

May 2026



Lund University Master of Sciences in
International Development and Management
May, 2026

Traditional midwifery in Chocó, Colombia

A case study of their recognition and integration in the Colombian health system by local and national actors, and international cooperation between 2017 and 2025

Authors: Gabrielle Yapp and Lorena Bejarano

Supervisor: Helle Rydström

ABSTRACT

Although maternal mortality rates have decreased globally, they remain a development concern, with their preventability and uneven burden highlighting inequalities both between and within countries. This study, through Post-Development Theory, the Epistemologies of the South framework, and Social Reproduction Theory, examines the integration and recognition of traditional-midwives in the Chocó region of Colombia within the health system from a multilevel approach. Using a qualitative methodology, this study develops a documentary review and conducts semi-structured interviews with key stakeholders. The macro-level results reveal that national and departmental policies and legal frameworks have produced symbolic recognition without ensuring real integration. At the meso level, institutional and international good intentions and efforts towards collaborative healthcare approaches coexist with academic disconnection and the absence of dignified labour conditions. At the micro level, the experiences and contributions of traditional-midwives expose a gap between community level recognition and support, and institutional ambivalence, contextualised in challenging working conditions. In conclusion, the recognition and integration of traditional-midwives is a complex process marked by structural inequalities and institutional racism. While there are efforts toward hybrid practices, many of these fall on traditional-midwives, rather than on a health system willing to change its structure to incorporate them genuinely.

Wordcount: 14,957

ACKNOWLEDGMENTS

We would like to start off by thanking the participants and people who put us in contact with them for sharing their experiences and expertise. Thank you all for providing this invaluable insight and your encouraging words.

We would also like to express our gratitude to our Supervisor Helle Rydström and our supervision group for their support and guidance, and encouragement throughout this process. We are also very thankful to the Crawford Foundation for supporting our data collection,

We would like to express a huge thank you to our wonderful family and friends who supported us in countless ways, from cooking food, listening about our topic for the hundredth time, your words of encouragement, and being incredible library company.

Last but most certainly not least, we would like to thank each other. This collaboration has provided a degree of support and joy that we could not imagine the past months without. To some, the idea of a join-thesis may not be tempting. For us it has maintained our smiles and sanity throughout. Through the laughs, time-zones, and many words, we did it!

Table of Contents

ABSTRACT	2
ACKNOWLEDGMENTS	3
LIST OF FIGURES	6
LIST OF ABBREVIATIONS	7
LIST OF DEFINITIONS	8
1. INTRODUCTION	9
1.2 RESEARCH QUESTIONS	11
2. LITERATURE REVIEW	13
2.1 CONTEXT	13
2.2 MATERNAL MORTALITY	14
2.2.1 <i>Inequalities in Maternal Health</i>	15
2.3 TRADITIONAL-MIDWIVES FROM A GLOBAL PERSPECTIVE	16
2.3.1 <i>Integration of Traditional-Midwives in Health Systems Worldwide</i>	17
2.4 TRADITIONAL MIDWIFERY IN COLOMBIA	18
2.4.1 <i>Historical Context of Traditional Midwifery</i>	18
2.4.2 <i>Current Role of Traditional Midwifery</i>	22
2.4.3 <i>Traditional Midwifery Associations</i>	23
2.4.4 <i>Barriers faced by Traditional Midwives</i>	24
2.5 CURRENT GAP IN THE RESEARCH	25
3. THEORETICAL FRAMEWORK	27
3.1 POST-DEVELOPMENT THEORY	28
3.1.1 <i>The “Development” Discourse and its Critique</i>	28
3.1.2 <i>Alternatives and the Concept of “Hybridism”</i>	29
3.2 EPISTEMOLOGIES OF THE SOUTH FRAMEWORK	30
3.2.1 <i>The Ecology of Knowledge</i>	31
3.2.2 <i>Intercultural Translation</i>	31
3.2.3 <i>Coloniality and Disobedience</i>	32
3.3 SOCIAL REPRODUCTION THEORY	32
4. METHODOLOGY	34
4.1 POSITIONALITY AND DIVISION OF TASKS	34
4.2 RESEARCH DESIGN	35
4.3 DATA SOURCES AND SELECTION CRITERIA	35
4.3.1 <i>Document Selection</i>	35
4.3.2 <i>Interview Participant Selection</i>	36
4.4 DATA COLLECTION METHODS	36
4.4.1 <i>Document Review</i>	36
4.4.2 <i>Fieldwork</i>	41
4.5 DATA ANALYSIS	42
4.6 ETHICAL CONSIDERATIONS	47
4.7 STRENGTHS AND LIMITATIONS	48
5. RESULTS	50
5.1 INTEGRATION	50

5.2 RECOGNITION.....	52
5.3 ECOLOGY OF KNOWLEDGES	54
5.4 INTERCULTURAL TRANSLATION	55
5.5 CARE LABOUR.....	57
5.6 STRUCTURAL INEQUALITIES.....	59
6. DISCUSSION	61
6.1 MACRO LEVEL: CONTRIBUTION OF NATIONAL AND DEPARTMENTAL POLICIES AND LEGAL FRAMEWORKS TO THE RECOGNITION AND INTEGRATION OF TRADITIONAL-MIDWIVES INTO THE HEALTH SYSTEM IN CHOCÓ	61
6.2 MESO LEVEL: THE ROLE OF POLICY IMPLEMENTATION, INTERNATIONAL COOPERATION AND ACADEMIA PROGRAMS THAT FACILITATED OR HINDERED THE RECOGNITION AND INTEGRATION OF TRADITIONAL-MIDWIVES IN CHOCÓ	63
6.2.1 <i>Institutional “expertise” and academia disconnection</i>	63
6.2.2 <i>International Cooperation</i>	64
6.3 MICRO LEVEL: PERCEPTIONS OF THE EXPERIENCES AND CONTRIBUTIONS OF TRADITIONAL-MIDWIVES IN CHOCÓ TOWARDS INTEGRATION AND RECOGNITION BY LOCAL, NATIONAL AND INTERNATIONAL ACTORS.....	64
6.3.1 <i>Recognition, trust, hybridism and midwifery associations</i>	65
6.3.2 <i>Social reproduction, care and peace agents</i>	66
7. CONCLUSION	67
8. REFERENCES.....	68
ANNEXES:	81
ANNEX 1. INTERVIEW GUIDELINES.....	81
ANNEX 2. INFORMED CONSENT	84
ANNEX 3. ORIGINAL SPANISH TEXT OF QUOTATIONS (IN ORDER OF APPEARANCE)	86
ANNEX 4. FULL DOCUMENT LIST - DOCUMENT REVIEW SYSTEMATISATION.....	89

LIST OF FIGURES

Figures

Figure 1. Map of Chocó Department	13
Figure 2. Maternal Mortality Colombia 2008-2024 (DANE, 2025a).....	14
Figure 3. Maternal Mortality Chocó 2008-2024 (DANE, 2025a)	15
Figure 4. Historical trends of people attending births in the Chocó department (Calderon Gonzalez et al, n.d.)	22
Figure 5. Document Exclusion Process	37
Figure 6. Codification results from Atlas Ti.: Frequency of Quotations per Category. Source: Atlas ti.....	47

Tables

Table 1. Turning Points for Traditional Midwives in Colombia	20
Table 2. Documents Included in the Documentary Review	38
<i>Table 3. Summary of interviewees profiles, place of interview, and codes</i>	<i>41</i>
Table 4. Definitions of the Analytical Levels and Categories	44
Table 5. Intersection of Analytical Levels and Categories	45
Table 6. Number of Documents and Interviews that Mention each Category.....	50

LIST OF ABBREVIATIONS

AECID: Agencia Española de Cooperación Internacional para el Desarrollo (Spanish Agency for International Development Cooperation)

ANC: Antenatal Care

ASOPARUPA: Asociación de Parteras Unidas del Pacífico (Association of Pacific United Midwives)

ASOREDIPARCHOCO: Red interétnica de partería afro e indígena tradicional del Chocó (Association of the Interethnic Network of Midwives and Birth Attendants of Chocó)

CONPES: Consejo Nacional de Política Económica y Social (National Council for Economic and Social Policy)

COVID: Coronavirus Disease

DANE: Departamento Administrativo Nacional de Estadísticas (National Administrative Department of Statistics)

GDPR: General Data Protection Regulation

HICs: High-Income Country

ICD: International Classification of Diseases

ILO: International Labour Organization

IOM: International Organization for Migration

LMICs: Low-and Middle-Income Country

MHSP: Ministry of Health and Social Protection

MM: Maternal Mortality

MMR: Maternal Mortality Ratio

PAHO: Pan American Health Organization

PDT: Post-Development Theory

SDH: Social Determinants of Health

SDG: Sustainable Development Goals

SRT: Social Reproduction Theory

UNESCO: United Nations Educational, Scientific and Cultural Organization

UNFPA: United Nations Population Fund

WHO: World Health Organization

LIST OF DEFINITIONS

1. **Antenatal Care:** “is the care provided by skilled health professionals to pregnant women to ensure the health of mother and child during pregnancy and childbirth” (WHO, 2020, p.30).
2. **Conventional Medicine:** In this thesis ‘conventional medicine’ refers to medical practices used by healthcare professionals within the formal health system i.e., doctors, nurses, obstetricians.
3. **Healthcare professional:** In this thesis ‘healthcare professional’ refers to medical personnel who have received formal medical training and practice conventional medicine within the formal health system i.e., doctors, nurses, obstetricians.
4. **Maternal Mortality:** “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes” (WHO, 2022, p.297)
5. **Maternal Mortality Ratio:** “the number of maternal deaths during a given time period per 100 000 live births during the same time period; thus, it quantifies the risk of maternal death relative to the number of live births.” (WHO et al, 2025, p.12)
6. **Traditional Midwives:** support the reproductive health of women, before, during and after birth through traditional practices, acquiring their knowledge from other traditional-midwives, family, and experience (Suárez-Baquero and Champion, 2022).

1. INTRODUCTION

Maternal health sits at the centre of the global development agenda. Sustainable Development Goal (SDG) 3 commits the international community to reducing the maternal mortality ratio (MMR) to fewer than 70 deaths per 100,000 live births and ensuring universal access to sexual and reproductive healthcare by 2030 (United Nations, 2024). Achieving these targets depends on access to quality maternal care, particularly antenatal care (ANC), which reduces complications and maternal mortality even with a single session (Kuhnt and Vollmer, 2017). However, although maternal mortality (MM) declined by 40% between 2000 and 2023 (WHO et al, 2025), the current rate falls short of SDG 3, and approximately 800 women continue to die each day from preventable causes related to pregnancy and childbirth (Olea-Ramirez et al., 2024; Cresswell et al, 2025).

While progress has been real, it is uneven. From an international development perspective, MM is not simply a health outcome but a marker of global inequity that reveals power imbalances in access to rights worldwide. It exemplifies a structural and social problem that highlight the disparities between and within countries (Olea-Ramirez et al., 2024). In 2020, the MMR in low and middle-income countries (LMICs) reached 430 deaths per 100,000 live births, compared to just 13 in high-income countries (HICs) (United Nations, 2024, p.13) revealing that health, from a multidimensional perspective, is not just an individual issue but part of a broader context shaped by social, cultural, political, and economic conditions. Social determinants of health (SDHs), reflect that ethnicity, income, and education, shape both access to healthcare and the risk of MM (WHO et al, 2025), supplemented by weaknesses in health systems, from staff and resource shortages and deprioritisation of women's health, (Kihara et al, 2025). As such, MMR reflects the "avoidable and unfair differences that affect the health of people from different population groups" (Rodríguez Hernández et al., 2023, p.2).

Colombia illustrates these dynamics sharply. As one of the most unequal countries in the world (World Population Review, 2024), it carries deep disparities in poverty, discrimination, and gender-based violence (Cuestas, 2023), disparities that map directly onto maternal health. The Department of Chocó, located on the Pacific coast, is predominantly Afro-Colombian and Indigenous, geographically isolated, and historically underserved by the State (Rodríguez Hernández et al, 2023), making it a critical site for understanding how structural inequity shapes maternal survival. While the national MMR has improved, the National Administrative

Department of Statistics (DANE, 2025a) reports that Chocó continues to experience rates roughly three times the national average.

From the SDH perspective, the "Three delays" model offers one useful lens for understanding MM in this context: delays in deciding to seek care, in reaching an appropriate obstetric facility, and in receiving adequate care once there (Olea-Ramirez et al., 2024). In Chocó, all three are amplified by overlapping structural racism conditions, through systematic discrimination by institutional actors perpetuating racial inequality. Internal armed conflict restricts mobility and disrupts service delivery; land control disputes, corruption and systematic abandonment from the State, weakens the government response; and the region's geography, accessible largely by river and sea, places many rural communities hours or days from the nearest emergency obstetric centre (Rodríguez Hernández et al., 2023).

Midwives play a critical role in maternal health, with UNFPA (2026) recently stating that one million more midwives are needed by 2035 to save four million lives yearly. Traditional-midwifery specifically has played a crucial role in maternal and perinatal care, particularly in hard-to-reach areas where the health system lacks a permanent presence (Laza Vásquez, 2012; Rodríguez Hernández et al, 2023; David et al, 2025). Chocó, one of Colombia's regions with the highest ethnic diversity, possesses several traditional and cultural practices that remain relevant to today's health challenges, but are unrecognised within the health system. Although traditional-midwifery was recognised as Intangible Cultural Heritage of Humanity by United Nations Educational, Scientific and Cultural Organization (UNESCO) in 2023 and by the Colombian Ministry of Culture in 2017, these practices have not been formally incorporated into the health system (Moreno-Potes et al, 2024), reflecting the dominance of conventional-medicine knowledge over traditional and community-based forms of care (Rodríguez Hernández et al, 2023). Nevertheless, in Chocó, these traditional processes have enabled care for thousands of women and children, attending an estimated 18,000 births between 2013 and 2023 (Rodríguez Hernández et al, 2023).

Public policies, institutions, international cooperation, and traditional-midwives themselves have all influenced the recognition and integration of traditional-midwifery practices and knowledges into the health system. Thus, this study adopts a comprehensive analytical perspective considering macro-level (public policies), meso-level (institutional actors), and micro-level (traditional-midwifery associations and communities) organization. This multi-

level analytical structure is essential to achieve a broad and holistic understanding of how actors across these three levels simultaneously shape this change, which can contribute to reducing MM in hard-to-reach areas of Chocó. Examining these levels together, rather than in isolation, makes visible the tensions and overlapping processes that a single-level analysis would obscure, particularly in a context of structural inequality.

1.2 Research questions

This research draws on three theoretical perspectives: 1. Post-Development Theory, 2. The Epistemologies of the South framework and 3. Social Reproduction Theory, to explore how national and departmental policies, institutional actors, academia, international cooperation, and traditional-midwives have contributed to the recognition and integration of Chocó's traditional-midwives into the Colombian health system. Following these frameworks, development is understood not as neutral progress, but a contested discourse shaped by power dynamics (Escobar 2012). This perspective allows an analysis of power relations within a complex context and shapes the design of the research questions from a multilevel approach.

For the purpose of this study, recognition is understood as the informal and formal processes through which value and legitimacy are conferred upon traditional-midwifery practices and knowledges, while integration refers to the processes through which these practices are included or excluded from the formal health system, public policies, and community health practices. These working definitions are developed further in the methodology section.

Central Research Question: How have traditional-midwives in the Department of Chocó been recognised and integrated into the Colombian health system between 2017 and 2025?

1. How have national and departmental policies and legal frameworks contributed to the recognition and integration of traditional-midwives into the health system in Colombia?
2. How has policy implementation, international cooperation and academia facilitated or hindered the recognition and integration of traditional-midwives in Chocó?
3. How are Chocó's traditional-midwives' experiences and contributions towards integration and recognition perceived by local and national actors, and international cooperation?

This research does not assess the impact of integrating and recognising traditional-midwives' practices on the MMR in Chocó. Such an analysis would require quantitative data and resources

beyond the scope of this study. Instead, the focus is on the processes of recognition and integration themselves.

2. LITERATURE REVIEW

This section presents the context surrounding our research and a review of the available related literature.

2.1 Context

The Department of Chocó lies on Colombia's Pacific Coast, covering 46,530 km² across 30 municipalities (Rodríguez Hernández et al, 2023; Figure 1¹), experiencing a tropical climate that brings heavy rainfall (Calderón et al, 2024). Most of its population lives in rural communities connected primarily by river and sea routes rather than roads (Rodríguez Hernández et al, 2023).

Chocó is one of the most ethnically distinct departments in the country: the majority of its population is Afro-Colombian, with a significant Indigenous minority (Valencia et al, 2025; Rodríguez Hernández et al, 2023). Colombia's population experiences significant social inequalities, disproportionately affecting rural populations (Ramos Jaraba et al, 2020), and thus significantly affecting Chocó's population (Rodríguez Hernández et al, 2023). Chocó also faces issues related to structural racism. For decades its Afro-descendant communities have been systematically discriminated against and geographically isolated by the Colombian State, rendering invisible the social problems they face, perpetuating human rights violations, and widening the gaps in access to services and rights (Rodríguez Garavito, 2007). Additionally, Chocó has suffered colonisation and exploitation and was one of the regions most affected by armed conflict that is still present (Calderón et al, 2024), with serious effects on the population, such as risk of murders and landmines (Valencia et al, 2025).

Figure 1. Map of Chocó Department



¹ Map of Chocó Department. Available at: <https://mapasinteractivos.didactalia.net/en/community/mapasflashinteractivos/resource/mapa-politico-de-choco-colombia-igac/a95bbfe4-4cba-480c-aa01-340a7da40ab3>

2.2 Maternal Mortality

Before examining data on maternal health in Colombia, it is important to acknowledge two methodological caveats. First, available data may underreport actual events: until recently, traditional-midwives lacked the authorisation to issue birth certificates, creating a risk that births they attended went unrecorded (Suárez-Baquero and Champion, 2022). Second, apparent increases in reported MM rates can sometimes be attributed to improved surveillance, rather than a change in rate of occurrence (Salazar Flórez et al, 2025).

Between 2000 and 2023, Colombia saw a 37% decrease in its MMR (WHO et al, 2025), and in 2024 recorded its lowest rate since 2008, at 45.6 per 100,000 live births (DANE, 2025a). Colombia's MMR has declined relatively steadily since 2010, with the notable exception of the COVID-19 pandemic period (Figure 2). However, this national progress masks departmental disparities (Rivillas et al, 2020). Chocó is one of the starkest examples of this, among the five Departments with the highest MMRs between 2022 and 2024 (DANE, 2025a), experiencing a far less regular decline, with an MMR consistently and significantly higher than the national rate (Figure 3). Like MM, maternal healthcare access in Colombia is also extremely unequal, significantly affecting Chocó, reporting the fourth lowest rate of ANC nationally (Rodriguez-Lopez et al, 2025).

Figure 2. Maternal Mortality Colombia 2008-2024 (DANE, 2025a)

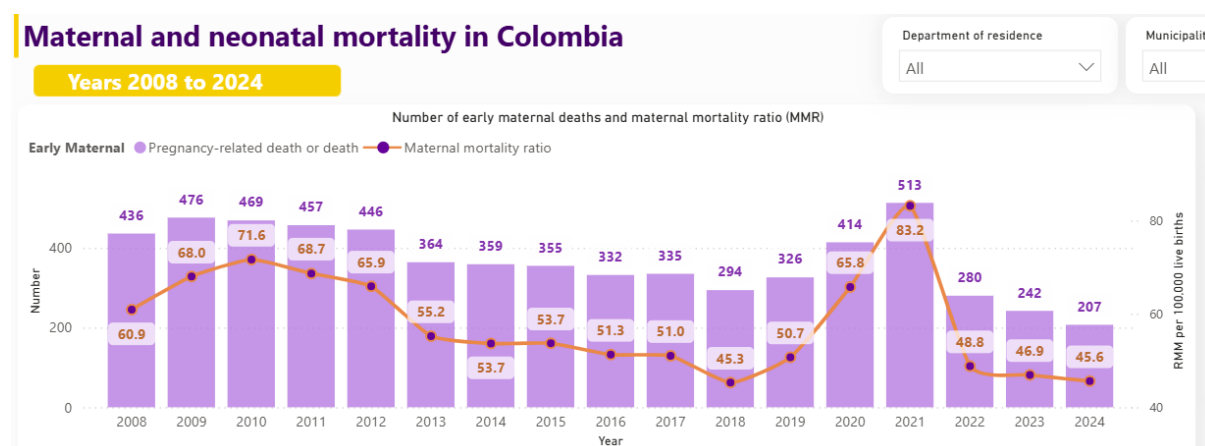
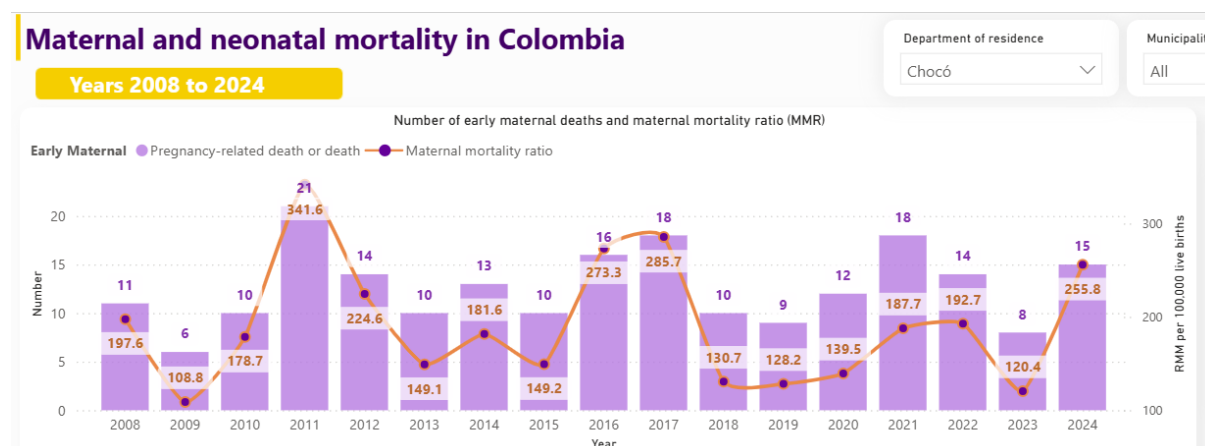


Figure 3. Maternal Mortality Chocó 2008-2024 (DANE, 2025a)



The pandemic period provides a useful illustration of how shocks interact with existing inequities. It did not affect all populations equally: existing inequities in maternal health were aggravated, with already vulnerable communities bearing a disproportionate share of the impact (Castañeda-Orjuela et al, 2023). While the pandemic is not the focus of this study, it underscores a broader pattern of unequal maternal health outcomes that is important to consider when examining the situation in Chocó.

2.2.1 Inequalities in Maternal Health

As is the case globally, many causes of MM in Colombia and Chocó are preventable and rooted in social injustice (Rodríguez Hernández et al, 2023). Factors related to higher rates of MM among certain populations appear to be similar to those found globally (WHO et al, 2025; Kihara et al, 2025; Hasan et al, 2020), such as rurality (Salazar Flórez et al, 2025; Bello-Álvarez and Parada-Baños, 2017), resources limitations (Rivillas et al, 2020), and ethnicity (Araújo et al, 2018). In Chocó specifically, four interrelated barriers shape access to quality maternal care: geography, health infrastructure, cultural barriers, and armed conflict.

Geography. Despite the majority of the population living in rural areas, most maternal healthcare facilities are located in urban areas, presenting several barriers for accessing maternal care (Rodríguez Hernández et al, 2023); some women travel up to six hours, by boat, foot, motorbike, or animal, to reach them; tropical rains experienced in the region renders travel even more challenging (Rodríguez Hernández et al, 2023), and sometimes impossible by boat (Engelkes, 1990); long distances incur additional expenses, such as transportation, lodging

and food, and lost workdays (Rodríguez Hernández et al, 2023; Ricaurte-Cepeda and Guerrero-Luna, 2024).

