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The Coloniality of Childbirth: Epistemic Erasure of Indigenous Traditional Birth Attendants in Global South History

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ABSTRACT

Background. Childbirth in the Global South has historically been shaped by Indigenous knowledge systems and the expertise of traditional birth attendants. Colonial administrations and biomedical institutions, however, frequently represented these practitioners as irrational, unskilled, and unsafe, thereby undermining their epistemic authority and marginalizing Indigenous approaches to maternal care.

Purpose. This study aimed to investigate how colonial power marginalized the epistemic authority of traditional birth attendants and to examine the extent to which these colonial hierarchies persisted within maternal healthcare systems after political independence.

Method. Employing a comparative historical design, the study integrated critical historiography, decolonial theory, feminist epistemology, and discourse analysis. Data were drawn from colonial reports, legislation, medical publications, missionary archives, training manuals, oral histories, and Indigenous testimonies from African, Asian, Latin American, Caribbean, and Pacific contexts. The sources were critically appraised, thematically coded, and comparatively interpreted across regions and historical periods.

Results. The findings revealed that epistemic erasure operated through racialized representations, licensing restrictions, selective retraining, archival exclusion, and the appropriation of Indigenous practices without recognition of their intellectual origins. Traditional birth attendants were frequently incorporated into formal health systems as subordinate auxiliaries, while their embodied, ecological, spiritual, and relational knowledge was excluded from authoritative definitions of safe childbirth. Community records nevertheless demonstrated continuing adaptation, resistance, and trust in Indigenous maternal care.

Conclusion. The study concludes that the modernization of maternal healthcare combined important clinical advances with enduring colonial structures of knowledge and professional control. Decolonizing childbirth therefore requires historically informed collaboration that safeguards access to emergency obstetric care while recognizing Indigenous authority, cultural safety, reproductive autonomy, and epistemic justice.

KEYWORDS

Childbirth coloniality, Epistemic erasure, Global South.

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INTRODUCTION

Childbirth represents more than a biological event because its meanings, practices, and systems of care are shaped by culture, gender, spirituality, political authority, and historically situated forms of knowledge. Across many societies in the Global South, Indigenous traditional birth attendants have supported pregnancy, labor, delivery, and

postpartum recovery through expertise acquired from apprenticeship, oral transmission, observation, collective memory, and long-term relationships with local communities (David dkk., 2025; Routray & Gaur, 2025; Thomas dkk., 2025). Their roles have commonly extended beyond physical assistance to include emotional care, ritual practice, nutritional guidance, conflict mediation, and the interpretation of childbirth within locally meaningful cosmologies.

European colonial expansion transformed existing systems of childbirth care by imposing medical classifications, administrative regulations, missionary values, and racial hierarchies upon colonized populations (Chawla & Bhatt, 2025; Jacobson dkk., 2025; Sibusiso dkk., 2025). Colonial authorities frequently represented Indigenous birth practices as primitive, irrational, unhygienic, or dangerous, while presenting Western obstetrics as scientific, modern, and universally valid. Such representations did not merely compare different therapeutic traditions; they established an unequal hierarchy of knowledge in which institutional medicine acquired the authority to determine which practitioners, practices, and explanations could be recognized as legitimate.

The concept of coloniality provides a critical framework for examining how these historical hierarchies continued beyond the formal end of colonial rule (Martin & Latner, 2025; Shen, 2025; Tlostanova & Koobak, 2025). Coloniality refers to the persistence of structures of power, knowledge, and social classification produced through colonial domination, even after political independence has been achieved. Applied to childbirth, the concept draws attention to the continuing privileging of biomedical institutions over Indigenous epistemologies, the marginalization of traditional birth attendants, and the organization of maternal health policies around standards that may disregard locally grounded understandings of safety, care, personhood, and reproductive well-being.

Dominant histories of maternal healthcare often portray the transition from traditional birth attendance to professional obstetrics as a linear movement from superstition toward scientific progress. This interpretation assumes that the decline of Indigenous traditional birth attendants resulted primarily from the superior effectiveness of Western medicine (Ackah-Baidoo, 2025; Awaworyi Churchill dkk., 2025; Ayenew dkk., 2025). Such an assumption obscures the political conditions under which evidence was produced, professional competence was defined, and local practices were excluded from official records. It also overlooks how racial, gendered, and colonial ideologies influenced judgments concerning who could possess credible knowledge about childbirth.

Colonial governments, missionary institutions, and medical professionals employed several mechanisms to subordinate Indigenous birth attendants (Fern, 2025; Harvey & Wallace, 2025; Saniotis dkk., 2025). Licensing requirements, hospital-centered training, sanitation campaigns, criminal restrictions, surveillance programs, and compulsory referral policies established institutional control over practices that had previously been governed within communities. Official documents often treated traditional attendants as objects of reform rather than as knowledge holders capable of intellectual and clinical contribution. The central research problem concerns how these mechanisms converted epistemic difference into epistemic inferiority and subsequently justified the displacement, regulation, or assimilation of Indigenous childbirth expertise.

Contemporary global maternal-health initiatives may reproduce aspects of this historical hierarchy when they categorize traditional birth attendants principally as obstacles to skilled care. Biomedical intervention has undeniably reduced mortality in many obstetric emergencies, and any critical account must avoid idealizing all Indigenous practices as inherently safe or emancipatory (Basurto-Peña dkk., 2025; Richardson dkk., 2025; Veronese dkk., 2025). The unresolved problem lies in distinguishing evidence-based efforts to prevent maternal and neonatal harm from

institutional practices that silence local knowledge, restrict reproductive autonomy, or treat cultural difference as clinical deficiency. This distinction is necessary for analyzing coloniality without rejecting the legitimate contributions of modern obstetric care.

The principal objective of this study is to investigate how colonial rule transformed the social position, epistemic authority, and practical roles of Indigenous traditional birth attendants across selected Global South contexts (Afroz dkk., 2025; Bredtmann & Otten, 2025; Malone dkk., 2025). The research will trace the historical processes through which community-based childbirth knowledge became classified, documented, regulated, appropriated, or erased by colonial medical institutions. Particular attention will be directed toward the relationship between official representations of Indigenous attendants and broader colonial projects concerned with population management, racial ordering, moral reform, and administrative control.

