RESPECTFUL MATERNITY CARE IN COLOMBIA

A case study on traditional birthing practices to improve emergency care training material

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Before delving into the body of this thesis, I want to pause and acknowledge what sustains it: the people, the places, and the care that made its existence possible. Every scene, conversation, gesture, and moment of encouragement and patience planted a part of what is presented here.

To all the places I visited and the people who walked with me —closely or from afar— I dedicate this project and these first words to you. Thank you.

To the traditional midwives I met, for sharing your stories with me, including you joys, sorrows, worries, hopes and blessings. And for teaching me new ways to think about care, starting with what it means to bring life.

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"Care is the human activity that includes everything that we do to maintain, continue, and repair our world..."

JOAN TRONTO

Summary

Respectful Maternity Care (RMC) is increasingly recognized as a fundamental component of quality maternal healthcare, yet its practical implementation within emergency training remains unclear. Existing training materials often emphasize clinical survival outcomes while providing limited guidance on how respectful care can be enacted in specific situations. This thesis explores how traditional midwifery practices in Colombia can inform emergency maternity care training by identifying locally grounded manifestations of respectful care and translating them into actionable educational material.

The project was conducted in collaboration with Laerdal Global Health and focused on the Colombian region of Chocó, where traditional midwifery remains a culturally significant and widely practiced form of care. Rather than framing the project as a problem-solving intervention, the investigation sought to learn from existing care systems that already sustain respectful, mother-centered practices. A participatory and decolonizing design approach guided the research, positioning traditional midwives and community actors as knowledge holders and collaborators throughout the process.

Fieldwork included engagement with the Kilombo Yumma collective in Bogotá and participation in a regional traditional midwife convention in Chocó, attended by over 450 midwives. Through interviews, observation, and participatory sessions, the project identified how respectful care is locally defined and practiced. Analytical methods including actor mapping, constellation mapping, manifestation categorization, and journey mapping were used to interpret qualitative fieldwork data and identify opportunities for training interventions.

A key finding was that respectful maternity care in this context is primarily enacted through communication. Traditional midwives described respect as the building of trust through listening, explaining, reassuring, and recognizing the mother's perspective. Communication emerged as a horizontal manifestation influencing multiple aspects of care, shaping both emotional wellbeing and clinical effectiveness. This insight provided a strategic entry point for intervention, as communication practices can be integrated into existing care interactions without requiring additional infrastructure or resources.

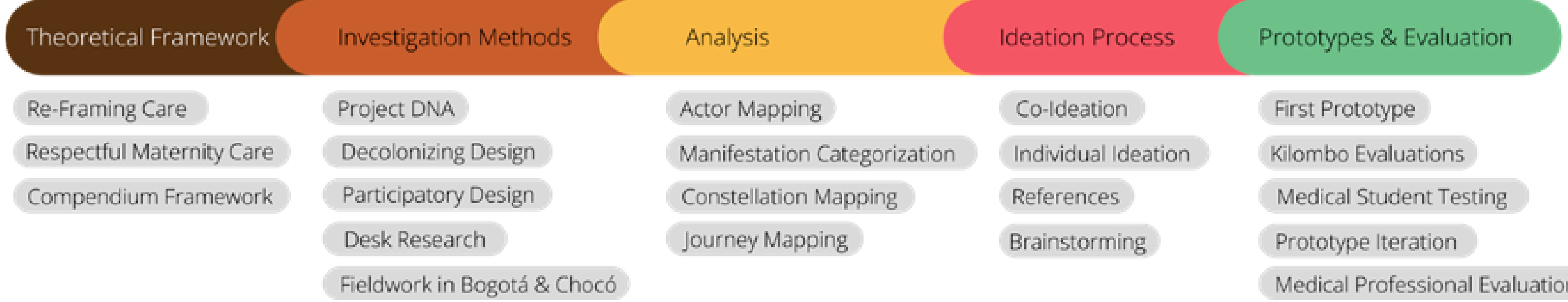

Figure 1. Visualization of the design process within the thesis project - Developed by the author, 2026.

Figure 2: Respectful Maternity Communication Volvelles: Final prototype of the RMC training material - Design by the author; photograph by Lucy Díaz, 2026.

