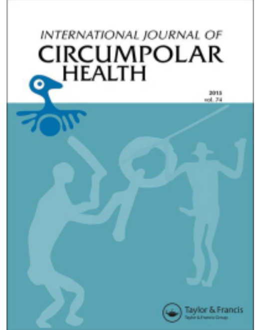

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Cultural competence and safety in Circumpolar countries: an analysis of discourses in healthcare

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ABSTRACT

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

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Highlights

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

Introduction

In recent decades, research exploring health inequities affecting Indigenous and minority populations has drawn attention to cross-cultural communication, misunderstandings, and experiences of interpersonal and systemic racism in healthcare settings – and to their contribution to poorer health outcomes in these populations. As a result, a number of key concepts such as cultural competence and cultural safety have emerged, with the aim of sensitising healthcare providers and systems to the needs of their minority service users.

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

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

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

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

> (1) Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. **Indigenous individuals also have the right to access, without any discrimination, to all social and health services**.
>
> (2) Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. **States shall take the necessary steps with a view to achieving progressively the full realisation of this right** [2, p.9, emphasis added].

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

Introducing the concepts of cultural competence and cultural safety

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

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

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

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

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

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

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

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

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

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

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

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

Healthcare among Indigenous peoples around the Circumpolar north

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

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

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

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

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

Table 1. Circumpolar Indigenous contexts [33–46]

Jurisdiction	Indigenous population, total population (% of total population)	Indigenous nations	Access to Indigenous-centric services
Alaska, USA	737,438, 112,828 (15.3%)	228 federally recognised tribes, including Iñupiat, Yupik, Siberian Yupik, Sugpiaq, Unangax, Eyak, Tlingit, Haida, Tsimshian, and Athabascan	• Alaska Native peoples may access healthcare through tribal, private, or military healthcare systems (dependent on military service history and Indigenous status) The Alaska Tribal Health System and Alaska Native Tribal Health Consortium provide Indigenous-centric PHC, secondary and tertiary care.
Yukon, Canada	8,195; 35,111 (23.3%)	Kutchin, Hän, Kaska, Tagish, Tutchone and Teslin	• Indigenous peoples access the same publicly funded services as other provincial/territorial residents. • PHC, secondary and tertiary care are provided at no cost to the individual. • Some Indigenous nations offer culturally-defined prevention-oriented services to their members (Yukon and NWT). • In Quebec and Labrador, Indigenous communities manage their own community-based PHC services and hospitals.
Northwest Territories, Canada	20,860, 41,135 (50.7%)	Deneh, Tłı̨chǫ, Slavey, Innuvialuit, Gwich'in, Sahtu, Métis	
Nunavut, Canada	30,550, 35,580 (85.9%)	Inuit	
Nunavik, province of Quebec, Canada	10,880, 7,965,450 (0.1%)	Although the overall province includes many nations, the circumpolar portion of the province includes primarily Inuit.	
Labrador province of Newfoundland & Labrador, Canada	1,285 (Innu) and 6,450 (Inuit)/ 512,250 (1.5%)	Nunatsiavut Inuit, Innu, Nunatukavut Inuit	
Greenland, autonomous constituent country of Denmark	50,171; 55,877 (89.8%)	Greenlandic Inuit or Kalaallit	• Greenlandic Inuit access the same services as any other resident. There is no cost to access services. • Services vary depending on place. For example, access to hospitals is limited to major cities and larger towns in Greenland. In remote settlements health stations are provided with severely limited services and trained staff.
Denmark	Estimated 16,470; 5,581,190 (0.30%)	Greenlandic Inuit or Kalaallit	Sámi access the same services as their national counterpart.
Sweden	Estimated 20,000–40,000; 10,230,185 (0.2–0.4%)	Sámi	Sámi access the same services as their national counterpart.
Finland	Estimated 9,000; 5,517,830 (0.2%)	Sámi	Sámi access the same services as their national counterpart.
Norway	Estimated 55,544; 5,295,619 (1.0%)	Sámi	Sámi access the same services as their national counterpart. Limited to the Saami Norwegian National Advisory unit on Mental Health and Substance Use (SANKS)
Russia (Regions of Muyrmansk Oblast, Kareliya Republic, Arkhangelsk Oblast, Nenet Autonomous Okrug (AO), Komi Republic, Yamalo Nenets AO, Khanty-Mansi AO, Taymyr AO, Evenki AO, Sakha Republic, Magadan Oblast, Koryak OA, Chukotka AO)	Estimated 270,000; 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	• Indigenous-centric health services do not exist in Russia. • Some efforts are directed to mobile medical complexes and centres and increased opportunities for air ambulance flights to remote places of indigenous peoples' residence as well as training doctors and nurses of indigenous heritage.