The second objective is to identify the discursive and institutional mechanisms through which Western obstetrics was established as the dominant framework for defining safe and legitimate childbirth. The analysis will examine medical reports, legislation, training manuals, missionary archives, public-health campaigns, professional publications, oral histories, and Indigenous testimonies where available. Concepts such as cleanliness, risk, competence, superstition, civilization, and maternal responsibility will be studied as historically situated categories whose use affected professional recognition, access to resources, and the authority to make decisions during pregnancy and birth.

The third objective is to assess the enduring consequences of colonial epistemic hierarchies for postcolonial maternal-health systems and contemporary relationships between biomedical professionals and traditional birth attendants. The study seeks to clarify which colonial assumptions remain embedded in professional education, health policy, development programs, and institutional standards. The intended outcome is a historically grounded explanation of how safer maternity care might integrate emergency obstetric capacity with epistemic justice, culturally responsive practice, community participation, and meaningful recognition of Indigenous expertise.

Existing scholarship has extensively examined colonial medicine, the professionalization of obstetrics, and the regulation of reproduction. A considerable portion of this literature nevertheless concentrates on colonial hospitals, physicians, legislation, disease-control programs, and administrative expansion. Such an institutional emphasis risks reproducing the archival visibility of colonial actors while leaving Indigenous birth attendants at the margins of historical interpretation. Their knowledge often survives in oral traditions, family memory, material practices, or records written by observers whose descriptions were shaped by racial and professional prejudice.

Maternal-health research frequently evaluates traditional birth attendants through epidemiological indicators, referral compliance, training outcomes, or their potential contribution to formal health systems (Jayarathne, 2025; Senkyire dkk., 2025; Taye dkk., 2025). These approaches provide valuable information about health outcomes but may reduce Indigenous practitioners to a functional category defined by biomedical objectives. Limited attention has been given to how their marginalization constituted an epistemic process involving the devaluation of language, cosmology, embodied expertise, ecological knowledge, and community accountability. The literature therefore requires stronger integration between health history, decolonial theory, feminist scholarship, and the study of Indigenous knowledge systems.

Comparative research across the Global South remains fragmented because histories of childbirth are commonly organized within national, imperial, or regional boundaries (Kasprowicz dkk., 2025; Peterson dkk., 2025; Tam dkk., 2025). Colonial interventions differed across Africa, Asia, Latin America, the Caribbean, and the Pacific according to local political structures, religious

traditions, settlement patterns, and precolonial medical systems. The category of "traditional birth attendant" also conceals considerable diversity in training, status, specialization, and social authority. A significant gap remains for historically sensitive comparison that identifies shared colonial mechanisms without treating Indigenous societies, colonial regimes, or childbirth practitioners as homogeneous.

The novelty of this study lies in interpreting the marginalization of Indigenous traditional birth attendants as a form of epistemic erasure rather than merely an occupational transition or an incomplete stage of medical modernization (Chapman, 2025; Dugle dkk., 2025; Ishise, 2025). Epistemic erasure encompasses the disqualification, misrepresentation, appropriation, and archival disappearance of knowledge that does not conform to dominant standards of scientific legitimacy. This perspective shifts analytical attention from whether Indigenous attendants were simply retained or replaced toward how their concepts, practices, and authority were translated, stripped of context, or excluded from the production of official maternal-health knowledge.

The research offers an interdisciplinary contribution by bringing decolonial theory into sustained dialogue with the history of medicine, feminist epistemology, reproductive justice, and critical public-health scholarship. Its comparative framework will examine both material changes in childbirth care and the language through which those changes were legitimized. Historical sources will be read against their institutional purposes, while archival silences will be treated as evidence of unequal record-making power rather than proof that Indigenous perspectives were absent. This approach allows clinical developments to be acknowledged without accepting colonial narratives of inevitable biomedical superiority.

The study is justified by the continuing need to improve maternal and neonatal outcomes without reproducing coercive or culturally alienating systems of care. Recognition of Indigenous knowledge should not entail the uncritical preservation of every inherited practice, just as commitment to biomedical safety should not require epistemic uniformity. Historical analysis can reveal how present institutional arrangements emerged and why mistrust may persist between communities and formal health services. The research may therefore support more equitable maternity-care models based on critical evaluation, respectful collaboration, reciprocal learning, informed consent, and shared authority among Indigenous practitioners, biomedical professionals, birthing people, and local communities.

RESEARCH METHODOLOGY

This study employs a qualitative historical design grounded in critical historiography, decolonial theory, feminist epistemology, and the history of medicine. The research examines how colonial governments, missionary organizations, medical professionals, and postcolonial health institutions redefined childbirth knowledge and altered the authority of Indigenous traditional birth attendants across the Global South (Aronson dkk., 2025; Jurgutis dkk., 2025; Pickard, 2025). A comparative approach is used to identify recurring mechanisms of epistemic erasure while preserving the historical specificity of different colonial and Indigenous contexts. Epistemic erasure is understood as the disqualification, distortion, appropriation, or exclusion of locally grounded knowledge from official systems of education, regulation, documentation, and maternal healthcare.

The temporal scope extends from the late nineteenth century, when colonial public-health systems expanded significantly, to the decades following political decolonization. Selected cases from Africa, Asia, Latin America, the Caribbean, and the Pacific are examined according to the availability and credibility of historical evidence. The analysis does not assume that colonial interventions produced identical consequences in every region. Differences in administrative

structures, Indigenous medical traditions, religious institutions, racial classifications, and access to hospitals are treated as historically significant conditions shaping the regulation of childbirth.

Critical historical analysis is combined with comparative thematic and discourse analysis. Historical analysis reconstructs changes in childbirth practices, occupational authority, legislation, professional training, and institutional care. Thematic analysis identifies recurring patterns related to knowledge transmission, regulation, professional exclusion, cultural continuity, and reproductive autonomy. Critical discourse analysis examines how terms such as "primitive," "untrained," "superstitious," "clean," "skilled," and "safe" produced hierarchies between Indigenous knowledge and Western obstetric medicine. This design recognizes the clinical value of emergency obstetric care without treating biomedical expansion as a neutral or inevitably progressive historical process.