Infrastructure. Many healthcare facilities in Chocó lack equipment, and few are equipped to deal with complex births, contributing to the department's high MMR. Also, there is a lack of human talent (Rodríguez Hernández et al, 2023), exacerbated by extremely high staff-turnover, further jeopardising the quality and consistency of care in a region of already stretched resources (Valencia et al, 2025).

Cultural barriers and structural racism. According to Rodríguez Hernández et al (2023), culturally insensitive maternal care and the lack of an intercultural approach to change this negatively impacts the care women receive, subsequently discouraging them from seeking help from healthcare professionals. For example, some indigenous women in Chocó have reported that they are not treated with respect, that birth is over medicalised, and that procedures are carried out sometimes without consent. Additionally, Chocó is a territory that faces systematic discrimination, limiting the access to health services (Rodríguez Garavito, 2007).

Armed conflict. The ongoing armed conflict in Chocó also creates barriers to accessing quality maternal care (Rodríguez Hernández et al, 2023) by limiting travel (Valencia et al, 2025), making it difficult to reach healthcare facilities and necessary supplies (Ramos Jaraba et al, 2020).

2.3 Traditional-Midwives from a Global Perspective

Traditional-midwives refer to women (mainly) who support the reproductive health of women, before, during and after birth through traditional practices, acquiring their knowledge from other traditional-midwives, family, and experience. (Alarcón-Nivia et al, 2011; Suárez-Baquero and Champion, 2022). While they play a significant and vital role globally, particularly in resource-limited settings such as rural communities, where access to formal healthcare institutions is limited (Alarcón-Nivia et al, 2011; Suárez-Baquero and Champion, 2022), the perception of their work has undergone significant changes.

Perceptions and treatment of maternal care have evolved significantly with midwifery practices globally dominated by the West (Ashley et al, 2022). Birth has become increasingly medicalised since the late 20th Century (Évora, 2025), through the promotion of medicalised midwifery and hospital births (Davis-Floyd and Cheyney, 2009). Consequently, the 1990s saw a shift towards “skilled birth attendance”, and a simultaneous push of traditional-midwives

outside of the health system (Argüello Avendaño and Mateo González, 2014), as they were no longer considered legitimate healthcare providers (Davis-Floyd and Cheyney, 2009). This marginalisation was further reinforced in many countries through outlawing or strategic exclusion of traditional-midwives from the health system (Sandwell et al, 2018), and through the WHO's introduction of the category "Traditional Birth Attendants", which used Western medical training as the criterion to distinguish between "skilled" and "non-skilled" providers (Suárez-Baquero and Champion, 2022). Despite the proven effectiveness of traditional-midwifery (Sandwell et al, 2018), and despite the State of the World's Midwifery Report (UNFPA, 2021) warning of a global shortfall of 900,000 midwives, this exclusion has persisted. Today, most policies and research on midwifery remain centred on Western conventional-medicine approaches (Ashley et al, 2022). Consequently, cultural traditions are diminishing (Davis-Floyd and Cheyney, 2009), and the number of traditional-midwives is declining across many countries, with their practice surviving primarily in marginalised communities (Alarcón-Nivia et al, 2011).

However, despite this marginalisation, traditional-midwives have proven resilient, continuing to serve and remaining highly valued by communities around the world (Alarcón-Nivia et al, 2011; Ashley et al, 2022; Suárez-Baquero and Champion, 2022).

2.3.1 Integration of Traditional-Midwives in Health Systems Worldwide

Several countries have recognised the importance of strengthening the role of traditional-midwives, acknowledging their crucial contribution particularly in rural communities. One approach to achieving this has been the integration of traditional-midwives into the formal health system, fostering collaboration between the two systems.

This approach has successfully improved maternal health outcomes across diverse contexts, including Indonesia, Samoa (Davis-Floyd et al, 2025), Burundi (Ombere, 2025), Uganda (Graham and Davis-Floyd, 2025) and Mexico (Buckner et al, 2022). In Mexico and Peru, integration has also increased the number of women attending healthcare facilities and improved their experiences within them, attributed to factors such as: reduced language barriers through the presence of traditional-midwives, greater respect for cultural practices, and women feeling more comfortable when a traditional-midwife is present (Buckner et al, 2022; Gabrysch et al, 2009).

The literature converges on a set of conditions that make such collaboration successful. Mutual respect and trust between healthcare professionals and traditional-midwives are identified as

foundational (Buckner et al, 2022; Graham and Davis-Floyd, 2025). Successful cases also share common practices such as, ongoing intercultural knowledge dialogue, co-design and joint evaluation of processes, cooperation and mutual learning, and knowledge sharing (Graham and Davis-Floyd, 2025; Buckner et al, 2022). Practical mechanisms, such as training traditional-midwives to detect early warning signs and strengthening referral pathways between the two systems, have also contributed to improved outcomes (Graham and Davis-Floyd, 2025; Davis-Floyd et al, 2025). These conditions, however, depend on a deeper attitudinal shift. For collaboration to work, healthcare professionals must recognise the value of traditional-midwifery (Alarcón-Nivia et al, 2011; Buckner et al, 2022), and there must be a sustained willingness for long-term engagement in respectful dialogue (Graham and Davis-Floyd, 2025). The diversity of contexts in which intercultural collaboration has succeeded is encouraging, suggesting that similar approaches could be viable elsewhere, including, potentially, in Colombia.

2.4 Traditional Midwifery in Colombia

In Colombia, there are no “professional midwives” in the sense understood in many other countries, with maternal care in healthcare facilities provided by nurses with maternal health training (UNFPA and MinSalud, 2014). Instead, midwifery, or ‘*Partería*’, is carried out by traditional-midwives, locally referred to as ‘*Parteras*’. Their practice is characterised by a combination of conventional-medicine and traditional knowledges (Rodríguez Hernández et al, 2023), typically providing their services free of charge, particularly as they often serve communities who lack the means to pay (Corte Constitucional de Colombia, 2022). Most traditional-midwives in Colombia practice in the Western Pacific Region and are predominantly Afro-Colombian and Indigenous (Suárez-Baquero and Champion, 2022). It is important to note that owing to the region’s ethnic diversity, multiple traditions coexist, including distinct indigenous or Afro-descendent midwifery practices (Moreno-Potes et al, 2024)

2.4.1 Historical Context of Traditional Midwifery

According to Moreno-Potes et al (2024), Colombia’s medical system underwent a Western homogenisation in the late 1800s and early 1900s, leading to the dismissal of other knowledges, including those of traditional-midwives. While some tolerance remained for traditional-midwifery in contexts without access to conventional-medicine, the practice was generally criminalised, with medical certificates required to provide maternal care. This exclusion

persisted until the adoption of the 1991 Constitution, which celebrated Colombia's diversity and instated a state obligation to recognise medical pluralism, including traditional-midwives. Since, traditional-midwives have experienced several significant changes in their recognition and treatment, outlined in the timeline presented in Table 1.

Table 1. Turning Points for Traditional Midwives in Colombia

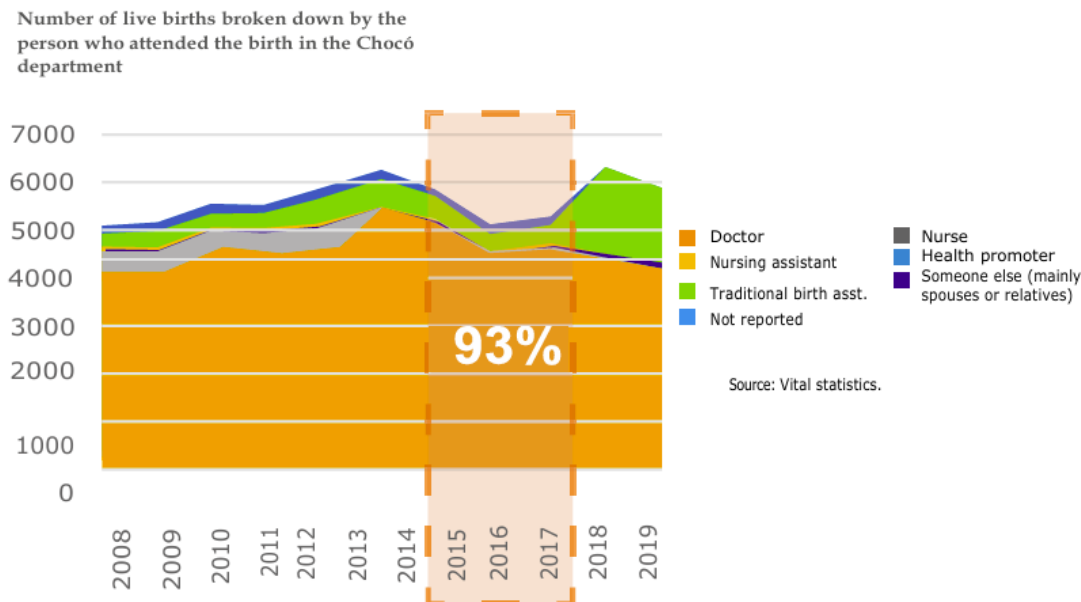
Date	Name	Short Description
1991	Colombian Constitution (The Constitutional Court of Colombia)	States the recognition and protection of the ethnic and cultural diversity of Colombia.
2013	Resolution No.1841 (Ministry of Health and Social Protection [MHSP])	Adopts the Ten-Year Public Health Plan 2012-2021. States the recognition of traditional midwives. Proposes a regularisation plan for complementary health personnel, including traditional midwives, in specific areas. Calls for designing and implementing trainings for traditional midwives on safe practices, for them to work in specific areas.
2017	Decree 356 (Colombia. Presidency of the Republic of Colombia)	Modifies the process of civil registration. Included traditional midwives in the list of actors who can register births in the case of late registration.
2017	Plan Especial de Salvaguardia de los Saberes Asociados a la Patería Afro Del Pacífico [Special Safeguarding Plan for Knowledge Associated with Afro-Pacific Midwifery] (PES) (Ministry of Culture and ASOPARUPA)	This document is designed to protect and promote the ancestral knowledge and practices of Afro-Pacific midwifery in Colombia.
2017	Resolution No.1077 (Ministry of Culture)	Includes Afro-Pacific midwifery and knowledge in the national Representative List of Intangible Cultural Heritage. Approves the Special Safeguarding Plan.
2021	Resolution 3676 (The National Registrar of Civil Status and DANE)	Authorises midwives of the Association of the Interethnic Network of Midwives of the Department of Chocó (ASOREDIPARCHOCO) to certify births they attend.

2022	Judgment T-128 (The Constitutional Court of Colombia)	Case presented by ASOREDIPARCHOCO and ILEX Legal Action, against the national and departmental MHSP, and the Departmental Secretariat of Health of the Valley of Chocó Cauca, in response to the lack of protection of traditional midwives during the COVID-19 Pandemic. Result: The Court recognised that the rights of traditional midwives were violated, ordered the protection of traditional midwifery, and urged their recognition and integration into the General System of Social Security in Health.
2022	Law 2244 (The Congress of Colombia)	Recognises the rights of women during pregnancy, labour and postpartum. Article 11 states that the State will promote and support the training of traditional midwives nationally, respect their beliefs and practices, and develop communication and referral mechanisms.
2022	Resolution No.1035 (MHSP)	Adopts the Ten-Year Public Health Plan 2022-2031. Includes specific chapters concerning ethnic minorities. Mentions traditional midwives significantly more than the previous Ten-Year Plan, including a detailed description of the work of traditional midwives. Calls for the registering, strengthening and recognition of traditional midwives, and knowledge exchange between traditional midwives and Western medicine.
2023	Resolution No.2367 (MHSP)	Modifies Resolution No.1035. New Points concerning traditional midwives: Details how traditional midwives should be supported i.e., food and resources, and that community-based care (including traditional midwifery) should be promoted. Additionally mentions the role of traditional midwives in supporting mental health of victims of armed conflict.
2023	UNESCO Intangible Cultural Heritage	Recognised “ <i>Midwifery: knowledge, skills and practices on the Representative List of the Intangible Cultural Heritage of Humanity</i> ”.
2025	CONPES 4143 (National Council for Economic and Social Policy)	“ <i>Constitutes the national care policy</i> ”. Speaks about the right to care under dignified conditions and calls for the recognition and strengthening of collective and community-based care in rural and ethnic communities. Presents a 10-year action plan which significantly encompasses traditional midwives.

2.4.2 Current Role of Traditional Midwifery

Chocó has one of the highest rates of births attended by traditional-midwives in the country (DANE, 2025b), and as shown in Figure 4, this number has been increasing.

Figure 4. Historical trends of people attending births in the Chocó department (Calderon Gonzalez et al, n.d.)



Given the critical gaps in healthcare infrastructure in the region, traditional-midwives play a vital role in their communities (Rodríguez Hernández et al, 2023). They continue to practise not only because their communities need them, but because they are trusted and respected within them (Suárez-Baquero and Champion, 2022). Through long term support across the reproductive cycle, encompassing family planning, nutrition advice, attending births, and supporting postpartum recovery, they form close relationships with the women they serve (Moreno-Potes et al, 2024). They offer a standard of relational, humanised and culturally attuned care that health facilities are often unable to provide, built around respect for the mother's birthing preferences and a shared understanding of birth as a deeply cultural moment (Rodríguez Hernández et al, 2023; Suárez-Baquero and Champion, 2022; Moreno-Potes et al, 2024). It is therefore unsurprising that many women in these communities express a preference for giving birth at home with a traditional-midwife, feeling safer and more at ease than in healthcare facilities (Gleason et al, 2022; Rodríguez Hernández et al, 2023).

Beyond providing care directly, traditional-midwives in Chocó also serve as a bridge to the formal health system (Mantilla Uribe et al, 2013). Drawing on their knowledge, they assess whether a birth is likely to be straightforward or whether medical assistance will be required

(Oviedo et al, 2014) referring women to healthcare facilities if complications arise (Mantilla Uribe et al, 2013). They also actively encourage women to attend prenatal checkups and assessments at healthcare facilities (Rodríguez Hernández et al, 2023). In a region marked by structural injustices and the legacy of armed conflict, some scholars go further still, framing traditional-midwives as peace agents whose care work contributes to the broader welfare and social fabric of their communities (Angola Valencia and Cano Molina, 2023).

2.4.3 Traditional Midwifery Associations

Traditional-midwives in Colombia have organised themselves into associations to defend their practice and advance their collective interests. The Association of Pacific United Midwives (ASOPARUPA), founded in 1988 was among the earliest and most influential of these. Its goals are to protect the wellbeing of traditional-midwives, promote recognition of their role, and safeguard their ancestral knowledge, pursued through knowledge exchange, dialogue and training (Moreno-Potes et al, 2024). ASOPARUPA's work has helped lay the groundwork for the emergence of further associations across the Pacific region in the decades that followed.

Among these is the principal association in Chocó, Association of the Interethnic Network of Midwives and Birth Attendants of Chocó (ASOREDIPARCHOCO), founded in 2010 and now with 1,050 members, they train, support, and promote the integration of traditional-midwives in the Department (Moreno-Potes et al, 2024). As the number of traditional-midwives in Chocó declines, ASOREDIPARCHOCO's role has become increasingly important, working to strengthen community care through dialogue and knowledge exchanges between traditional-midwives and healthcare professionals (Rodríguez Hernández et al, 2023).

Together, these associations have had a significant impact on traditional-midwifery in the Pacific region. Their work has protected traditional-midwifery, affirmed its community role and bridged ancestral practices with state institutions (Moreno-Potes et al, 2024). Through their work and sustained engagement with the Colombian State, NGOs, and communities, traditional-midwives have won greater recognition and rights, including; the designation of their practice as part of Colombia's cultural heritage; the passing of the T-128 Judgement which condemned the violation of their rights during the pandemic and urged their recognition and integration; and the adoption of the integration project "Partera Vital" developed in partnership with the National Administrative Department of Statistics (DANE), the United Nations Population Fund (UNFPA) and the Spanish Agency for International Development Cooperation (AECID) (Moreno-Potes et al, 2024). In parallel, educational institutions have

begun integrating intercultural approaches into health programs (Ricaurte-Cepeda and Guerrero-Luna, 2024), suggesting that future cohorts of healthcare professionals may be better prepared to engage with traditional-midwifery and their associations.

2.4.4 Barriers faced by Traditional Midwives

Despite the progress outlined above, traditional-midwives in Colombia continue to face significant barriers to recognition and inclusion. These operate at multiple levels: institutional, interpersonal, and contextual.

Institutional and legal exclusion. Although several initiatives to regulate traditional-midwifery have been proposed, they remain legally excluded from the health system, leaving them unintegrated and unprotected, reinforcing the perception of traditional-midwives as untrained, which in turn justifies their continued exclusion (Moreno-Potes et al, 2024). Moreover, systematic racism normalises this exclusion and renders it largely invisible (Rodríguez Hernández et al, 2023), despite it standing in tension with the 1991 Constitution's commitment to protecting cultural and ethnic diversity (Moreno-Potes et al, 2024).

Interpersonal discrimination and stigma. Traditional-midwives face stigma, marginalisation, delegitimization and discrimination in their daily work (Moreno-Potes et al, 2024; Rodríguez Hernández et al, 2023). Power dynamics underpin much of this, with healthcare professionals often viewing conventional-medicine as the only legitimate form of care, treating traditional-midwives disrespectfully and dismissing their work as inferior or even as witchcraft (Rodríguez Hernández et al, 2023). Many traditional-midwives report being turned away from healthcare facilities when accompanying women, and most hospitals do not permit their presence at births (Gleason et al, 2022; Rodríguez Hernández et al, 2023). Healthcare professionals also raise concerns about traditional-midwives' hygiene standards, perceiving them as a risk to mother and infant, and blaming them for delays in accessing critical care (Suárez-Baquero and Champion, 2022; Rodríguez Hernández et al, 2023). These criticisms, however, reflect structural conditions rather than simply individual failings. Traditional-midwives are in fact attentive to hygiene (Suárez-Baquero and Champion, 2022) and actively encourage attendance at health checkups, though they often lack basic equipment such as gloves, blades and adequate lighting (Rodríguez Hernández et al, 2023). Many birthing rooms also lack the physical space for an additional attendant (Gleason et al, 2022). The poor working relationship between traditional-midwives and healthcare professionals can therefore be attributed in part to the

absence of an intercultural approach within healthcare facilities, rather than individual prejudice alone (Rodríguez Hernández et al, 2023).

Contextual barriers in Chocó. The wider context in which traditional-midwives operate in Chocó introduces further challenges. The ongoing armed conflict places them at direct risk, with documented reports of violence against them, and poor road conditions and limited transport further inhibits the effectiveness of their work (Suárez-Baquero and Champion, 2022; Moreno-Potes et al, 2024; Rodríguez Hernández et al, 2023).

Threat of Disappearance and Resistance. Together, these pressures help explain the decline in traditional-midwife numbers in parts of Chocó and the difficulty of forming a next generation of practitioners (Rodríguez Hernández et al, 2023). Additionally, the ongoing westernisation of healthcare and culture places Colombian traditional-midwifery at risk of disappearance (Suárez-Baquero and Champion, 2022; Alarcón-Nivia et al, 2011). The communities that rely on them are consequently seeing their local health system disappear, with corresponding implications for MM risk (Rodríguez Hernández et al, 2023.)

Yet traditional-midwives are actively resisting this trajectory, fighting for recognition and protecting their practices by continuing to provide maternal care in their communities (Suárez-Baquero and Champion, 2022; Rodríguez Hernández et al, 2023). In this sense, traditional-midwifery practices in the Colombian Pacific can be understood as a political act, and a form of resistance against the colonisation of the culture of these populations (Suárez-Baquero and Champion, 2022; Moreno-Potes et al, 2024).

2.5 Current Gap in the Research

The literature on traditional-midwifery in Colombia remains limited (Évora, 2025), and studies focusing specifically on Chocó are scarcer still. The few recent publications addressing traditional-midwifery in this department tend to focus on the role of traditional-midwifery within their communities (Mantilla Uribe et al, 2013; Oviedo et al, 2014; Suárez-Baquero and Champion, 2022; Rodríguez Hernández et al, 2023;), while broader work on the recognition and integration of traditional-midwives in the Colombian health system has so far been addressed primarily by Moreno-Potes et al (2024). What remains underexplored is how the multilevel influence of national and departmental policy, international cooperation, academia, and traditional-midwives and their associations, has shaped the recognition and integration of traditional-midwifery in Chocó. This gap matters. As outlined in the preceding sections, traditional-midwives in Chocó provide vital maternal care in a region marked by significant

healthcare gaps and high MM. Also, they continue to face institutional exclusion, discrimination, and contextual risks that threaten the survival of their practice. Understanding how recognition and integration have been advanced is therefore essential to identifying which approaches have worked, which have not, and what conditions enable meaningful change. Thus, this thesis seeks to contribute to closing this gap. It is important to mention that there may be literature on traditional-midwifery at the local level; however, much of this does not reach academic publication spaces, thus revealing an inequality in academia and the difficulty in accessing information that may already exist.

3. THEORETICAL FRAMEWORK

This research examines how international cooperation, academia, traditional-midwives and national and departmental policies have contributed to the recognition and integration of traditional-midwifery in Chocó, Colombia, a question that is simultaneously discursive, epistemic, and material. The theoretical framework therefore integrates three perspectives drawn from two critical traditions: the postcolonial/decolonial tradition and Marxism feminism. Each perspective addresses a distinct dimension of the research problem.

While postcolonial and decolonial perspectives differ in important ways, both critique the Eurocentric narrative of a superior Western modernity (Bhambra, 2014). For this reason, this thesis draws selectively on concepts, lenses, and frameworks from authors working within each tradition engaging them where they are most useful for analysis.

Post-Development Theory (PDT) provides a lens for analysing how development discourse and global health agendas have historically marginalised non-Western knowledge systems while shaping institutional spaces through which recognition and integration are now pursued and provides an insight into resistant alternatives and hybridisations (Escobar, 2012; Dunlap and Tornel, 2025). Santos' Epistemologies of the South, particularly the concepts of ecology of knowledges and intercultural translation (Santos, 2016), offer tools for examining how institutional actors mediate between conventional and traditional knowledge, and whether integration constitute genuine dialogue or absorption into dominant frameworks. Social Reproduction Theory (SRT) grounds the analysis in the political economy of care, centring the feminised labour that remains largely invisible to the State (Federici, 2019).

Despite their different intellectual origins, these perspectives converge in attending to how power produces the absence of alternative development paths, and absence of marginalised knowers from decision-making spaces, and the absence of recognition for the reproductive labour that sustains communities where formal health systems fail to reach, while highlighting resilient forms of resistance.

3.1 Post-Development Theory

PDT, rooted in postcolonialism and decolonialism, provides a critical lens for examining the dominant development discourse and its effects on the integration and recognition of traditional-midwifery. Unlike critical development theories, which critique capitalist-centred approaches but maintain optimism that development can be improved (Spronk and Anderson, 2021), PDT rejects the dominant model entirely, calling instead for alternatives (Escobar, 2012; Dunlap and Tornel, 2025).

3.1.1 The “Development” Discourse and its Critique

A central characteristic of PDT is its rejection of the “development discourse”, a collection of knowledges and power structures that take shape through, behaviour, and policy (Escobar, 2012; Ziai, 2021). PDT argues that the dominant model of development is built around this discourse created by HICs, positioning them as the superior model of progress while framing LMICs as undeveloped, inhibited by traditions, and in need of HIC’s knowledge and assistance (Escobar, 2012). This discourse shapes not only thought, but concrete actions and policies, by determining whose voices and knowledges are heard and valued, and suppressing the existence of varied knowledges, cultures and histories (Escobar, 2012; Ziai, 2021).