Based on these findings, the project developed a training proposal consisting of a workshop format facilitated by traditional midwives and a set of circular role-play tools called Respectful Maternity Communication Volvelles. These tools present emergency care scenarios from the perspectives of the mother, traditional midwife, and doctor, enabling participants to engage with relational care dynamics through experiential learning. The workshop structure reflects the community's knowledge transmission practices, particularly horizontal dialogue formats such as Uramba, aligning both content and learning format with local epistemologies.

Prototype testing with medical students and healthcare actors demonstrated the potential of role-play to support perspective-taking, empathy, and reflection on respectful communication practices. Participants engaged actively with the material and expressed interest in integrating such training into their formal education.

This thesis contributes both a design proposal and a methodological framework for identifying and translating respectful care practices into training material. It demonstrates how design can function as a mediator between traditional and biomedical knowledge systems, supporting the integration of locally grounded respectful care practices into healthcare education. By positioning respectful communication as an operational component of clinical care, this project offers a scalable and context-sensitive approach to strengthening respectful maternity care training.

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01 INTRODUCTION

This project originates from the convergence of a personal drive, pluricultural care partners, and a distinctive vocabulary.

This section begins with a the author's personal statement, followed by guidance on how to read this document. It then situates the partner organization and core topic—Laerdal Global Health and Respectful Maternity Care—and outlines the project background, including the initial project proposal. The section concludes with a list of keywords intended to support the understanding and navigation of the thesis.

PERSONAL STATEMENT

- Going back to my roots
- Joining a bigger conversation
- Discussing the invisibly necessary

DOCUMENT NOTES

- Designers' Perspective
- Community Interaction

LAERDAL GLOBAL HEALTH & RESPECTFUL MATERNITY CARE

- Partner organization in maternity and emergency care
- Simulation-based training material
- Respectful Maternity Care in emergency training

PROJECT PROPOSAL

- Defining Respectful Maternity Care
- Simulation-based training material
- Respectful Mate

Personal statement

The following are three concepts that illustrate the personal perspectives, interests and questions I had which led me to propose this project (Figure 3).

Going back to my roots

This master's thesis is an attempt at reconnecting with my roots — with the design practices and perspectives I adopted during my education in Colombia, and with the culture, territory, and people I grew up with and wish to support through my work. Colombia is not just the project's context; it is also mine.

Joining a bigger conversation

As part of reconnecting with Colombia, this thesis also became an exploration of a side of its healthcare system I was unfamiliar with. Before starting this project, I understood medicine almost exclusively through a western lens. Hospitals, doctors, protocols—this was the language of care I knew. I was aware that other approaches existed, but they felt distant, something I had only heard about in passing. As I immersed myself in Colombian healthcare design, I began to realize that a much larger conversation was unfolding, and I wanted to be part of it.

Through discussions with friends and colleagues, I became more aware of the coexistence—and ongoing debate—between traditional and western medicine. Friends shared their opinions about proposals to allow traditional caregivers to practice in city hospitals, asking whether I would trust them with my own health. A colleague spoke about a podcast they were working on that explored the dialogue between the two approaches in the capital city. These encounters made me wonder what coexistence between these knowledge systems could come to look like. It became clear that their relationship is marked by points of tension, often shaped by misunderstanding, prejudice, and uncertainty. Wanting to understand—to recognize what I knew, but also to unlearn it and engage with what I had never been taught—became an important part of this process.

Learning about the traditional approach to care became another way of getting to know my context, and of exploring how it could flourish rather than be absorbed or converted in a western-dominated coexistence.

Discussing the invisibly necessary

When reflecting on my own healthcare experiences and discussing those of others in previous projects, I noticed that many of the elements that make an impact in care often remain unseen, unnamed, or undervalued. Beyond medical procedures and technical decisions, there are small acts that sustain trust, dignity, and emotional safety—listening, explaining, reassuring, translating, and creating space in moments of uncertainty. These forms of psychological and immaterial care are rarely formalized, yet they are deeply necessary. Becoming attentive to these invisible layers of care shaped how I approached this project, and why I became interested in respect as something practiced through everyday health interactions. This thesis emerges from a desire to make space for those invisible dimensions—to acknowledge their value, and to explore how design might help them be recognized, reflected upon, and sustained as a necessary part of health education, rather than simply an added bonus.

Document notes

In addition to the design proposal, this document contains several other results and purposes. The following notes explain how to interact with the document and get the most out of it.

DESIGNERS' PERSPECTIVE

One outcome of this thesis is a reflection on the investigation, analysis and creation methodologies used throughout the project. The following sections provide a detailed documentation of the project's design process including conclusions, guides and practical insights. These materials are thought to support designers and professionals who wish to reflect, adapt or build upon the learnings found in this project.