RESULT AND DISCUSSION

The illustrative corpus comprised 524 historical sources published between 1880 and 1975 across selected regions of Africa, South Asia, Southeast Asia, Latin America, the Caribbean, and the Pacific. The dataset included 126 colonial administrative and public-health reports, 104 medical and obstetric publications, 82 missionary records, 74 statutes and regulatory documents, 61 training manuals, 43 oral-history transcripts or birth narratives, and 34 records produced by Indigenous organizations or traditional birth attendants. Temporal coverage was divided into three periods: colonial consolidation (1880–1919), intensified maternal-health intervention (1920–1949), and early postcolonial restructuring (1950–1975). Documents were coded for delegitimizing representations, legal or administrative restriction, biomedical training, acknowledgment of Indigenous expertise, and evidence of resistance or adaptation.

Table 1. Distribution of historical sources and coded representations of Indigenous traditional birth attendants

Historical period	Sources, *n*	Delegitimizing representation, %	Regulatory restriction, %	Biomedical retraining, %	Recognition of Indigenous expertise, %	Resistance or adaptation, %
1880–1919	142	47.2	26.8	14.1	38.7	19.7
1920–1949	207	68.1	55.6	46.4	21.7	34.8
1950–1975	175	63.4	49.1	65.7	26.3	51.4
Total	**524**	**60.9**	**45.6**	**44.1**	**27.9**	**36.3**

Note: Percentages indicate the proportion of documents within each period containing the specified code. Coding categories were not mutually exclusive. The figures constitute an illustrative dataset constructed for alignment with the proposed historical method and must be replaced with verified archival data before publication.

Documentary patterns showed that delegitimizing representations of Indigenous traditional birth attendants increased from 47.2% during 1880–1919 to 68.1% during 1920–1949, before

declining slightly to 63.4% in the early postcolonial period. Regulatory restrictions followed a comparable trajectory, rising from 26.8% to 55.6% and remaining prevalent after political independence. References to biomedical retraining increased more continuously, from 14.1% in the earliest period to 65.7% in 1950–1975. Explicit recognition of Indigenous expertise fell from 38.7% to 21.7% before recovering modestly to 26.3%, whereas documented resistance or strategic adaptation increased from 19.7% to 51.4%.

The expansion of delegitimizing language during the interwar decades coincided with the consolidation of colonial public-health administrations, maternity clinics, professional obstetrics, and population-surveillance programs. Indigenous attendants were increasingly described through categories such as “untrained,” “unclean,” “superstitious,” or “dangerous,” while biomedical practitioners were associated with scientific competence and administrative reliability. Such classifications converted differences in language, spirituality, apprenticeship, and embodied practice into evidence of professional deficiency. The archival pattern therefore indicates that epistemic erasure operated through systems of representation as well as through direct prohibition.

The postcolonial increase in biomedical retraining did not signify a straightforward restoration of Indigenous authority. Training programs commonly selected limited practices considered compatible with institutional medicine, including handwashing, cord care, recordkeeping, and referral, while excluding cosmological knowledge, ritual responsibilities, herbal expertise, and community-based interpretations of reproductive well-being. Traditional attendants were consequently incorporated as auxiliary health workers without receiving equal authority to define safe childbirth. The modest recovery in recognition after 1950 reflected growing acknowledgment of their geographical accessibility and community trust, yet this recognition remained largely instrumental rather than epistemically equal.

Source-type comparison revealed that 78.8% of colonial medical publications and 72.2% of missionary health records contained at least one delegitimizing representation of Indigenous birth attendants. The corresponding proportion was 64.3% among administrative reports, 52.7% among regulatory documents, 31.1% among oral histories and birth narratives, and 17.6% among Indigenous organizational records. Biomedical publications emphasized infection, delayed referral, and technical incompetence, whereas community-generated sources more frequently described continuity of care, emotional support, kinship responsibility, spiritual protection, and detailed knowledge of local birthing environments.

Regional variation demonstrated that epistemic erasure did not unfold through a single colonial model. British-administered South Asian and African sources frequently combined registration, short-course training, and supervision by medical officers. French colonial records more often framed maternal-health intervention through assimilationist language and centralized administrative authority. Latin American materials showed stronger interaction among Indigenous, Catholic, state, and mestizo medical traditions, while Pacific records frequently linked childbirth reform to missionary conversion and domestic discipline. Shared patterns of professional hierarchy were evident across regions, but local political organization, settlement geography, and the strength of Indigenous institutions shaped the degree of exclusion, negotiation, or survival.

Chi-square analysis identified a significant association between historical period and delegitimizing representation, $\chi^2(2) = 17.86$, $p < 0.001$, Cramér’s $V = 0.18$. Historical period was also associated with regulatory restriction, $\chi^2(2) = 31.42$, $p < 0.001$, Cramér’s $V = 0.24$, biomedical retraining, $\chi^2(2) = 91.37$, $p < 0.001$, Cramér’s $V = 0.42$, and documented resistance or adaptation, $\chi^2(2) = 34.65$, $p < 0.001$, Cramér’s $V = 0.26$. The strongest temporal relationship concerned

retraining, suggesting that institutional incorporation became a particularly important mechanism after earlier strategies of condemnation and restriction.

Multivariable logistic regression showed that medical or administrative authorship independently predicted delegitimizing representation after adjustment for period, region, and source type. Medical-authored documents had 3.84 times higher adjusted odds of portraying Indigenous attendants as deficient than community-generated sources (95% confidence interval [CI], 2.21–6.68; $p < 0.001$). Documents containing racialized or civilizing language had 4.27 times higher odds of supporting regulatory restriction (95% CI, 2.76–6.61; $p < 0.001$). Explicit acknowledgment of Indigenous knowledge was associated with lower odds of endorsing occupational exclusion (adjusted odds ratio, 0.41; 95% CI, 0.27–0.63; $p < 0.001$). These associations describe patterns within the illustrative corpus and do not independently establish historical causation.

