CRUSHING COLONIALISM

THE MAGAZINE

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RIVER OF SURVIVAL

A community facing a growing daily health risk.

A SYSTEMIC FAILURE

Racial bias and reproductive injustice in “U.S.” healthcare.

WHO CONTROLS CHILDBIRTH IN SÁPMI?

What healthcare for Indigenous women should be.

LETTER FROM THE EDITOR

Healthcare is often spoken about in clinics, hospitals, and policy rooms—but for many communities, it begins much closer to home: at the tap, in the soil, in the air they breathe every day.

In this issue, we turn our attention to what happens when those everyday essentials become sources of risk rather than protection. Across different contexts, the same pattern emerges: communities carrying the burden of health threats they did not create, and systems struggling—or failing—to respond in time.

This is not only about illness. It is about access, inequality, and resilience. Across this issue, we examine how environmental conditions, infrastructure gaps, and structural inequities converge to shape health outcomes, determining who is protected and who is left at risk.

For many Indigenous communities, these realities are compounded by long histories of displacement, environmental injustice, and health systems that have too often failed to reflect their knowledge, needs, and rights. Health is not only clinical: it is cultural, relational, and deeply tied to land, identity, and self-determination.

On our cover, we bring these realities into focus through three distinct but connected stories. River of Survival (Nigeria) follows a community facing a daily health risk tied to its water source, where what should sustain life instead becomes a source of danger.

Another story examines emerging research on Indigenous women in Tribal communities in the "U.S.", where limited access to screening and systemic neglect are driving disproportionately high rates of high-risk HPV and cervical cancer, alongside the psychological toll of navigating a system that repeatedly fails them.

A third piece turns to Sápmi, asking what respectful and culturally safe healthcare could look like when Indigenous women's traditions, bodily autonomy, and community support are fully centered in care.

Together, these stories invite us to look beyond symptoms and settings, and instead confront the conditions that determine health itself, and to imagine systems of care rooted in dignity, equity, and trust.

In solidarity,

Isabel Riofrío
Editor-in-Chief





Photo credit: Neryne Ayitso and Albright Alitsi, March 2025.

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**Throughout* The Magazine, *we default to using Indigenous place names unless otherwise stated. Colonial names are indicated in quotation marks for context.*

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TAKING BACK CHILDBIRTH

BY CHRISTINE OLSEN-NIKKINEN



A snow sculpture depicting a woman giving birth while supported by two trees, photographed on Christine Olsen's farm. Photo credit: Christine Olsen, April 2021.

Swedish maternity care is often presented as safe and equitable for all. Yet behind this image lies a highly centralized and standardized system that, in practice, can strip women—especially those in Sápmi—of the right to give birth on their own terms and in connection with Sámi culture.

Sápmi is the traditional homeland of the Sámi, the Indigenous people of northern Europe, spanning parts of present-day Norway, Sweden, Finland, and Russia. For centuries, Sámi communities have faced colonization, forced assimilation, and the suppression of their spiritual and cultural practices. Christianization campaigns and witchcraft laws targeted traditional healing, ceremonies, and midwifery knowledge, disrupting practices that had long been central to Sámi maternity care.

These colonial dynamics did not disappear with history. Scholars describe today's exploitation of Sámi lands and limitations on Sámi self-determination as a continuation of settler colonial policies in new forms.

Through my work as a doula and birth support worker, as well as through my own birth experiences, I have seen how the structure of the maternity system shapes the experiences of birthing people—and how transformative it can be when women can follow their instincts, beliefs, and traditions. As a Sámi woman and chairwoman of the Sámi women's organization Niejda (meaning "daughter/girl" in Sámi), I also see clearly how colonization and Christianization continue to affect Sámi women today.

DISPATCHES FROM OUR RELATIVES

MY BODY, MY CHILD—BUT NOT MY CONDITIONS

When I gave birth to my first child in 2009, I had wanted a home birth, but financial constraints led us to a hospital instead. Although the birth went well and without interventions, I often felt pressured to ignore my instincts and adapt to hospital routines. I was required to lie on my back for monitoring, staff repeatedly attached monitors to my baby's head despite my feeling that she was fine, and her umbilical cord was cut immediately according to protocol.

By my second birth in 2014, also in a hospital, it became even clearer that medical staff trusted their assessments more than my own experience of my body. When I felt the urge to push, the medical staff told me I still had hours left before birth and left the room. Fifteen minutes later, my son was born into my own hands. That moment changed something in me. For the first time, I fully understood that my body knew how to receive my child.

Afterward, I asked to delay cutting the cord until it had turned white, but the doctor was in a hurry and cut it almost immediately. Soon after, my son began having trouble breathing.

By the time of my third birth, I knew I no longer wanted to compromise or feel controlled during labor. Since there were no home birth midwives available in our town, I decided to give birth at home on my own, in a way that felt fully undisturbed and true to my beliefs.

Although there were no home birth midwives available in our town, I received support from Agneta Bergenheim, one of Sweden's most experienced home birth midwives, who encouraged me to trust myself and my decision. In February 2022, my daughter was born at home, witnessed only by her father and her two older siblings. For the first time, I felt I was giving birth exactly as I was created to do.

A COLONIAL SYSTEM THAT CENTRALIZES AND CONTROLS

In "Sweden" today, colonialism rarely appears as direct violence. Instead, it operates through institutions and systems that centralize power and decision-making away from Sámi communities. In maternity care, this means that services are increasingly concentrated in larger cities, while the specific cultural, geographical, and emotional needs of Sámi women are deprioritized. Women are often forced to leave their homes, languages, traditions, and support systems at one of the most vulnerable and transformative moments of their lives.

This process has deep historical roots. During the 1800s, traditional midwives in Sweden and Sápmi were gradually absorbed into state-controlled medical education systems, leading to the loss of traditional birthing knowledge. Home births nevertheless remained common well into the 1900s. After World War II, Sweden still had maternity units in most rural communities. But over time, care became increasingly centralized. In 1973, Sweden had 95 birthing units; by 2025, only 45 remained, with just six serving the entire northern half of the country, including Sápmi. Today, some women must travel up to 350 kilometers to reach the nearest hospital.

As a result, around a hundred women each year in Sweden give birth on the way to the hospital. One of them was Marie Rahkola, who lives in the Sápmi territory. In January 2019, while traveling the long road from Kiruna to the hospital in Gällivare—known locally as "The Road of Death"—her baby became stuck during birth. With only a midwife on the phone to guide them, her partner had to deliver the baby himself on the roadside. "He didn't cry because the umbilical cord was around his neck," Rahkola later told SVT, Sweden's national public broadcaster. "Eventually, we got him breathing, but then I went into shock."

REVIVAL OF HOME BIRTH

Although more women in Sweden are seeking home births or more home-like birthing environments, these options are becoming increasingly difficult to access. Maternity wards focused on personalized care are closing, and many midwives are leaving home birth practice due to growing legal and institutional pressure. Midwives who attend home births are often questioned by colleagues, restricted from bringing essential medications, and risk losing their licenses if they assist births classified by the medical system as "high-risk."

This pressure became clear in the case of Agneta. In 2025, she was banned from attending home births after assisting a planned twin birth at home. Although the birth went well, the case was reported to IVO, the Swedish authority responsible for overseeing healthcare. Agneta continued supporting women who wanted to give birth at home, arguing that women deserve the right to give birth with dignity and on their own terms. As a result, she now faces legal prosecution.