PDT critiques the dominant development model as a continuity of Eurocentric superiority and colonial structures through which HICs exercise control over LMICs (Murrey and Daley, 2023; Ziai, 2021), applying universal technical solutions to achieve modernisation without consideration for local cultures, histories, diverse knowledges, and contextual needs, warning that this repression of diversity risks its complete erasure (Escobar, 2012). It questions the assumption that development is universally desired or inherently beneficial, noting that it can reduce autonomy (Dunlap and Tornel, 2025; Ziai, 2021), and prove destructive to the populations it claims to help (Escobar, 1999). While PDT acknowledges the benefits of modernisation, such as advances in medicine, and recognises that rural populations may desire it, it insists these advances should not come at this cost of people and cultures (Dunlap and Tornel, 2025). Thus, it calls for the dismantling of the development model, emphasising that solutions cannot be found within the current structure (Ziai, 2021). However, Escobar (2012) recognises that changing the development discourse will be a long and difficult process.

The PDT perspective is crucial for this study, allowing critical engagement with the power relations that shape whose knowledges are heard and considered “legitimate” in maternal healthcare and how this manifest in actions taken by government bodies, international

cooperation and communities. While development goals such as SDG 3 Target to reduce MM (WHO et al, 2025) – remains essential, PDT enables analysis of how this target should be pursued within Chocó’s specific context.

Decolonial feminists such as Lugones (2008; 2010) extend this critique by showing that colonial structures operate not only through economic and epistemic domination but also through the reorganisation of gender relations, imposing hierarchies that specifically devalued feminised knowledge and care practices. This helps explain why traditional-midwifery, as feminised, community-based, ancestral care labour, has been particularly targeted for marginalisation, connecting the post-development critique to the gendered dimensions that SRT addresses.

3.1.2 Alternatives and the Concept of “Hybridism”

Rather than seeking reforms within the existing development paradigm, PDT calls for “alternatives to development, rather than development alternatives” (Escobar, 2012, p.xiii), arguing that finding alternatives within development leaves the development discourse intact (Ziai, 2021). Escobar (2017, xvi) develops this through the concept of “pluriverse”, a “world in which many worlds fit”, and where communities define their own paths rather than following externally imposed models. PDT highlights that alternatives already exist in local communities and grassroots organisations in their varying forms of active resistance (Escobar, 2012; Ziai, 2021), including everyday acts (Dunlap and Tornel, 2025), promoting autonomy and pluralism rooted in specific contexts rather than universal applicability (Escobar, 2012; Dunlap and Tornel, 2025). It is important to note however, that alternatives to development are not an attempt to return to a pre-development past (Escobar, 2012). This perspective is particularly relevant to the present study, as traditional-midwifery associations and the continued practice of traditional-midwifery can be read as forms of resistance. Importantly, PDT highlights the Western tendency to romanticise these alternatives, resulting either in their dismissal or uncritical acceptance (Escobar, 2012). Through this, it encourages critical thinking about these alternatives, recognising that all development approaches are imperfect, and that grassroots movements too have their faults (Escobar, 2012). This approach allows us to examine critically, for example, the associations of traditional-midwives, and remain vigilant of their romanticisation by various actors.

A key “alternative” for this study is presented by Escobar (2012); “hybridism”, the combination of modern and traditional approaches into something new. Hybrids are not alternatives bending the demands of the development discourse, but forms of resistance that call for restructuring on both sides. PDT cautions, however, that alternative knowledges must not be appropriated by the dominant model. This hybridity concept enables critical examination of how traditional-midwives adopt elements of conventional-medicine, and whether integration and recognition processes of traditional-midwifery in Chocó constitute genuine hybrids facilitating dialogue, or whether they merely absorb traditional practices into the dominant conventional-medicine framework.

The concept of hybridity is also presented by the postcolonial scholar Bhabha who argues that cultures are not pure or fixed, but fluid, temporal, and unstable hybrids formed in the “in-between space”, where contrasting cultures interact (2004, p.37). Like Escobar, Bhabha emphasises that hybrids are not mere combinations, but negotiations that remould past and present cultures into something new. For Bhabha, hybrids are also forms of resistance, as by highlighting the temporal and hybrid nature of culture, they delegitimise the supposed “purity” (2004, p.72) of dominant cultures and blur the boundaries between superior and inferior, modern or traditional. He further describes how people from formerly colonised countries enact this resistance by remoulding, reorganising and adopting the coloniser’s culture. This framework helps situate traditional-midwifery in Chocó as part of a hybrid culture composed of past and present, foreign and local.

3.2 Epistemologies of the South Framework

Santos’s Epistemologies of the South approach offers an epistemological framework anchored in the experiences of resistance of social groups that have systematically suffered the injustices and oppressions of capitalism, colonialism, and patriarchy (Santos, 2018). Although not a theory, it complements PDT by examining the power relations that govern knowledge production. Through concepts such as the “ecology of knowledge” or “intercultural translation”, it allows us to assess whether integration processes are genuinely inclusive or whether they reproduce hierarchies of knowledge, and how international cooperation and government projects promote or not this knowledge integration.

Santos (2016) conceives the “South” not as a physical space, but as a metaphor for the suffering caused by capitalism and colonialism, and for the resistance of marginalised groups. Central to

this notion is that modern Western thinking is “abyssal thinking”, a system of distinction dividing social reality into “this side of the line” and “the other side of the line” (Santos, 2016, p.95). For people on “this side” (societies in the metropolis), social conflicts are managed through regulations and emancipation. However, according to Santos, for those on the “other side” (colonised areas), reality is shaped by appropriation and violence. A central concept here is “invisibility”, which he describes as those realities on the “other side” where the knowledge produced, usually by Indigenous peoples and marginalised groups, is “non-existent” or irrelevant (2007; 2016). This dynamic produces what Santos terms “epistemicide”, as “the murder of knowledge...when unequal exchanges among cultures have always implied the death of the knowledge of the subordinated culture” (2016, p. 92). For Santos, there can be no global justice without global cognitive justice, calling for the recognition of the plurality of knowledge in the world (Santos, 2016).

3.2.1 The Ecology of Knowledge

To counter “abyssal thinking” and “epistemicide”, Santos proposes an “ecology of knowledge”: the recognition of plural and heterogeneous forms of knowledge and the interconnected dynamics between them. From this perspective, all knowledge is “incomplete” and it is therefore crucial to promote an “interknowledge” rather than prioritise science as the sole source of truth (2016, pp.188-189). This framework proves particularly relevant when considering the ancestral knowledge of the Pacific region, which has been passed down from generation to generation and yet remains a living, evolving guide that contributes to maternal health in Chocó.

3.2.2 Intercultural Translation

As an alternative to power relations between forms of knowledge, Santos (2016, p.212), proposes “intercultural translation” as a living process that searches for isomorphic concerns and shared assumptions across cultures while identifying their similarities and differences. Much like PDT, this approach advocates a hybrid form of intercommunication built through alliances between social movements resisting colonialism and other system of oppression, with the aim of pursuing social justice and dignity (Santos, 2016). This concept allows us to understand the importance of challenging rigid dichotomies and to consider alternatives that recognise different ways of knowing and different forms of knowledge. This stems from an intellectual and political stance that advocates for a world where general knowledge is not reduced to Western knowledge but rather promotes pluriversality (Santos, 2016).

3.2.3 Coloniality and Disobedience

Burman extends these debates with the concepts of “coloniality of knowledge” (2012) and “coloniality of reality” (2017), referring to the repression and delegitimization of the epistemologies and ontologies of colonised countries. He outlines how Western ontologies are imposed universally as factual truths, while indigenous ontologies are framed as “cultural (mis) representations of the world” (Burman, 2017, p.924), relating somewhat to Escobar’s critique of romanticisation of alternatives. This dismissal allows institutions to adopt elements of indigenous ontologies and epistemologies superficially without altering their own foundations (Burman, 2017).

However, coloniality breeds resistance. Burman terms this “epistemological disobedience” (2012) and “ontological disobedience” (2017), referring to historically subordinated groups rejecting the reduction of their realities and knowledges. Like PDT’s “alternatives to development”, Burman highlights that despite domination, diverse and alternative realities continue to exist, and thus challenge colonisation and modernity (2017). Also, Burman emphasises that ontological disobedience is not an attempt to return to a past ontology exactly as it was (2017). Finally, he presents an idea that is similar, yet importantly different to that of hybridisation; contrasting ontologies do not mix or remain separate through resistance, but rather become an overlapping grey area where realities co-exist (2017). This perspective offers a useful complementation to examining how traditional-midwifery is delegitimised institutionally, and how traditional-midwives engage in everyday ‘disobedience’ through their continued practice.

3.3 Social Reproduction Theory

SRT, rooted in the Marxism-feminist tradition, frames care work as essential to sustaining life in vulnerable contexts (Federici, 2019), such as those served by traditional-midwives. It enables analysis of how public policies and the international cooperation programmes engage with the care practices that reduce MM, situating traditional-midwifery as not only a health or cultural matter but also a form of life-sustaining labour in contexts of socio-economic vulnerability (Sarmiento et al, 2021).

SRT identifies the work of “life making” as the structural foundation of capitalist society, contrasting with the narrow focus on “profit making”. While traditional economics separates

the economy from social life, SRT insists that the production of goods and the production of life are inextricably entangled within a single capitalist totality (Mezzadri et al, 2025).

According to Tovar (2022), this framework offers core categories for understanding how daily activities regenerate the workforce and social relations. For instance, the birth of new generations of potential workers, the activities like feeding, cleaning, and resting that allow current workers to return to the production processes, and the care and maintenance of children, the elderly, the ill and the unemployed, those who were or will be part of the labour force .

SRT's central contribution is to broaden the concept of labour and work beyond factories or public workplaces, extending it to the home and communities, where undervalued and unpaid work takes place (Mezzadri et al, 2025). It exposes the invisibility of such labour, such as domestic work, which they refer to as a "labour of love", while recognising that these are social necessary tasks that enable the generation of labour power (Federici, 1974, p.76). This perspective is essential for understanding traditional-midwifery practices, which may be undervalued and often seen as unimportant, yet which have sustained, without fixed pay, maternal care. Hence, another important concept is to understand work as something relational. In other words, these care tasks are not mechanical processes but require interaction and the building of networks to support them (Federici, 2019).

4. METHODOLOGY

The following section will describe our positionality as researchers, the research design, data sources and selection criteria, data collection methods, data analysis, ethical considerations, and limitations and strengths of the study.

4.1 Positionality and Division of Tasks

This study was conducted collaboratively by two researchers. We adopted a team-based qualitative research approach (Cornish et al, 2014), ensuring multiple perspective collaborations throughout the entire research process. Also, with consideration that positionality shapes every stage of qualitative inquiry, from access and rapport to interpretation (Hammett et al, 2015), this methodological commitment shaped how we designed, collected, analysed, and wrote up the research, and it is the foundation against which the division of fieldwork roles should be understood.

Concretely, we ensured that we were both involved in the entire process, co-developing the interview guidelines and consent forms, reading through the transcripts after each interview, and co-agreeing on the exclusion criteria of the document review. This shared analytical engagement supported methodological triangulation, allowing us to discuss our reflections, questions, and possible changes we wanted to make. Additionally, it allowed each method to inform the other, i.e., interviewees mentioned documents of interest, and documents highlighted questions to ask. While in different locations, we maintained this continuous communication through calls twice weekly and daily texting.

Within this collaborative design, fieldwork roles were divided so that Gabrielle led the document review from Sweden, while Lorena conducted interviews in Colombia. This division was guided primarily by methodological commitments to reflexive research practice (Sultana, 2007), with practical considerations of time and necessity playing secondary role. We therefore reflected critically on how each researcher's positionality would influence data collection in the Colombian Pacific, considering that positionality is not static and can position a researcher as insider, partial-insider or outsider depending on the context (Merriam et al, 2001). In this case, Lorena is Colombian, is a native Spanish speaker, and has prior professional experience in the region, placing her in a more partial-insider position. Gabrielle is British, does not speak

Spanish, and has not been to the region, which would have positioned her as an external researcher and requiring a translator for all interviews.

Two methodological considerations informed the decision that Lorena would conduct fieldwork in person. First, conducting interviews in participant's first language without a translator preserves linguistic nuance, reduces interpretive layers, and supports the conversational rapport that semi-structured interviewing depends on (Squires, 2009). Second, we would only be in the region for a short time, so would not be able to build the contextual familiarity and relationships that ethical engagement with host communities requires.

4.2 Research design

We chose a case study design as it allows us to explore in-depth and contextualised research, as well as allowing the inclusion of multiple perspectives and levels of analysis (Bhattacharjee, 2019). A qualitative study was conducted, including a documentary review, a form of qualitative secondary analysis to draw inferences from the content of existing documents (Camfield, 2019), and semi-structured one-to-one interviews. Qualitative methods were selected for their capacity to highlight attitudes and lived experiences (Creswell, 2014). The documentary review allows to capture the broad institutional and policy contexts, in this case those surrounding the midwifery practices (Bowen, 2009), while semi-structured interviews surface individual perspectives and allow for flexibility in a conversational setting (Flick, 2014). Together, the two methods complement and enrich each other (Braun and Clarke, 2006).

4.3 Data Sources and Selection Criteria

4.3.1 Document Selection

This study conducted a documentary review involving documents, policies, laws, and resolutions, related to traditional-midwifery in Colombia and Chocó. The first step was a systematic online search. Key words and phrases were used to find relevant publications, including: *“traditional midwifery Chocó/Colombia”*, *“UNFPA traditional midwives Chocó”*, *“Partera Vital”*, and *“maternal health Chocó/Colombia”*. Following what Bowen (2009) mentions as an iterative process through skimming, reading and interpreting documents, and considering an emergent strategy, this process involved directly searching for key actors, laws and policies that were mentioned in the sources found. This was continuously done with each source until saturation was reached. Additionally, interviews also contributed to this process,

with many interviewees mentioning key actors, policies and laws, however, many of the mentioned actors did not have visible reports or publications on the topic.

For the document analysis, the following exclusion criteria were applied: a) Documents before 2017, b) documents that do not mention traditional-midwives c) or mention them only in passing, d) documents that speak specifically about another location or demographic (i.e., indigenous communities), e) and webpages f) and articles. The cut off point of 2017 was chosen after a review of policies, resolutions and laws, concluding that it marked the most significant shift in the recognition and integration of traditional-midwives. Additionally, we decided to exclude webpages and articles as they did not appear to provide significant additional information.

4.3.2 Interview Participant Selection

The study was conducted using purposive sampling, considering that it was a specific study related with location (Chocó) and topic (traditional-midwifery and their integration in the health system). This approach implied an inclusion criterion to capture information (Creswell, 2014) and cover a diverse range of perspectives to achieve a more robust understanding of our research, as perspectives are inherently subjective (Oswald et al, 2019). The inclusion criteria included people who had experience and/or participated in; traditional-midwifery and their associations in Chocó or Colombia, government policies and programs for integration, international cooperation programs, and academia related with maternal health and intercultural practices. This was considering that research often does not include the voices of marginalised communities, making it all the more important to work in partnership with these populations during our research (Oswald et al, 2019). Starting in September 2025, online zoom meetings were used to establish rapport ahead of the January 2026 fieldwork. A snowball sampling strategy was used, contacting participants who were both interested in the study and met the inclusion criteria through existing connections, which also facilitated trust and openness thanks to these mutual acquaintances (Naderifar et al, 2017).

4.4 Data Collection Methods

4.4.1 Document Review

The document review collected 131 relevant documents, webpages, and news articles. A full list of texts can be found in Annex 4. Applying to the exclusion criteria (see Figure 5), this number was reduced to 19 documents (see Table 2). Documents in Spanish were translated

using DeepL. For documents concerning several topics, only sections concerning traditional-midwives were analysed.

Figure 5. Document Exclusion Process

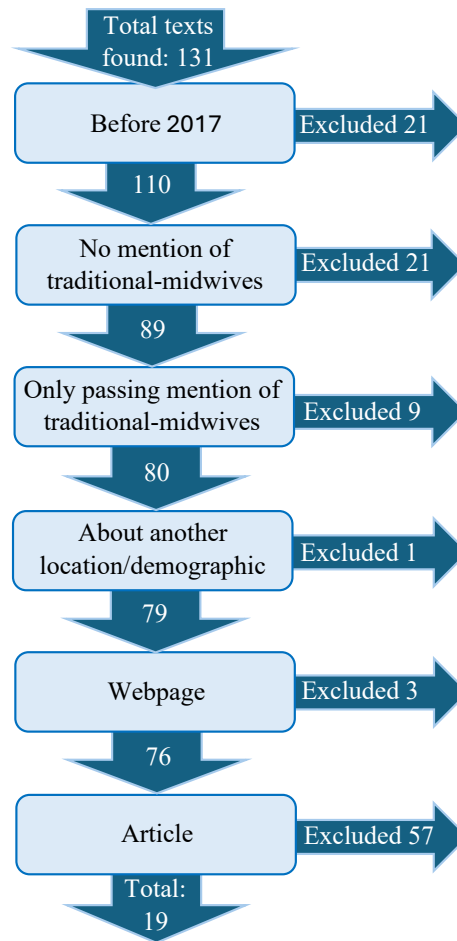


Table 2. Documents Included in the Documentary Review

Nº	Date	Title	Short Description	In-Text Code
1.	2017	Decree 356 (Colombia, Presidency of the Republic of Colombia)	Modifies the process of civil registration. Included midwives in the list of actors who can register births in the case of late registration.	D-GOV1
2.	2017	Plan Especial de Salvaguardia de los Saberes Asociados a la Patería Afro Del Pacifico [Special Safeguarding Plan for Knowledge Associated with Afro-Pacific Midwifery] (PES) (Ministry of Culture and ASOPARUPA)	This document is designed to protect and promote the ancestral knowledge and practices of Afro-Pacific midwifery in Colombia.	D-GOV2
3.	2017	Resolution No.1077 (Ministry of Culture)	Includes Afro-Pacific midwifery and knowledge in the national Representative List of Intangible Cultural Heritage. Approves the Special Safeguarding Plan.	D-GOV3
4.	n.d.	In-depth analysis of ethnic births in Colombia. A case study of indigenous populations in the Chocó department (Calderon Gonzales et al, n.d.)	Provides a summary of gaps in Vital Statistics in Chocó, particularly for monitoring births in Indigenous populations and births attended by traditional midwives.	D-IC1
5.	2020	Departmental Development Plan, Chocó 2020–2023 (Chocó’s Departmental Government)	Outlines the Departmental Development Plan of Chocó for 2020-2023. Calls for traditional midwives to be integrated into the National General Social Security Health System and calls for the support of the PES.	D-GOV4
6.	2021	Resolution No. 3676 (The National Registrar of Civil Status and DANE)	Authorises midwives of ASOREDIPARCHOCO to certify births they attend.	D-GOV5
7.	2022	Judgment T-128 (The Constitutional Court of Colombia)	Case presented by ASOREDIPARCHOCO and ILEX Legal Action, against the national and departmental MHSP, and the Departmental Secretariat of Health of the Valley of Chocó Cauca, in response to the lack of protection of traditional midwives during the COVID-19 Pandemic. Result: The Court recognised that the rights of traditional midwives were violated, orders the protection of traditional midwifery, and urges their recognition and integration into the General System of Social Security in Health.	D-GOV6
8.	2022	Law 2244 (The Congress of Colombia)	Recognises the rights of women during pregnancy, labour and postpartum. Article 11 states that the state will promote and support the training of traditional midwives nationally, respect their beliefs and practices, and develop communication and referral mechanisms.	D-GOV7

9.	2022	Resolution No.1035 (MHSP)	Adopts the Ten-Year Public Health Plan 2022-2031. Includes specific chapters concerning ethnic minorities. Mentions traditional midwives significantly more than the previous Ten-Year Plan, including a detailed description of the work of traditional midwives. Calls for the registering, strengthening and recognition of traditional midwives, and knowledge exchange between traditional midwives and Western medicine.	D-GOV8
10.	2023	Plan de aceleración para la reducción de la mortalidad materna [Acceleration plan for the reduction of maternal mortality] (MHSP)	Outlines an action plan for reducing maternal mortality. Calls for the strengthening of alliances with traditional midwives to improve reporting lines.	D-GOV9
11.	2023	Resolution No.2367 (MHSP)	Modifies Resolution No.1035. New Points concerning traditional midwives: Details how traditional midwives should be supported i.e., food and resources, and that community-based care (including traditional midwifery) should be promoted. Additionally mentions the role of traditional midwives in supporting mental health of victims of armed conflict.	D-GOV10
12.	2023	Lineamientos para la implementación del enfoque diferencial étnico en salud para comunidades Negras, Afrocolombianas, Raizales y Palenqueras de áreas urbanas y rurales [Guidelines for the implementation of the ethnic differential approach in health for Black, Afro-Colombian, Raizal and Palenquera communities] (MHSP)	A toolkit for a differential and intercultural approach to health. Calls for the registering and recognition of traditional midwives, and the exchange of knowledge and collaboration between traditional midwives and Western medicine.	D-GOV11
13.	2023	Partería Tradicional y su incorporación en las Estadísticas vitales de Colombia [Traditional Midwifery and its incorporation into the Vital Statistics of Colombia] (DANE, Spanish Colombian Cooperation and UNFPA)	Presents how they are working towards reduce gaps in sexual and reproductive health and improve coverage in the Vital Statistics register through the inclusion of traditional midwives.	D-IC2
14.	2024	Development Plan 2024-2027. Chocó on the Road to Progress (Chocó's Departmental Government)	Adopts the Departmental Development Plan of Chocó for 2024-2027. Calls for the recognition and strengthening of traditional midwives, the protection of their knowledge, and their integration.	D-GOV12

15.	2024	Interwoven Lives, Threads of Hope. Ending inequalities in sexual and reproductive health and rights (UNFPA)	Provides a global overview of the current state of reproductive health, rights, inequalities and changes. Highlights why some women in Colombia actively choose traditional midwifery over hospitals, the prejudices and exclusion faced by traditional midwives, and the impact of the Partera Vital project.	D-IC3
16.	2024	Partera Vital 3.0 - Comunidad Vital [Partera Vital 3.0 – Community Vital] (DANE, Spanish Colombian Cooperation, and UNFPA)	Provides an overview of traditional midwifery, and the ‘ <i>Vital Community</i> ’ that is working towards “ <i>the recognition, strengthening, protection, and sustainability of the networks and organisations of traditional ethnic midwifery in the Colombian Pacific</i> ”.	D-IC4
17.	2024	Partera Vital: Comunidad Vital inicia su fase tres en el Pacífico colombiano [Partera Vital: Community Vital begins its phase three in the Colombian Pacific] (DANE, Spanish Colombian Cooperation, and UNFPA)	Outlines the Partera Vital project: how it integrates traditional midwives in the health system, promotes the safeguarding and protection of traditional midwifery, and improves sexual and reproductive health and reporting of births in the region.	D-IC5
18.	2024	Una mirada a las experiencias territoriales de cuidado comunitario en Colombia [A look at the territorial experiences of community care in Colombia] (ILO)	Provides an analysis of the community care sector in Colombia, exploring how organisations such as cooperatives or associations, provide essential services to vulnerable populations, including the traditional midwifery practices.	D-IC6
19.	2025	CONPES 4143 (National Council for Economic and Social Policy)	“ <i>Constitutes the national care policy</i> ”. Speaks about the right to care under dignified conditions and calls for the recognition and strengthening of collective and community-based care in rural and ethnic communities. Presents a 10-year action plan which significantly encompasses traditional midwives.	D-GOV13

4.4.2 Fieldwork

Between December 2025 and January 2026, 9 semi-structured interviews were conducted in three different cities in Colombia (Bogotá, Medellín and Quibdó²). The participants included 6 women, and 3 men. These were conducted in-person, on an individual basis, with a maximum duration of one hour and 20 minutes and a minimum of 40 minutes. An additional online group interview was conducted with 16 traditional-midwives that are members of a Midwifery association in Chocó in January 2026. In March one online interview was conducted with a midwife from Chocó (See Table 3).