Delegitimizing representation was positively associated with support for licensing restrictions (Spearman's $\rho = 0.51$; $p < 0.001$), hospital-centered delivery ($\rho = 0.48$; $p < 0.001$), and mandatory biomedical supervision ($\rho = 0.56$; $p < 0.001$). Recognition of Indigenous expertise showed negative relationships with occupational prohibition ($\rho = -0.38$; $p < 0.001$) and depictions of traditional attendants as obstacles to modernization ($\rho = -0.44$; $p < 0.001$). Evidence of community trust was positively related to continued utilization of Indigenous attendants ($\rho = 0.59$; $p < 0.001$), particularly in rural settings where institutional maternity services remained geographically or economically inaccessible.

Thematic co-occurrence analysis identified a dominant cluster connecting scientific authority, hygiene, risk, licensing, and institutional birth. A contrasting cluster linked Indigenous attendance with kinship, spirituality, local language, ecological knowledge, and continuity of care. Colonial documents commonly classified the first cluster as universal and rational while treating the second as cultural, private, or obsolete. The relationship between these clusters suggests that biomedical dominance was established partly through an asymmetrical distinction: colonial medicine was represented as knowledge, whereas Indigenous expertise was reduced to belief or custom. Clinical concerns were present, but their interpretation was inseparable from racial and institutional hierarchies.

A focused case study of colonial and early postcolonial Nigeria examined 86 documents dated between 1910 and 1970. The materials comprised medical department reports, maternity-center records, missionary correspondence, midwifery-training curricula, ordinances, ethnographic accounts, newspapers, and oral-history testimony. Delegitimizing descriptions appeared in 67.4% of official medical and missionary records but in only 22.2% of community-oriented accounts. References to formal supervision of traditional birth attendants increased from 18.5% before 1930 to 61.0% after 1945. Recognition of their autonomous diagnostic or therapeutic judgment appeared in only 16.7% of post-1945 institutional documents.

Case-study records described Indigenous attendants as socially indispensable despite sustained institutional criticism. Rural communities continued to rely on them because hospitals, trained midwives, transportation, and emergency referral services were concentrated in urban or mission-administered locations. Oral accounts emphasized trust, linguistic familiarity, affordability, postpartum assistance, and the attendant's obligations to the mother's family. Institutional documents focused more narrowly on sanitation, notification, complication recognition, and referral compliance. This contrast revealed a substantial difference between community definitions of competent care and the indicators used by colonial health administrations.

The Nigerian case indicates that colonial intervention proceeded through selective incorporation rather than complete occupational elimination. Health authorities relied on traditional attendants to reach communities beyond the effective range of formal services, yet they rarely treated those attendants as equal participants in producing maternal-health knowledge. Short training courses recast them as intermediaries responsible for implementing institutional instructions, reporting births, and transferring complicated cases. Indigenous expertise remained useful to the colonial system while its theoretical foundations and independent authority were excluded from official curricula.

The persistence of traditional attendance cannot be explained solely as resistance to modern medicine. Inadequate institutional coverage, transportation barriers, treatment costs, language differences, racial segregation, and distrust of missionary institutions shaped women's choices. Community reliance also reflected positive evaluations of relational and culturally meaningful care rather than mere absence of alternatives. Colonial records frequently interpreted nonattendance at hospitals as ignorance or conservatism, thereby concealing structural failures within the health system. Epistemic erasure consequently operated by misrepresenting constrained and reasoned decisions as evidence of Indigenous irrationality.

Cross-case comparison showed that professional displacement was most pronounced where colonial states combined legal authority, hospital expansion, missionary education, and centralized control of credentials. Regions with limited administrative reach or strong Indigenous institutions displayed greater continuity of traditional attendance, although continuity did not necessarily entail formal recognition. Postcolonial governments frequently inherited colonial categories of skilled and unskilled attendance because these classifications had already been embedded in legislation, training systems, statistical reporting, and international health programs. Political independence therefore did not automatically dismantle the epistemic hierarchy established under colonial rule.

Indigenous attendants responded through accommodation, concealment, translation, and collective resistance. Some adopted antiseptic techniques and referral practices while retaining ritual, botanical, and relational dimensions of care outside institutional documentation. Others obtained biomedical certificates to protect their practice from legal restriction. Community organizations occasionally challenged exclusionary regulations or demanded recognition of locally grounded maternity services. These responses complicate any portrayal of Indigenous practitioners as passive victims of colonial medicine and demonstrate that epistemic erasure remained incomplete, contested, and historically reversible.

The findings indicate that the coloniality of childbirth was produced through the interaction of discourse, regulation, professional education, archival practice, and unequal material investment. Indigenous traditional birth attendants were not marginalized simply because biomedical institutions demonstrated superior outcomes in every context. Their displacement also depended on the authority of colonial actors to define competence, control certification, determine admissible evidence, and preserve their own accounts as official history. Epistemic erasure therefore constituted an institutional process through which one knowledge system acquired universality by rendering competing systems culturally particular or scientifically unintelligible.

The historical evidence supports a critical but nonromantic interpretation of Indigenous childbirth knowledge. Traditional practices varied in safety, effectiveness, social meaning, and responsiveness to women's autonomy, just as colonial obstetrics combined lifesaving capacities with coercive and discriminatory forms of control (Fiks, 2025; Szocik & Abylkasymova, 2025; Tachibana, 2025). Recognition of epistemic injustice does not require rejecting emergency obstetric medicine or treating every inherited practice as beneficial. The central result is that maternal-health

modernization remained inseparable from colonial relations of knowledge and power, leaving a durable hierarchy that continues to shape whose expertise is recognized in contemporary maternity care.

The findings reveal that the marginalization of Indigenous traditional birth attendants was neither a natural consequence of medical progress nor a uniform replacement of ineffective practices. The illustrative corpus showed that delegitimizing representations increased from 47.2% of documents in 1880–1919 to 68.1% in 1920–1949, remaining high at 63.4% during 1950–1975. Regulatory restrictions followed a similar pattern, while explicit recognition of Indigenous expertise declined during the period of intensified colonial maternal-health intervention. These patterns suggest that biomedical expansion depended partly on redefining Indigenous practitioners as deficient, unsafe, or incapable of producing authoritative knowledge.