Guides, Tips & Notes — How-to guides, tips and author notes will be introduced in separate boxes, as shown in figure 4. These elements highlight practical considerations that emerged throughout the design process.

Tags — Visual tags, such as those shown in figure 5, are used to signal when design approaches discussed in the theoretical framework are applied in the design process. These are meant to evidence the implementation of theory in practice.

How-To / Learnings:

Purpose

Text

Figure 3: Guide, tip and note box example.

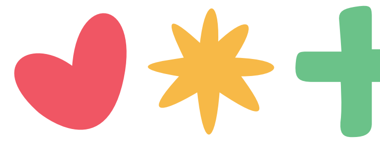


Figure 4: Tag examples.

DOCUMENT INTERACTION

This document aims to foster a sense of connection between its readers and the community that contributed to the project: the midwives and their territories. Care has been taken to represent experiences and perspectives respectfully, without claiming to speak on behalf of the community and protecting the identity of the participants.

Quotes

Quotes used as illustrative examples throughout the investigation can be found scattered within the main body of the document and are also complied on a dedicated quotes page. Quotes are presented in both Spanish and English. This approach is intended to preserve the original wording while supporting accessibility across languages. All quotes are anonymized and included with participant consent.

Translations

Certain words and concepts in the document are intentionally kept in Spanish when direct translation risks altering their meaning. In these cases, explanations are provided within the text and in the Keywords section of the document.

QR Codes

QR codes are placed to offer access to supplementary materials, such as digital visualizations and external resources related to the project. They can be be scanned in the physical version of the document or clicked directly in the digital PDF version.

Laerdal Global Health & Respectful Maternity Care

Partner organization in maternity and emergency care

This project was proposed in collaboration with Laerdal Global Health (LGH), a Norwegian organization dedicated to improving maternal and newborn health through training initiatives in low- and middle-income countries with high mortality rates. LGH's work provided initial questions surrounding the relationship between maternity, emergency, and respectful care.

Simulation-based training material

LGH develops simulation-based training material for medical professionals or caregivers, allowing trainees to practice emergency maternity scenarios. They use a combination of technology ranging between digital resources such as scenario-based apps, and physical equipment including mannequins, to develop high-quality training.

Respectful Maternity Care in Emergency Training

While LGH's training materials place strong emphasis on survival and physiological perspectives and outcomes, questions regarding immaterial elements of care—such as psychological, emotional, and overall wellbeing—continue to arise. During a series of discussions, specific gaps and opportunities in LGH's training material regarding these elements were identified and further contemplated.

In particular, LGH highlighted the promotion of Respectful Maternity Care (RMC) as gaining increasing recognition within maternal health discourses, however its interpretation and application remaining complex and vague in care settings and training. As seen in examples of existing LGH training materials (figure 6 & 7), current respectful care guidelines often remain vague. Caregivers are encouraged to provide respectful care, privacy, and