For many women, especially Sámi women, the loss of midwives like Agneta has deep consequences. While not Sámi herself, Agneta has worked extensively in the Norwegian part of Sápmi and has learned from the Sámi women she has supported through birth. She understands the cultural and spiritual dimensions of childbirth that are often absent from institutional care. "Our society today has a mechanistic view of human beings, where women are forced to become units of production," Agneta says. "We live in a strong culture of fear around birth and death, the most natural parts of life."



A fireplace symbolizing the home of Sáráhkka, the Sámi goddess of pregnancy and childbirth. Photo credit: Christine Olsen, September 2019.

DISPATCHES FROM OUR RELATIVES

A DIGNIFIED BIRTH

The Sámi book *Čalbmeeadni* ("Eyemother") collects birth stories from across Sápmi. In Sámi, *čalbmi* means "eye" and *eadni* means "mother," and the word can be understood as "a wise woman" or "one who sees and cares for others." Traditionally, it referred to the woman who attended a birth, whether formally trained or not. The concept reflects a view of childbirth as something grounded in community, trust, and women's knowledge.

For generations, childbirth and midwifery were part of everyday life in Sámi society, as in many Indigenous and traditional cultures. Today, many Sámi women are fighting to reclaim that connection. This includes the right to give birth close to home, to speak Sámi during labor, to avoid long and dangerous travel during active birth, and to access care that respects cultural traditions and women's autonomy. International frameworks such as the International Labour Organization Convention No. 169 and the United Nations Declaration on the Rights of Indigenous Peoples affirm that Indigenous communities should be able to organize and provide healthcare in ways that reflect their own knowledge systems and needs.

Agneta encourages women to ask themselves: "What feels peaceful, pleasurable, and calm within me?" She believes change must begin by rebuilding trust in women's bodies and restoring community-centered birth practices. The Sámi women's organization Niejda has twice applied for government funding to preserve traditional Sámi women's health knowledge, without success. In 2025, the organization launched the small-scale project *Nissonolbmo eallin* ("Life of Women in Sámi") with support from the Swedish Sámi Parliament to continue preserving and sharing the knowledge of Sámi elders.

Decolonizing maternity care in Sápmi requires more than expanding medical services. It means redistributing power so that women's experiences, Sámi perspectives, and traditional knowledge are respected within maternity care systems.

About the author

Christine is a Sámi doula (birth support), massage therapist, writer, artist, and mother of three. She is also president of the Sámi women's organization Niejda and a defender of women's rights. Instead of finding her on social media platforms, you often find her barefoot on her farm or doing her job, which she loves. You can connect to her through her website, www.moemo.se.

A SYSTEMIC FAILURE: REPRODUCTIVE NEGLECT AND RACIAL BIAS IN "U.S." HEALTHCARE

BY NEELANJANA RAI

For Black Americans, distrust in the healthcare system is not incidental; it is historical. From the era of slavery, when Black bodies were subjected to non-consensual medical experimentation, to the mid-19th century, when J. Marion Sims performed experimental gynecological surgeries on enslaved Black women, including Anarcha Westcott, Lucy (enslaved woman), and Betsey (enslaved woman), without anesthesia or consent, the foundations of modern medicine were built, in part, on exploitation. These patterns continued into the 20th century through practices such as the Tuskegee Syphilis Study, where treatment was deliberately withheld from Black men. Together, these violations were not isolated incidents. Still, part of a broader structure that normalized neglect, dehumanization, and unjust care—shaping a legacy of mistrust that continues to influence Black patients' experiences within the healthcare system today.



Tuskegee Syphilis Study doctor injects a Black man with placebo. Photo credit: National Archives at Atlanta.

> *Structural inequities [...] continue to jeopardize lives and erode the quality of life for marginalized populations.*

Structural inequities within the American healthcare system continue to jeopardize lives and erode the quality of life for marginalized populations. These failures manifest as lower standards of medical care, higher mortality, and significantly shortened life expectancy. Data indicate that one in five adults in the "United States" has encountered discrimination in a medical setting, largely driven by racial or ethnic bias. This injustice is most visible in the longevity gap: as of 2019, life expectancy for non-Hispanic white individuals stood at 78.8 years, while non-Hispanic Black Americans averaged 74.8 years, and American Indian/Alaska Native (AI/AN) populations*[1] averaged just 71.8 years, a stark seven-year deficiency that highlights the human cost of systemic neglect.

Even after the formal end of segregation, disparities persisted through more subtle but equally harmful mechanisms—implicit bias, unequal access to hospitals, and systemic underinvestment in Black communities. Studies have shown that Black patients are less likely to receive adequate pain management, more likely to have their symptoms dismissed, and often face delays in critical care.

[1]"American IndianAlaska Native (AI/AN)" is a demographic classification used in cited studies and may not reflect how Indigenous communities self-identify.

DISPATCHES FROM OUR RELATIVES

12 years of study data indicate that Black patients are 10% less likely to be admitted to the hospital, and they are 1.26 times more likely to die in the Emergency Department (ED) compared to white patients.

A recent PhillyCEAL study conducted in "Philadelphia, Pennsylvania," provides a localized look at how these systemic issues manifest. Between February and April 2024, 327 Black Philadelphia residents participated in a cross-sectional study by completing online surveys regarding their experiences in medical settings. The research revealed that nearly two-thirds (64.5%) of the participants reported experiencing racial discrimination in healthcare. Statistical analysis showed a direct association between this discrimination and increased levels of loneliness, depression, and anxiety. Notably, loneliness was found to be a key mechanism in these mental health outcomes. When researchers controlled for loneliness, the link between healthcare discrimination and depression became non-significant, suggesting that depressive symptoms are largely driven by the social isolation and rejection felt during discriminatory medical encounters. However, the association with anxiety remained significant even after accounting for loneliness, indicating that anxiety may also stem from other structural and emotional consequences of such experiences. Furthermore, the study indicates that individuals with existing medical conditions reported significantly higher levels of loneliness following discriminatory experiences compared to those without.

A 2023 review in the *Western Journal of Emergency Medicine* highlights how structural racism and implicit bias continue to obstruct access, degrade quality, and worsen health outcomes for communities of color across the healthcare system. Recent data from "Denver, Colorado", collected between 2021 and 2022 by Johns Hopkins University, reveals troubling experiences: nearly 30% of American Indian and Alaska Native respondents reported feeling uncomfortable during a healthcare visit because of their race. Of these, 51% say they are now less likely to seek medical care in the future because of experiences categorized as racial microaggressions or outright racism.

The systemic neglect highlighted in Black communities mirrors a parallel, often invisible crisis within Tribal nations. For Native American women, the barriers to care are not only psychological but are deeply embedded in a landscape of geographic isolation, chronic underfunding, and environmental hazards.

Rachael Lorenzo, a queer Indigenous parent from the Laguna Pueblo and Mescalero Apache tribes and the Co-Founder of Indigenous Women Rising, emphasizes that these outcomes are a direct result of structural failures. Lorenzo, who also served as a political appointee at the New Mexico State Land Office (2019–2023), notes that the disparity is starkly evident in reproductive health.

These figures are corroborated by clinical research published in *Gynecologic Oncology* analyzing a decade of healthcare visits (2010–2020) across Indian Health Service (IHS) and Tribal clinics in the Pacific Northwest. It found that cervical cancer screening rates for Native American women range between 57.1% and 65.0%, significantly lower than the "U.S." national average of 73.5%. The disparity was most pronounced in the 50–64 age group, where screening rates fell to 51.2%.