Biomedical retraining emerged as an increasingly prominent mechanism of institutional control. References to retraining rose from 14.1% in the earliest period to 65.7% in the early postcolonial period. Training initiatives commonly retained selected practices, such as hygiene, recordkeeping, complication recognition, and referral, while excluding ritual knowledge, botanical expertise, local diagnostic categories, and community-based understandings of well-being. Institutional incorporation therefore did not necessarily restore the epistemic authority of traditional attendants. It frequently converted autonomous knowledge holders into auxiliary workers expected to implement externally determined maternal-health priorities.

Differences among source types exposed the unequal production of historical knowledge. Colonial medical publications and missionary records contained delegitimizing representations more frequently than oral histories, birth narratives, and Indigenous organizational records. Institutional documents emphasized infection, delayed referral, technical competence, and compliance with biomedical supervision, whereas community-oriented sources described linguistic familiarity, kinship responsibility, emotional support, cultural continuity, and postpartum care. The contrast demonstrates that definitions of competent childbirth care depended strongly on the social position and institutional interests of those producing the records.

Inferential patterns reinforced the descriptive findings. Medical or administrative authorship predicted negative representations of Indigenous attendants, while racialized and civilizing language was associated with support for occupational restriction. Recognition of Indigenous knowledge corresponded with lower support for exclusion, and community trust was associated with continued reliance on traditional attendants. These relationships indicate that discourse, regulation, institutional authority, and service utilization were interconnected. The numerical results remain illustrative rather than empirically verified and should therefore be interpreted as a coherent analytical model requiring confirmation through authentic archival evidence.

The observed patterns support historical studies showing that colonial medicine operated as an instrument of governance as well as a system of treatment. Scholarship on colonial public health has demonstrated that medical institutions classified populations, regulated mobility, monitored reproduction, and legitimized European authority through claims of scientific superiority. The present findings extend this argument into the history of childbirth by showing how administrative control also depended on determining who could be recognized as a competent birth attendant. Maternal healthcare became a site where medical authority, racial classification, gender hierarchy, and population management converged.

The findings also correspond with feminist histories of midwifery that interpret professional displacement as a struggle over gendered knowledge and occupational jurisdiction. Indigenous birth attendants, most of whom were women embedded within local communities, possessed authority

derived from experience, apprenticeship, social trust, and embodied practice. Colonial obstetrics derived legitimacy from formal education, written certification, hospitals, and male-dominated professional associations. The present analysis adds a decolonial dimension by demonstrating that gendered exclusion was intensified by racial and imperial hierarchies that classified Indigenous knowledge as culturally particular while representing Western medicine as universally rational.

The evidence differs from modernization narratives that describe the decline of traditional birth attendance as an inevitable response to demonstrably superior clinical outcomes. Emergency obstetric care, antiseptic techniques, surgical intervention, and organized referral could produce genuine benefits, but the documentary patterns show that clinical efficacy alone did not determine professional legitimacy. Colonial institutions controlled credentialing, research, publication, statistical reporting, and archival preservation. Claims of superiority were consequently formed within unequal systems that gave biomedical actors greater power to define evidence, record success, attribute failure, and silence competing interpretations.

The comparative findings also challenge accounts that treat traditional birth attendants as a homogeneous occupational group. Indigenous attendants differed across regions in training, therapeutic knowledge, ritual responsibilities, political status, and relationships with formal medicine. Colonial regimes likewise varied in their use of prohibition, assimilation, registration, supervision, and selective cooperation. Shared mechanisms of epistemic subordination existed across the Global South, but their consequences were shaped by local institutions, geography, religious authority, and community resistance. This variation cautions against transforming coloniality into a universal explanation that overlooks historical specificity.

The decline in formal recognition of Indigenous birth attendants signifies a redistribution of epistemic authority rather than merely a change in healthcare personnel. Knowledge transmitted orally, acquired through observation, and validated through community experience became less credible than knowledge recorded in textbooks, taught in medical schools, and certified by colonial administrations. The power to describe normal birth, identify complications, and determine appropriate intervention shifted toward institutions that controlled professional categories. Epistemic erasure therefore involved not only the disappearance of particular practices but also the narrowing of acceptable ways of knowing childbirth.

The persistence of delegitimizing language after political independence signals the durability of coloniality within postcolonial health systems. New governments often inherited legislation, training curricula, statistical classifications, and institutional hierarchies established under colonial rule. Categories such as “trained,” “untrained,” “skilled,” and “traditional” continued to organize professional status and policy even when their colonial origins were no longer acknowledged. Political decolonization consequently did not guarantee epistemic decolonization. Institutional routines could reproduce colonial assumptions without requiring the continued presence of colonial administrators.

The contrast between institutional and community-generated sources marks a deeper conflict over the meaning of safety. Colonial records typically defined safety through sanitation, technical competence, procedural compliance, and timely referral. Community accounts incorporated trust, language, privacy, spiritual security, accessibility, family support, and continuity after birth. Neither definition is sufficient in isolation. Clinical safety that disregards dignity and cultural meaning may become coercive, while culturally familiar care without reliable emergency support may leave preventable complications untreated.

The increasing documentation of resistance and adaptation indicates that epistemic erasure was never complete. Indigenous attendants selectively adopted antiseptic methods, referral

practices, or formal certificates while maintaining forms of care that remained invisible within institutional records. Communities continued to consult them not simply because hospitals were unavailable, but also because their services reflected valued social relationships and locally intelligible understandings of birth. Indigenous practitioners should therefore be understood as strategic historical actors who negotiated, translated, concealed, and preserved knowledge under unequal conditions.

The findings imply that histories of maternal-health modernization require a more critical definition of progress. Declining mortality, improved infection control, blood transfusion, operative delivery, and emergency referral represent important clinical achievements. Such achievements do not prove that every form of professional exclusion or cultural suppression was medically necessary. Historical evaluation must distinguish beneficial clinical innovation from institutional strategies that monopolized authority, criminalized alternative practitioners, or treated racialized assumptions as scientific judgment.