For all semi-structured interviews, informed consent forms were read, and physically or digitally delivered and signed by all participants (Hammett et al, 2015), who were made aware that their participation is entirely voluntary, and that they could exit the process at any time (Kvale and Brinkmann, 2008). Likewise, data confidentiality and anonymity were guaranteed, and data is presented in aggregate form (Creswell, 2014). Interviews were conducted in Spanish and were recorded to be later transcribed using Otter.ai. Transcripts were proofread for accuracy and then translated to English using DeepL and reviewed again for accuracy. After this process, all audio recordings were deleted. Transcripts were saved into a password protected SharePoint folder, and all data was deleted from Otter.ai. Every transcript was codified and names were deleted to ensure anonymity.

Table 3. Summary of interviewees profiles, place of interview, and codes

Nº	Role	Type of organization	City	In-Text Code
1.	Doctor, professor and researcher in obstetrics and gynaecology	Academia	Medellín	I-ACA1
2.	International cooperation professional – Nurse with specialization in epidemiology, demography and a master in population studies	International Cooperation	Bogotá	I-IC1
3.	Researcher of midwives practices and their importance in the Chocó communities and midwife	Researcher and midwife	Online (Chocó)	I-MID1
4.	International cooperation professional – Public Health Specialist	International Cooperation	Medellín	I-IC2
5.	Professor and researcher in public health	Academia	Medellín	I-ACA2

² Although the main city of this thesis is Chocó, the interviews in Bogotá were conducted to gain access to the most national-level interviewees, and in Medellín because it is the biggest city closest to Chocó where the academic interviewees live.

6.	Midwifery Association	Association	Online (Chocó)	I-MID2
7.	Health regional government professional	Departmental Government	Chocó	I-GOV1
8.	Ex-researcher. Nurse with quality management and health auditing	Academia	Medellín	I-ACA3
9.	Health municipal government professional	Municipal Government	Chocó	I-GOV2
10.	Public Hospital Manager	Government	Chocó	I-GOV3
11.	Public First-level Hospital Director	Government	Chocó	I-GOV4

4.5 Data analysis

Data analysis included methodological rigor using multiple methods and the triangulation of findings (Tracy, 2010). The same data analysis process was applied to both documents and interviews. Firstly, a qualitative thematic analysis (Skovdal and Cornish, 2015) was used as a strategy to identify and analyse emerging and predefined categories (Álvarez-Gayou, 2003), for guided data collection, systematisation, and analysis.

As mentioned earlier, this project is structured around three interconnected levels (macro, meso, and micro), following Skovdal and Cornish's (2015) multilevel analytical framework for development research. This is based on the understanding that complex social phenomena require attention to be paid simultaneously on several fronts: namely, the structural, institutional, and more everyday dimensions of the same problem.

The thematic analysis was guided by Braun and Clarke's (2006), six steps; 1) data familiarisation, 2) initial code generation, 3) search, 4) review and 5) definition of themes, before 6) presenting the results. In our case, categories derived from a hybrid approach, deductive from theory and inductive from interviews and documents (Hammett et al, 2015). We initially carried out the first three steps independently, before comparing the codes and categories we had uncovered. We found a large degree of agreement and were able to explain and resolve areas of difference. We then applied the same approach of comparison and discussion to the remaining steps. The three predefined levels were applied deductively to the categories of the analysis, to provide a more comprehensive understanding of each of them. The results and discussion will also be presented in multilevel approach.

Through the thematic analysis five categories were initially identified: 1. Integration, 2. Recognition, 3. Ecology of knowledges, 4. Intercultural translation and 5. Care labour. However, in the reading and interpreting process, as researchers we decided to incorporate an emergent category named Structural inequalities that is transversal to the other ones.

It is important to mention that the content of categories and levels can overlap, as the tensions and situations that occur in reality do not operate in isolation but are entangled. Additionally, the six categories can be largely understood within or in connection to a broader understanding of recognition and integration. For clarity, the developed categories are explained in two tables; Table 4 represents the meaning of each analytical level (macro, meso and micro) and analytical categories, and Table 5 highlights the intersection between each level and category.

Table 4. Definitions of the Analytical Levels and Categories

ANALYTICAL LEVELS	
Macro	Overall structure and conditions of the discourse within which traditional midwifery in Chocó is situated. This includes regional, national and international legal frameworks, the design of the Colombian health system, discursive policies, and development paradigms that shape how maternal health is understood and governed.
Meso	Institutional actors and actions that act as intermediaries between legal frameworks and communities, particularly those involved in international cooperation, government agencies, academia, and health authorities. At this level, it is possible to assess how policy intentions and the expected outcomes for communities are actually being implemented, considering power dynamics.
Micro	Everyday experiences and actions within communities. It draws more on a theoretical framework of social reproduction by examining how midwifery is a feminised act of care. It explores how midwives perceive their role and, in turn, form associations and build support networks. The material and relational conditions of care are also explored.
ANALYTICAL CATEGORIES	
Integration	Processes through which traditional midwifery practices are included or excluded from the formal health system, policies, and institutional programs, and community health practices.
Recognition	Informal or formal processes through which value and legitimacy are conferred upon practices, in this case, traditional midwifery. Recognition has various levels, ranging from legal recognition to community recognition and the validity these practices hold within their respective territories. It also involves processes of protecting and strengthening traditional practices, as these practices are valued independently of Western medicine.
Ecology of knowledges	It is a concept created by Santos. In this context, it is understood as the process through which the coexistence of different knowledge systems, such as scientific and ancestral knowledge, is acknowledged, recognising that each has its own rationale and is, in turn, incomplete. Refers to the recognition and respect of traditional midwives' knowledges.
Intercultural Translation	It is also a concept by Santos, which in this case refers to the processes of creating dialogues between different systems of knowledge, without one "absorbing" the other. This connects directly with Escobar's concept of "hybridism" reinforced by Bhabha and Burman, and where it is possible to create dialogues of knowledge
Care labour	It draws inspiration from the theory of Social Reproduction and refers to the processes of care and work that enable the reproduction of human life, in this case, the traditional practices of midwifery. For example, actions such as prenatal checkups, childbirth care, postpartum recovery, and emotional support are recognised within a system of work, whether paid or unpaid.

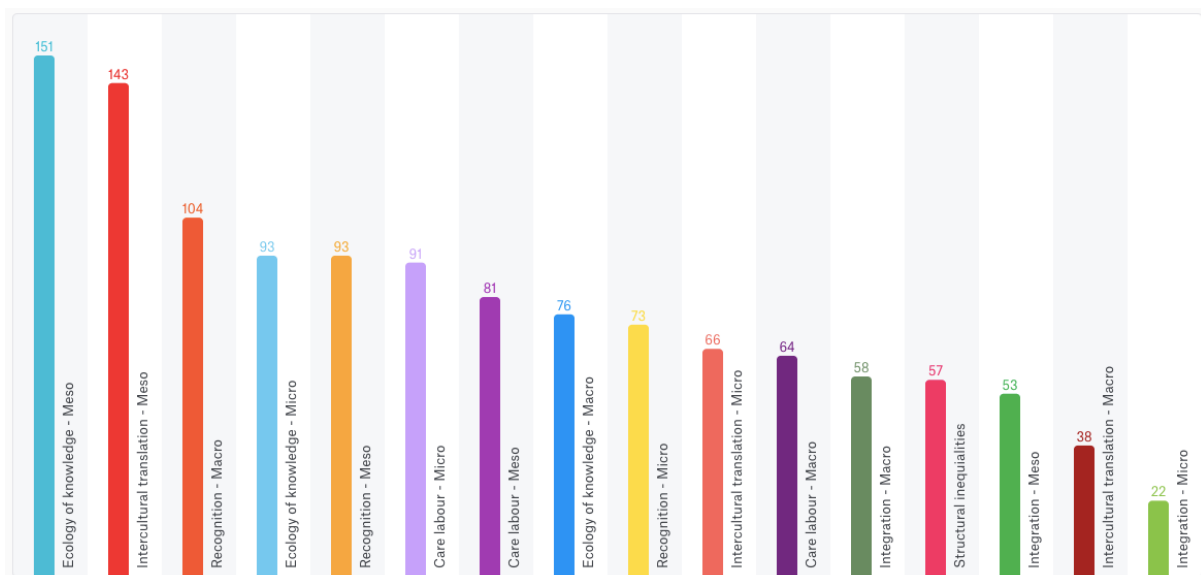
Table 5. Intersection of Analytical Levels and Categories

		ANALYSIS CATEGORIES					
		Integration	Recognition	Ecology of knowledges	Intercultural translation	Care labour	Structural inequalities
ANALYSIS LEVELS	Macro	How legal and policy frameworks define the integration of traditional midwifery practices into the Colombian Health System and how they do it or not.	How legal, and policy frameworks formally recognise traditional midwifery practices as legitimate, and in need of effective protection and empowerment.	How legal and policy frameworks, embrace traditional midwifery knowledges or generate epistemic exclusion.	How legal and, policy frameworks generate mechanisms and guidelines to develop a genuine dialogue between knowledge systems, considering Colombia as a “pluridiverse” country.	How legal policy frameworks acknowledge traditional midwifery practices as labour deserving of compensation, social protection and inclusion in the health system.	The systematic conditions that can be economic, geographic, social and political, that shape access to health services and determine the maternal health in Chocó. For instance, poverty, armed conflict, geographic isolation, racism, poor infrastructure.
	Meso	How international cooperation, institutional actors, and academia integrate traditional midwifery practices into the health system or maternal health processes.	How international cooperation, institutional actors and academia recognise traditional midwifery practices as legitimate, and in need of effective protection and empowerment.	How international cooperation, institutional actors and academia understand and value or not traditional midwifery knowledge, and respect it as equal and autonomous.	How international cooperation, institutional actors and academia develop concrete actions to close the gap between conventional-medicine and traditional knowledges and how they facilitate co-creation and dialogue between them.	How international cooperation, institutional actors and academia generate mechanisms to address the traditional midwives working conditions, including material needs and training, and how these actions can or not be sustainable	

	Micro	How traditional midwives' and communities experience and influence integration.	How traditional midwives and communities experience and promote trust and recognition of their work as legitimate.	How traditional midwives' experience the coexistence or conflict between knowledges. Experience of being valued or dismissed, and how they maintain, adapt, or defend their epistemic practices.	How traditional midwives and communities experience navigating the two health/knowledge systems, and how they create "hybrids" in their daily lives.	Traditional midwives' experiences of and efforts to change working conditions: unpaid or poorly compensated under structural conditions. Also, how these practices sustain communities where the health system is absent.	
--	-------	---	--	--	--	---	--

In the next stage we used ATLAS.ti (Preiser et al, 2021) where codes were then quantified, so frequency of categories could be reviewed (Bhattacharjee, 2019). We again chose to initially code texts separately and then compare our analysis to see if we reached the same conclusions (Weston et al, 2001), finding again that we largely agreed and could reach a consensus. As different types of data collection methods were implemented, the information was triangulated between documentary sources and interview results to ensure greater depth in the findings (Hammett et al, 2015). In Figure 6, it is possible to see the frequency at which each category was coded during the codification process.

Figure 6. Codification results from Atlas Ti.: Frequency of Quotations per Category. Source: Atlas ti.



4.6 Ethical considerations

Throughout this research, we followed Lund's General Data Protection Regulation (GDPR) Guidelines and prioritised self-reflexivity and sincerity, as recommended by Tracy (2010). This required a constant awareness of our biases and a commitment to being transparent regarding the limitations and expectations of the study. The study also sought to reduce the risks or exposure of participants by using an analysis of secondary information, reducing the number of interviews needed, and anonymised the data of those who participated. Chocó is a region with significant inequality, particularly in Afro-descendant communities, being the fifth department with more multidimensional poverty in the country (DANE, 2025c). Therefore, the interviews were conducted carefully and respectfully, creating a space of trust and only with

people who were interested in participating in the study (Palmer et al, 2014). To reduce any pressure to participate, informed consent forms were read aloud and physically delivered. Lorena's familiarity with the Colombian context and language was also intended to create a more comfortable interview environment. Nevertheless, there is an inherent power asymmetry between a researcher studying in the Global North and the complex inequality Chocó context. To mitigate this situation, Lorena was careful with her words and mostly listened and learned from the interviewees from a respectful and empathic perspective.

Throughout the process, we maintained a culturally sensitive and gender-aware approach, grounded in respect for traditional knowledge. This study did not pose any physical risks to participants and was conducted directly in the cities where the people were located or virtually. In terms of potential mental harm, the study addressed issues that, although sensitive, posed a minimal risk.

4.7 Strengths and Limitations

One of the main strengths lies in the social and political relevance of the study, addressing MM in connection with inequality and structural racism. Colombia, ranked as the ninth most unequal country in the world (World Population Review, 2024), continues to exhibit patterns of discrimination and exclusion toward Afro-descendent communities, who experience significantly higher MM compared to non-afro-descendent communities (Mosquera-Córdoba and Cuesta-Caicedo, 2022). Moreover, the study stands out for its interdisciplinary nature, integrating intercultural perspectives, development studies, and public health through a combination of methods and triangulation processes. Similarly, it was important for this research to include authors from LMICs, as the topic largely concerns the invisibility of voices from these contexts. However, despite this conscious effort, one of our major limitations is that we were unable to include important studies concerning this topic by researchers from Chocó and Colombia as they are not published in peer reviewed journals.

As described in section 4.3, triangulation of the document review with interview data has strengthened the validity of our findings (Skovdal and Cornish, 2015; Hammett et al, 2015); the document review provided institutional and policy-level breadth, while the interviews added depth through personal experiences and insights.

Conducting the research as a pair also strengthened our analysis. We coded interviews and documents independently before cross-checking results (Weston et al, 2001), and our different

geographical, linguistic, and disciplinary backgrounds enriched interpretation by bringing two distinct perspectives to the analysis. This continuous dialogue, alongside the use of multiple data sources, methods, and theoretical lenses, moves our study towards what Tracy (2010) calls “crystallisation”, reducing the risk of interpretive bias.

The research had certain limitations. One was the limited access to disaggregated MM data in Chocó. Additionally, while there was considerable information in international cooperation reports and public policy documents, academic literature on the topic in Colombia remained scarce. The study’s setting, marked by a history of armed conflict (Cuestas, 2023), also posed challenges, such as limiting time and travel on the ground since the researcher who went to do fieldwork is a woman and was alone in the territory, so to prevent risks, she spent only a few days in Quibdó and only in the municipal capital. Similarly, we recognize that using other methods, such as ethnography, could provide greater insight and understanding of, for example, the daily work practices of midwives. Likewise, surveys for another study would be valuable in easily reaching more midwives and capturing as much information as possible.

5. RESULTS

This section presents the main findings obtained following the process of triangulation and systematisation of information coded in Atlas Ti. The findings are presented below in accordance with the project's general structure and its six categories: a) integration, b) recognition, c) ecology of knowledge, d) intercultural translation, e) care labour, and f) structural inequalities, each highlighting information at the macro, meso and micro levels. The number of documents and interviews that have quotations in each category at each level is displayed in Table 6 (i.e., 12 of the 19 documents mention integration at the macro level).

Table 6. Number of Documents and Interviews that Mention each Category

		Documents (19)	Interviews (11)
Integration	Macro	12	4
	Meso	11	8
	Micro	7	3
Recognition	Macro	14	4
	Meso	15	9
	Micro	13	9
Ecology of Knowledge	Macro	11	7
	Meso	13	11
	Micro	13	11
Intercultural Translation	Macro	8	6
	Meso	13	11
	Micro	10	10
Care Labour	Macro	7	4
	Meso	8	6
	Micro	8	8
Structural Inequalities		3	10

5.1 Integration

Integration was one of the least frequent categories, particularly at the micro level. The dominant finding across interviews and documents was that while there is some mention of integrating traditional-midwives, with international cooperation particularly committed to this goal, there are few policies putting this into practice, and there are concerns around how it may be implemented.

5.1.1 Macro

Regional and national bodies are open to integrating traditional-midwives, and are making efforts towards this, such as granting them the right to register births through Decree 356 and Resolution 3676. The T-128 ruling was frequently mentioned as a significant document

concerning integration, as it urged the Ministry of Health and Social Protection (MHSP) to initiate “*integrating midwives into the General Social Security System for Health so that they have the same rights, benefits, and obligations as those already part of it*” (D-GOV6), stating it as a constitutional and legal obligation. However, integration appears to be progressing slowly, if not at all, with frequent mentions that traditional-midwifery to date is unintegrated, and that there is a lack of public health policies working to change this, exhibited by their continued exclusion from the National Registry of Human Talent (in which healthcare providers are registered) justified by their lack of formal training.

5.1.2 Meso

At the departmental level, integration strategies are being implemented, including dialogues and knowledge exchanges, and incorporation of traditional-midwives into healthcare teams. Nationally, the MHSP has committed to strengthening links between traditional-midwives and the health system by improving referral mechanisms, establishing guidelines for their incorporation into health programs, and implementing educational strategies for integration. As one interviewee mentioned:

the ministry and other entities also began to take them into account in those dialogues on linking up with the National Health System, which is still very weak, but now they know who they are. They are now part of the acceleration plan to reduce maternal mortality (I-IC1).

The MHSP has also committed to designing a system for registering and characterising traditional-midwives, stating this is a necessary requirement for their integration, to ensure a standard of care. International cooperation was also frequently mentioned with the Partera Vital project, led by UNFPA and DANE, standing out for its work on removing barriers traditional-midwives face in registering births, such as limited access to digital registering tools, and strengthening registration systems broadly.

However, steps towards formal integration have had implementation shortcomings, with reports of some registration officials rejecting traditional-midwives’ certificates due to a lack of information concerning the policy change. Additionally, there are concerns around integration leading to the imposition of conventional medical models upon traditional-midwives: “*there is a risk of ‘medicalising’ midwifery through excessive regulation, thus*

transforming its essence” (D-GOV6) particularly concerning their characterisation and registration.

5.1.3 Micro

Traditional-midwives are actively working towards and successfully increasing their integration. Thanks to their work in associations, they have made achievements such as gaining the right to certify births, for instance “*the National Civil Registry, to address the request submitted by ASOREDIPARCHOCO, as a pilot program will authorize midwives registered with [this association] to certify the births they attend*” (D-GOV5). They have also fought to be integrated into the social security system, to be considered as human talent, to be treated with the same consideration as healthcare professionals, and for integration to be done on their terms, considering their specific needs and without imposing conventional medical structures.

5.2 Recognition

Recognition was one of the most frequent categories, particularly at the macro level. The dominant finding across documents and interviews was that while there is a strong awareness across all actors of the importance of recognising traditional-midwives, this does not appear translate into tangible action. However, they also highlight recognition occurring within communities.

5.2.1 Macro

There are policies, resolutions, judgements and national and departmental public health plans, all mentioning the importance of recognising, and protecting traditional-midwives as a legitimate and crucial form of care. D-GOV5 states that Resolution 1077 aimed to “*ensure the continuity, strengthening, and recognition of Afro-Pacific midwifery as a district system of traditional medicine*”. It is also stated that conventional medical structures will not be imposed on traditional-midwives. Despite this, there has been little success in increasing actual formal recognition in the health system, with traditional-midwives continuing to experience exclusion.

5.2.2 Meso

National and departmental policies both outline strategies for increasing traditional-midwives’ recognition; dialogues between traditional-midwives and healthcare professionals, awareness raising events, and communication campaigns, to strengthen and promote their work and

increase their visibility as legitimate and valued healthcare providers. International cooperation has also committed to and successfully increased recognition of traditional-midwifery and their associations within their communities, the health system, and among national ministries, as one interviewee mentioned: *“international cooperation has taken up a very important cause of rescuing that ancestral knowledge” (I-IC2)*. The Partera Vital project and UNESCO’s inclusion of traditional-midwifery in the cultural heritage list were frequently mentioned as successful examples of this.

However, recognition within healthcare facilities remains largely unchanged. While some interviews mentioned that some healthcare facilities are making efforts to recognise traditional-midwives, most continue to reject and disrespect them, stemming from prejudices and a lack of recognition of their work as “skilled”. Linked to this, there was also some mention that while some academic institutions are promoting the recognition of traditional-midwives, there continues to be a lack of medical staff training on how to respectfully incorporate intercultural medical approaches.

5.2.3 Micro

The continued work and generational knowledge transfer of traditional-midwives strengthens their recognition, reinforcing and protecting their presence as healthcare providers; *“care as a traditional practice in the Department of Chocó is an intrinsic element of the resistance processes of the ethnic and ancestral communities that have historically sustained life and social well-being in this territory” (D-GOV12)*. Additionally, traditional-midwives are recognised, trusted, valued and respected by their communities, with many women actively choosing their care despite having access to a hospital: *“They felt the health centre was a hostile place filled with darkness and fear, but that a midwife was their friend” (I-MID1)*. Traditional-midwifery associations have also significantly contributed to their recognition and strengthening at an institutional, social and international level. Several sources highlight their work on the PES and the T-128 ruling, both of which were significant in promoting their recognition and protection.

However, traditional-midwives continue to *“suffer from stigmatisation and rejection, due to the lack of recognition by the State and Social Security System in Health” (D-GOV6)*, contributing to the spread of misinformation, stigmas and perceptions of them as unskilled or *“witches” (I-ACA3)*. Additionally, some documents mention that traditional-midwifery

numbers may be struggling, due to factors such as reluctance among the next generation to engage in a vocation that faces so many challenges (*D-GOV3*).

5.3 Ecology of knowledges

This was the most frequently category mentioned across documents and interviews. It captures a power struggle in which conventional-medicine holds hegemony over traditional knowledge. While macro-level recognition of ancestral knowledge has advanced, practice remains unequal, shaped by structural racism and a lack of academic awareness of territorial realities. Some integration efforts further professionalise traditional-midwifery on conventional-medicine terms, forcing this knowledge into a framework that suits conventional-medicine rather than its own worldview.

5.3.1 Macro

There is a clear tension between the intentions in policy documents and their limited reach in practice. Structural racism excludes traditional knowledge from formal health systems, legitimised by a hierarchy that treats scientific knowledge as superior, a dynamic the PES names when describing the unequal relationship between Afro-Pacific midwifery and the health system. Although rulings such as Judgement T-128, “*recognise and extol midwifery as an ancestral knowledge that forms part of the ethnic and cultural expression of the Nation*” (*D-GOV6*), legal gaps persist.

5.3.2 Meso

This was the most frequently coded category overall, and it is where tensions over knowledge and power are sharpest. This tension is evident across all the healthcare sector that goes beyond maternal health. A recurring gap separates the conventional-medicine training of health professionals from territorial realities reinforcing a superiority complex among healthcare staff. As one interviewee noted “*the problem lies, to put it this way, in the fact that health personnel say, 'I studied and you didn't, I know, and you don't'* (*I-IC1*). This issue is compounded by curricula disconnected from primary care and local contexts resulting in little empathy and sensitivity towards knowledge such as midwifery. For instance, one interviewee mentioned, “*when I studied, they never taught me how to properly treat a patient with malnutrition according to the ministry's regulations. They did it suddenly with American literature*” (*I-GOV4*). Although, international cooperation has helped bridge this gap to integrating

knowledge, through knowledge sharing and capacity building, some projects remain stuck in a concept of one-way training, where some people are the ones who know and others are the ones who learn, without there necessarily being an exchange of knowledge.

5.3.3 Micro

Here, traditional-midwives' associations have been central to preserving traditional knowledge and advocating for its recognition as intangible heritage, highlighting positive aspects and progress, such as the importance of strengthening these associations. Furthermore, communities value this knowledge as wisdom tied to identity and territory, and traditional-midwives function as community leaders, not only health providers. One of the interviewees describe the mission of the associations as:

“the promotion of the vision of each midwife so that they can develop holistically and be recognised, bearing in mind their values and knowledge. This holistic development is achieved through self-esteem, resources, training and identity” (I-MID2).

This trust and recognition of knowledge from traditional-midwives stems from humane treatment and women-led care. However, knowledge transmission is fragile due to armed conflict displacing knowledge-holders, younger generations migrating, and health professionals often disparage traditional-midwives' knowledges, as mentioned in the Resolution 1077: *“Some doctors and healthcare professionals react with suspicion toward traditional midwifery practices, and in many cases, they exclude midwives from the birthing process and support when women in labour are brought to the health centre by them” (D-GOV3).*

5.4 Intercultural translation

This category captures efforts to bridge traditional-midwifery knowledge and conventional-medicine including initiatives across all three levels of actors to foster hybridisation of knowledge through intercultural dialogue. However, most translations move in one direction: traditional-midwives adopt elements from conventional knowledge, while the health system itself does not transform to accommodate them.