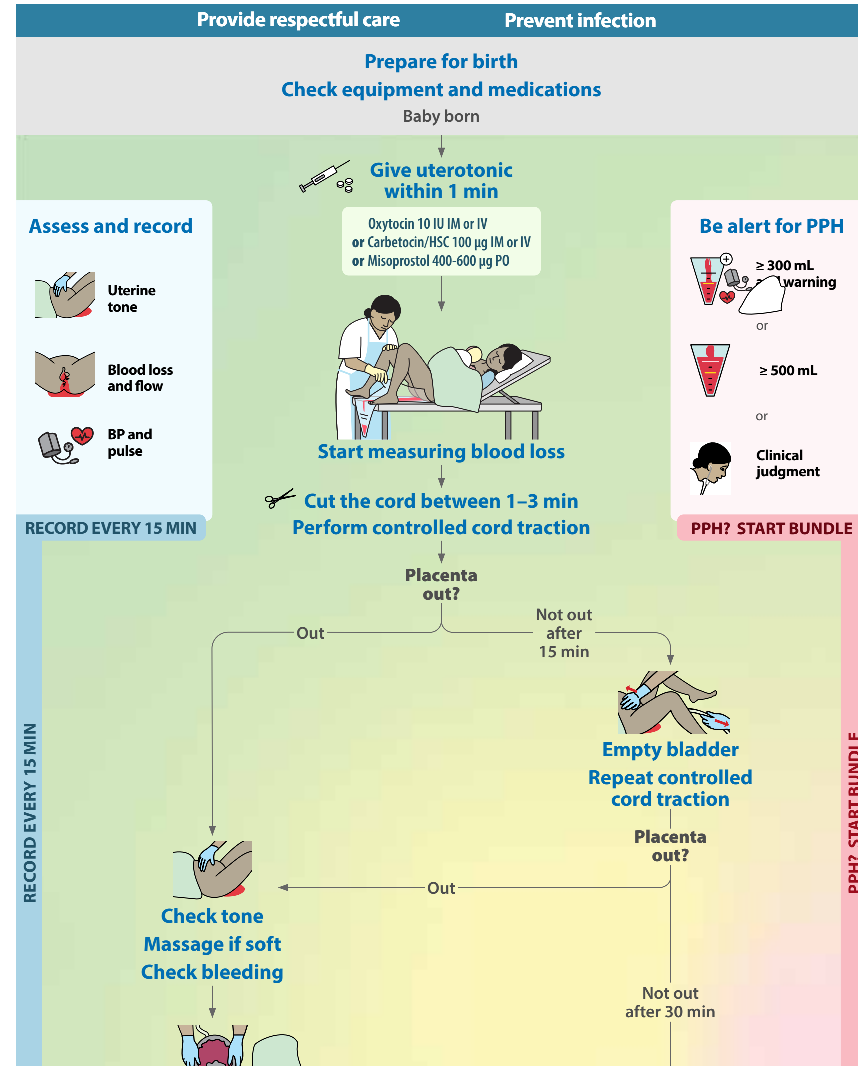
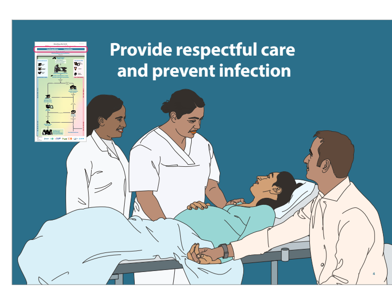


Figure 5: Example of current applications of RMC in LGH training material. Reminders to "provide respectful care" within the Bleeding After Birth: Emergency Action Plans (World Health Organization et al., 2025)

a calming presence, yet concrete guidance on what these practices look like in specific situations, how to execute them in different contexts, or how to assess if they did so successfully, is not specified. As Kamala (2024) mentioned during one meeting regarding conclusions from her own research, this reflects the fact that RMC is often referred to as a 'non-medical' element, and that it is also considered context-dependent, taking shape through specific local cultures, beliefs, and care practices. Additionally, in emergency situations, elements such as time pressure and clinical protocols made it difficult to recognize, evaluate and support specific respectful practices (cite conversation with laerdal?). The following section therefore introduces a global understanding of Respectful Maternity Care, while emphasizing the necessity of approaching RMC as a locally defined and situated practice when developing meaningful educational material.

These challenges discussed with LGH formed part of the initial basis for this project and motivated an exploration of how respect is specifically understood, practiced, and supported within emergency maternity care in different contexts.



Facilitation note

- Begin this page introducing Action Plan 1.
- As you explain respectful care and infection prevention, point out were they are on the Action Plan.

Explain

Provide respectful care

- All good relationships begin with **respect and trust.**
- This is important in healthcare – people trust us to help them.
- During complications, respectful care also involves being a calming presence.

Key points for respectful care

- Women make their own informed choices, even when unexpected things happen.
- Women feel safe and cared for.
- Women have privacy, even during an emergency.
- Women are enabled to have a companion of their choice.

Respectful communication

- **Introduce yourself** by name, and use the woman's name.
- **Inform the woman** and her family of progress, options, and concerns throughout care.
- **Listen** without interrupting, and confirm you understand her.
- **Explain early** if transfer for advanced care is needed.
- **Always be honest:**
  — admit if you don't know something
  — maintaining trust matters more than appearing knowledgeable.

Prevent Infection

- Wash hands and wear sterile gloves.
- Wear apron, mask, and eye shield to protect yourself.
- To protect the baby:
  — wear double gloves before birth
  — remove the soiled pair before clamping and cutting the cord.
- Properly dispose of or process contaminated supplies and equipment. Follow protocols.

Discuss

1. How does respectful care save lives?
2. How do you support a woman to make her own choices, especially when something unexpected happens?
3. What changes, big or small, could improve respectful care in your daily work?
4. Are there any challenges with infection prevention at your facility?

