018. Nuuk, Greenland: Statistics Greenland. Available at http://www.stat.gl/publ/en/GF/2018/pdf/Greenland%20in%20Figures%202018.pdf. Accessed 4 August 2020.

Statistics Sweden. 2019. Population in the country, counties and municipalities on 31 December 2018 and Population Change in 2018. Stockholm, Sweden: Statistics Sweden. Available at https://www.scb.se/en/finding-statistics/statistics-by-subject-area/population/population-composition/population-statistics/pong/tables-and-graphs/yearly-statistics —municipalities-counties-and-the-whole-country/population-in-the-country-counties-and-municipalities-on-31122015-and-population-change-in-2015/. Accessed 4 August 2020.

Statistisk sentralbyra. 2019. 07520: Sami statistics. Population at 1 January, births, deaths and migration. STN area—total 1990—2017. Oslo, Norway: Statistisk sentralbyra. Available at https://www.ssb.no/en/statbank/table/07520/tableViewLayout1/. Accessed 4 August 2020.

Steinmann, G, van de Bovenkamp, H, de Bont, A, Delnoij, D. 2020. Redefining value: A discourse analysis on value-based health care. *BMC Health Services Research* **20**(1): 862. DOI: http://dx.doi.org/10.1186/s12913-020-05614-7.

Strommer, GD, Osborne, SD. 2015. The history, status, and future of Tribal self governance under the Indian self-determination and education assistance act. *American Indian Law Review* **39**(1): 1–75.

Sweden. 2019. Sami in Sweden. Stockholm, Sweden: Sweden. Available at https://sweden.se/society/sami-in-sweden/. Accessed 4 August 2020.

Tagalik, S. 2018. Inuit knowledge systems, Elders, and determinants of health: Harmony, balance, and the role of holistic thinking, in Greenwood, M, de Leeuw, S, Lindsay, NM eds., *Determinants of indigenous peoples' health: Beyond the social*. 2nd edition. Toronto, Canada: Canadian Scholars' Press: 93–110.

Tenbensel, T, Dwyer, J, Lavoie, JG. 2013. How not to kill the golden goose: Reconceptualising accountability relationships in community-based third sector organisations. *Public Administration Review* **16**(7): 925–944. DOI: http://dx.doi.org/10.1080/14719037.2013.770054.

Teufel-Shone, NI, Tippens, JA, McCrary, HC, Ehiri, JE, Sanderson, PR. 2016. Resilience in American Indian and Alaska native public health: An underexplored framework. *The American Journal of Health Promotion*. DOI: http://dx.doi.org/10.1177/0890117116664708.

Tobin, J. 2012. *The right to health in international law*. Oxford, UK: Oxford University Press.

Toebes, B. 1999. Towards an improved understanding of the international human right to health. *Human Rights Quarterly* **21**: 661–679.

United Nations. 1948. Universal Declaration of Human Rights, adopted and proclaimed by General Assembly resolution 217 A (III) of 10 December 1948. Geneva, Switzerland: United Nations.

United Nations. 1965. International Convention on the Elimination of All Forms of Racial Discrimination adopted and opened for signature and ratification by General Assembly Resolution 2106 (XX) of 21 December 1965. Geneva, Switzerland: United Nations.

United Nations. 1966. International Covenant on Economic, Social and Cultural Rights adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966. Geneva, Switzerland: United Nations.

United Nations. 1979. Convention on the Elimination of All Forms of Discrimination against Women adopted and opened for signature, ratification and accession by General Assembly resolution 34/180/ of 18 December 1979. Geneva, Switzerland: United Nations.

United Nations. 2007. United Nations declaration on the rights of indigenous peoples. Geneva, Switzerland. Available at www.cwis.org/drft9329.html/. Accessed 21 September 2020.

United Nations Department of Economic and Social Affairs IP. 2008. United Nations declaration on the rights of indigenous peoples in languages. Geneva, Switzerland: United Nations Department of Economic and Social Affairs, Indigenous Peoples. Available at https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples/previous-updates.html. Accessed 21 September 2020.

United Nations Permanent Forum on Indigenous Issues. 2007. Press release, "Message of Victoria Tauli-Corpuz, chairperson of the UN Permanent Forum on indigenous issues on the occasion of the adoption by the general assembly of the declaration on the rights of indigenous peoples. Geneva, Switzerland: United Nations Permanent Forum on Indigenous Issues. Available at www.un.org/esa/socdev/unpfii/documents/2016/Docs-updates/Statement-Press-Release-IDWIP-2007.pdf. Accessed 4 August 2020.

United Nations Permanent Forum on Indigenous Issues. n.d. Who are indigenous peoples? Geneva, Switzerland: United Nations. Available at https://www.un.org/esa/socdev/unpfii/documents/5session_factsheet1.pdf. Accessed 22 December 2020.

United Nations Regional Information Centre for Western Europe. 2019. *The Sami of Northern Europe—one people, four countries*. Brussels, Belgium: United Nations. Available at https://www.unric.org/en/indigenous-people/27307-the-sami-of-northern-europe —one-people-four-countries. Accessed 8 April 2020.