THE INFRASTRUCTURE OF INEQUITY

The Indian Health Service (IHS), which many Native people rely on in the "U.S.", is described by Lorenzo as "the most underfunded health program in the federal government." This financial neglect manifests in a lack of basic specialty care. In many IHS service units, such as the one in "Albuquerque, New Mexico," there is "very limited access to different kinds of birth control" and often no obstetrician or OB-GYN on staff.

This infrastructure gap creates dangerous delays. "If someone is having a miscarriage or needing emergency pregnancy-related care, they're going to have to travel a lot farther to get care," Lorenzo says. This is compounded by geographic and economic barriers. Lorenzo recounts their own struggle to complete the HPV vaccine series: "It was really hard for me to continue to go back because I had to leave college to go back and forth to the reservation, and that wasn't always possible. There's that geographic barrier."

The data reflects this struggle on a systemic level, noting that while HPV vaccination rates have reached 58.6% among AI/AN individuals, they remain well below the national public health goal of 84.3%, leaving a significant portion of the population vulnerable to preventable malignancies.

> *The "biological harm" often attributed to Indigenous bodies is frequently a byproduct of their environment.*

SOCIOECONOMIC AND ENVIRONMENTAL ASSAULTS

The "biological harm" often attributed to Indigenous bodies is frequently a byproduct of their environment. Lorenzo argues against the concept of "biological susceptibility," instead pointing to socioeconomic factors. On many reservations, basic nutrition is a luxury. “Buying fresh fruits and vegetables on the reservations is really expensive... trucks have to drive further to deliver that food,” Lorenzo notes. “It’s almost impossible to buy bananas; it’s like $8 for a few. Meat is also really expensive.”

These external pressures may have direct biological consequences, too. A 2024 pilot study published in *Cancer Prevention Research* examined women in northern “Arizona” and found a higher prevalence of high-risk HPV and vaginal dysbiosis—a depletion of protective Lactobacillus bacteria among Native American participants compared to non-Native women. The researchers identified that these biological risks are compounded by sociodemographic stressors and limited access to care, suggesting that the environment and social standing directly influence the body's ability to defend against infection.

Environmental racism further compromises health. During their tenure at the State Land Office, Lorenzo witnessed the direct impact of industry on Tribal lands. They describe oil and gas companies "dumping produced water wherever they wanted...contaminating aquifers" and flaring that makes breathing a painful experience. “Breathing just stings your throat,” they recount, noting that the chemicals used in fracking remain "proprietary information," leaving communities in the dark about what they are consuming.

POLICY AND THE "CLIMATE OF DISREGARD"

The failure of the system often feels deliberate to those on the ground. Lorenzo points to a lack of political alignment between Tribal nations and the federal government as a barrier to emergency aid. They cite the 2020 response to the COVID-19 pandemic as a low point: “We saw the Trump administration send body bags instead of PPE to the Navajo Nation...like, body bags for dead people instead of masks and suits and gloves”.

The internal policy of Tribal nations also plays a role, as many are led by men who may not prioritize sexual or reproductive health. “The sad part is that a lot of tribes are led by men, and there isn't a lot of focus on sexual health, reproductive health, or HPV,” Lorenzo observes. This lack of cultural alignment and the persistent "historical distrust of doctors" create an environment where even simple diagnostic tools like pap smears can be viewed with apprehension.

> *“This lack of cultural alignment and the persistent "historical distrust of doctors" create an environment where even simple diagnostic tools [...] can be viewed with apprehension.”*

For many Indigenous women, navigating this system is an act of survival against a backdrop of "racist notions" that continue to separate them from their autonomy and their health. Whether it is the lack of a screening kit at an IHS clinic or the high cost of a healthy meal, the results are the same: a systemic failure that translates directly into lost lives and broken bodies.

About the author

Neelanjana Rai is an independent investigative journalist covering the intersections of climate, Indigenous rights, science, health, gender inequality, and music. Her work connects global systems to human stories; exposing power, amplifying marginalized voices, and uncovering truths that matter.

WHEN HEALTHCARE ACCESS DETERMINES SURVIVAL

BY TUNJI OFFEYI

In “Nigeria,” both the immense population and diversity highlight a central crisis: systemic failures in healthcare. While insecurity dominates headlines, the daily reality is that many lack timely, adequate care—especially in the north. Nigeria’s scale reveals not just strengths, but stark inequalities.

In 2007, during my service with the National Youth Service Corps (NYSC), I lived and lectured in Bauchi State. What haunted me most was not only the absence of infrastructure but the sound—the low, endless wailing outside hospital walls. I remember shattered families, sobbing not at a diagnosis but at helplessness. There were no medications. No choices. Illness was only part of the cruelty; distance, delay, and scarcity crushed what hope remained.

During that period, I briefly returned home to Lagos for treatment after falling ill myself within weeks of arriving. I felt unsafe and exposed, unable to trust the very system that should have healed me—its limits already painfully clear. The journey home took over ten hours; each hour throbbed with anxiety, but it was the only way I could find care I could truly trust.

Around the same period, I learned that Mr. Lott, one of the lecturers at the institution where I lectured—the Social Development Institute in Ningi, Bauchi State—had died suddenly. From conversations with colleagues at the time, his condition appeared to be one that might have been manageable with timely and adequate care, though I cannot speak to the full medical circumstances surrounding his death. The news left me overwhelmed by helplessness, reinforcing how fragile access to care could be. In moments like that, the system’s limitations felt impossible to ignore.

Living conditions also quietly underscored these realities. We relied on water pumped from the ground with hard labor. Bathing involved drawing water from a very deep well inside the lodge where we stayed. These were everyday conditions, not exceptional ones, but they still carried health implications. The people were kind and supportive, but kindness could not compensate for the structural limits of care and infrastructure around us.

Years later, those memories return differently when placed alongside official assurances. Nigeria’s Health Minister, Muhammad Ali Pate, recently said the government is “pushing for the highest health allocation in Nigeria’s history... and strengthening accountability across the system.” The statement suggests motion, even reform. But on the ground, in places like Bauchi State, the lived experience contradicts that narrative.

A recent Special Report from Bauchi describes communities navigating a fragile system in which access remains uneven, and outcomes are stark. Data from the latest National Demographic and Health Survey shows that the mortality rate for children in the state under 5 years of age remains significantly higher than the national average. A separate report by the National Population Commission examining community health workers in Ganjuwa LGA found gaps in disease recognition and response capacity. Researchers noted that many health workers struggled to identify common epidemic-prone diseases or understand how they spread—an issue that weakens early detection at the community level. What emerges from this report is a simple truth: even the first layer of care is under strain.

That strain becomes personal in the stories that follow. In Misau, a young mother, Hadiza Muhammad, described a labor that unfolded in uncertainty. Care was being provided by students in training at the facility, reflecting the limited availability of fully supervised clinical staff at the time. “In my previous experiences, I got injections when I was struggling. But on this day, I was struggling, but they couldn’t do anything,” she explained. “Even when I finally gave birth to the baby, the students were not too sure what to do; they were talking to themselves, and if one said this, the other would say something else.”

She recalled pleading for a more experienced healthcare worker to intervene, but none came. After the traumatic birth, she said the students were unable to stop her bleeding and referred her to the Federal Medical Centre (FMC) in Misau. The experience reflects broader pressures within parts of northern Nigeria’s healthcare system, where shortages of experienced personnel and limited emergency capacity can leave patients dependent on overstretched or still-training staff. But the experience left her questioning whether she could risk another pregnancy.

Hadiza Muhammad survived, and so did her baby. Others have not been as fortunate.