5.4.1 Macro

Although less frequently cited, macro level sources reveal both progress and tension around hybrid approaches. Intercultural translation appears in rulings such as T-128, which frames integration as *“harmonising the ancestral knowledge of midwifery with that of allopathic medicine. In other words, it is about complementing both forms of medicine”* (D-GOV6). This also translates into concrete administrative recognition in Decree 356/2017 and Resolution 3676/2021, which authorise midwives in Chocó to issue live birth certificates. However, there persists a tension: intercultural language at the policy level coexists with the absence of any concrete intercultural health system, as CONPES itself acknowledges when noting the *“limited coordination between the institutional response and the organisational processes of ethnic, peasant and territorial groups”* (D-GOV13), whose own care practices remain unrecognised by the State.

5.4.2 Meso

This was the second most coded subcategory overall, reflecting active efforts by international cooperation, academia, and institutions to generate genuine knowledge exchange and the hybridisation of traditional-midwifery practices. Departmental Plans for Chocó demonstrate a dialogue and exchange of knowledge between health teams and communities. Similarly, international cooperation projects such as Partera Vital sought to generate intercultural training processes that combined ancestral and conventional knowledge. Furthermore, the guidelines for the ethnic differential approach include protocols for respectful engagement in intercultural contexts. International cooperation has worked collaboratively with traditional-midwives' associations, functioning as bridges, supplying tools adapted to context, for example, *“community blood pressure monitors that no longer worked with numbers but with colours. Yes, for those who could not read or write”* (I-IC1). They have enabled international exchanges that expose Colombian practitioners to functioning intercultural models, as one government professional recalled after visiting a dual model in Ecuador where spaces for Western and traditional birthing practices coexist (I-GOV2). However, barriers remain; health education carries little intercultural content, and dialogue is often asymmetrical, expecting traditional-midwives to adapt to the health system rather than the reverse. Also, even though international cooperation programs have been sensitive to intercultural processes, sometimes, as one interviewee commented (I-MIDI), projects are written behind closed doors and don't address the needs and assessments of the communities. In fact, one midwifery association, after feeling they had to implement a project that didn't meet their needs, created a research committee to evaluate all projects before accepting them, and expressed concern for a “midwifery house”

built between international cooperation and government that they not feel is a representation of their practices (*I-MID2*).

5.4.3 Micro

Hybridisation processes are most visible in this category, led by traditional-midwives in Chocó. It is they who have, to the greatest extent, adopted a hybrid approach by incorporating conventional medical approaches, such as the use of gloves or blood pressure monitors, while retaining traditional practices such as medicinal plants for pain relief (*D-GOV3*; *D-GOV2*). However, this hybrid approach is fragile in the sense that it depends largely on the traditional-midwives themselves integrating conventional-medical methods, but there is no real institutional support to provide a solid foundation at the community level for effective intercultural integration. Furthermore, while midwifery associations have generated interesting hybrid processes, it is crucial to note that their reach is not uniform across all municipalities. This has prompted organic responses at the local level, for example, one interviewee mentioned the formation of smaller traditional-midwife group (The Quilombo group) in municipalities where larger associations were not fully present.

5.5 Care labour

This category exposes a contradiction between the recognition of traditional-midwifery as a vital role to sustaining life in Chocó's remote areas, and the continued lack of visibility, pay, support or protection by formal health structures.

5.5.1 Macro

As traditional-midwives are not officially recognised or integrated as healthcare providers, their work is not recognised as labour deserving compensation or protection. The T-128 judgement offers the clearest illustration of this, proving that during COVID-19 pandemic, the MHSP excluded traditional-midwives from vaccine priority, protective equipment, training and financial compensation afforded to other health staff, despite their continued provision of care in their communities (*D-GOV6*). The Constitutional Court ruled this a violation of their fundamental rights and ordered the MHSP to include traditional-midwives in the vaccine plan, provide compensation, and launch a targeted information campaign. In parallel, the CONPES mentions a language of care and commits to protecting ethnic care practices and guaranteeing “the rights of caregivers to improve their quality of life and conditions in which they provide care” (*D-GOV13*), framing care work as a key pillar of society. However, several sources

highlight that they currently continue to be largely unprotected, and the biggest gap lies in implementation of the legal frameworks, for example, if something goes wrong at work, they can be penalised. One interviewee highlighted that:

In Colombia, home births are not regulated. What does that mean? You can have your baby at home? Yes, but if there's a risk, you can go to jail. And one of the things happening with midwifery in Colombia today is that it lacks legal protection (I-MIDI).

5.5.2 Meso

This category exposes that policy disconnects recognition from the decent work conditions that dignifies traditional-midwifery practices. Government institutions propose capacity-building, organisational support, training, and even the provision of food, housing and resources (D-GOV7; D-GOV10), but stop short of financial compensation or protection. As D-GOV3 notes, necessary conditions include “adequate workspaces and resources, but also include community recognition and support, backing from the medical community, participation in training programs”. For this reason, the institutional consequences of non-recognition are concrete. For instance, one traditional-midwife was replaced by a nursing assistant because she could not produce a written report (I-MIDI). On the other hand, international cooperation has played an important role in providing resources such as medical equipment to strengthen midwifery practice, but these are temporary and insufficient.

5.5.3 Micro

Everyday practice reveals the sharpest contradictions faced by traditional-midwives in Chocó, beyond any declarations of recognition or intentions of integration that may exist at a macro level. Behind the non-payment of traditional-midwives lies a perception of this work as rooted in solidarity and community, and therefore not necessarily requiring payment, as Resolution 1077 states:

a large part of the community does not have stable sources to guarantee their economic sustenance, because the practice of midwifery is not for profit, since it is a community work and in it is above all present the spirit of solidarity (D-GOV3).

However, this lack of payment exacerbates precarious living conditions in a context where most do not make a living from midwifery but survive through other activities such as fishing and mining, as one interviewee noted:

“most traditional midwives die impoverished. That also needs to be said. How come they don't have a steady source of income? For example, none of the women here work. They live hand to mouth, fishing, and rice farming” (I-MID1).

Remoteness and armed conflict amplify the risks they absorb; during COVID-19, many kept working without protection, proving that midwives often fill gaps the State cannot:

There are distances of 8 or 9 hours, and the system, in the conditions in which you find yourself, makes it very difficult to have a professional at every point. So, it is they [traditional-midwives] who provide first aid, who identify risks” (I-GOV1).

In this context, midwives' associations remain the most consistent force, linking practitioners to aid organizations and government, legitimising traditional knowledge, and sustaining generational continuity while advocating for recognition that dignifies their work.

5.6 Structural inequalities

This category emerged during coding and, although not subdivided by level, intersects with every finding above. Rather than introducing new evidence, it names the intersecting conditions that determine the role of traditional-midwifery in Chocó.

These inequalities can be divided into four main aspects that converge with one another:

1. Structural and institutional racism. This is the most recurrent finding and underlines the gap between policy and practice already traced in the ecology of knowledges categories. Also, traditional-midwives in Chocó face a triple burden of inequalities: they are Black or Indigenous women historically discriminated against; women in a patriarchal society; and rural workers whose livelihoods combine farming and fishing. Institutional racism manifests as non-recognition, and the knowledge hierarchy between conventional-medicine and traditional knowledge.

2. Armed conflict and territorial control. Documents and interviews consistently situate traditional-midwifery in Chocó within a humanitarian crisis in which armed conflict restricts movement and exposes traditional-midwives to violence. Midwives have articulated an explicit stance of resistance: *“Our children were not born for war and that, as an act of resistance, we will not give birth anymore in the context of armed conflict” (I-MID2).* In a complex context of conflict, and as mentioned earlier, traditional-midwives perform a crucial role in providing care before, during and after childbirth, but their care goes beyond that, as they act as

“guardians” of the territories they inhabit and as social leaders, as one of the midwives mentioned: *“We are caretakers of a territory” (I-MID2).*

3. *Poverty and lack of basic services.* Many traditional-midwives survive in precarious conditions, practicing *“in very extreme conditions of vulnerability, being emotionally and economically disadvantaged” (I-IC1).* For this reason, MM is not merely a health issue but is embedded in social determinants such as limitations in education, public services, decent housing and employment. As mentioned by one of the interviewees explaining some of the situations that midwives and women can experienced in Chocó:

every time the river rises, I must leave my house... how am I going to feed myself? I don't have food rations, I don't have public services, so where do I go to the toilet? I drink water from the same river that I use to feed myself. If there is armed conflict, then I must move...” (I-IC2).

4. *Geographic dispersion:* Much of Chocó lies far from urban centres, limiting service provision and the support traditional-midwives can receive. Poor roads, limited electricity and inadequate sanitation shift disproportionate burdens onto midwives and mothers, who travel long distances to reach care:

there are places where if you don't go by some means, you die. Because there is no other way... they are roads, and they are not wide roads, they're bridle paths, because some people have their mule and can bring things, because if you don't have a motorbike, you can't get to a health centre” (I-GOV2).

Dispersion also drives out-migration of local talent to larger cities, deepening the departmental skills gap.

Read together, these four dimensions explain why the recognition advanced at the macro level, and the dignity claims raised at the meso and micro levels continue to fall short in practice. Structural inequality is the terrain on which every other tension in this study is contested.

6. DISCUSSION

This study has examined how traditional-midwives in Chocó have been recognised and integrated into the Colombian health system between 2017 and 2025, considering their influence in maternal health and development efforts to reduce MMR worldwide by 2030 as part of the SDGs. The findings reveal that recognition and integration are not linear processes, but tensions navigated across three interconnected levels. At the macro level, national and departmental policies and legal frameworks have produced symbolic recognition without ensuring real integration, leaving traditional-midwives in a normative limbo where their knowledge is acknowledged in discourse but excluded from formal processes. At the meso level, the implementation of these policies and of international cooperation programmes have had good intentions, however this coexists with academic disconnection, and the absence of dignified labour conditions. At the micro level, the contributions and experiences of traditional-midwives expose a gap between community recognition and institutional ambivalence. However, traditional-midwives are perceived overall as active agents engaged in creating change through daily practices and associations. These levels show that recognition without structural transformation risks reproducing the epistemic and material exclusions it claims to overcome.

6.1 Macro Level: Contribution of national and departmental policies and legal frameworks to the recognition and integration of traditional-midwives into the health system in Chocó

While national and departmental bodies agree on the importance of recognising and integrating traditional-midwives into the health system, few policies implement this. This lack of implementation aligns with claims presented in previous literature that despite awareness of the importance of traditional-midwifery, conventional-medical models continue to be considered the only legitimate form of medicine and thus dominate healthcare spaces and policies (Ashley et al, 2022; Rodríguez Hernández et al, 2023). Notably, integration, intercultural translation and care labour were coded less frequently than recognition and ecology of knowledge, suggesting greater institutional willingness to broadly acknowledge traditional-midwives than to implement structural change. PDT highlights how the Western-centred development discourse shapes actions and policies (Escobar, 2012), which in this case manifests as a lack of policies oriented towards traditional-midwives. Additionally, this theoretical approach provides a lens to understand why current efforts are falling short,

highlighting that change cannot be achieved within an intact discourse (Ziai, 2021) that privileges conventional-medicine. Similarly, Burman (2017) and Escobar (2012) allow us to expand on the factors inhibiting foundational change, suggesting that traditional-midwifery may still be considered a cultural practice or romanticised ideal, and thus Ministries can engage with them, without implementing concrete change.

Despite recent efforts to ensure the rights of traditional-midwives are respected, the lack of official recognition and integration renders them invisible, legally unprotected, and unremunerated, aligning with previous research (Moreno-Potes et al, 2024). SRT explains this, highlighting that while care labour is crucial, it remains invisible and unappreciated (Federici, 2019). In the case of traditional-midwives in Chocó, this has several consequences concerning their working conditions, becoming particularly apparent during the pandemic. Lugones's (2008; 2010) statement that feminised knowledge is not truly valued also helps unpack why despite apparent recognition of the importance of traditional-midwives, there appears to be a lack of true appreciation of their work and knowledges, reflected in the absence of policies and action.

Structural racism maintains the discrimination and exclusion of traditional-midwives' knowledges from the health system. Rodríguez Hernández et al (2023) speaks to this point, stating that structural racism maintains and normalises this exclusion and invisibility of traditional-midwives, manifesting in this case in various forms of exclusion, including the lack of policies to integrate and recognise them. Santos (2007; 2016) and Burman (2012; 2017) provide an explanation for this; the knowledges and realities of previously colonised countries continue to be systematically delegitimized and repressed, displayed in this case in the lack of structural change to truly legitimise and value the work and knowledge of traditional-midwives or engage in hybrid approaches with them. While Bhabha (2004) would argue that all cultures are hybrids, the one-sided engagement in hybridisation in Chocó suggests that this is occurring extremely unevenly.

6.2 Meso Level: The role of policy implementation, international cooperation and academia programs that facilitated or hindered the recognition and integration of traditional-midwives in Chocó

The meso level reveals how the implementation of policies and cooperation programs in Chocó facilitated integration and recognition, integrating the tensions between macro-level intentions and micro-level realities. Two intertwined dynamics emerge: institutional and academic disconnection, which primarily hinders integration, and international cooperation, which both facilitates and constrains it.

6.2.1 Institutional “expertise” and academia disconnection

National and departmental governments demonstrate good intentions regarding the recognition and integration of traditional-midwives, promoting dialogues, communication campaigns, and greater visibility as legitimate healthcare providers. The Chocó Departmental Plans, for instance, promote knowledge exchanges. However, these intentions lack clear pathways for implementation, perpetuating institutional racism.

Although the government recognizes the importance of traditional-midwives, they are excluded from the “Human Talent in Health” policy, leaving them in a “limbo” between recognition and real integration. This exclusion of the Human Talent National Register may generate what Santos (2016) call the “epistemicide” of certain knowledge, since their treatment reflects a power dynamic where “the only valid understanding of the world is the Western understanding of the world” (Santos, 2018, p.6). Additionally, rather than adjusting to receive traditional-midwives, the health system forces them into pre-existing structures, causing a professionalization without consideration of their knowledge that only simulates inclusion. As Suárez-Baquero and Champion (2022, p.304) warn, “the medicalization of Traditional Partería is a cultural genocide that must be avoided.”

Added to this is the lack of guarantees for dignified labor; institutions propose capacity-building but not financial compensation. From a social reproduction perspective, Federici (2019) notes that relegating reproductive work to “private”, “personal”, and “feminine” spheres makes it invisible as work and naturalizes its exploitation, positioning traditional-midwifery as a solidarity labor performed out of goodwill. This recognition gap also implicates the education system. University curricula remain rigid and lack intercultural approaches, generating limited empathy toward territories like Chocó. As such, Santos approach appears to be needed, enabling genuine knowledge exchange without oppressive hierarchies and epistemicide (2016).

6.2.2 International Cooperation

International cooperation programs have been crucial in making traditional-midwifery practices visible. Organizations as UNFPA, International Organization for Migration (IOM), International Labour Organization (ILO), and Pan American Health Organization (PAHO) have acted as bridges between governments and traditional-midwives, promoting what Santos calls “intercultural translation” identifying “differences and similarities, and developing, whenever appropriate, new hybrid forms of cultural understanding and intercommunication” (2016, p. 212). International cooperation programs such as Partera Vital project link ancestral knowledges with health services, government institutions and midwifery associations, producing an example of what Escobar (2012) calls hybridism through the merging of knowledge systems. As Buckner et al, (2022) suggest, intercultural knowledge succeeds through collaboration, co-designing and sharing evaluating processes.

Nevertheless, international cooperation also reproduces what Escobar (2012, p.46) describes as the “landing of experts” and the “institutionalization of development”. Some agencies, drawing on “Western” frameworks, design projects with concepts foreign to community realities, reinforcing dynamics in which “right” knowledge comes from the North. The midwifery house in Quibdó illustrates this tension: while governments and cooperation agencies celebrate it as progress, for some traditional-midwives it does not reflect their essence or dignify their work.

Strategies such as twinning offer promising alternatives. Exchanges between healthcare professionals in Colombia and Ecuador, for instance, have generated diverse perspectives on integrating traditional-midwifery with conventional-medicine. As Fjellström et al (2025) argue, twinning fosters knowledge exchange, and ensures traditional-midwives are present where decisions are made.

6.3 Micro Level: Perceptions of the experiences and contributions of traditional-midwives in Chocó towards integration and recognition by local, national and international actors

At the micro level, all actors perceive traditional-midwives in Chocó as facing a range of structural challenges that create precarious working conditions. However, they are also perceived as resilient and trusted health agents and social leaders in their community, and active change makers. As Alarcón-Nivia et al (2011) note, Colombia has prioritized hospital

infrastructure over strengthening traditional-midwives knowledge, leaving them to carry the burden of care with limited institutional support. Examining the micro level, therefore, reveals how recognition is constructed from below, through community trust, hybrid knowledge practices, and leadership in contexts of violence (Escobar, 2012; Bhabha, 2004), exposing the gap between how communities and institutions value midwives' contributions, and how agency of midwives confronts structural inequalities and a frequent triple burden.

6.3.1 Recognition, trust, hybridism and midwifery associations

From the community perspective, recognition stems from trust. As Gabrysch et al (2009) note, respect and trust in traditional-midwives' knowledge is the key element generating recognition and integration. Women choose midwives not only in the absence of hospitals, but also for the proximity and intercultural ties they share. This trust has transformed traditional-midwives into social leaders, particularly in geographically distant contexts where they have often been the only support available. Moreno-Potes et al (2024) describe Afro-descendant midwifery as a political act that sustains Pacific communities' resistance across generations, engaging in what PDT identifies as everyday forms of resistance (Dunlap and Tornel, 2025). Midwifery associations have reinforced this trust by advocating fair pay and dignified recognition, challenging a Western and colonial system that does not materially value their work (Federici, 2019).

Moreover, these associations have built genuine intercultural approaches, bridging midwives in hard-to-reach areas with governments and international cooperation organizations. As Santos (2018) argues, intercultural translation works as practical hybridization identifying similarities across cultures to strengthen them. Associations enact this by combining traditional knowledge as plant-based medicines with Western tools to prevent risks before, during and after birth, although such alternatives progress slowly and unevenly across regions (Escobar, 2012).

This engagement in hybridity can be perceived as a form of resistance against what Burman (2017) calls the “coloniality of knowledge”, which relegates traditional practices to folklore rather than valuing them alongside Western expertise. Read through Bhabha's lens, it blurs the boundaries between traditional and conventional knowledge, and the “in-between” emerges as resistance to dominant power. Similarly, Burman (2017) allows us to recognise how traditional-midwives' resistance creates a context of overlapping realities within which they

practice. In doing so, they advance the pluriversality Santos (2018, p.8) envisions: "a kind of thinking that promotes decolonization ... through intercultural translation".

Additionally, as the PDT mentions (Escobar, 2012), it is crucial to avoid romanticizing traditional-midwifery associations and practices, understanding that these populations are not “perfect” in their approaches but are also subject to biases imperfections and real tensions that may arise in the territories. Finally, despite their achievements, associations and traditional-midwives continue to exist in the absence of a clear path toward systemic integration leaving them facing constant discrimination in daily practice, where genuine intercultural respect remains lacking (Buckner et al, 2022).

Facing power imbalances in knowledge, traditional-midwives have done remarkable work incorporating Western medicine into their traditional practice, demonstrating that alternative development does not reject modernization (Dunlap and Tornel, 2025). Here intercultural translation and hybridity gain considerable strength. As Barroso and Paiva (2019) argue, hybridity is not a sense of completeness but a constant reformulation of identity through assimilation and differentiation with the “other”.

6.3.2 Social reproduction, care and peace agents

Federici (2019) allows us to clarify how traditional-midwives' work forms part of life-sustaining care, that, despite preventing MM in remote areas, remains invisible to markets and institutions and goes largely unremunerated. From decolonial feminism, is useful to understand how these caregiving tasks are assigned mostly to women in such complex contexts (Lugones, 2008). Traditional-midwives describe themselves as "guardians of the territory," echoing Federici's (2019, xvi) "weavers of memory" women who actively protect the territories where they work and embody traditional-midwifery practice (Suárez-Baquero and Champion, 2022). Practicing in precarious contexts, Chocó's midwives are also peace agents and social leaders whose work extends beyond birth attendance to accompanying communities on sexual and reproductive health deepening trust and empowering them as knowledgeable women (Angola Valencia and Cano Molina, 2023).

7. CONCLUSION

This thesis has explored how traditional-midwives in Chocó have been recognised and integrated into Colombia's health system, and how this process has been shaped by national and departmental policies, international cooperation, academia, and community-level actions. As Colombia continues to face maternal mortality rates above the SDG 3 target, disproportionately affecting departments such as Chocó, the role of traditional-midwives has gained increasing attention. A clear pattern arose from this research: while national and departmental bodies agree on the importance of recognising traditional-midwives' practices and knowledges, this recognition is mainly symbolic, with the hegemony of conventional-medicine firmly in place. As a result, there is a notable absence of policies and strategies aimed at genuine integration, leaving traditional-midwives unprotected and unremunerated. Similarly, although international cooperation has made significant, if at times misguided or unsustainable, efforts to support integration, these have not always been successfully implemented, and academia continues to fall short of generating true intercultural exchange.

Meanwhile, traditional-midwives, their associations, and the communities they serve play a significant role in advancing their own recognition, despite facing discrimination, lack of protection, and resource-poor conditions. While their power to drive integration is limited by the absence of change at the institutional level, their continued practice, advocacy, and selective incorporation of conventional-medical techniques remain a powerful force for recognition. Crucially, these dynamics unfold within broader structures of inequality and institutional racism, which shape every level of the system and context. The findings thus demonstrate the persistence of epistemic exclusion and of dominant discourses around "quality" maternal healthcare, which marginalise this crucial form of reproductive care labour and inhibit the hybridisation of the Colombian health system.

Future research may wish to explore the causal effects of recognition and integration on maternal mortality in the region. Greater participation of traditional-midwives in future studies would also be valuable, helping to capture their experiences of shifting policies, laws, and international strategies, particularly given concerns that such changes may impose conventional medical structures upon them.

8. References

- Alarcón-Nivia, M.Á., Sepúlveda-Agudelo, J., and Alarcón-Amaya, I.C. (2011). Las parteras, patrimonio de la humanidad [Midwives, part of the human race's cultural heritage]. *Revista Colombiana de Obstetricia y Ginecología*, 62(2), pp.188-195.
- Álvarez-Gayou, J.L. (2003). Introduction to qualitative research. In: *How to conduct qualitative research: foundations and methodology*. Mexico City: Paidós, pp. 13–38.
- Angola Valencia, M. and Cano Molina, P.A. (2023). Parteras tradicionales afrodescendientes del Pacífico colombiano y su aporte a la construcción de paz [Traditional midwives of African descent from the Colombian Pacific and their contribution to peacebuilding], *Análisis*, 55(102), doi: 10.15332/21459169.7682.
- Araújo, F.H., Ardila, M.A., Gutiérrez, E., Herrera, D., Díez, G., Montes, L.M. (2018). ODS en Colombia Los Retos para 2030 [The SDGs in Colombia: Challenges for 2030]. Available at: <https://www.undp.org/es/colombia/publications/ods-en-colombia-los-retos-para-2030> (Accessed: 26 February 2026).
- Argüello Avendaño, H.E. and Mateo González, A. (2014). Parteras tradicionales y parto medicalizado, ¿un conflicto del pasado? Evolución del discurso de los organismos internacionales en los últimos veinte años [Traditional midwives and medicalised childbirth: a conflict of the past? The evolution of the discourse of international organisations over the last twenty years]. *Revista LiminaR. Estudios Sociales y Humanísticos*, 12(2), pp. 13-29.
- Ashley, R., Goodarzi, B., Horn, A., de Klerk, H., Ku, S.E., Marcus, J.K., Mayra, K., Mohamied, F., Nayiga, H., Sharma, P., Udho, S., Vijber, M.R., and van der Waal, R. (2022). A call for critical midwifery studies: Confronting systemic injustice in sexual, reproductive, maternal, and newborn care. *Birth (Berkeley, Calif.)*, 49(3), p.355. doi:10.1111/birt.12661.
- Barroso, I.C. and Paiva, A.C.S. (2019). Parteiras tradicionais da Amazônia amapaense: capacitação, incorporação de saber e resistência cultural [Traditional midwives in the Amazon region of Amapá: training, the incorporation of knowledge, and cultural resistance]. *Revista de Ciências Sociais*, 50(1), pp. 313–361.
- Bello-Álvarez, L.M., and Parada-Baños, A.J. (2017). Characterisation of maternal mortality in Colombian indigenous communities, 2011 to 2013. Study of cases based on sentinel surveillance. *Revista Colombiana de Obstetricia y Ginecología*, 68(4), p.256. doi:10.18597/rcog.2925.
- Bhabha, H.K. (2004). *The location of culture*. London: Routledge.