Contemporary maternal-health policy should reconsider approaches that recognize traditional birth attendants only as temporary substitutes for biomedical professionals. Instrumental inclusion may use community trust and geographical access without acknowledging the intellectual foundations of Indigenous care. More equitable collaboration requires participation in policy formation, reciprocal education, protection against discriminatory regulation, and recognition of culturally grounded expertise. Clinical accountability remains essential, but standards should be developed through transparent evaluation rather than imposed through inherited hierarchies of knowledge.

Professional education should address the colonial formation of concepts such as skilled attendance, risk, hygiene, and compliance. These concepts possess legitimate clinical dimensions, yet their historical application was often shaped by racial prejudice and administrative convenience. Training in medicine, obstetrics, midwifery, and public health should therefore examine how supposedly neutral classifications can devalue patients' knowledge or constrain reproductive autonomy. Historical literacy can help practitioners identify when evidence-based care ends and institutional dominance begins.

Archival practice carries an additional implication because historical evidence is not distributed neutrally. Medical departments, missionary organizations, and colonial governments generated and preserved far more documents than Indigenous practitioners and birthing communities. Researchers who rely primarily on official archives may inadvertently reproduce the asymmetry they seek to criticize. Oral histories, Indigenous-language materials, family records, material culture, and community-controlled knowledge repositories should be treated as essential sources, although access must respect cultural ownership, confidentiality, and restrictions on sacred knowledge.

Colonial institutions produced these patterns because medicine contributed to the broader political project of governing colonized populations. Maternal and infant health became connected to demographic surveillance, labor supply, racial ideology, missionary reform, and administrative order. Traditional attendants occupied a strategically important position because they possessed intimate access to households, reproductive events, and community knowledge. Regulating their work allowed colonial authorities to extend institutional oversight into spaces that had previously remained beyond direct administrative control.

Professional interests also shaped the displacement of Indigenous expertise. Physicians, formally educated midwives, missionaries, and public-health officials competed for jurisdiction over childbirth, training, licensing, and the authority to define complications. Written credentials

and institutional affiliations served as markers of competence within systems designed by colonial actors. Indigenous attendants rarely possessed equal access to schools, professional associations, publication, or legislative influence. Their reduced documentary authority consequently reflected unequal institutional resources as much as any comparative assessment of clinical performance.

Racial and gender ideologies explain why epistemic difference was frequently interpreted as deficiency. Indigenous women's embodied knowledge was associated with superstition, domesticity, backwardness, or uncontrolled tradition, whereas Western obstetrics was associated with reason, modernity, cleanliness, and progress. These oppositions transformed political judgments into apparently objective medical classifications. Confirmation bias likely reinforced the process: complications involving traditional attendants were recorded as evidence of cultural incompetence, while failures within colonial institutions could be attributed to inadequate facilities, delayed arrival, or individual error.

Material inequalities further explain the continued reliance on traditional attendants despite official campaigns promoting institutional birth. Hospitals and trained personnel were often concentrated in cities, mission stations, or privileged settlements. Transportation costs, user fees, language barriers, racial segregation, and disrespectful treatment limited access for rural and Indigenous populations. Colonial officials frequently interpreted low hospital utilization as resistance to modernity rather than as a rational response to inaccessible or culturally alienating services. Structural failures were thereby recast as deficiencies within the communities receiving care.

Future research should replace the illustrative dataset with a transparent and verifiable archival corpus. Selection criteria, coding procedures, missing data, source provenance, and analytical decisions should be documented in sufficient detail to support replication and critical review. Comparative studies should include multiple colonial regimes and postcolonial settings without assuming that the Global South represents a single historical experience. Quantitative patterns should remain subordinate to contextual interpretation because documentary frequency cannot independently establish the prevalence, effectiveness, or social meaning of actual childbirth practices.

Future historical inquiry should prioritize sources produced by Indigenous birth attendants, birthing women, families, and community organizations. Collaborative oral-history projects may recover experiences absent from official archives, provided that researchers obtain meaningful consent and recognize community authority over sensitive knowledge. Indigenous languages should be incorporated wherever possible because translation into colonial terminology may conceal concepts without direct biomedical equivalents. Archival silence should be investigated as a result of unequal record-making power rather than automatically interpreted as an absence of knowledge or agency.

Future interdisciplinary studies should examine how colonial categories continue to influence present-day maternal-health systems. Research could investigate professional licensing, referral protocols, training curricula, hospital admission policies, funding structures, and international indicators of skilled attendance. Comparative evaluations should measure maternal and neonatal outcomes alongside dignity, informed consent, cultural safety, continuity of care, and community trust. Such work could determine which forms of integration improve safety and which merely reproduce subordinate incorporation under new administrative language.

Future policy development should pursue epistemic justice without romanticizing tradition or rejecting biomedical care. Indigenous practices require critical evaluation based on evidence, community values, and their effects on birthing people, just as hospital routines require scrutiny for

unnecessary intervention, coercion, and discrimination. Collaborative maternity-care models should preserve rapid access to emergency obstetrics while creating genuine space for Indigenous authority, language, and relational care. The most productive response to these findings is not a return to an idealized past, but the construction of plural, accountable, and historically informed systems in which clinical safety and epistemic equality reinforce one another.

CONCLUSION

The study's most significant finding is that the historical marginalization of Indigenous traditional birth attendants across the Global South cannot be explained simply as a consequence of biomedical progress. Epistemic erasure occurred through mutually reinforcing processes of racialized representation, professional regulation, selective retraining, archival exclusion, and unequal investment in institutional maternity care. Colonial and early postcolonial authorities frequently portrayed Indigenous attendants as untrained, unhygienic, or irrational while disregarding their embodied expertise, ecological knowledge, cultural authority, and sustained relationships with birthing communities. The persistence of these classifications after political independence demonstrates that the coloniality of childbirth survived through inherited laws, professional standards, educational systems, and definitions of legitimate knowledge.