Almost two years ago, Laraba Ishaku recalled leading her younger sister, who was in labor, to a local healthcare center, where volunteer health workers insisted there was still time and directed them to return home. “They asked us to come back later at night or the next morning, but we had to go back before the time because of how intense it was getting for her,” she recalled. By the time they returned, the situation had worsened. There were too few staff on duty and little urgency in response. Within hours, her sister was gone. For Laraba, the memory remains stark not because it is unusual but because it is so familiar.

Independent assessments reinforce what these stories suggest. The 2024 State of States report by civic technology organization BudgIT found that only about 10.9% of health facilities in Bauchi State have at least one medical doctor, leaving the vast majority without physician coverage. Further analysis reported by SBM Intelligence highlights the scale of the imbalance, noting that Bauchi has the worst doctor-to-patient ratios in the country, among Nigeria's 36 states and the Federal Capital Territory (FCT), with 54,249 people per 139 doctors, leaving tens of thousands of residents relying on severely limited numbers of doctors. Even within government, there is an acknowledgement of systemic failure. Speaking at a national forum, Minister Muhammad Ali Pate admitted that "Nigeria's health outcomes reflect deep structural inequality."

Across northern Nigeria, geography and system capacity shape survival. In rural areas, reaching a clinic can take hours, with unreliable roads and uncertain transport compounding delays. In Gombe State, this convergence is particularly evident in the treatment of snakebites and other emergencies, where delayed arrival often meets limited treatment capacity. The World Health Organization classifies snakebite envenoming as a neglected tropical disease, disproportionately affecting rural populations. Local health officials in Gombe have reported a steady rise in cases over the past few years, alongside persistent shortages of antivenom. The implication is clear: treatment may exist, but it is not consistently available when or where it is needed, leaving lives at risk when seconds matter most.

Yet snakebite is only one expression of a broader pattern. Similar threats arise from maternal emergencies, severe infections, and childhood illnesses—conditions that are routinely managed in other health systems—which can become life-threatening when care is delayed. This challenge is further illustrated by research analyzing World Bank General Household Survey data, which confirms that longer distances and waiting times increase the likelihood of reliance on public facilities in Northern Nigeria, where women and those with severe illness face the greatest barriers to access.

Indigenous healers bridge gaps caused by distance, delayed care, and limited medical capacity. Among Hausa-Fulani, Kanuri, Tiv, and other groups, they are often the first contact for treatment. Their importance is both cultural and practical. The World Health Organization notes that traditional medicine remains central to healthcare, especially where formal systems are limited.

Indigenous healers bridge gaps caused by distance, delayed care, and limited medical capacity.

In practice, traditional medicine in Nigeria is layered and complex. It draws on extensive knowledge of local plants, many of which are used in treating common illnesses. It incorporates spiritual and communal elements, such as prayer rituals, divination, and the involvement of family or community elders in decision-making, reflecting a broader understanding of health that extends beyond the physical. Knowledge is passed down through generations, often orally, creating a system that is adaptive, localized, and deeply trusted.

But trust does not eliminate limitation. Traditional practitioners can stabilize, comfort, and sometimes heal—but they cannot replace emergency obstetric care, blood transfusions, or antivenom treatments.

The central tension, then, is not between traditional and modern medicine. It is between availability and access. Communities are not choosing one over the other in ideological terms—they are navigating what exists. When hospitals are distant or under-resourced, traditional care becomes the default. This navigation is often sequential and pragmatic: a patient may begin with a local healer for immediate relief or culturally familiar care, then turn to a clinic if symptoms persist or worsen—provided distance, cost, or transport does not prevent it.

In other cases, both systems are used simultaneously, with herbal remedies or spiritual practices continuing alongside prescribed medication. Decisions are shaped not only by belief, but also by urgency, affordability, perceived severity of illness, and past experiences with formal care. Delays often arise not from hospital rejection, but from uncertainty, referral gaps, or the time required to move between these parallel systems. These dynamics can have particularly severe consequences for children, whose conditions may deteriorate rapidly in the absence of timely and appropriate care.

There is increasing recognition that a more integrated approach could improve outcomes. The World Health Organization's global health frameworks suggest that incorporating traditional practitioners into referral systems—while validating effective remedies through research—can extend the reach of care. In settings where traditional healers are trusted first points of contact, they can play a role in early detection and timely referral, particularly for infectious diseases and other conditions requiring urgent intervention.

Research from Cephas Health Research Initiative on traditional Sakkiya practitioners in northern Nigeria, published in the book *The Traditional Sakkiya Practice: A Public Health Issue in Northern Nigeria*, confirms that traditional practitioners serve as "trusted, accessible, and affordable care options in communities where formal healthcare is distant or unaffordable," operating within cultural frameworks that formal systems often fail to reach.

Similarly, a study published by Matthew Michael in the Journal of Religion in Africa, documenting referral networks across 250+ clients in Nigeria, confirms that "lively networks of referrals" exist between traditional healers and biomedical facilities, with practitioners actively guiding patients toward hospital care when conditions exceed their expertise. But integration, on its own, cannot resolve structural deficits. Without investment in infrastructure, staffing, and supply chains, the system remains uneven, and patients will continue to navigate care based more on constraint than choice.

What I saw in Bauchi years ago was not an anomaly. It was an early glimpse into a pattern that persists. The faces have changed, the statistics have been updated, the policies have been revised—but the core experience remains familiar. I saw it firsthand at the General Hospital in Ningi, a place I often found difficult to approach yet could not avoid. With little leisure activity in the community where I served, one of the few outlets was watching football at a nearby practice pitch—ironically located close to the hospital grounds. From there, I watched patients arrive not in ambulances but on motorcycles—achaba, as they are known in the north—carrying urgency without dignity.

My connection to the hospital grew through my membership in the Nigeria Christian Corpers’ Fellowship (NCCF), which met on the hospital compound. I often spoke with corps members serving as medical staff. I soon saw the constraints they faced: staff, equipment, and basic supplies were in short supply. They wanted to help but felt powerless, their frustration mirroring the patients' helplessness.

I tried, in small ways, to contribute—serving, alongside my primary assignment as a lecturer, as a corps road marshal with the Federal Road Safety Corps and supporting community safety efforts. But those actions felt minor compared to what I witnessed in the hospital. Some moments remain difficult to forget: mothers and children in visible distress, families waiting without clarity, and the sense that, too often, there was little anyone could do.

The human cost is carried quietly. It is in the child who does not survive a treatable illness. Meanwhile, vaccine-preventable diseases thrive: only 20 percent of children are fully immunized, and dropout rates across critical vaccine series point to systemic failures in routine care delivery—failures that leave children exposed to illnesses no child should die from, the farmer left disabled by a preventable complication, or the mother who never returns from childbirth.

Northern Nigeria's healthcare crisis is, at its core, not only a question of distance—physical, economic, and political—but also of how these forces intersect to shape who receives care, when, and under what conditions. It reflects longstanding disparities in public investment and uneven distribution of medical personnel, with policy priorities, budget allocation patterns, and uneven implementation of national health strategies further deepening these gaps, particularly in historically underserved northern regions, with governance challenges that, according to the World Health Organization, have left "weak accountability and law enforcement at all governance levels, consequently slowing progress towards universal health coverage.” In this sense, distance is not merely geographic; it is also institutional, reflecting gaps between policy commitments and lived realities. These gaps persist where funding falls short. Weak oversight and fragmented service delivery limit the ability of local facilities to function effectively, even where policies exist.

When healthcare is miles away—whether in distance, cost, or capacity—survival becomes an improvisation shaped by constraint. Yet improvisation, no matter how resilient, is not a system. To prevent needless suffering, we must urgently invest in reliable, accessible emergency transport systems that meet the needs of every community. Now is the moment to act decisively: policymakers, donors, and healthcare leaders must commit concrete resources and oversight to ensure that no community is left behind and that every Nigerian can access timely, life-saving care without compromise.