- Bhambra, G. K. (2014). Postcolonial and Decolonial Dialogues. *Postcolonial Studies*, 2,115. doi: 10.1080/13688790.2014.966414.
- Bhattacharjee, A. (2019). *Social Science Research: Principles, Methods and Practices*. Tampa, Fla. A. Bhattacharjee.
- Bowen, G.A. (2009). Document Analysis as a Qualitative Research Method. *Qualitative Research Journal*, 9(2), pp. 27–40.
- Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), pp. 77–101.
- Buckner, M., Montaña, M. and Vanegas, I. (2022). Integrating Traditional Midwives into the State Health System: A Critical Case Study from Chiapas, Mexico. *Medical Anthropology*, 41(8), pp. 824–838. doi: 10.1080/01459740.2022.2113395.
- Burman, A. (2012). Places to Think With, Books to Think About. Words, Experience and the Decolonization of Knowledge in the Bolivian Andes. *Human Architecture: Journal of the Sociology of Self-Knowledge*, 10(1), pp.101-120.
- Burman, A. (2017). The political ontology of climate change. Moral Meteorology, Climate Justice, and the Coloniality of Reality in the Bolivian Andes. *Journal of Political Ecology*, 24(1), pp. 921-938. doi: 10.2458/v24i1.20974.
- Calderon Gonzalez, J. C., Ospina Bohorquez, M. F., and Ramirez Hernandez, C. A. (n.d.). In-depth analysis of ethnic births in Colombia. A case study of indigenous populations in the Chocó department. Converge. Connecting Vital Events Registration and Gender Equality. DANE, UNFPA, Centre of Excellence for CRVS Systems. Available at: https://colombia.unfpa.org/sites/default/files/pub-pdf/articulo_dane_unfpa_eevv_en.pdf (Accessed: 26 February 2026).
- Calderón, C.R., Ascanio-Noreña, C., Castrillón-Arias, G.P., and Zarama-Alvarado, S. (2024). Interseccionalidad, resistencia y resiliencia de mujeres afro en búsqueda de una paz que aún no llega, caso de los municipios de Istmina y Condoto (Chocó, Colombia) [Intersectionality, resistance and resilience among Afro-Colombian women in the quest for a peace that has yet to arrive: the case of the municipalities of Istmina and Condoto]. *Territorios*, 51(Especial).
- Camfield, L. (2019). Methodologies in Development Studies: An Overview. In: *Building development studies for the new millennium*. EADI Global Development Series. Cham: Palgrave Macmillan, pp. 243–262.

- Castañeda-Orjuela, C., Hilarion Gaitan, L., Diaz- Jimenez, D., Cotes- Cantillo, K., and Garfield, R. (2023). Maternal mortality in Colombia during the COVID- 19 pandemic: time series and social inequities. *BMJ Open*; 13:e064960. doi:10.1136/ bmjopen-2022-064960.
- Colombia. Presidency of the Republic of Colombia (2017). Decreto 356. *Bogotá, D.C.* Por el cual se modifica la Sección 3 del Capítulo 12 del Título 6 de la Parte 2 del Libro 2 del Decreto 1069 de 2015, Decreto Único Reglamentario del Sector Justicia y del Derecho [Amending Section 3 of Chapter 12 of Title 6 of Part 2 of Book 2 of Decree 1069 of 2015, the Single Regulatory Decree for the Justice and Legal Sector]. Available at: https://www.funcionpublica.gov.co/eva/gestornormativo/norma_pdf.php?i=79927 (Accessed: 14 February 2026).
- Consejo Nacional de Política Económica y Social (2025). CONPES 4143. *Política Nacional de Cuidado, Bogotá D.C.* Available at: <https://colaboracion.dnp.gov.co/CDT/Conpes/Econ%C3%B3micos/4143.pdf>. (Accessed: 14 February 2026).
- Cornish, F., Gillespie, A. and Zittoun, T. (2014). Collaborative Analysis of Qualitative Data. In: Flick, U. (ed.) *The SAGE Handbook of Qualitative Data Analysis*. London: SAGE Publications Ltd, pp. 79–93.
- Corte Constitucional de Colombia (1991). Constitución Política de Colombia de 1991 [Political Constitution of Colombia of 1991]. *Primera edición 2023, Bogotá, Colombia*. Available at: <https://www.refworld.org/es/leg/legis/pleg/1991/es/126622>. (Accessed: 14 February 2026).
- Corte Constitucional de Colombia (2022). Sentencia T-128. *Bogotá, D. C. Referencia: Expediente T-8.291.835*. Available at: <https://www.corteconstitucional.gov.co/relatoria/2022/t-128-22.htm>. (Accessed: 14 February 2026).
- Cresswell, J.A., Alexander, M., Chong, M.Y.C., Link, H.M., Pejchinovska, M., Gazeley, U., Ahmed, S.M.A., Chou, D., Moller, A.B., Simpson, D., Alkema, L., Villanueva, G., Sguassero, Y., Tunçalp, Ö., Long, Q., Xiao, S., and Say, L. (2025). Global and regional causes of maternal deaths 2009-20: a WHO systematic analysis. *The Lancet. Global health*, 13(4), e626–e634. doi: 10.1016/S2214-109X(24)00560-6.
- Creswell, J.W. (2014). *Research design: qualitative, quantitative, and mixed methods approaches*. 4th edn. Los Angeles: SAGE.
- Cuestas, J. (2023). *Mortalidad materna en Colombia: un estudio ecológico con enfoque de determinantes sociales en salud [Maternal mortality in Colombia: an ecological study*

focusing on the social determinants of health]. Repositorio Seneca. Available at: <http://hdl.handle.net/1992/68415> (Accessed: 31 March 2026).

DANE (2025a). Estadísticas Vitales, Septiembre de 2025 [Vital Statistics, September 2025]. Microsoft Power BI. Available at: <https://app.powerbi.com/view?r=eyJrIjojMDQxMzM4MDItNzI5Ny00MmYzLWFIMzctNDU3MmZlODVjM2ZhIiwidCI6IjBkMWRIMzRkLWFmNDktNGJmNS1iOGVILTNIjM2M0NGNINzk0MiIsImMiOiR9> (Accessed: 26 February 2026).

DANE (2025b). Estadísticas Vitales, Tablero De Indicadores [Vital Statistics, Dashboard]. Microsoft Power BI. Available at: <https://app.powerbi.com/view?r=eyJrIjojYWVhNmM2ZDIhNTg1MC00YjRmLWE1OTYtNjg3NmRmOGM4MTFmIiwidCI6IjBkMWRIMzRkLWFmNDktNGJmNS1iOGVILTNIjM2M0NGNINzk0MiIsImMiOiR9> (Accessed: 26 February 2026).

DANE (2025c). Pobreza Multidimensional en Colombia. Año 2024 Boletín Técnico [Multidimensional Poverty in Colombia. 2024 Technical Bulletin]. Bogotá D.C. Available at: <https://www.dane.gov.co/files/operaciones/PM/bol-PMultidimensional-2024.pdf> (Accessed: 26 February 2026).

DANE, Cooperación Española Colombia, and UNFPA (2023a). Partera Vital 3.0 - Comunidad Vital [Partera Vital 3.0 – Community Vital]. *Colombia Potencia de la Vida*. Available at: <https://colombia.unfpa.org/es/publications/partera-vital-3-comunidad-vital>. (Accessed: 26 February 2026).

DANE, Cooperación Española Colombia, and UNFPA (2023b). Partería Tradicional y su incorporación en las Estadísticas vitales de Colombia [Traditional Midwifery and its incorporation into the Vital Statistics of Colombia]. Accessed at: <https://www.dane.gov.co/files/investigaciones/notas-estadisticas/06022023-NotaEstadistica-ParteraTradi-EVColombia.pdf>. (Accessed: 26 February 2026).

DANE, Cooperación Española Colombia, and UNFPA (2024). Partera Vital: Comunidad Vital inicia su fase tres en el Pacífico colombiano [Partera Vital: Community Vital begins its phase three in the Colombian Pacific]. *Colombia Potencia de la Vida*. Bogotá D.C. Available at: a. <https://www.dane.gov.co/files/investigaciones/enfoque-diferencial/poblacion-negra-afro-raizal-palen/cp-parteraVitalPacificoColombiano.pdf>. (Accessed: 26 February 2026).

David, S., Bradfield, Z., Hauck, Y. and Kelly, M.A. (2025). Traditional birth attendant training programs in low resource countries: an integrative literature review. *Midwifery*, 148, 104532.

- Davis-Floyd, R. and Cheyney, M. (2009). Birth and the Big Bad Wolf: An Evolutionary Perspective. In: Selin, H., and Stone, P.K. *Childbirth Across Cultures. Ideas and Practices of Pregnancy, Childbirth and the Postpartum*. Springer.
- Davis-Floyd, R., Daviss, B.A. and Ali, I. (2025). Conclusions to Traditional Midwives: Cross-Cultural Perspectives. In: Davis-Floyd, R., Daviss, B.A. and Ali, I. (eds) *Traditional Midwives: Cross-Cultural Perspectives*. New York: Routledge, pp. 425–457.
- Dunlap, A. and Tornel, C. (2025). Was postdevelopment too much? Autonomous struggle, academic coloniality and the radical roots of the pluriverse. *Globalizations*, 22(2), pp. 221–244. doi: 10.1080/14747731.2024.2349317.
- El Congreso de Colombia (2022). Ley 2244. *Bogotá, D. C.* Por medio de la cual se reconocen los derechos de la mujer en embarazo, trabajo parto, parto y posparto y se dictan otras disposiciones o "ley de parto digno, respetado y humanizado [Which recognises the rights of women during pregnancy, labour, childbirth and the postnatal period, and enacts other provisions, or the 'law on dignified, respectful and humanised childbirth']. Available at: https://www.funcionpublica.gov.co/eva/gestornormativo/norma_pdf.php?i=189347. (Accessed: 26 February 2026).
- El Registrador Nacional del Estado Civil y El Director Del Departamento Administrativo Nacional De Estadística (2021). Resolución No. 3676. *Bogotá, D. C.* Por la cual se autoriza a las parteras y parteros de la Asociación de la Red Interétnica de Parteras y Parteros del departamento del Choco - ASOREDIPARCHOCO – a certificar los nacimientos que atiendan, utilizando los formatos de Notificación de Nacimiento para Personas Pertenecientes a Grupos Étnicos, expedidos por el DANE. [This authorises midwives belonging to the Association of the Inter-Ethnic Network of Midwives of the Department of Chocó (ASOREDIPARCHOCO) to certify the births they attend, using the Birth Notification forms for Persons Belonging to Ethnic Groups issued by DANE]. Available at: <https://www.suin-juriscol.gov.co/viewDocument.asp?id=30054657> (Accessed: 26 February 2026).
- Engelkes, P.E.M. (1990). Women and health in Chocó, Colombia. *Journal of tropical pediatrics*, 36(6), pp. 299-305. doi: 10.1093/tropej/36.6.299.
- Escobar, A. (1999). The Invention of Development. *Current History*, 98(631), pp. 382–386. doi: 10.2307/45318380.
- Escobar, A. (2012). *Encountering Development: The Making and Unmaking of the Third World*. Princeton, NJ: Princeton University Press.

- Escobar, A. (2017). *Designs for the Pluriverse: Radical Interdependence, Autonomy, and the Making of Worlds*. Duke University Press. <http://www.jstor.org/stable/j.ctv11smgs6>.
- Évora, M.A. (2025). Intersectionality and Birth in Latin America: A Research Protocol on Maternal Health of Indigenous and Afro-Descendant Women in La Guajira, Colombia. *Social Sciences*, 14(1), p. 15. doi:10.3390/socsci14010015.
- Federici, S. (1974). Wages against housework. In: *Revolution at Point Zero: Housework, Reproduction, and Feminist Struggle*. Oakland: PM Press, pp. 74–87.
- Federici, S. (2019). *Re-enchanting the World: Feminism and the Politics of the Commons*. Oakland: PM Press.
- Fjellström, H., Sandberg, E., Blomgren, J., Grahn, M., Hanson, F., Ackon, N., Baidoo, G., Nordström, L. and Bogren, M. (2025). A twinning initiative between midwife associations in Ghana and Sweden - A process evaluation study. *Global Health Action*, 18(1), doi.org/10.1080/16549716.2025.2457824.
- Flick, U. (ed.) (2014). *The SAGE Handbook of Qualitative Data Analysis*. London: SAGE
- Gabrysch, S., Lema, C., Bedriñana, E., Bautista, M.A., Malca, R., Campbell, O.M. and Miranda, J.J. (2009). Cultural adaptation of birthing services in rural Ayacucho, Peru. *Bulletin of the World Health Organization*, 87(9), 724.
- Gleason, E.G., López Ríos, J.M., Molina Berrío, D.P., and Mejía Merino, C. (2022). Multistakeholder perspectives on the mistreatment of indigenous women during childbirth in Colombia: drivers and points for intervention. *BMC Pregnancy and Childbirth*, 22(1), doi: 10.1186/s12884-022-04495-4.
- Gobernación Del Chocó (2020). Plan Departamental De Desarrollo, Chocó 2020-2023 [Departmental Development Plan, Chocó 2020–2023]. Available at: <https://www.choco.gov.co/planes/plan-de-desarrollo-departamental-2020-2023-generando> (Accessed: 25 February 2026).
- Gobernación Del Chocó (2024). Plan De Desarrollo 2024-2027. El Chocó en Ruta hacia el Progreso [Development Plan 2024-2027. Chocó on the Road to Progress]. *Gobernadora del Departamento del Chocó*. Available at: <https://www.choco.gov.co/planes/plan-de-desarrollo-departamento-del-choco-2024-2027> (Accessed: 25 February 2026).
- Graham, S. and Davis-Floyd, R. (2025). Traditional Birth Attendants and the Biomedical System among the Karamojong of Uganda: Introducing the Partnership Paradigm. In: Davis-Floyd, R., Daviss, B.A. and Ali, I. (eds) *Traditional Midwives: Cross-Cultural Perspectives*. New York: Routledge, pp. 220–247.

- Hammett, D, Twyman, C. and Graham, M (2015). *Research and fieldwork in development*. Abingdon: Routledge. doi: 10.4324/9780203649107.
- Hasan, M., Soares Magalhaes, R.J., Ahmed, S., Ahmed, S., Biswas, T., Fatima, Y., Islam, S. Hossain, S. and Mamun, A.A. (2020). Meeting the Global Target in Reproductive, Maternal, Newborn, and Child Health Care Services in Low- and Middle-Income Countries. *GLOBAL HEALTH-SCIENCE AND PRACTICE*, 8(4), 654-665. doi:10.9745/GHSP-D-20-00097.
- ILO (2024). Una mirada a las experiencias territoriales de cuidado comunitario en Colombia [A look at the territorial experiences of community care in Colombia]. *Primera edición. Oficina de la OIT para los Países Andinos Colombia Bogotá*. Available at: <https://www.ilo.org/es/publications/una-mirada-las-experiencias-territoriales-de-cuidado-comunitario-en>. (Accessed: 01 March 2026).
- Kihara, A.B., Oguttu, M., Gülmezoglu, A.M., Nieto-Calvache, A.J., Ubom, A.E., Evans, C., Ramasauskaite, D., Malel, Z.J., Schlembach, D., Nunes, I., Jacobsson, B., Beyeza-Kashesya, J., Begum, F., and Wright, A. (2025). Gender inequity in postpartum hemorrhage. *International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics*, 171(3), p. 965. doi:10.1002/ijgo.70526.
- Kuhnt, J., and Vollmer, S. (2017). Antenatal care services and its implications for vital and health outcomes of children: evidence from 193 surveys in 69 low-income and middle income countries. *BMJ Open*;. doi:10.1136/bmjopen-2017-017122
- Kvale, S. and Brinkmann, S. (2008). *InterViews: Learning the craft of qualitative research interviewing*. Sage.
- Laza Vásquez, C. (2012). An approach to the state of traditional midwifery in Colombia. *Index de Enfermería*, 21(1–2), pp. 53–57.
- Lugones, M. (2008). Colonialidad y género. [Colonialism and gender]. *Tabula Rasa*, (9), pp. 73–101. Available at: <https://www.revistatabularasa.org/numero-9/05lugones.pdf> (Accessed: 13 March 2026).
- Lugones, M. (2010). Toward a Decolonial Feminism. *Hypatia*, 25(4), pp. 742-759.
- Mantilla Uribe, B.P., Oviedo Cáceres, M.P., Hernández Quirama, A., and Flórez García, N.Z. (2013). Educación para la salud: una experiencia con población indígena del departamento de Chocó [Health education: an experience with the indigenous population of the department of Chocó]. *Hacia promoci. salud*; 18(2):96-109.

- Merriam, S.B., Johnson-Bailey, J., Lee, M.-Y., Kee, Y., Ntseane, G. and Muhamad, M. (2001). Power and positionality: negotiating insider/outsider status within and across cultures. *International Journal of Lifelong Education*, 20(5), pp. 405–416.
- Mezzadri, A., Rai, S.M., Stevano, S., Alessandrini, D., Bargawi, H., Elias, J., Hassim, S., Kesar, S., Lingham, J.T., Natile, S., Neetha, N., Ossome, L., Raghuram, P., Tsikata, D. and Wöhl, S. (2025). Pluralizing social reproduction approaches. *International Feminist Journal of Politics*, 27(1), pp. 6–33. doi: 10.1080/14616742.2024.2447594.
- Ministerio de Cultura (2017). Resolución 1077. *Bogotá, D. C.* Por la cual se incluye la manifestación “Saberes asociados a la partería afro del Pacífico” en la Lista Representativa de Patrimonio Cultural Inmaterial del ámbito nacional, y se aprueba su Plan Especial de Salvaguardia [By which the manifestation "Knowledge associated with Afro-Pacific midwifery" is included in the Representative List of Intangible Cultural Heritage at the national level, and its Special Safeguarding Plan is approved]. Available at: https://normograma.mincultura.gov.co/compilacion/docs/resolucion_mincultura_1077_2017.htm (Accessed: 14 February 2026).
- Ministerio de Cultura y La Asociación de Parteras Unidas del Pacífico (2017). Plan Especial de Salvaguardia de los Saberes Asociados a la Patería Afro Del Pacífico [Special Safeguarding Plan for Knowledge Associated with Afro-Pacific Midwifery]. Available at: <https://www.mincultura.gov.co/direcciones/patrimonio-y-memoria/Documents/20-parteria-afro-del-pacifico-PES.pdf#search=PLAN%20ESPECIAL%20DE%20SALVAGUARDIA%20DE%20LOS%20SABERES%20ASOCIADOS%20A%20LA%20PARTER%C3%8DA%20AFRO%20DEL%20PAC%C3%8DFICO>. (Accessed: 14 February 2026).
- Ministerio de Salud y Protección Social (2013). Resolución Número 1841. *Bogotá, D.C.* Available at: <https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/DIJ/resolucion-1841-de-2013.pdf> (Accessed: 14 February 2026).
- Ministerio de Salud y Protección Social (2022). Resolución Número 1035 de 2022 (14 de junio) Por el cual se adopta el Plan Decenal de Salud Pública 2022-2031 [Whereby the Ten Year Public Health Plan is adopted]. *Bogotá: MinSalud*. Available at: <https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/DIJ/resolucion-1035-de-2022.pdf> (Accessed: 14 February 2026).
- Ministerio de Salud y Protección Social (2023a). Lineamientos para la implementación del enfoque diferencial étnico en salud para comunidades Negras, Afrocolombianas, Raizales y

Palenqueras de áreas urbanas y rurales [Guidelines for the implementation of the ethnic differential approach in health for Black, Afro-Colombian, Raizal and Palenquera communities]. Bogotá D.C. Available at: <https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/PS/lineamiento-implementacion-enfoque-diferencial-etnico-salud-comunidades-negras-afrocolombianas.pdf> (Accessed: 14 February 2026).

Ministerio de Salud y Protección Social (2023b). Plan de aceleración para la reducción de la mortalidad materna. *Versión 5 Dirección de Promoción y Prevención – Grupo Salud Sexual y Reproductiva – Grupo Curso de Vida* [Acceleration Plan for Reducing Maternal Mortality]. Available at: <https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/PP/plan-reduccion-aceleracion-msps.pdf> (Accessed: 14 February 2026).

Ministerio de Salud y Protección Social (2023c). Resolución Número 2367. Por el cual se modifican artículos del Plan Decenal de Salud Pública. [Which modifies articles from the Ten Year Public Health Plan]. Available at: https://www2.minsalud.gov.co/Normatividad_Nuevo/Resoluci%C3%B3n%20No%202367%20de%202023.pdf (Accessed: 14 February 2026).

Moreno-Potes, J.F., Hurtado-Martínez, J.E., and Hineostroza-Cuesta, L. (2024). Regulación de la partería tradicional afrocolombiana del Pacífico: entre exclusión e inclusión [Regulation of traditional Afro-Colombian midwifery in the Pacific region: between exclusion and inclusion]. *Revista CES Derecho*. 15(2) pp. 49-68. doi: 10.21615/cesder.7664.

Mosquera-Córdoba, M. and Cuesta-Caicedo, Á.P. (2022). Factores biosociales asociados a la mortalidad materna en el departamento de Chocó 2013–2019. *Revista Investigaciones Andina*, 23(42). doi: 10.22517/25395203.24934.

Murrey, A. and Daley, P. (2023). Coloniality, Racial Logics and the Ethos of International Development. In: *Learning Disobedience: Decolonizing Development Studies*. London: Pluto Press, pp. 32–53.

Naderifar, M., Goli, H. and Ghaljaie, F. (2017). Snowball Sampling: A Purposeful Method of Sampling in Qualitative Research. *Strides in Development of Medical Education*, 14(3), e67670. doi: 10.5812/sdme.67670.

Olea-Ramirez, L.M., Leon-Larios, F. and Corrales-Gutierrez, I. (2024). Intervention Strategies to Reduce Maternal Mortality in the Context of the Sustainable Development Goals: A Scoping Review. *Women*, 4(4), pp. 387–405. doi: 10.3390/women4040030.