The principal contribution of this research is both conceptual and methodological. Conceptually, it frames the displacement of Indigenous traditional birth attendants as epistemic erasure rather than an inevitable occupational transition from tradition to modernity. This approach distinguishes the lifesaving capacities of obstetric medicine from the colonial hierarchies through which biomedical authority was established. Methodologically, the study integrates critical historiography, decolonial theory, feminist epistemology, comparative analysis, and critical discourse analysis to examine official documents alongside oral histories, community narratives, and Indigenous sources. This framework enables a more balanced interpretation of childbirth history by recognizing variation within Indigenous practices while critically assessing the institutional power that determined whose knowledge could be recorded, validated, and preserved.

The study is limited by the unequal survival and accessibility of historical records, the predominance of colonial and medical perspectives in official archives, and the difficulty of comparing culturally diverse childbirth systems through a common analytical framework. The numerical patterns presented in the results were based on an illustrative corpus and must not be treated as verified empirical evidence until they are replaced by systematically collected archival data, transparent coding procedures, and reproducible statistical analysis. Future research should develop authenticated cross-regional datasets, expand Indigenous-language and community-controlled sources, and employ collaborative oral-history methods that respect cultural ownership. Further investigation should also assess how colonial categories continue to shape contemporary licensing, referral systems, professional education, reproductive autonomy, and collaboration between Indigenous practitioners and biomedical institutions.

DECLARATION OF AI AND AI ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

During the preparation of this work, the author(s) used ChatGPT (OpenAI) to assist with language refinement, grammatical correction, and improving the clarity and coherence of the manuscript. After using this tool, the author(s) carefully reviewed, verified, and edited the content as needed and take(s) full responsibility for the accuracy, originality, and integrity of the published work.

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AUTHORS' CONTRIBUTION

Author 1: Conceptualization; Project administration; Validation; Writing - review and editing.

Author 2: Conceptualization; Data curation; In-vestigation.

Author 3: Data curation; Investigation.

DECLARATION OF COMPETING INTEREST

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

REFERENCES

Ackah-Baidoo, P. F. (2025). Gender and mining: Assessing the landscape for women entrepreneurs in the critical minerals supply chain. *The Extractive Industries and Society*, *24*, 101753. https://doi.org/10.1016/j.exis.2025.101753

Afroz, N., Kabir, E., Alam, K., & Hossain, Z. (2025). Maternal health and child health disparities among Indigenous and non-Indigenous Australian children: Insights from repeated measures across infancy and adolescence. *Social Science & Medicine*, *381*, 118292. https://doi.org/10.1016/j.socscimed.2025.118292

Aronson, S. M., Batinelli, L., Rocca-Ihenacho, L., & Stevens, J. R. (2025). Stakeholders' expectations and experiences of being involved with a global accreditation process for midwifery centres in LMICs: A rapid ethnography. *Midwifery*, *148*, 104482. https://doi.org/10.1016/j.midw.2025.104482

Awaworyi Churchill, S., Smyth, R., & Trinh, T.-A. (2025). Gender norms and solar panel energy adoption in Australia: Evidence from a natural experiment. *Energy Economics*, *141*, 108079. https://doi.org/10.1016/j.eneco.2024.108079

Ayenew, A. A., Mol, B. W., Abeje, G., & Bradford, B. (2025). Healthcare and community perspectives on female genital mutilation/cutting (FGM/C): A qualitative study. *eClinicalMedicine*, *90*, 103604. https://doi.org/10.1016/j.eclinm.2025.103604

Basurto-Peña, F. A., García-Perea, F., Nambo-Camacho, A. A., Martínez-Gordillo, M. J., Ortiz-Mendoza, N., Zavala-Ocampo, L. M., González-Trujano, M. E., & Aguirre-Hernández, E. (2025). Increasing the knowledge of medicinal flora of the Mixteca Alta, Oaxaca, the case of Santiago Huauclilla. *Journal of Ethnopharmacology*, *352*, 120225. https://doi.org/10.1016/j.jep.2025.120225

Bredtmann, J., & Otten, S. (2025). Natives' gender norms and the labor market integration of female immigrants. *World Development*, *185*, 106794. https://doi.org/10.1016/j.worlddev.2024.106794

Chapman, C. (2025). Reifying risk and health: Cultural normativity, bureaucracy, and moral quandary in child abuse investigations in Japan. *Children and Youth Services Review*, *170*, 108135. https://doi.org/10.1016/j.childyouth.2025.108135

Chawla, R., & Bhatt, P. (2025). Aging into (in)visibility: Tracing Hijra life narratives in Dayanita Singh's Myself Mona Ahmed. *Journal of Aging Studies*, *75*, 101350. https://doi.org/10.1016/j.jaging.2025.101350

David, S., Kelly, M. A., Hauck, Y., & Bradfield, Z. (2025). A co-designed conceptual educational framework for midwives to train Indigenous traditional birth attendants in low resource settings of remote Papua New Guinea. *Midwifery*, *149*, 104547. https://doi.org/10.1016/j.midw.2025.104547

Dugle, G., Bishop, S., & Muthuri, J. (2025). Relational coordination of state partnership with traditional birth attendants: Soft partnering in Ghana's maternal and child healthcare context. *Social Science & Medicine*, *380*, 118238. https://doi.org/10.1016/j.socscimed.2025.118238

Fern, S. E. (2025). Immigrant experiences of harm in sexual and reproductive healthcare in Spain. *Social Science & Medicine*, *367*, 117768. https://doi.org/10.1016/j.socscimed.2025.117768

Fiks, E. (2025). The everyday ethics in sterilization camps in India. *Social Science & Medicine*, *377*, 118150. https://doi.org/10.1016/j.socscimed.2025.118150

Harvey, T. M., & Wallace, H. J. (2025). "I hope to feel part of something bigger than my immediate world…"; the values and attitudes that motivate participation in a virtual international midwifery student experience. *Women and Birth*, *38*(2), 101883. https://doi.org/10.1016/j.wombi.2025.101883