About the author

Dr. Tunji Offeyi is an award-winning Nigerian-British journalist, poet, and heritage researcher. He holds a doctorate in Heritage from the University of Wales Trinity Saint David and is a Salzburg Global Fellow. His work spans creative practice, public scholarship, and political organising, including service as Regional Executive of the Liberal Democrats in the West Midlands, UK.

RECLAIMING DISABILITY JUSTICE IN INDIGENOUS HEALTHCARE

BY ALBRIGHT ALITSI

Across East Africa, healthcare inequality is shaped by colonial histories and ongoing systemic neglect. For Indigenous communities, these inequalities deepen when disability becomes part of lived experience. Clinics without ramps, health services without sign language interpretation, and systems that fail to recognize Indigenous healing practices all combine to restrict access to care.

Yet Indigenous disabled people are not passive recipients of exclusion; they are organizing, resisting, and reimagining care rooted in dignity, culture, and justice. At the center of this story is Sabthio Balcha, a deaf youth from the Rendille Indigenous pastoralist community in northern "Kenya" whose experience reveals how exclusion is built into everyday healthcare.

SABTHIO'S FIGHT FOR ACCESSIBLE CARE

Sabthio grew up in the Rendille pastoralist Indigenous community of northern "Kenya," where life followed livestock routes, seasonal movement, and deep ties to land. Health services came through mobile outreach programs and community gatherings, but these spaces rarely considered deaf communication or Indigenous language realities.

There was no accessible sign language interpretation that reflected her Indigenous community's language and cultural context, and no healthcare information designed around how she experienced the world.

So she learned to stay outside.

"I would sit outside the meeting hall, watching other girls go in," she recalls. "It felt like my body, my language, and my community did not matter."

For years, she carried that silence alone. Then she began connecting with other deaf Indigenous girls from her Rendille community who had faced similar exclusions. Together, they gathered in small circles shaped by their own communication needs rather than institutional rules. Later, in broader peer gatherings with deaf girls from other pastoralist communities, supported by young women allies, she began to hear her own story reflected to her. Girls spoke of being ignored in clinics, of health workers speaking past them, and of information they could see but never truly access.

But in informal peer gatherings with other Indigenous deaf girls from pastoralist communities, supported by other young women, she found shared experiences among peers living within communities targeted by mobile outreach health programs designed to serve remote Indigenous populations, but that often did not meet their intended goal of accessible and inclusive care. Some described sitting through consultations without understanding what was being said. Others recalled being denied opportunities to ask questions about reproductive health because healthcare workers assumed disability meant dependence or incapacity. In many cases, communication barriers forced deaf patients to rely on relatives or strangers to interpret sensitive medical information. That was when Sabthio realized her exclusion was not individual neglect, it was systemic absence. The healthcare system had never been built for them.



Youth reproductive health rights champions from Isiolo, Turkana, Rendille, Ogiek, and Samburu participate in a disability-inclusive training in Nairobi, joining hands in a circle to symbolize solidarity. Photo credit: Albright Alitsi, March 2025.



The Young Feminist Organization (YFO) team poses together after coordinating advocacy work behind a disability-inclusive reproductive healthcare initiative in Nairobi. Photo credit: Albright Alitsi, March 2025.

FROM ISOLATION TO COLLECTIVE ACTION

The turning point came when they walked into a local clinic together. Inside, nothing had been prepared for them: no interpretation, no communication support, and no adjustments for deaf patients. But this time, they did not leave.

"We were tired of being invisible," Sabthio said. "Walking into the clinic together was our way of saying: we exist, and we deserve care."

After that moment, the group began speaking with health workers and local leaders, asking questions that had rarely been considered: How do deaf patients receive information? Who explains consent? Who ensures understanding?

Those conversations spread through youth circles, transforming personal exclusion into collective advocacy. Through these gatherings, young disabled people began sharing experiences not only of inaccessible healthcare, but also of the emotional weight of constantly being treated as invisible within systems meant to support them.

Sabthio's experience reflects a wider regional reality.

In "Kenya," deaf patients face significant barriers in accessing healthcare due to the limited availability of sign language interpretation in public health facilities, which affects communication, informed consent, and quality of care, as documented by the Kenya National Commission on Human Rights in 2020. The World Health Organization in 2022 notes that health systems globally often fail to provide accessible communication for persons with disabilities, leading to reliance on informal interpretation that undermines privacy and accuracy. The United Nations Population Fund in 2023 further highlights that persons with disabilities in "Kenya" and East Africa face persistent exclusion from sexual and reproductive health services due to inaccessible information, stigma, and structural barriers.

Communities such as the Samburu (northern Kenya, mainly Samburu County), Ogiek (forest communities in the Rift Valley region, including Mau Forest areas), and Turkana (northwestern Kenya, Turkana County) in "Kenya" continue to report persistent discrimination, which is closely connected to their indigeneity, similar to Sabthio's Rendille pastoralist Indigenous community in northern "Kenya." This discrimination especially affects women and youth. In many rural and remote areas, healthcare facilities remain physically inaccessible, while outreach programs fail to account for disability inclusion or Indigenous communication realities.



Activists from the Indigenous hard-of-hearing community display a campaign banner calling for diversity and inclusion during a disability-inclusive healthcare advocacy gathering in Nairobi. Photo credit: Neryne Ayitso and Albright Alitsi, March 2025.

SYSTEMIC BARRIERS AND POLICY GAPS

Stigma from dominant non-Indigenous systems is directed toward both Indigenous pastoralist communities and persons with disabilities, often portraying pastoralist communities as "backward" or resistant to modern healthcare while viewing disabled people as dependent or incapable of making informed decisions.

At the same time, Indigenous sovereignty is overlooked when healthcare policies and outreach programs are designed without the leadership or decision-making authority of Indigenous communities, or without integrating their languages and knowledge systems into how care is delivered.

Although the United Nations Sustainable Development Goals, adopted in 2015, and the African Union's Agenda 2063, launched in 2013, both emphasize inclusion through commitments to equitable healthcare access, reduced inequality, disability inclusion, gender equality, and the participation of marginalized communities in development, implementation often continues to leave Indigenous disabled communities behind. National healthcare reforms in "Kenya," "Tanzania," and "Uganda" have expanded community healthcare strategies, including mobile outreach services, community health worker programs, maternal and reproductive health initiatives, and decentralized primary healthcare systems aimed at improving access in rural and underserved areas. However, few of these reforms explicitly address accessibility, disability inclusion, or culturally responsive care for Indigenous communities.

RECLAIMING JUSTICE AND SOVEREIGNTY

Sabthio's journey shows how exclusion can inspire collective resistance when people recognize that their silence is shared.

Reclaiming disability justice in Indigenous healthcare is not only about access. It is about dignity, cultural recognition, accessible communication, and the right of communities to define wellness on their own terms.

About the author

Albright Ayoyi Alitsi is a university scholar, disability rights advocate, and Founder of the Lola Crochet Organization, where she leverages crochet and textile artistry to promote disability inclusion, women's empowerment, and sustainable community development.

PHOTO ESSAY

RIVER OF SURVIVAL

BY BUKUNMI OYEWOLE



Children in Langbin gather at the river to collect water for their families. As the community's only source for drinking and daily use, the river is also tied to a recurring health crisis, with many residents, particularly children, experiencing symptoms such as blood in their urine. Photo credit: Bukunmi Oyewole, December 11, 2020.