- Ombere, S.O. (2025). The Roles of Traditional Midwives during Healthcare Crises in Kenya: Experiences from the Giriama Community in Coastal Kenya. In: Davis-Floyd, R., Daviss, B.A. and Ali, I. (eds) *Traditional Midwives: Cross-Cultural Perspectives*. New York: Routledge, pp. 180–196.
- Oswald, K., Leach, M., and Gaventa, J. (2019). Chapter 6: Engaged excellence in development studies. In: Baud, I., Basile, E., Kontinen, T., von Itter, S., *Building development studies for the new millennium*. EADI Global Development Series. Palgrave Macmillan. ISBN: 978-3-030-04051-2 pp.119-139.
- Oviedo, M., Hernández, A., Mantilla, B.P., Arias, K.N., and Florez, N.Z. (2014). Comunidades Embera y Wounaan del departamento de Chocó: prácticas de cuidado durante el proceso de gestación. [The Embera and Wounaan communities in the department of Chocó: care practices during pregnancy] *Rev. Fac. Nac. Salud Pública*; 32(2): 17-25.
- Palmer, J., Fam, D., Smith, T., & Kilham, S. (2014). Ethics in Fieldwork: Reflections on the Unexpected. *The Qualitative Report*, 19(28), 1-13. doi:10.46743/2160-3715/2014.1136
- Preiser, R. Mancilla García, M., Hill, L., and Klein, L. (2021). Qualitative content analysis. In: Biggs, R. de Vos, A., Preiser, R., Clements, H., Maciejewski, K., and Schlüter, M. (eds.) *The Routledge handbook of research methods for social-ecological systems*. Abingdon: Routledge, pp. 270–281.
- Ramos Jaraba, S.M., Quiceno Toro, N., Ochoa Sierra, M., Ruiz Sánchez, L., García Jiménez, M.A., Salazar-Barrientos, M.Y., Bedoya Bedoya, E., Vélez Álvarez, G.A., Langer, A., Gausman, J. and Garcés-Palacio, I.C. (2020). Health in conflict and post-conflict settings: reproductive, maternal and child health in Colombia. *Conflict and Health*, 14(1), 1. doi: 10.1186/s13031-020-00273-1.
- Ricaurte-Cepeda, M., and Guerrero-Luna, Y.P. (2024). Salud materna de mujeres indígenas. Experiencias tradicionales e institucionales [Maternal health among indigenous women. Traditional and institutional experiences.]. *Rev. Fac. Nac. Salud Pública*; 42:353540 doi: 10.17533/udea.rfnsp.
- Rivillas, J.C., Devia-Rodriguez, R., and Ingabire, M.G. (2020). Measuring socioeconomic and health financing inequality in maternal mortality in Colombia: a mixed methods approach. *International Journal for Equity in Health*, 19(1), 1. doi: 10.1186/s12939-020-01219-y
- Rodríguez Garavito, C. (2009). Del Chocó al Chicó. *Dejusticia*. Available at: <https://www.dejusticia.org/del-choco-al-chico/> (Accessed: 4 May 2026).
- Rodríguez Hernández, J.M., Ariza Ruiz, L.K., Castro Barbudo, D., Vivas Sánchez, P., Matallana Gómez, M.A., Gómez Hernández, L.J., Romero Mendoza, L. and Chaparro Narváez, P.E.

- (2023). Analysis of Inequalities and Inequities in Maternal Mortality in Chocó, Colombia. *International Journal of Environmental Research and Public Health*, 20, 6095. doi: 10.3390/ijerph20126095.
- Rodriguez-Lopez, M., Botero Jaramillo, D., Prada, S., Merlo, J., and Leckie, G. (2025). Social and geographical inequalities in prenatal care coverage in Colombia: a multilevel analysis of individual heterogeneity and discriminatory accuracy (MAIHDA). *BMJ Glob Health*; 10:019608. doi:10.1136/bmjgh-2025-019608.
- Salazar Flórez, J.E., Arias-Castro, C.E., Montenegro Martínez, G., Castro Montoya, B.A., Quintero Zea, K., and Betancur Usma, D. (2025). Urban–rural disparities in maternal mortality between 2014 and 2021 in Colombia. *Rural and Remote Health*; 25: 9032. doi:10.22605/RRH9032.
- Sandwell, R., Bonser, D., Hebert, E., Kilroy, K., Leshabari, S., Mwanga, F., Mtawa, A., Wilson, A. and Moritz, A. (2018). Stronger together: midwifery twinning between Tanzania and Canada. *Globalization and Health*, 14, 123.
- Santos, B. de S. (2007). Beyond Abyssal Thinking: From Global Lines to Ecologies of Knowledges. *Review (Fernand Braudel Center)*, 30(1), pp. 45–89.
- Santos, B. de S. (2016). *Epistemologies of the South: Justice against Epistemicide*. Abingdon: Routledge.
- Santos, B. de S. (2018). Why the Epistemologies of the South? Artisanal Paths for Artisanal Futures. In: *The End of the Cognitive Empire: The Coming of Age of the Epistemologies of the South*. Durham, NC: Duke University Press, pp. 1–18.
- Sarmiento, I., Paredes-Solís, S., Dion, A., Silver, H., Vargas, E., Cruz, P., Pimentel, J., Zuluaga, G., Cockcroft, A. and Andersson, N. (2021). Maternal health and Indigenous traditional midwives in southern Mexico: contextualisation of a scoping review. *BMJ Open*, 11, p. e054542. doi: 10.1136/bmjopen-2021-054542.
- Skovdal, M., and Cornish, F. (2015). Chapter 1: Improving programme impact and accountability through qualitative research. In: *Qualitative research for development: a guide for practitioners. Practical Action (Organization)*. pp.1-30.
- Spronk, S. and Anderson, J.A. (2021). The Critical Political Economy of Development. In: Haslam, P.A., Schafer, J. and Beaudet, P., *Introduction to international development: Approaches, actors, issues, and practice*. 4th ed. Don Mills, Ontario: Oxford University Press, pp.61-76.
- Squires, A. (2009). Methodological challenges in cross-language qualitative research: A research review. *International Journal of Nursing Studies*, 46(2), pp. 277–287.

- Suárez-Baquero, D. F. M., and Champion, J. D. (2022). The Embodiment of Traditional Partería in the Colombian Pacific Region. *Qualitative Health Research*, 32(2), pp. 291 - 306. doi:10.1177/10497323211050908.
- Sultana, F. (2007). Reflexivity, Positionality and Participatory Ethics: Negotiating Fieldwork Dilemmas in International Research. *ACME: An International E-Journal for Critical Geographies*, 6(3), pp. 374–385.
- Tovar, L.F. (2022). Social reproduction, the popular economy and informality: Feminist reflections from Latin America. *Cuadernos de Economía*, 41(86), pp. 367–392. doi: 10.15446/cuad.econ.v41n86.88531.
- Tracy, S.J. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative Inquiry*, 16(10), pp. 837–851.
- UNESCO Intangible Cultural Heritage (n.d.). Midwifery: Knowledge, skills and practices. Inscribed in 2023 (18.COM) on the Representative List of the Intangible Cultural Heritage of Humanity. Available at: <https://ich.unesco.org/en/RL/midwifery-knowledge-skills-and-practices-01968>. (Accessed: 20 February 2026).
- United Nations Population Fund (UNFPA) (2021). The State of the World's Midwifery 2021: Building a health workforce to meet the needs of women, newborns and adolescents everywhere. New York: UNFPA. Available at: <https://www.unfpa.org/sowmy> (Accessed: 2 February 2026).
- United Nations Population Fund (UNFPA) (2024). Interwoven Lives, Threads of Hope. Ending inequalities in sexual and reproductive health and rights. Available at: <https://www.unfpa.org/swp2024>. (Accessed: 2 February 2026).
- United Nations Population Fund (UNFPA) (2026). One million more midwives, four million lives saved. Available at: <https://www.unfpa.org/news/one-million-more-midwives-four-million-lives-saved> (Accessed: 4 May 2026).
- United Nations Population Fund (UNFPA) and MinSalud (2014). Protocolos Para la Atención de Enfermería a la Salud Sexual y Reproductiva de la Mujer [Protocols for Nursing Care in Women's Sexual and Reproductive Health], Bogotá D.C. Available at: <https://colombia.unfpa.org/es/publications/protocolos-para-la-atenci%C3%B3n-de-enfermeria-la-salud-sexual-y-reproductiva-de-la-mujer> (Accessed: 01 March 2026).
- United Nations (2024). The 17 Goals. Available at: <https://sdgs.un.org/goals> (Accessed: 01 March 2026).

- Valencia, O., Montoya, J., López, M., and Damelines, J. (2025). Addressing nutritional inequities in vulnerable Colombian communities. *BMC Public Health*, 25(1), doi:10.1186/s12889-025-22694-4.
- Weston, C., Gandell, T., Beauchamp, J., McAlpine, L., Wiseman, C. and Beauchamp, C. (2001). Analyzing interview data: The development and evolution of a coding system. *Qualitative sociology* 24(3): pp.381-400.
- World Health Organization (WHO) (2020). Sexual, reproductive, maternal, newborn, child and adolescent health policy survey, 2018–2019: report. Geneva: World Health Organization. Available at: https://platform.who.int/docs/default-source/mca-documents/policy-documents/policy-survey-reports/srmncah-policysurvey2018-fullreport-pt-3.pdf?sfvrsn=3465d5a7_4 (Accessed: 11 Apr 2026).
- World Health Organization (WHO) (2022). *ICD-11 International Classification of Diseases for Mortality and Morbidity Statistics, Eleventh Revision, Reference Guide*. Available at: <https://icdcdn.who.int/icd11referenceguide/en/refguide.pdf>. (Accessed: 26 February 2026)
- World Health Organization (WHO), United Nations Children’s Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank Group and UNDESA/Population Division (2025). Trends in maternal mortality 2000 to 2023: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Available at: <https://iris.who.int/server/api/core/bitstreams/29f43a3d-2228-489c-b1e7-b2f28e9101ce/content>. (Accessed: 26 February 2026).
- World Population Review (2024). *Top 10 Countries with the Highest Gini Coefficients (%) – World Bank*. Available at: <https://worldpopulationreview.com/country-rankings/gini-coefficient-by-country>. (Accessed: 26 February 2026).
- Ziai, A., (2021). ‘Post Development and Alternatives to Development.’ In: Haslam, P.A., Schafer, J. and Beaudet, P., *Introduction to international development: Approaches, actors, issues, and practice*. 4th ed. Don Mills, Ontario: Oxford University Press, pp.77-93.

Annexes:

Annex 1. Interview guidelines

Interview Guideline – Government Actors

BASIC INFORMATION	
Date	
Time	
City	
Duration	
Participant Name	
Institution	

Introduction

Hello and welcome to this interview. My name is Lorena Bejarano, a current student from the International Development máster at Lund university in Sweden. The idea is for this to be a space for conversation of one or one and a half hours duration. This conversation is part of research for the master's degree that I am currently pursuing with my classmate Gabrielle Yapp. The aim of our research is to identify the impact that Public health policies and international cooperation programs focusing on traditional midwifery practices have on maternal health in Chocó. The idea is that we can gather information from different actors, including the government, international cooperation organizations, academia, and midwifery organizations. Your input is very useful in identifying the contribution and potential impact of these programs in reducing maternal mortality. Please, if you do not wish to answer any questions, that is perfectly fine. If you have any questions, I am more than happy to discuss them with you, and of course, once we have written the document, we will send you a copy so you can see the results.

Questions

1. Could you tell me a little about your role in this institution and what the objective or mandate of this department is?
2. From the government's perspective, and specifically from what you know in your role, what are the guidelines that define the work of preventing maternal mortality in Choco?
3. Of these guidelines, which do you consider to be the most challenging in the department and why?
4. What do you consider to be the determining factors that create difficulties when implementing these guidelines?
5. From the government's perspective, could you tell me a little about the intercultural public policies and documents that exist to incorporate ancestral practices, such as midwifery, into the prevention of maternal mortality?
6. What do you consider to be the successes of these guidelines, and how have you seen them incorporated in Choco? Do you have any specific examples?
7. What do you consider to be the areas for improvement in these guidelines? Why?
8. Please describe some ways in which you think these improvements could be made.

9. Are you aware of any international cooperation projects that have strengthened or supported the government's guidelines on the prevention of maternal mortality in the department through ancestral practices? What are they?
10. What stands out to you about these projects?
11. What do you think could be done better?
12. How would you describe the perception of midwives work in Choco?
13. If you could choose one thing to improve the international cooperation implementation with the intercultural public policies that already exist related to maternal mortality, what would it be?

Close

Thank you very much for your time and support. If you have any questions please feel free to ask now or contact me after.

Questions – Academia

1. Could you tell me a little about your role in this university and what the objective or mandate of this department is?
2. From an academic perspective, and specifically from what you know in your role, what are the guidelines that define the work of preventing maternal mortality in Choco?
3. Of these guidelines, which do you consider to be the most challenging in the department and why?
4. What do you consider to be the determining factors that create difficulties when implementing these guidelines?
5. From an academic perspective, could you tell me a little about the intercultural public policies and documents that exist to incorporate ancestral practices, such as midwifery, into the prevention of maternal mortality?
6. What do you consider to be the successes of these guidelines, and how have you seen them incorporated in Choco? Do you have any specific examples?
7. What do you consider to be the areas for improvement in these guidelines? Why?
8. Please describe some ways in which you think these improvements could be made.
9. Can you talk more about the international cooperation projects that you know have strengthened or supported the government's guidelines on the prevention of maternal mortality in the department through ancestral practices? What are they?
10. What stands out to you about these projects?
11. What do you think could be done better?
12. What is the impact of the international cooperation project in this area in Choco?
3. What is the impact of academia research in this area in Choco?
13. How would you describe the perception of midwives work in Choco?
14. If you could choose one thing to improve the international cooperation implementation with the intercultural public policies that already exist related to maternal mortality, what would it be?

Questions – International cooperation

1. Could you tell me a little about your role in this organization and what the objective or mandate of this department is?
2. From the international cooperation perspective, and specifically from what you know in your role, what are the guidelines that define the work of preventing maternal mortality in Choco?
3. Of these guidelines, which do you consider to be the most challenging in the department and why?

4. What do you consider to be the determining factors that create difficulties when implementing these guidelines?
5. From international cooperation perspective, could you tell me a little about the intercultural public policies and documents that exist to incorporate ancestral practices, such as midwifery, into the prevention of maternal mortality?
6. What do you consider to be the successes of these guidelines, and how have you seen them incorporated in Choco? Do you have any specific examples?
7. What do you consider to be the areas for improvement in these guidelines? Why?
8. Please describe some ways in which you think these improvements could be made.
9. Can you talk more about the international cooperation projects that you know have strengthened or supported the government's guidelines on the prevention of maternal mortality in the department through ancestral practices? What are they?
10. What stands out to you about these projects?
11. What do you think could be done better?
12. What is the impact of the international cooperation project in Choco?
13. How would you describe the perception of midwives work in Choco?
14. If you could choose one thing to improve the international cooperation implementation with the intercultural public policies that already exist related to maternal mortality, what would it be?

Questions – *Midwives*

1. Could you tell me a little about your role in this institution and what the objective or mandate of this department is?
2. From your perspective, and specifically from what you know in your role, what are the guidelines that define the work of preventing maternal mortality in Choco?
3. Of these guidelines, which do you consider to be the most challenging in the department and why?
4. What do you consider to be the determining factors that create difficulties when implementing these guidelines?
5. From your perspective, could you tell me a little about the intercultural public policies and documents that exist to incorporate ancestral practices, such as midwifery, into the prevention of maternal mortality?
6. What do you consider to be the successes of these guidelines, and how have you seen them incorporated in Choco? Do you have any specific examples?
7. What do you consider to be the areas for improvement in these guidelines? Why?
8. Please describe some ways in which you think these improvements could be made.
9. Are you aware of any international cooperation projects that have strengthened or supported the government's guidelines on the prevention of maternal mortality in the department through ancestral practices? What are they?
10. What stands out to you about these projects?
11. What do you think could be done better?
12. How would you describe the perception of midwives work in Choco?
13. From your perspective, what are the most important goals that the midwifery Association have in Choco? WHY?
14. What are the challenges to incorporate an intercultural approach that embraces traditional practices in maternal healthcare in Choco?
13. If you could choose one thing to improve the international cooperation implementation with the intercultural public policies that already exist related to maternal mortality, what would it be?

Annex 2. Informed consent

Consent to participate in a Master Thesis at the Faculty of Social Sciences

Masters Thesis Title: Traditional midwifery and reduction of maternal mortality: a case study on public policies and international cooperation programs between 2020 and 2024 in Chocó, Colombia.

Researchers: Lorena Bejarano and Gabrielle Yapp,

Masters Program: International Development and Management, Lund University

Thesis Supervisor: Helle Rydström

Purpose of the research

This thesis is a student project, running from January until May 2026. This study will examine the extent to which public policies and international cooperation programs influence the promotion of traditional midwifery in Chocó. We will also examine the extent to which they have contributed to a reduction in maternal mortality in this region since 2020.

Participation

You are invited to participate in an initiative to gather information on the public policies and international cooperation programs and their influence in the promotion of traditional midwifery in Chocó. Before accepting the invitation, it is important that you understand why this initiative is being carried out and what it entails. Please ask if anything is unclear or if you need more information.

You will participate in an interview/focus group, lasting approximately X time.

Can you change your mind and withdraw from the initiative?

Your participation is entirely voluntary. You are completely free to decide whether or not to participate. You may refuse to answer any question you do not feel comfortable or wish to answer. You may withdraw from the research and request, without needing to give any reason, and without consequence. This includes before, during and after the completion of the interview. If you decide to withdraw from the session and the initiative, and do not want your personal information or answers to be used, we will delete it immediately.

We will need to collect some personal data for the purpose of our research.

Information on the processing of personal data

The following personal data will be processed:

Name

Email and/or phone number

Profession

No sensitive personal data will be processed.

Personal data will be processed in the following ways:

Name and contact information will only be used by Lorena and Gabrielle to contact you for clarification and to share the thesis findings with you upon completion.

Your identity will not be used in the thesis. Your profession will be referred to in broad terms such as: “NGO staff member 1 stated that....” Your specific role will not be included in our thesis.

Interviews/focus groups will be audio-recorded with your permission

Recordings will be transcribed and translated into English.

Only anonymized data will be used in the final thesis.

All data will be stored on password-protected digital files, accessible only to Lorena and Gabrielle.

Personal identifiers and audio recordings will be deleted once the thesis has been submitted and examined in June 2025.

We do not share your personal data with third parties.

Lund University, Box 117, 221 00 Lund, Sweden, with organisation number 202100-3211 is the controller. You can find Lund University's privacy policy at www.lu.se/integritet

You have the right to receive information about the personal data we process about you. You also have the right to have inaccurate personal data about you corrected. If you have a complaint about our processing of your personal data, you can contact our Data Protection Officer at dataskyddsbud@lu.se. You also have the right to lodge a complaint with the supervisory authority (the Data Protection Authority, IMY) if you believe that we are processing your personal data incorrectly.

What are the benefits? The main benefit is having more and up-to-date information on the contributions of international cooperation programs and intercultural public policies to reducing maternal mortality in Choco. The findings can be taken into account by decision-makers for future interventions.

What are the risks? This interview does not pose any physical, emotional, or mental risk. While it may address sensitive issues related to a public health problem, the information requested is related to a variety of actors in the territory.

I have read and understood the information above.

I agree to participate in the thesis titled: Traditional midwifery and reduction of maternal mortality: a case study on public policies and international cooperation programmes between 2020 and 2024 in Chocó, Colombia.

Location

Signature

Date

Name

Annex 3. Original Spanish Text of Quotations (in order of appearance)

No.	Source	In-Text Quote	Original Quote
1.	D-GOV6	<i>“integrating midwives into the General Social Security System for Health so that they have the same rights, benefits, and obligations as those already part of it”</i>	<i>“integrar a las parteras al Sistema General de Seguridad Social en Salud con el objetivo de que tengan los mismos derechos, beneficios y obligaciones de quienes ya hacen parte de él”</i>
2.	I-IC1	<i>“the ministry and other entities also began to take them into account in those dialogues on linking up with the National Health System, which is still very weak, but now they know who they are. They are now part of the acceleration plan to reduce maternal mortality”</i>	<i>“el ministerio y las otras entidades empezaran a tenerlas en cuenta en esos diálogos de vinculación al Sistema Nacional de Salud, que sigue siendo todavía muy débil, pero ya saben quiénes son. Ya hacen parte del plan de aceleración para la reducción de la muerte de la materna.”</i>
3.	D-GOV6	<i>“there is a risk of ‘medicalising’ midwifery through excessive regulation, thus transforming its essence”</i>	<i>“se corre el riesgo de “medicalizar” la partería mediante excesiva regulación y, así, transformar su esencia”</i>
4.	D-GOV5	<i>“the National Civil Registry, in order to address the request submitted by ASOREDIPARCHOCO, as a pilot program will authorize midwives registered with the Association of the Interethnic Network of Midwives of the Department of Chocó to certify the births they attend”</i>	<i>“la Registraduría Nacional del Estado Civil, con el fin de atender la solicitud presentada por la ASOREDIPARCHOCO, como plan piloto autorizará a las parteras y parteros inscritos en la Asociación de la Red Interétnica de Parteras y Parteros del Departamento del Chocó, a certificar los nacimientos que atiendan”</i>
5.	D-GOV5	<i>“ensure the continuity, strengthening, and recognition of Afro-Pacific midwifery as a district system of traditional medicine”</i>	<i>“garantizar la continuidad, fortalecimiento y reconocimiento de la partería afro del pacífico como un sistema propio de medicina tradicional,</i>
6.	I-IC2	<i>“international cooperation has taken up a very important cause of rescuing that ancestral knowledge”</i>	<i>“eso es una bandera súper importante que ha tenido la cooperación internacional de rescatar esos saberes ancestrales”</i>
7.	D-GOV12	<i>“care as a traditional practice in the Department of Chocó is an intrinsic</i>	<i>“El cuidado como práctica tradicional en el Departamento del Chocó es un</i>

		<i>element of the resistance processes of the ethnic and ancestral communities that have historically sustained life and social well-being in this territory"</i>	<i>elemento intrínseco a los procesos de resistencias de las comunidades étnicas y ancestrales que han sostenido de manera histórica la vida y el bienestar social de este territorio."</i>
8.	I-MID1	<i>"They felt the health centre was a hostile place filled with darkness and fear, but that a midwife was their friend".</i>	<i>"Que sentían que el centro de salud era un sitio hostil donde solo había oscuridad y miedo, pero que una partera era su amiga."</i>
9.	D-GOV6	<i>"suffer from stigmatisation and rejection, due to the lack of recognition by the State and Social Security System in Health"</i>	<i>"sufren de estigmatización y rechazo, debido a la ausencia de reconocimiento por parte del Estado y del Sistema de Seguridad Social en Salud."</i>
10.	D-GOV6	<i>"recognise and extol midwifery as an ancestral knowledge that forms part of the ethnic and cultural expression of the Nation"</i>	<i>"reconocerá y exaltará la partería como un saber ancestral que forma parte de la expresión étnica y cultural de la Nación"</i>
11.	I-MID1	<i>"In Colombia, home births are not regulated. What does that mean? You can have your baby at home? Yes, but if there's a risk, you can go to jail. And one of the things happening with midwifery in Colombia today is that it lacks legal protection"</i>	<i>"En Colombia el parto en casa no está regulado. ¿Qué quiere decir? ¿usted puede tener su hijo en casa? Sí, pero si hay un riesgo, usted puede ir presa y una de las cosas que está pasando con la partería hoy en Colombia es que no tiene un respaldo jurídico."</i>
13.	I-IC1	<i>"the problem lies, to put it this way, in the fact that health personnel say, 'I studied and you didn't, I know, and you don't'"</i>	<i>"el problema radica en te lo digo así, en que el personal de salud dice yo estudié y usted no, yo sé, y usted no."</i>
14.	I-GOV4	<i>"when I studied, they never taught me how to properly treat a patient with malnutrition according to the ministry's regulations. They did it suddenly with American literature"</i>	<i>"yo cuando estudié a mí nunca me enseñaron a tratar adecuadamente a un paciente con desnutrición de acuerdo a la normatividad del ministerio. Ellos lo hacían pues de pronto con literatura gringa"</i>
15.	I-MID2	<i>"the promotion of the vision of each midwife so that they can develop holistically and be recognised, bearing in mind their values and knowledge. This holistic development is achieved through self-esteem, resources, training and identity"</i>	<i>"promover la vision de cada partera para que se desarrollen integralmente y sean reconocidas. Teniendo presente sus valores y saberes. Ese desarrollo integral se logra a traves de la autoestima, insumos, capacitaciones e identidad."</i>
16.	D-GOV3	<i>"Some doctors and healthcare professionals react with suspicion toward traditional midwifery practices, and in many cases, they exclude midwives from the birthing process and support when women in labour are brought to the health centre by them"</i>	<i>"Algunos médicos y personal de salud reaccionan con escrúpulos hacia las formas de trabajo propias de la partería tradicional, y en muchos casos relegan a la partera del proceso de parto y acompañamiento cuando las parturientas son llevadas por ellas al centro de salud."</i>
17.	D-GOV6	<i>"harmonising the ancestral knowledge of midwifery with that of allopathic medicine. In other words, it</i>	<i>"armonizar los saberes ancestrales de la partería con los de la medicina alopática. Dicho de otra manera, se</i>