Figure 6: Example of current applications of RMC in LGH training material. Guidance in explaining concepts regarding providing respectful care, within the Bleeding After Birth: Flipchart. (World Health Organization et al., 2025)

Project Proposal

Defining Respectful Maternity Care

This project is situated within the domain of Respectful Maternity Care (RMC). While RMC has been described by multiple recognized organizations, it does not have a single consolidated definition, as it is context-dependent. For example, the International Confederation of Midwives (ICM) describes RMC as the resources and practices that ensure pregnancy, childbirth, and postnatal care is provided with dignity, compassion, and respect (cite). Therefore, rather than adopting a fixed global definition, this project seeks to understand how RMC is interpreted and practiced within a specific care context.

Learning from existing practices in Colombia

Rather than approaching RMC through a problem–solution lens, this project was initially framed as an opportunity to learn from communities that already practice forms of mother-centered and respectful care within their own contexts. This, based on decolonizing and participatory design methodologies detailed in the following sections. The intention was not to identify deficits, but to work alongside caregivers who are experts in their own knowledge systems, and to explore how respect is embodied, taught, and sustained in their everyday care.

Within this framing, Colombia emerged as a meaningful context for the project. Traditional midwifery in Colombia is officially recognized as national cultural heritage and, since 2023, has been designated as Intangible Cultural Heritage of Humanity by UNESCO; recognizing its ancestral value, its role in maternal health, and the importance of preserving and passing on this knowledge within communities (Ministry of Foreign Affairs of Colombia, 2023). A collaboration was proposed with traditional midwives, doctors and nurses from the rural region of Chocó, Colombia, who have experience with traditional birthing practices grounded in mother-centered values.

RMC emergency training material based on traditional Colombian midwifery practices and experiences.

PROBLEM FRAMING

Within this context, the project is framed around the question of how elements of traditional, mother-centered care might inform educational approaches to Respectful Maternity Care (RMC), particularly within emergency maternity training in Colombia. The project engages caregivers across different systems of care in Chocó, including traditional midwives as well as western doctors and nurses. It seeks to understand how respectful care is specifically interpreted, manifested and practiced in moments of urgency in the context, and how such practices might be supported and transmitted through educational materials created along local knowledge and lived experience.

Rather than adopting a traditional problem–solution framing that assumes deficits within the community, this project takes a learning-oriented approach. It begins from the recognition that situated forms of respectful care already exist—particularly within traditional midwifery knowledge—and explores how these practices can be articulated into locally grounded educational material through observable manifestations and actionable practices that proactively generate respectful care, as defined by community perspectives.

02 THEORETICAL FRAMEWORK FOR RMC

How can we begin to understand the global context and concept of Respectful Maternity Care?

This section sets the theoretical base for the project and addresses the guiding question above by introducing key medical concepts and perspectives. It begins by examining how care is commonly framed through clinical and psychological dimensions of care. Thi section then reviews literature that defines Respectful Maternity Care (RMC) from a global perspective, describing its relation to care dimensions, human rights and emergency maternity care. Finally, the Compendium on Respectful Maternal and Newborn Care (WHO, 2025) is introduced as the primary reference framework for this project, providing a starting point for understanding how RMC can be advanced through local adaptation, observable manifestations, and education-based opportunities.

RE-FRAMING CARE

- Clinical vs. Psychological Dimensions of Care
- Psychological Components Connected to Clinical Outcomes
- An Imbalance Between Care Dimensions