United States of America. 1868. Treaty with the Eastern Band Shoshoni and Bannock. Washington, DC: Government Printing Office. Available at http://www.littlebighorn.info/Articles/chey68.htm. Accessed 8 April 2020.

United States of America. 1904a. Treaty of Fort Laramie with the Sioux, in Kappler, CJ ed., *Indian affairs: Laws and Treaties Vol II (Treaties)*. Washington, DC: Government Printing Office: 594–595.

United States of America. 1904b. Treaty with the Kiowa, Comanche, and Apache; October 21, 1867, in Kappler, CJ ed., *Indian affairs: Laws and Treaties Vol II (Treaties)*. Washington, DC: Government Printing Office: 489–490.

United States of America. 1921. Public law 67–85, The Act of November 2, 1921, The Snyder Act. Washington, DC: US Congress. Available at https://www.aps.edu/indian-education/documents/jom-contracting-legislative-documents/2.%20Snyder%20Act.pdf. Accessed 8 April 2020.

United States of America. 1924. Public Law 175–168, The Act of December 3rd, 1921, The Indian Citizenship Act. Available at https://www.docsteach.org/documents/document/indian-citizenship-act.

United States of America. 1971. Alaskan native claims settlement act. Washington, DC: United States of America. Available at https://www.govinfo.gov/content/pkg/STATUTE-85/pdf/STATUTE-85-Pg688.pdf. Accessed 8 April 2020.

United States of America. 1975. 25 USC Ch. 46: Indian self-determination and education assistance. Washington, DC: United States of America. Available at http://uscode.house.gov/view.xhtml?path=/prelim@title25/chapter46&edition=prelim. Accessed 8 April 2020.

United States of America. 1992. The constitution of the United States, The bill of rights & all amendments. Washington, DC: Government of the United States. Available at https://constitutionus.com/. Accessed 8 April 2020.

United States of American Office of the Legislative Counsel. 2010. Compilation of patient protection and affordable care act [As Amended Through May 1, 2010] including patient protection and affordable care act health-related portions of the health care and education reconciliation act of 2010. Washington, DC: United States of American Office of the Legislative Counsel. Available at http://housedocs.house.gov/energycommerce/ppacacon.pdf. Accessed 8 April 2020.

U.S. Census Bureau. 2018. QuickFacts Alaska. Washington, DC: U.S. Census Bureau. Available at https://www.census.gov/quickfacts/ak. Accessed 8 April 2020.

Vorobyev, P, Bezmelnitsyna, L, Hołownia, M. 2012. The organization of the health care system in the Russian Federation. *Journal of Health Policy and Outcome Research* **2**: 6–12. DOI: http://dx.doi.org/10.7365/JHPOR.2012.1.16.

Wetterhall, S, Burrus, B, Shugars, D, Bader, J. 2011. Cultural context in the effort to improve oral health among Alaska Native people: The dental health aide therapist model. *American Journal of Public Health* **101**(10): 1836–1840. DOI: http://dx.doi.org/10.2105/AJPH.2011.300356.

Wexler, L. 2014. Looking across three generations of Alaska Natives to explore how culture fosters indigenous resilience. *Transcultural Psychiatry* **51**(1): 73–92.

Wilson, D. 2008. The significance of a culturally appropriate health service for Indigenous Mâori women. *Contemporary Nurse* **28**(1–2): 173–188.

World Conference to Combat Racism and Racial Discrimination. 1978. The Declarations and Programmes of Action adopted by the First (1978) World Conference to Combat Racism and Racial Discrimination. Available at www.racism.gov.za/substance/confdoc/declfirst.htm. Accessed 8 April 2020.

World Conference to Combat Racism and Racial Discrimination. 1983. The Declarations and Programmes of Action adopted by the Second (1983) World Conference to Combat Racism and Racial Discrimination. Available at http://www.racism.gov.za/substance/confdoc/decl1983.htm. Accessed 8 April 2020.

World Health Organization. 1946. *Constitution of the World Health Organization*. Geneva, Switzerland: World Health Organization.

World Health Organization, ed. 1978. *Declaration of Alma-Ata, international conference on primary health care, Alma-Ata, USSR, 6–12 September*. Geneva, Switzerland: World Health Organization.

Xanthaki, A. 2004. Indigenous rights in the Russian Federation: The case of numerically small peoples of the Russian North, Siberia, and Far East. *Human Rights Quarterly* **26**(1): 74–105.

Young, TK. 2012. *Circumpolar health atlas*. Toronto, Canada: University of Toronto Press.

Young, TK, Broderstad, AR, Sumarokov, YA, Bjerregaard, P. 2020. Disparities amidst plenty: A health portrait of Indigenous peoples in circumpolar regions. *International Journal of Circumpolar Health* **79**(1): 1805254. DOI: http://dx.doi.org/10.1080/22423982.2020.1805254.

Young, TK, Chatwood, S. 2011. Health care in the north: What Canada can learn from its circumpolar neighbours. *CMAJ: Canadian Medical Association Journal = journal de l'Association medicale canadienne* **183**(2): 209–214.

Yukon. 2002. Health Act. Whitehorse: Yukon Government. Available at http://www.gov.yk.ca/legislation/acts/health_c.pdf. Accessed 21 September 2020.

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