Langbin, a rural community in Ido Local Government Area of Oyo State in southwestern "Nigeria", revolves around a single flowing river. For its roughly 250 residents, the river is life itself—the only source of water for drinking, cooking, washing, and other daily needs. Running alongside the community's main road, it draws residents to its banks throughout the day, where women and children gather with buckets to fetch water for their households.

But the same river that sustains the community has also become a source of harm. With no lasting support from local authorities and packaged water too costly for many families, residents have little choice but to keep relying on untreated water from the open, exposed river. Over time, troubling health problems have emerged. Many residents—especially children have experienced a recurring and alarming symptom: passing blood in their urine, a sign associated with exposure to contaminated water Aswaterborne illness has quietly spread through household after household, the river has come to embody both survival and risk.

I visited Langbin in December 2020 during a medical outreach organized for the community, where residents received free consultations, medication, and basic care. Led by a team of 30 medical professionals, including doctors and support staff, the outreach included testing for schistosomiasis, a waterborne disease caused by parasites found in contaminated water. Several cases consistent with the disease were identified during the visit, reinforcing residents' longstanding concerns about the river's impact on their health.

This outreach was a one-time intervention to support communities with limited access to healthcare. Following the medical outreach, many residents reported relief after receiving treatment, with symptoms improving in the short term. But the underlying conditions remained unchanged. With no alternative water source available, the community continues to rely on the same river for daily survival.



AT THE REGISTRATION DESK, a medical volunteer digitizes patient information while two community leaders of Langbin review their clinical tracking slips. This initial intake is a critical step in the medical brigade, allowing the team to document patient histories and prioritize those requiring immediate intervention for chronic, water-borne illnesses. Photo credit: Bukunmi Oyewole, December 11, 2020.

DECOLONIZED BEATZ

INSIDE A MAKESHIFT LABORATORY in Langbin, medical laboratory scientists process dozens of samples collected during the outreach. This rapid on-site testing is critical for diagnosing water-borne infections immediately, allowing the team to provide over 250 residents with the necessary medications before the day's end. Photo credit: Bukunmi Oyewole, December 11, 2020.





A HEALTH WORKER in Langbin uses a diagnostic strip to test a resident's urine sample for signs of blood and infection. These rapid tests help establish a direct link between the community's health issues and parasites present in the local river water. Photo credit: Bukunmi Oyewole, December 11, 2020.

DECOLONIZED BEATZ

MEDICAL VOLUNTEERS in Ido Local Government meticulously label and track every patient sample. This careful documentation ensures that each resident receives the specific medication required to treat the water-borne symptoms identified during their consultation. Photo credit: Bukunmi Oyewole, December 11, 2020.



DECOLONIZED BEATZ



INSIDE A REPURPOSED CLASSROOM in Langbin, an elderly resident, Mrs. Alice (left), and her neighbors wait for clinical consultations. The crowded waiting area reflects the high demand for care in a community where chronic health issues—ranging from waterborne infections to deteriorating vision—affect residents of all ages. Photo credit: Bukunmi Oyewole, December 11, 2020.

MRS. ADERONKE (left) and her neighbor wait at a makeshift pharmacy window to receive prescriptions and advice. This medical outreach in Ido Local Government serves as a vital bridge for families in Langbin who must otherwise manage chronic, water-borne health issues without local access to professional medical care. Photo credit: Bukunmi Oyewole, December 11, 2020.



DECOLONIZED BEATZ



RESIDENTS OF LANGBIN COMMUNITY gather in the waiting area as Mr. Adeboye coordinates the flow of patients during the medical outreach in the community. His role was central to managing the high volume of over 250 people, ensuring that each individual moved efficiently from the initial briefing to their clinical consultations and pharmacy pick-ups. Photo credit: Bukunmi Oyewole, December 11, 2020.

About the artist

Bukunmi Oyewole is a travel and documentary photographer whose work captures the realities of everyday life within communities, preserving these stories for future generations through photography. His work also explores themes related to climate change, using visual storytelling to raise awareness and encourage public engagement around its impacts.

PERSONAL NARRATIVE

AUTISM: BETWEEN ANCESTRAL CARE AND COLONIAL SURVIVAL

BY LUNE FEU

Not all minds are made to survive colonialism. Being Indigenous and neurodivergent is not a sum of vulnerabilities. It is an intersection of structural violences—on territory, knowledge, and the body. You cannot separate health from history, nor the mind from the land.

TERRITORY: WHERE THE RUPTURE BEGINS

The Muisca territory, located in the Andean Cundiboyacense region of “Colombia,” has been profoundly transformed; it was looted, fragmented, and reconfigured.

Our sacred hills were destroyed or absorbed by urban expansion. Our language was forbidden for centuries. Our systems of organization, knowledge, and care were dismantled.

This transformation was not merely a cultural loss. It was a profound reorganization of life that also altered how people related to one another. As communal structures weakened under colonialism, relationships of care became increasingly individualized, and difference became something to discipline through imposed religion.

Disability emerges where the communal fabric is torn. Not because the body stops hurting—it hurts in any system, in any territory—but because the communal structures of care collapse.

I grew up in the midst of that rupture: On the one hand, the colonial system demanded that I adapt: be efficient and functional within rigid structures.

On the other hand, our ancestral systems of care—sometimes fragmented, sometimes fragile, but still present in everyday practices—offer forms of support that colonial institutions fail to provide.

As someone who is autistic, I move through the world deliberately and at my own pace, but in a system that values speed, that way of relating becomes uncomfortable and inadequate. Conversely, in contexts where complexity is recognized, that same sensitivity can become a form of knowledge.

THE ANCESTRAL SYSTEMS OF CARE HAVE NOT DISAPPEARED

Care in contemporary Muisca processes is relational and territorial. In practice, this happens in the Cusmuy (ceremonial communal house), it's the body reflecting the world and the territory, where each element serves a purpose, a ceremonial house built with guaiacum wood and a thatched roof. Before any gathering, harmonization happens—a spiritual cleansing to restore balance to the space. Sacred plants like hozca (tobacco snuff) and mambe (powdered coca leaf) purify and align the energies. Only then does the circle begin.

Around the fire, we listen to each other, to the silence between us, too. No one's distress is singled out as "their problem." The community holds it together. Because, in the Muisca understanding, nothing exists in isolation. The word "Muysca" means "people"—and everything is people: the Sie (water), the Quyca (territory). All beings deserve the same respect we give ourselves.

The Law of Origin, which holds that every action must follow the Earth's natural rhythms, does not ask how much you produce. It asks: Who are you in balance with the community? With the land? With yourself? This is how neurodivergence is perceived: not by fixing what is different, but by finding where that difference belongs.

I have been in these spaces. And choosing this path was not easy. In Sugamuxi—as in many territories across “Colombia”—ancestral identity and practices are looked down upon. They are not promoted. They are not valued. Those of us born outside urban centers, or in campesino families, were taught to reject these spaces. But for me, as an autistic person, this place—this circle around the fire—became my refuge. Not because all tensions disappear. I am still autistic, still sensitive, still exhausted from surviving the colonial world. But the meaning of those tensions shifts.

Here, “functionality” is measured in relation to collective balance. There are many ways to contribute: in Muisca tradition, seeds are cleansed spiritually and infused with gratitude through song before planting—a process that honors not only the plant but also the being who will receive it and the earth from which it comes. This is a relationship. Ritualidad Muisca does not pathologize difference; it integrates it within cycles of reciprocity and balance.