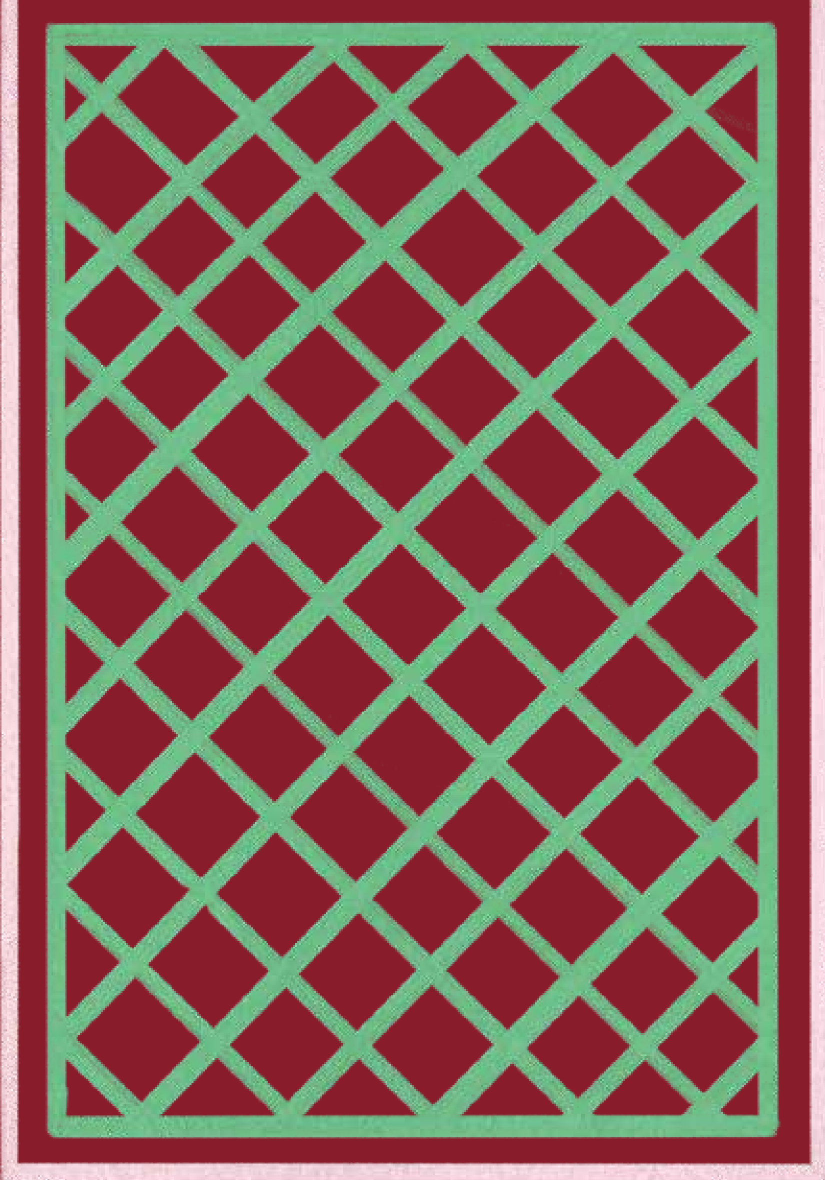
(RMC) RESPECTFUL MATERNITY CARE

- What is Respectful Maternity Care?
- RMC within Care Dimensions
- RMC as a fundamental human right
- RMC in Emergency Situations

WHO'S RESPECTFUL MATERNITY CARE FRAMEWORK

- Compendium on Respectful Maternal and Newborn Care
- Framework Takeaways for this Project

SECTION TAKEAWAYS



Re-Framing Care

This project sits at the intersection between different dimensions and levels of care. Before delving into the specific framework of Respectful Maternity Care, it is important to examine the health dimensions in which it is embedded. Doing so requires first understanding how care is commonly framed within healthcare systems—specifically, which elements are prioritized and which are rendered secondary. This provides the foundation to question how care is currently framed, and to reconsider the importance of its elements through this work.

Clinical vs. Psychological Dimensions of Care

In many healthcare settings, care is primarily understood through a clinical lens that prioritizes biomedical, measurable and protocol-driven interventions and outcomes. Models following standardized protocols— such as monitoring vitals, executing technical procedures, and ensuring survival rates—are widely recognized as essential components of medical practice (IOM, 2001). In this sense, what is considered 'clinical care' is largely associated with, and dominated by, what can be observed, quantified and controlled—prioritizing biomedical aspects of care (Engel, 1977).

Within this dimension and framing of care, components such as respect, emotional support, clear communication and psychological wellbeing are often pushed aside (Engel, 1977). More specifically, these immaterial and relational components—referred to here as the psychological dimension of care—are often categorized separately as 'quality of care' or 'patient experience', rather than integral parts of clinical care itself (Epstein & Street, 2011; WHO, 2016; Bohren et al., 2020).

Psychological Components Connected to Clinical Outcomes

Despite the conceptual separation of clinical and psychological dimensions of care, a growing body of research has described how psychological aspects of care have tangible clinical consequences. For example, disrespectful interactions and actions in maternity care have been associated with birth-related trauma, higher chance of complications during birth, postpartum depression and post-traumatic stress disorder (United Nations General Assembly, 2019; Reed, Sharman, & Inglis, 2017).