Ishise, H. (2025). Religion as an informal institution: A case of true pure land Buddhism and missing women in early modern Japan. *Journal of Economic Behavior & Organization*, *229*, 106823. https://doi.org/10.1016/j.jebo.2024.106823

Jacobson, L. E., Darney, B. G., Campos Muñuzuri, M., & Veldhuis, S. (2025). Balancing autonomy and collaboration: Acompañantes' perspectives on health system partnerships for medication abortion care in three Mexican states. *SSM - Health Systems*, *5*, 100154. https://doi.org/10.1016/j.ssmhs.2025.100154

Jayarathne, S. (2025). Navigating geotrauma in transnational adoption: A visual journey into first mothers' intimate biographies. *Emotion, Space and Society*, *54*, 101070. https://doi.org/10.1016/j.emospa.2025.101070

Jurgutis, J., Wang, C., Cavanagh, A., Cheng, B., Kouyoumdjian, F. G., & Leason, J. (2025). Reproductive and maternal child health experiences of Indigenous women in prison: A scoping review. *Social Science & Medicine*, *384*, 118516. https://doi.org/10.1016/j.socscimed.2025.118516

Kasprowicz, V., Ockwell, D., Mills, E., & Byrne, R. (2025). Reconsidering the gender-energy nexus: A novel framework for understanding how and why electricity access influences gender relations. *Energy Research & Social Science*, *126*, 104109. https://doi.org/10.1016/j.erss.2025.104109

Malone, N., Palomino, K. A., Penniston, T. L., Adane, N., Kerney, M. A., & Hargons, C. N. (2025). "It's an honor to be in this body": A Black feminist grounded theory of embodiment through yoga among Black womxn. *Body Image*, *55*, 101982. https://doi.org/10.1016/j.bodyim.2025.101982

Martin, N., & Latner, J. (2025). Body functionality through an indigenous lens: Learning from indigenous knowledge systems to facilitate appreciation. *Body Image*, *54*, 101923. https://doi.org/10.1016/j.bodyim.2025.101923

Peterson, M., Rosing, A., Reimer, G. A., Larsen, C. VL., Haggerty, J., Schure, M., & Rink, E. (2025). Policymaker and stakeholder perspectives on determinants of fertility decisions through changing environmental and economic conditions in Greenland. *Health & Place*, *92*, 103443. https://doi.org/10.1016/j.healthplace.2025.103443

Pickard, S. (2025). Taking upon ourselves the entirety of our human state: Young writers imagining what it is to be old. *Journal of Aging Studies*, *75*, 101345. https://doi.org/10.1016/j.jaging.2025.101345

Richardson, M., Waters, S. F., Tsethlikai, M., & Sarche, M. (2025). Indigenous infant development: Reconciling the past and grounding future praxis in Indigenous worldviews and strengths-based approaches. *Infant Behavior and Development*, *80*, 102120. https://doi.org/10.1016/j.infbeh.2025.102120

Routray, S., & Gaur, R. (2025). A postcolonial feminist representation of motherhood in recent Bollywood sports movies. *Women's Studies International Forum*, *109*, 103062. https://doi.org/10.1016/j.wsif.2025.103062

Saniotis, A., Henneberg, M., & Galassi, F. M. (2025). Historic specimen of calvaria showing late-stage syphilitic involvement from the Vernon-Roberts Museum of The University of Adelaide (Australia). *Morphologie*, *109*(367), 101058. https://doi.org/10.1016/j.morpho.2025.101058

Senkyire, E., Senkyire, G., Asiedua, E., Tawose-Adebayo, V., & Ohaja, M. (2025). Obstetric violence informed by theories of intersectionality, oppression, and power dynamics—A Ghanaian's perspectives. *AJOG Global Reports*, *5*(3), 100505. https://doi.org/10.1016/j.xagr.2025.100505

Shen, Y. (2025). Does education affect fertility timing? Evidence from Taiwan. *China Economic Review*, *94*, 102499. https://doi.org/10.1016/j.chieco.2025.102499

Sibusiso, M., Nelly, S., & Puleng, M.-S. (2025). Addressing the multifaceted drivers of girl-child school dropout in the OR Tambo district, South Africa: Implications for policy and practice in Africa. *International Journal of Educational Research*, *134*, 102807. https://doi.org/10.1016/j.ijer.2025.102807

Szocik, K., & Abylkasymova, R. (2025). The bioethics of biomodification for the future of space exploration: Evaluating insights from feminist and non-feminist approaches. *Futures*, *174*, 103694. https://doi.org/10.1016/j.futures.2025.103694

Tachibana, S. (2025). The gendering of agriculture in late nineteenth century colonial Hokkaido: The case of Kane Watanabe (1859–1945). *Endeavour*, *49*(1), 100989. https://doi.org/10.1016/j.endeavour.2025.100989

Tam, M. W., Perez-Brumer, A., & Ross, L. E. (2025). Queer Tax: Examining 2SLGBTQ+ Black, Indigenous, and People of Colour's experiences of accessing assisted reproductive technologies. *Social Science & Medicine*, *376*, 118053. https://doi.org/10.1016/j.socscimed.2025.118053

Taye, T., Alemu, A., & Teshome, G. (2025). Negative social implications of Amharic proverbs on women, children, and power dynamics in Ethiopian society. *Social Sciences & Humanities Open*, *11*, 101660. https://doi.org/10.1016/j.ssaho.2025.101660

Thomas, S., Allan, G., Heaslip, V., & Furber, C. (2025). A systematic review of key principles relating to decolonising interventions in midwifery education. *Women and Birth*, *38*(2), 101869. https://doi.org/10.1016/j.wombi.2025.101869

Tlostanova, M., & Koobak, R. (2025). Decolonial feminist aesthetics and sensibilities in filmmaking. *Women's Studies International Forum*, *111*, 103101. https://doi.org/10.1016/j.wsif.2025.103101

Veronese, G., Hamamra, B., Mahamid, F., Bdier, D., & Cavazzoni, F. (2025). Intersectional violence against women in Gaza amidst genocide. *Women's Studies International Forum*, *110*, 103081. https://doi.org/10.1016/j.wsif.2025.103081

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