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

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

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

Circumpolar cultural competence and cultural safety discourses across jurisdictions

In the **Canadian** context, discourses have shifted away from cultural competence to cultural safety [7]. Cultural competence-based approaches have been seen as essentializing and codifying cultures, reinforcing stereotypes rather than challenging them. The National Aboriginal Health Organization has advocated for the recognition of diversity among Canadian Indigenous populations, for an acknowledgement of the power differential that exists in the provider-patient relationship, and for raising awareness of cultural, social and historical issues in organisations and institutions [24]. More recently, Browne, Varcoe and colleagues [69,70] have advocated to include trauma- and violence-informed care to cultural safety-informed programs, recognising that the colonial project is on-going and that Indigenous patients remain largely "disadvantaged by systemic inequities [and] experience varying forms of violence that have traumatic impacts on an ongoing basis" [70, p. 5]. This might include, for examples, racial profiling by the justice system, discrimination in employment opportunities and when trying to secure safe housing, increased vigilance by child welfare agencies, and differential access to health care options based on assumptions.

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

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

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

Patient legislation underpinning the universal healthcare systems in **Finland** [87]. **Sweden** [88] and **Norway** [89] acknowledge the rights of users' access to care regardless of ethnic background. Also, in Norway, Sámi service users within certain defined Sámi administrative areas have the right to access healthcare in their own language [90], and some regional healthcare authorities in Sámi areas of Sweden and Finland have entered into agreements with their Norwegian counterparts, to address their own lack of health services in Sámi language and/or cultural competence. However, the simultaneous existence of universal healthcare systems and acknowledgement of status as Indigenous peoples (for Sámi) does not necessarily translate into adapted health services. In the Swedish case, the United Nations rapporteur on the right of everyone to the highest attainable health status, Paul Hunt, reported in 2007 "*regret[ting] that he found little, if any, evidence that Sweden has translated the special status of the Sami into meaningful, practical measures in the health context*" [55]. We noted little progress since. Instead, Norway has been leading developments of health policy specifically addressing Sámi needs – starting with the "Plan for health and social services for the Sámi population in Norway" [91]. A body of literature has emerged, focusing on how Sámi people, as well as their therapists and caregivers, understand and cooperate towards improving Sámi health [92–96]. Furthermore, a new wave of research has taken a critical stance towards previous policy and (Sámi) healthcare research, criticising it for lacking perspectives of diversity and complexity, resulting in risk of spreading essentialist understandings of Sámi culture and patients by, for example, reducing Sámi culture as uniquely centred around reindeer herding thereby perpetuating stereotypes [56,97]. To some extent, this body of work mimics international developments, in the sense that there have been two main waves of research, i.e: first the call for cultural competence, followed by a critical reaction and a call for more nuances. A new study by Mehus and colleagues [98] documenting culturally unsafe encounters Sámi have with health care in Norway signals that the concept of cultural safety is getting traction.

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

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

Conclusions

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

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

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

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

Disclosure statement

No potential conflict of interest was reported by the author(s).

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