Additionally, these experiential components of care have been recognized as contributing to health outcomes including morbidity and mortality (WHO, 2016; Kruk, Gage, Arsenault, Jordan, Leslie, et al., 2018), highlighting their relevance beyond solely patient experience. In this sense, the psychological dimension of care is not separate from clinical practice, but actively shapes its outcomes in how clinical interventions are conducted, received, and remembered..

An Imbalance Between Care Dimensions

Although these immaterial dimensions of care are increasingly acknowledged as valuable, they are often treated as secondary, optional or as a bonus. In many settings—especially high-pressure environments where time constraints, standardized protocols, and institutional hierarchies or agendas dominate decision-making—psychological dimensions of care are often deprioritized (Reed, Sharman, & Inglis, 2017; Bohren et al., 2020).

Emotional wellbeing, dignity, and respectful communication are rarely taught, practiced, or evaluated with the same rigor or importance as clinical procedures, resulting in the marginalization of psychological care within both training and practice (WHO, 2016; Epstein & Street, 2011; Reed, Sharman, & Inglis, 2017).This imbalance suggests that, despite growing recognition of their documented influence on how care is experienced and their significant contribution to care outcomes, psychological and relational dimensions of care remain undervalued, specifically within clinical education and emergency training.

(RMC) Respectful Maternity Care

To understand Respectful Maternity Care (RMC), it is helpful to examine how global health organizations have defined, studied, and advocated for it, and how it has been positioned within broader frameworks of care quality, clinical outcomes, and health rights.

What is Respectful Maternity Care?

Although there is no single universally accepted definition of Respectful Maternity Care, World Health Organization et al. (2025) define it as:

> "Person-centred care organized for, and provided to and with, all women, gender-diverse people, newborns, parents and families throughout the antenatal, childbirth and postnatal periods. It prioritizes maintaining dignity, privacy and confidentiality, protects against harm and mistreatment, and enables informed choice and continuous support during labour and childbirth."

This definition is used in this project as a global reference point for understanding RMC, while recognizing that its concrete meaning is context-dependent.

RMC within Care Dimensions

Within the framing presented in the previous section, RMC is often situated within the psychological and relational dimension of care, as it seeks to make immaterial aspects of care visible and intentional within maternity practice. These aspects are difficult to measure, quantify, standardize, or protocolize (Bohren et al., 2020), which contributes to their frequent categorization outside of what is typically recognized as clinical care.

At the same time, the WHO positions RMC as a central pillar of its Quality of Care Framework for maternal and newborn health, which addresses both the provision and experience of care (2016). This positioning reflects a growing acknowledgment that mistreatment in maternity care has serious and lasting consequences. Research has shown that disrespectful, abusive, or neglectful care not only undermines women's psychological and physical wellbeing but also erodes trust in health systems, discourages care-seeking, and can negatively influence health outcomes over time (Kasaye et al., 2024; ICM, 2024; Reed et al., 2017; Bohren et al., 2014).

These findings highlight that RMC is not only a matter of care experience or satisfaction, but is closely tied to what is considered clinical care and outcomes, challenging its continued treatment as an optional aspect of maternal care.

RMC as a fundamental human right

Beyond its relevance to quality and clinical outcomes, RMC has also been firmly linked to rights-based care. International organizations such as the World Health Organization (WHO), the International Confederation of Midwives (ICM), and the White Ribbon Alliance (WRA) have argued that respectful care must be examined in the context of human and reproductive rights, rather than treated solely as a component of care quality (ICM, 2024; WRA, 2020; WHO, 2025).

This push is underlined by the view that mistreatment, obstetric violence, and violence during childbirth are understood not only as failures of care, but as human rights violations and recognized forms of gender-based violence (ICM, 2024; United Nations General Assembly, 2019). In this light, the WHO emphasizes that "quality, respectful, person-centred care is not a luxury or an optional add-on – it is a fundamental human right and a cornerstone of effective health systems" (2025). Importantly, research has also shown that these rights violations disproportionately affect women from marginalized and racialized communities (Bohren et al., 2015; United Nations General Assembly, 2019). Therefore, RMC emerges not only as a clinical and ethical concern, but as a deeply structural and global issue concerning inequality and access to care.