This circle gave my life meaning. It gave me a reason to stay—for the living memory and the sacrifice of revitalizing a territory that was never meant to disappear.

PSYCHIATRY IS A COLONIAL TECHNOLOGY WHEN IT IMPOSES UNIVERSAL CATEGORIES

Psychiatry imposes universal categories onto unequal realities. The DSM-5 defines autism as a neurodevelopmental “disorder” through a Western framework that treats certain ways of thinking, behaving, and relating as inherently abnormal. Presented as objective, these categories often ignore the effects of coloniality, poverty, territorial dispossession, and historical violence, isolating the individual from their social and territorial context: it names symptoms, but not systems. Receiving a diagnosis often means being taught to adapt to dominant norms.

My people were colonized. So was my mind. So was my body. It is not my autism that wears on me most; it is the need to constantly adapt to a colonized world that does not recognize me.

Masking (the forced adaptation to comply with social norms) and burnout (commonly understood as a state of extreme exhaustion) are not simply facets of autism. They are a response to the excessive demands of existing in systems not designed to honor neurodiversity.

These reflect the body’s need to hide its differences to survive. It is the body learning to constantly translate itself. It is a form of colonization of behavior.

Under what conditions does neurodiversity become a problem? The problem is not how the mind works, but for whom it must function.

INHABITING THE CONTRADICTION

There is a constant tension: Trying to revitalize our cultures while surviving within structures that deny them.

Muyscas try to rebuild systems of care in territories marked by social and economic inequality; they have more access to our history, to our memories, than we do ourselves. Collective memory is held hostage in academia and museums. Accessing an identity and a community purpose is a collective and individual decision we make every day. We try to



Lune stands wearing traditional clothing inspired by Muisca symbols, including an Inzona handwoven belt crafted using ancestral weaving techniques currently being revitalized within the Muisca community. Behind her is Ruchical, in Sugamuxi, a solar calendar and ceremonial site where connections to the sun and cosmic cycles have been preserved across generations. Photo credit: Amer Alomari, April 2026.

exist in a world that constantly pushes us to be something else—something that, for neurodivergent people, is particularly difficult to take on.

I grew up with the guilt and shame of everything I had to face just to access more opportunities. I dreamed of a university I could never reach. Society drilled into my head an idea of success that I still don't fully understand—in my case, I would have to work twice as hard, study twice as hard as others, for what? When I was exhausted from these efforts, I thought about why I should make myself a cog in a machine that turns the rivers of my village into dumps, the mountains into mines that bleed the earth, the skies into clouds of poison. It was hard for me to imagine a future for myself while I was losing my life and my land in the process.

At the Christian school I was forced to attend, we were taught to believe there were no other ways of living, that deeply loving the land was something the “sinful Indians of the past" did. Every single day, school started with a 7 a.m. mass. They taught me to pray, to cleanse myself of sin, and to memorize books to "be someone” in life someday. But with my neurodivergent mind, I secretly hid in the bathrooms. There, I always carried my botany sketchbook. There, I drew images of my land.

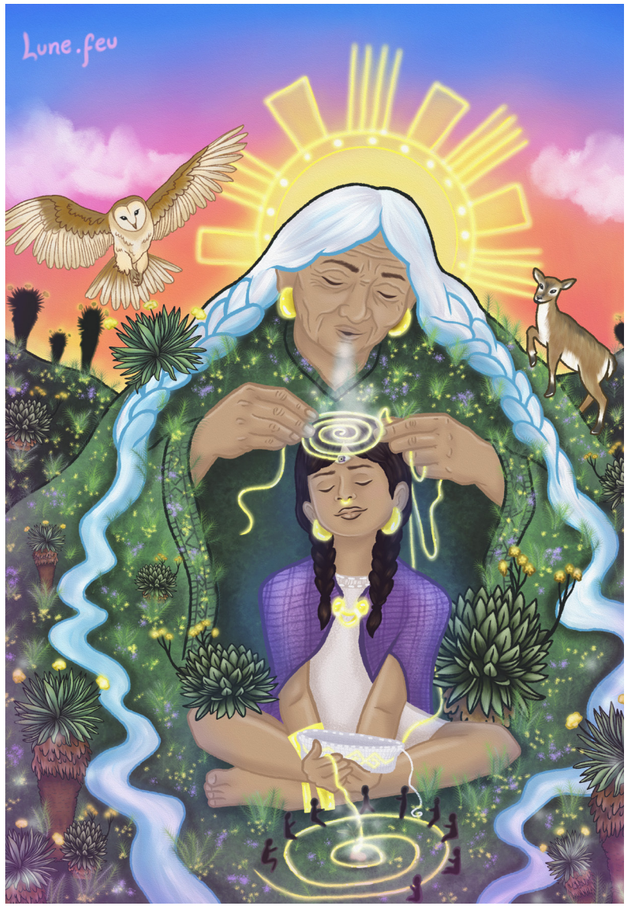
In the afternoons, I played traditional Andean music and took part in what the school deemed "pagan rites." I remember once getting punished for sneaking out to the late-night Zocam ceremony at the Muisca Sun Temple in Suamuxi (a historic meeting temple for the sharing of wisdom between nations from the south and north). I was 15 and had been medicated for depression by a psychiatrist because I was not considered a suitable student.

I learned from walking through the territory—the páramos, the lakes—to recognize a web of life that fed from one being to another. While suffering through a lonely childhood, I found refuge in the spaces where we build community. And community was not just music, culture, and spirituality: community and identity are also political struggles: the defense of land, confronting neocolonialism within our families and institutions. Recognizing the heritage we carry in our blood is not romantic. Recognizing myself as native to this land is an effort that, in my neurodivergent mind, made more sense than anything else.

Revitalizing our culture is a commitment that weighs on us and costs a great deal—but we suffer it collectively. When I was diagnosed with autism at 17, something eased; I felt that many things began to make sense. I had been carrying the shame of feeling that everything was too much for me. They stopped medicating me. Still, my family wasn't going to easily accept that a girl could have autism when she seems so "functional"—because as women, we are taught to be more accommodating. But I never felt those pressures to pretend, to overexert myself, to please others, in the community that forms around land and identity. I embraced autism and left diagnoses behind to understand that I simply have a different way—and that way makes more sense outside of systems of productivity.

In Muisca culture, life is spent weaving. Time is not linear; rather, it is woven into a great spiral. Thinking that I am connected to others and to this land relieves me of the responsibility of being an individual and falling into the void of understanding my existence as a zero point where I am born and begin to be. Instead, I understand that I am part of a history, that I carry the memories of the ancestors, from whom I can learn without having to start everything over from scratch. I am part of a land that is asking for help. My life here has a purpose: to plant for new generations and to honor those who came before. Being part of this effort to revitalize Muisca culture is hard; it is a sacrifice that is rewarded every day by the embrace of the territory and the community that accepts what, in the exploitative neocolonial system, is considered a deficiency. Here, I am part of our history.

My story and identity emerge from that contradiction. Here we say: "I am because we are." With or without a diagnosis, we are building that world where we can all exist, divergently. We are planting seeds of hope. Today we call it revitalization; tomorrow, the medicine of memory. The medicine that saved me one day. I will plant more medicine for future divergent minds.



About the author

Lune is a Colombian artist, educator, and territorial defender from the Muysca land. Her work intertwines art, decolonial education, and community resistance, centering Indigenous sovereignty, environmental justice, and collective memory. Through intercultural projects across Abya Yala and the Mashriq, she builds connections between territories shaped by shared resilience for life, land, dignity, and liberation.