		<i>is about complementing both forms of medicine”.</i>	<i>trata de complementar ambas formas de medicina.”</i>
18.	D-GOV13	<i>“limited coordination between the institutional response and the organisational processes of ethnic, peasant and territorial groups”</i>	<i>“existe una limitada articulación de la respuesta institucional con los procesos organizativos étnicos, campesinos y territoriales”</i>
19.	I-IC1	<i>“community blood pressure monitors that no longer worked with numbers but with colours. Yes, for those who could not read or write”</i>	<i>“una compra de tensiómetros comunitarios que ya no funcionaban con números sino con colores. Sí para aquellos que no supieran leer o escribir”</i>
20.	D-GOV13	<i>“the rights of caregivers to improve their quality of life and conditions in which they provide care”</i>	<i>“los derechos de las personas cuidadoras para mejorar su calidad de vida y mejorar las condiciones en las que proveen cuidados”</i>
21.	D-GOV3	<i>“adequate workspaces and resources, but also include community recognition and support, backing from the medical community, participation in training programs”</i>	<i>“espacios de trabajo adecuados y dotación: también comprenden el reconocimiento y apoyo de la comunidad, el respaldo de la comunidad médica, la participación en procesos de formación”</i>
22.	D-GOV3	<i>“a large part of the community does not have stable sources to guarantee their economic sustenance, because the practice of midwifery is not for profit, since it is a community work and in it is above all present the spirit of solidarity”</i>	<i>“gran parte de la comunidad portadora no cuenta con fuentes estables para garantizar su sustento económico, debido a que el ejercicio de la partería no tiene un fin lucrativo, ya que es una labor comunitaria y en ella ante todo está presente el espíritu de solidaridad”</i>
23.	I-MID1	<i>“most traditional midwives die impoverished. That also needs to be said. How come they don't have a steady source of income? For example, none of the women here work. They live hand to mouth, fishing, and rice farming”</i>	<i>la mayoría de las parteras tradicionales se mueren empobrecidas. También hay que decirlo. Cómo es que no tienen una fuente de ingreso exponencial, por ejemplo las de acá ninguna labora. Ella vive del diario vivir, vive de la pesca, viven de sembrar arroz.</i>
24.	I-GOV1	<i>“There are distances of 8 or 9 hours, and the system, in the conditions in which you find yourself, makes it very difficult to have a professional at every point. So, it is they who provide first aid, who identify risks”</i>	<i>“Hay distancias de 8 o 9 horas, y el sistema, dadas las condiciones en las que uno se encuentra, hace muy difícil tener un profesional en cada punto. Por lo tanto, son ellas quienes brindan primeros auxilios, quienes identifican los riesgos”.</i>
25.	I-MID2	<i>“Our children were not born for war and that, as an act of resistance, we will not give birth anymore in the context of armed conflict”</i>	<i>“Nuestros hijos no nacieron para la guerra y como acto de resistencia, no vamos a parir mas en medio de un contexto de conflicto armado.”</i>
26.	I-MID2	<i>“We are caretakers of a territory”</i>	<i>“Somos cuidadores de un territorio”</i>
27.	I-IC1	<i>“in very extreme conditions of vulnerability, being emotionally and economically disadvantaged”</i>	<i>“en unas condiciones de mucha vulnerabilidad muy extremas, estando mal emocionalmente, mal económicamente todo.”</i>

28.	I-IC2	<i>“every time the river rises, I must leave my house... how am I going to feed myself? I don't have food rations, I don't have public services, so where do I go to the toilet? I drink water from the same river that I use to feed myself. If there is armed conflict, then I must move...”</i>	<i>“cada que crece el río tengo que salirme de mi casa... como de que me alimento, no tengo las raciones de comida adicionalmente, no tengo servicio público, entonces donde hago mis necesidades fisiológicas es donde consumo el agua para para alimentarme el mismo río entonces es el mismo que me sirve para para para alimentarme. Si están en conflicto armado entonces yo tengo que desplazar”</i>
29.	I-GOV2	<i>“there are places where if you don't go by some means, you die. Because there is no other way... they are roads, and they are not wide roads, they're bridle paths, because some people have their mule and can bring things, because if you don't have a motorbike, you can't get to a health centre”</i>	<i>“Hay lugares a los que, si no vas de alguna manera, mueres. Porque no hay otra manera, si me entiendes, porque son caminos, y no son caminos anchos, son senderos para caballos, porque algunas personas tienen su mula y pueden traer cosas, porque si no tienes una moto, no puedes llegar a un centro de salud”</i>

Annex 4. Full Document List - Document Review Systematisation

No.	Date	Title	Author
1.	2017	Decree 356	Colombia. The Presidency of the Republic of Colombia
2.	2017	Plan Especial de Salvaguardia de los Saberes Asociados a la Patería Afro Del Pacífico [Special Safeguarding Plan for Knowledge Associated with Afro-Pacific Midwifery] (PES)	Ministry of Culture and ASOPARUPA
3.	2017	Resolution No.1077	Ministry of Culture
4.	n.d.	In-depth analysis of ethnic births in Colombia. A case study of indigenous populations in the Chocó department	Calderon Gonzales et al
5.	2020	Departmental Development Plan, Chocó 2020–2023	Chocó's Departmental Government
6.	2021	Resolution No. 3676	The National Registrar of Civil Status and DANE
7.	2022	Judgment T-128	The Constitutional Court of Colombia
8.	2022	Law 2244	The Congress of Colombia
9.	2022	Resolution No.1035	MHSP
10.	2023	Plan de aceleración para la reducción de la mortalidad materna [Acceleration plan for the reduction of maternal mortality]	MHSP
11.	2023	Resolution No.2367	MHSP

12.	2023	Lineamientos para la implementación del enfoque diferencial étnico en salud para comunidades Negras, Afrocolombianas, Raizales y Palenqueras de áreas urbanas y rurales [Guidelines for the implementation of the ethnic differential approach in health for Black, Afro-Colombian, Raizal and Palenquera communities]	MHSP
13.	2023	Partería Tradicional y su incorporación en las Estadísticas vitales de Colombia [Traditional Midwifery and its incorporation into the Vital Statistics of Colombia]	DANE, Spanish Colombian Cooperation and UNFPA
14.	2024	Development Plan 2024-2027. Chocó on the Road to Progress	Chocó's Departmental Government
15.	2024	Interwoven Lives, Threads of Hope. Ending inequalities in sexual and reproductive health and rights	UNFPA
16.	2024	Partera Vital 3.0 - Comunidad Vital [Partera Vital 3.0 – Community Vital]	DANE, Spanish Colombian Cooperation, and UNFPA
17.	2024	Partera Vital: Comunidad Vital inicia su fase tres en el Pacífico colombiano [Partera Vital: Community Vital begins its phase three in the Colombian Pacific]	DANE, Spanish Colombian Cooperation, and UNFPA
18.	2024	Una mirada a las experiencias territoriales de cuidado comunitario en Colombia [A look at the territorial experiences of community care in Colombia]	ILO
19.	2025	CONPES 4143	National Council for Economic and Social Policy
20.	n.d.	Política Nacional de Sexualidad, Derechos Sexuales y Derechos Reproductivos [National Policy on Sexuality, Sexual Rights and Reproductive Rights]	MHSP, Profamilia, IOM, UNFPA
21.	2016	Política de atención integral en salud “Un sistema de salud al servicio de la gente” [Comprehensive Healthcare Policy “A health system at the service of the people”]	MHSP
22.	2013	Dimensión sexualidad, derechos sexuales y reproductivos [Dimension of sexuality, sexual and reproductive rights]	MHSP
23.	2024	Decree 1409	MHSP
24.	2014	Resolution 2003	MHSP
25.	n.d.	Norma Técnica para la atención del parto [Technical guidelines for the management of childbirth]	MHSP
26.	n.d.	Norma Técnica para la detección temprana de las alteraciones del embarazo [Technical guidelines for the early detection of pregnancy complications]	MHSP
27.	n.d.	Determinantes sociales de la morbilidad y la mortalidad maternas. Acciones para superar las demoras I y II [Social determinants of maternal morbidity and mortality. Measures to address delays I and II]	MHSP, UNFPA
28.	2014	Calidad y humanización de la atención en salud a mujeres gestantes, niñas, niños y adolescentes [Quality and patient-centred care for pregnant women, children and adolescents]	MHSP

29.	n.d.	Garantizar la atención segura de la gestante y el recién Nacido [Ensuring safe care for expectant mothers and newborns]	MHSP
30.	2012	CONPES 147	MHSP, UNFPA
31.	n.d.	Guía de atención de las complicaciones hemorrágicas asociadas al embarazo [Guidelines for the management of bleeding complications associated with pregnancy]	MHSP
32.	2014	Protocolos para la atención de enfermería a la salud sexual y reproductiva de la mujer [protocols for nursing care related to women's sexual and reproductive health]	MHSP, UNFPA
33.	2014	Modelo de vigilancia de la morbilidad materna extrema. Evaluación de la implementación. [Monitoring model for severe maternal morbidity Evaluation of implementation]	MHSP, UNFPA
34.	2014	Modelo de vigilancia de la morbilidad neonatal extrema y primer análisis agregado de casos. [Surveillance model for extreme neonatal morbidity and first aggregate analysis of cases]	MHSP, UNFPA
35.	2014	Morbilidad Materna Extrema. Análisis agregado de casos de 2007 a 2012 [Extreme maternal morbidity. Aggregate analysis of cases 2007-2012)	MHSP, UNFPA
36.	2022	Circular 047	MHSP
37.	2016	Perfil de Salud de la Población Indígena, y medición de desigualdades en salud. Colombia 2016 [Health Profile of the Indigenous Population, and measurement of health inequalities. Colombia 2016]	MHSP
38.	2019	Política Andina de Salud Intercultural [Andean Intercultural Health Policy]	Andean Health Organisation - Hipólito Unanue (ORAS-CONHU)
39.	2023	Colombia, Potencia Mundial de la Vida. Plan Nacional de Desarrollo 2022-2026. [Colombia, a Global Powerhouse of Life. National Development Plan 2022–2026.]	Departamento Nacional de Planeación
40.	2022	Plan Decenal de Salud Pública PDSP 2022-2031 [Ten-Year Public Health Plan PDSP 2022-2031]	MHSP
41.	2021	Lineamientos Generales para la formulación del Plan Decenal de Salud Pública 2022-2031 [General Guidelines for the Development of the 2022–2031 Ten-Year Public Health Plan]	MHSP
42.	2023	Resolution 100	MHSP
43.	2013	Plan Decenal de Salud Pública PDSP, 2012-2021 La salud en Colombia la construyes tú [Ten-Year Public Health Plan (PDSP), 2012–2021: You shape healthcare in Colombia]	MHSP
44.	2018	CONPES 3918	National Council for Economic and Social Policy
45.	2015	Plan Nacional de Desarrollo. Todos por un Nuevo País. 2014-2018[National Development Plan. All for a New Country.]	Departamento Nacional de Planeación
46.	2023	Law 2281	The Congress of Colombia

47.	2022	Decree 1228	The President of the Republic of Colombia
48.	1991	Colombian Constitution	The Constitutional Court of Colombia
49.	2013	Resolution No.1841	MHSP
50.	2023	Sentence T-583	The Constitutional Court of Colombia
51.	2023	Judgement T-159	The Constitutional Court of Colombia
52.	2023	Law 2294	The Congress of Colombia
53.	2019	Plan Nacional de Desarrollo 2018-2022. Pacto por Colombia, pacto por la equidad [National Development Plan 2018–2022. Pact for Colombia, Pact for Equity]	Departamento Nacional de Planeación
54.	2017	Decree 1848	The President of the Republic of Colombia
55.	2001	Law 691	The Congress of Colombia
56.	1991	Law 21	The Congress of Colombia
57.	1993	Law 70	The Congress of Colombia
58.	2016	Study for training of traditional midwives in Chocó, Colombia	Sinergias
59.	2025	La sabiduría ancestral da luz en el Sistema Nacional de Cuidado: nace la Casa de Partería en Quibdó. [Ancient wisdom shines through in the National Health System: the Midwifery Centre opens in Quibdó]	Ministry of Equality and Equity
60.	2025	Gobierno inauguró en Quibdó la primera Casa de Partería en Colombia [The government has opened Colombia’s first midwifery centre in Quibdó]	Ministry of Equality and Equity
61.	n.d.	REDIPARCHOCÓ	Webpage
62.	n.d.	XV Congress of Midwives and Obstetricians of Chocó	Casa Hogar
63.	2016	322 women are changing Colombia from the Public Health sector	Sinergias
64.	n.d.	Asociación de Parteras Unidas del Pacífico ASOPARUPA [United Midwives Association of the Pacific]	Webpage
65.	2018	Nuevas rutas integrales de atención en salud revolucionarán al Sistema [New integrated healthcare pathways will revolutionise the system]	MHSP
66.	2024	Gobierno revive la figura del ‘promotor de salud’ para la atención primaria en Colombia [Government revives the role of the ‘health promoter’ for primary care in Colombia]	MHSP
67.	2017	ONIC: La Partería Indígena, saber propio que garantiza vida [ONIC: Indigenous Midwifery, Own Knowledge That Guarantees Life]	Organización Nacional Indígena de Colombia
68.	2025	Programa Nacional de Cuidado [National Care Program]	Ministry of Equality and Equity
69.	2025	¿Cual es la verdadera crisis de la fecundidad en Colombia? [What is the real fertility crisis in Colombia?]	UNFPA

70.	2025	Nace la primera Casa de Partería de Quibdó, Colombia: hacia el reconocimiento de este oficio como un trabajo [The first Midwifery House of Quibdó, Colombia, is born: towards the recognition of this trade as a work]	ILO
71.	n.d.	Safe, culturally sensitive, empowering childbirth for Colombia's Afrodescendent women	UNFPA
72.	2021	Partnering with traditional birth attendants to reach Afro-descendant and indigenous women in Colombia	UNFPA
73.	2023	Traditional midwives: Saving Lives by Combining the Knowledge of Ancestral and Western Medicines	PAHO
74.	2020	Partera Vital: un proyecto pionero que articula la sabiduría ancestral con los servicios de salud y estadística en Chocó [Partera Vital: a pioneering project that combines traditional knowledge with health and statistical services in Chocó]	UNFPA
75.	2023	Una red de parteras que se fortalece en Chocó [A network of midwives that is strengthening in Chocó]	UNDP
76.	2017	La partería tradicional ahora es Patrimonio de la Nación [Traditional midwifery is now a National Heritage Site]	IOM
77.	n.d.	Better health care prevents maternal and newborn deaths in Colombia's Chocó Department	PAHO
78.	2025	Radiografía del cuidado comunitario en Colombia: OIT advierte sobre la amplia brecha en derechos laborales que tienen las mujeres en el sector [Snapshot of community care in Colombia: ILO warns of the wide gap in labour rights faced by women in the sector]	ILO
79.	2021	Maternal health for all: indigenous communities in Colombia	WHO
80.	n.d.	Training Midwives in Colombia's Indigenous Communities	Malteser International
81.	2021	Women in leadership: Marcelina Solis, midwife and traditional doctor in Colombia, at the service of the response in times of COVID-19.	UNWOMEN
82.	2023	Midwifery training saves lives in remote communities	OCHA
83.	2023	UNESCO Intangible Cultural Heritage	UNESCO
84.	2025	Midwives of Latin America and the Caribbean: Saving lives on the front lines	UNFPA
85.	2025	Teófila Betancurt: partera tradicional, cuidadora de la vida, el territorio y la memoria. [Teófila Betancurt: traditional midwife, caretaker of life, territory and memory]	UNWOMEN
86.	n.d.	La partería, un rol y una práctica que preserva la cultura de los Nasa We'Sx [Midwifery, a role and practice that preserves the culture of the Nasa We'Sx]	IOM
87.	2019	Aumentando el acceso y mejorando la calidad de la atención en los servicios de salud materna-neonatal en Chocó [Increasing access and improving the quality of care in maternal-neonatal health services in Chocó]	PAHO/WHO
88.	2025	Colombia presenta resultados del proyecto "Mejorando la salud de mujeres y adolescentes en situación de vulnerabilidad", desarrollado con apoyo del gobierno de Canadá [Colombia presents results of the project "Improving the health of women and adolescents in vulnerable situations", developed with support from the government of Canada]	PAHO/WHO
89.	2025	Chocó is more than a territory of victims	MSF

90.	2024	Culturally conscious care for remote communities in Colombia	MSF
91.	2021	Partera Vital: un proyecto pionero que articula la sabiduría ancestral con los servicios de salud y estadística en Chocó, Colombia [Partera Vital: a pioneering project that combines traditional knowledge with health and statistical services in Chocó, Colombia]	UNFPA
92.	2023	Maternal Health of Women and Girls of African Descent in the Americas	UNFPA, UNICEF, UNWOMEN, PAHO, NBEC
93.	2024	United Nations Population Fund - Country programme document for Colombia	Executive Board of the United Nations Development Programme, the United Nations Population Fund and the United Nations Office for Project Services
94.	2024	Organge book of results: Key Results Achieved at the Country Level	UNFPA
95.	2025	Avanza la implementación del proyecto “Parterías Étnicas Ancestrales Vivas” en 29 municipios PDET del Pacífico colombiano [The implementation of the "Living Ancestral Ethnic Midwives" project is progressing in 29 PDET municipalities in the Colombian Pacific]	UNFPA
96.	2024	The ILO and the Ministry of Equality and Equity promote care organizations in Cesar and Chocó, Colombia	ILO
97.	2024	Providing care through the social and solidarity economy	ILO
98.	2025	“Traer vida con las manos y el alma”: las guardianas del parto tradicional en el Chocó ["Bringing life with hands and soul": the guardians of traditional childbirth in Chocó]	UNWOMEN
99.	2024	Partera Vital inicia su tercera fase en el Pacífico colombiano [Vital Midwife begins its third phase in the Colombian Pacific]	UNFPA
100.	2024	Centering Reward and Representation for Domestic Workers in the Care Economy	ILO
101.	2011	The State of the World's Midwives 2011	UNFPA
102.	2024	Strengthening Maternal Health and Care Networks in Colombia: Use of Community Perinatal Technologies Workshop	PAHO/WHO
103.	2023	La OPS promueve el intercambio de experiencias y saberes ancestrales en la partería desde los pueblos Indígenas [PAHO promotes the exchange of experiences and ancestral knowledge in midwifery from Indigenous peoples]	PAHO/WHO
104.	2025	Salvaguardia de la partería para el cuidado del territorio, la paz y la vida [Safeguarding midwifery for the care of territory, peace and life]	UNFPA
105.	2023	Comunicado Partera Vital, proyecto innovador para reducir la mortalidad materno perinatal en Buenaventura y Quibdó, finaliza su segunda fase [Press Release Vital Midwife, an innovative project to reduce perinatal maternal mortality in Buenaventura and Quibdó, completes its second phase]	UNFPA

106.	2022	“Partería tradicional, un compromiso, una dedicación y un rescate de los saberes ancestrales”, Rosmilda Quiñones, Partera Tradicional, lideresa, creadora y presidenta de ASOPARUPA [“Traditional midwifery, a commitment, a dedication and a rescue of ancestral knowledge”, Rosmilda Quiñones, Traditional Midwife, leader, creator and president of ASOPARUPA]	UNFPA
107.	2022	Partera Vital, un reconocimiento a los saberes ancestrales de la partería tradicional [Vital Midwife, a recognition of the ancestral knowledge of traditional midwifery]	UNFPA
108.	2022	“¡Traer vida me encanta!”, María Ignacia - Partera del Medio Baudó en el Chocó. [“I love bringing life!”, María Ignacia - Midwife from Medio Baudó in Chocó]	UNFPA
109.	2022	Comienza segunda fase de Partera Vital en Chocó [Second phase of Vital Midwife begins in Chocó]	UNFPA
110.	2021	Hilda María Rojas	UNFPA
111.	2020	Celebrando a las parteras, las heroínas anónimas en la primera línea de respuesta a la crisis de la COVID-19 [Celebrating midwives, the unsung heroines on the frontline of response to the COVID-19 crisis]	UNFPA
112.	2018	Reconocer y fortalecer el trabajo de las parteras es el camino para mejorar la salud materna de las mujeres en las zonas más apartadas de Colombia [Recognizing and strengthening the work of midwives is the way to improve women's maternal health in the most remote areas of Colombia]	UNFPA
113.	2019	Boletín No. 2. Estrategia de Cooperación Interagencial en Salud Materna y Neonatal Indígena 2015-2019. Reducción de la mortalidad materna y neonatal con enfoque etnocultural, de derechos y de género. [Bulletin No. 2. Strategy for Interagency Cooperation in Indigenous Maternal and Neonatal Health 2015-2019. Reducing maternal and neonatal mortality with an ethnocultural, rights and gender approach]	UNFPA
114.	2024	Scaling up the Interagency Strategy for the Reduction of Maternal and Neonatal Mortality in Vulnerable Communities to support national health priorities in Colombia	WHO
115.	2026	“Ser partera para mí significa ser dadora de vida” Herminia, partera tradicional en el municipio de Olaya Herrera, Nariño. [History “Being a midwife for me means being a giver of life” Herminia, traditional midwife in the municipality of Olaya Herrera, Nariño]	UNFPA
116.	2025	A new chapter for midwives in Quibdó, yet challenges persist	The Bogota Post
117.	2025	Quibdó inaugura la primera casa de partería oficial. [Quibdó inaugurates the first official midwifery house]	El Pais
118.	2016	Colombia’s traditional midwives included in cultural heritage list of nation	The City Paper
119.	2025	Traditional Midwifery in the Americas: Bridging Intercultural Health and Maternal Wellbeing	Durham University
120.	2022	Understanding, respecting, and honouring traditional partería	Scholars Strategy Network
121.	2023	Traditional midwives: Saving Lives by Combining the Knowledge of Ancestral and Western Medicines	McMaster University
122.	n.d.	Midwives Assist in Reducing Maternal Deaths in Colombia	Borgen Magazine

123.	2021	COVID-19 sees more expectant Colombian mothers turn to traditional help	The New Humanitarian
124.	2024	Midwifery at UNESCO: celebrating and lifting-up	Maternity and Midwifery Forum
125.	2022	Colombia – Failure to prioritize midwives in Vaccination Plan against COVID-19 violates their fundamental rights to health, equality, non-discrimination, and ethnic diversity	Covid-19 Litigation. Open-access case law database
126.	2023	Colombia's Traditional Midwifery Declared a Cultural Heritage by UNESCO	Colombia One
127.	2023	New Group Comes Together to Spur Scaling of Innovation at the UN	Medium – United Nations Global Pulse
128.	2024	UNFPA and AECID launch new phase of project to support traditional midwifery in Colombia	Swissinfo.ch
129.	2022	Comienza segunda fase de Partera Vital en Chocó [Second phase of Vital Midwife begins in Chocó]	chocó7días.com
130.	2024	Arranca partera vital 3.0 en el Pacífico Colombiano para la salvaguarda de la patería tradicional Étnica [Vital midwife 3.0 kicks off in the Colombian Pacific for the Safeguarding of Traditional Ethnic Midwifery]	Revista Chocó
131.	n.d.	Alumbradoras de vida [Illuminators of life]	ILEX – Acción Jurídica