MIDWIVES: THE CRAFT OF BIRTH

BY LAURA MARTÍNEZ

Midwifery in Indigenous communities in “Colombia” has historically been a practice sustained mainly by women, though not limited to them. “In the past, there wasn’t a specific figure responsible for attending births; rather, it was shared knowledge within the community. The mother, the father, and others close to them knew how to accompany the arrival of life, understanding birth as a collective process rather than an isolated one,” explains a midwife from Colombia’s Andean region.

Over time, this communal capacity has been gradually lost. Factors such as the institutionalization of healthcare, shifts in social dynamics, and a distancing from traditional knowledge have created a disconnection from these practices. In this process, not only has the way births are attended changed, but so has the relationship people have with caring for their own bodies. As Indigenous midwives in the country describe it, a kind of “uninhabiting” has taken place—a gradual forgetting of knowledge that was once part of everyday life.

However, midwifery has not disappeared. In many territories, especially rural ones, it remains active and is in the process of being reclaimed. More than a purely technical practice, it reflects a way of understanding health across multiple dimensions. Birth rituals, territorial offerings, healing ceremonies, and other associated practices show that supporting childbirth is not limited to the physical or medical, but also integrates spiritual, cultural, and ancestral aspects.

These illustrations emerge from that context. They aim to represent midwifery not only as a practice of attending birth, but also as a broader system of care, connected to territory and to the ways of life of communities. They also seek to reflect the tension between loss and forgetting, and recovery and resistance, showing how these forms of knowledge remain alive, even as they continue to evolve.

> *[...] not only has the way births are attended changed, but so has the relationship people have with caring for their own bodies.*

In that sense, rather than offering a nostalgic perspective, the intention is to recognize midwifery as a living practice, one that continues to be shaped by the experiences and knowledge of those who sustain it today.

> *Birth rituals, territorial offerings, healing ceremonies, and other associated practices show that supporting childbirth is not limited to the physical or medical, but also integrates spiritual, cultural, and ancestral aspects.*



AFRO WOMEN, CAUCA

The illustration reads: "When I come here and sit with you, I feel that I am reaching my own community—and any community—because this learning is for oneself and for everyone around us. When I accompany a birth at home or alongside doctors, I stay with them. I only step away once the child is born and everything is well."



AFRO WOMEN, CHOCÓ

The illustration reads: "The midwife understands with her hands and her heart."



AFRO WOMEN, CAUCA VALLEY

The illustration reads: “Our work does not end with birth. We continue caring for the life of the child and the mother.”

DECOLONIZED BEATZ



LA OMBLIGADA DE PALENQUE, SAN BASILIO DE PALENQUE

The illustration reads: “During the first days of life, the umbilical cord is carefully watched over. Later, it is buried alongside a seed or beneath a tree, symbolizing a vital connection. The plant that grows becomes a reminder: “there lies that person’s umbilical cord,” reinforcing the roots between the individual and their territory.”

About the artist

Laura Martínez was born and raised in the Colombian Caribbean. Her work stands as a political bet, where social criticism and protest are the pillars on which she builds her narrative. Laura firmly believes in the transformative power of art and in the capacity of each individual to contribute to social change. She trusts in the construction (for many utopian) of a better future. “The social function of the artist is to provoke and encourage humanity, that's why I decided from full awareness that my task in this world is to CREATE instead of answering.”

CALL FOR A GLOBAL STUDY OF FORCED STERILIZATION OF MARGINALIZED POPULATIONS

BY CRUSHING COLONIALISM



The United Nations Headquarters in New York City, NY hosted the 25th session of the UN Permanent Forum of Indigenous Issues from April 20, 2026 to May 1, 2026. Photo credit: Shana Baumgartner, April 21, 2026.

On April 21, 2026, at the 25th session of the United Nations (UN) Permanent Forum on Indigenous Issues in New York City, Jean Whitehorse (Diné) recounted her experience with forced sterilization and called for a global study and a statement from the UN against these practices.

Whitehorse shared how in 1972, she went to the Gallup Indian Medical Center in "New Mexico," an Indian Health Service (IHS) hospital that serves the Native community, for a ruptured appendix. She was in pain and distress and quickly signed the papers given to her before the emergency surgery. Only later did she discover that, unbeknownst to her, the hospital had included paperwork for approving sterilization. Whitehorse went in for an emergency appendectomy and received an additional procedure—a tubal ligation. At 22 years old, she was denied the right to bear more children by a government-run, federally funded hospital.

"I felt shame and guilt," Whitehorse explained. "In our culture, true wealth is our children. They are the guardians of our heritage. When Native women were sterilized, it wasn't only an individual loss, it was a loss of a generation...For years, I carried this burden in silence." It wasn't until 2010 that Whitehorse broke her silence at a conference organized by the American Indian Movement (AIM-West). Since then, she has continued to lend her voice to the cause, calling for acknowledgement, investigation, and accountability.

"This is not only a personal tragedy," she continued during her speech at the UN forum. "It is a grave violation of the right to health and bodily autonomy and informed consent under the United Nations Declaration of the Rights of Indigenous Peoples. These acts constitute crimes against humanity."

Control over the bodies of Native women in the "U.S." can be traced back to the 1907 eugenics laws, which labeled Native communities and women of color as "undesirable." Keely Badger, international human rights advocate and senior advisor to the American Indian Movement (AIM-West), explained how these laws laid the foundation for eugenics policies that enabled the forced sterilization of Indigenous women. "Over decades, the rhetoric changed a bit to population control and family planning," said Badger, "but the objective was always the same, which was cultural and biological erasure."

Decades later, the 1970 Family Planning Services and Population Research Act, which federally funded sterilizations for low-income families under the guise of "family planning," provided the impetus for the sterilizations of Indigenous women, like Jean Whitehorse, seeking medical care at IHS facilities.

While the "U.S." government has never apologized for the forced and coerced sterilizations of marginalized populations, "New Mexico" has recently taken a big step toward investigating this dark history.

Thanks in large part to AIM-West's Keely Badger and testimony from survivors like Jean Whitehorse, the "New Mexico" Senate unanimously passed Senate Memorial 14 in February 2026. This bill greenlights a statewide study of forced or coerced sterilization of Indigenous women and other women of color in "New Mexico" and lays the groundwork for a state truth and reconciliation commission.

While "New Mexico's" Senate Memorial 14 is an important step toward exposing this dark past, Whitehorse and Badger say that it is not enough.

"Acknowledgement is important, but we are looking for real change in the state," said Badger, who called for the creation of a curriculum to teach people about these eugenics-based policies and practices, and a bill that ensures such practices are made illegal. Whitehorse called for a global study on coerced or forced sterilizations of marginalized populations worldwide and international accountability for those who commit these crimes.

Since the end of World War II, international law has deemed forced sterilization a crime against humanity, but laws in the "U.S." are less clear. Reproductive injustice continues to be a modern-day issue impacting marginalized populations.



Speakers discuss reproductive health rights and the history of forced sterilization of Indigenous women. Pictured are (from left to right) Casey Camp-Horinek (Poca Nation), Jean Whitehorse (Navajo Nation), Keely Badger, and William "Jimbo" Simmons (Choctaw Nation). Photo credit: Shana Baumgartner, April 21, 2026.

Call for submissions!

The Magazine **seeks submissions for our next issue, which will focus on celebrating Indigenous arts and traditions. We invite Indigenous journalists, artists, and content creators to submit pithces for thought-provoking stories. insighful articles, artistic creations, and powerful narratives that embody this topic. Submit your pitches to iriofrio@crushingcolonialism.org**



Photo credit: Bukunmi Oyewole, December 11, 2020

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