RMC in Emergency Situations

In emergency maternity care, conditions that make the situation urgent such as time pressure, rapid decision-making, high clinical risks, and uncertainty, often make respectful care more difficult to recognize, prioritize and implement. Studies documenting mistreatment during childbirth show that forms of disrespect and abuse often peak around the time of birth, when urgency is highest (Bohren et al., 2019). Decision-making research on obstetric emergencies also illustrates how clinicians' sense-making in high-stakes situations can prioritize speed, risk management and protocol adherence rather than explanations, shared decision-making, and relational support (Raoust et al., 2022). As a result, RMC practices are often deprioritized during emergencies.

> "Respectful care is not a luxury – it is a fundamental human right that shapes health outcomes and people's experiences of care,"
>
> Dr Hedieh Mehrtash, Technical Officer and co-lead of the Compendium (WHO, 2025).

WHO's Respectful Maternity Care Framework

Compendium on Respectful Maternal and Newborn Care

To explore how Respectful Maternity Care (RMC) can be supported through training, it is first necessary to examine how RMC has been approached at a global level. Several frameworks and guidelines have been proposed by international institutions; however, for this project, the Compendium on Respectful Maternal and Newborn Care (Figure 11), published by the World Health Organization, was selected as the primary reference framework (WHO, 2025).

A decade of accumulated research and resources

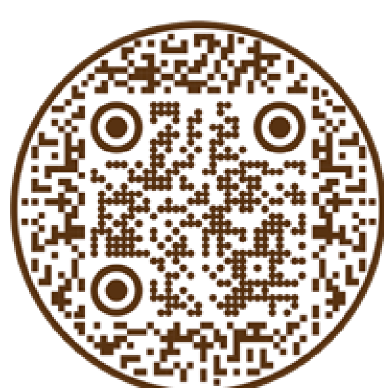
The Compendium is a comprehensive global resource that consolidates current research evidence, practical experience, tools and practical implementation guidance and support related to RMC across different contexts and levels of the health system. It represents WHO's first major update on respectful care since its 2014 statement on the prevention and elimination of disrespect and abuse during childbirth, reflecting a decade of accumulated research, policy development and field experience (WHO, 2025).

From principles to a call for action

The compendium is a major milestone for RMC by being the first global effort to translate principles and declarations of respectful care into tangible implementation strategies and actions (WHO, 2025). It serves both as a call to action—urging stakeholders to proactively embed RMC through systemized practices—and as a common reference point that offers a shared language and vision for understanding and advancing RMC in practice. In this sense, the compendium helps fill the "how to do it" gap, as many previous documents gave principles but limited operational guidance.

Limitation: Novelty

While the compendium provides a structured and actionable framework, it also acknowledges its current limitations. Among these is its novelty. Given its recent publication, there are limited evaluations of its application across diverse settings (WHO, 2025). As a result, there is uncertainty in how to translate its guidance into practice within specific cultural and clinical contexts.



Scan for the online Compendium document.

FRAMEWORK TAKEAWAYS FOR THIS PROJECT

The Compendium's framework contains multiple sections and steps, as illustrated in figure #, which together propose diverse routes and approaches to advance RMC. Given the scope and purpose of this thesis, a selection of three key elements were chosen as relevant and are outlined below.

1. A global guide for local action

A main principle of the Compendium is its emphasis on context and adaptability. It explicitly recognizes that RMC is context-dependent, shaped by local systems, cultures, belief systems, health structures, resources and limitations. Rather than a prescriptive checklist, the Compendium therefore positions itself as a global guide for local action—providing shared and general concepts and routes while emphasizing the need for contextual interpretation and local adaptation. Therefore, rather than offering a universal model of respectful care, the Compendium supports stakeholders in identifying how RMC can be pursued depending on their specific conditions.

2. RMC as Positive and Negative Manifestations

Central to the Compendium's approach is the use of "manifestations" to describe both respectful care and mistreatment. These manifestations, summarized in Figure 12, offer a way to make RMC identifiable under a general understanding of common behaviors.

According to the Compendium (WHO, 2025), negative manifestations refer to forms of negative behaviors or mistreatment that RMC seeks to reduce, eliminate or prevent. Positive manifestations describe forms of positive behaviors that actively enable respectful care and should therefore be supported. As there manifestations are shared categories of behaviors, the Compendium emphasizes that their concrete expressions require contextual interpretation. Given the breadth of these manifestation types, the Compendium further recommends that initiatives aiming to advance RMC initially focus on a single or limited set of manifestations, as each represents a complex domain (WHO, 2025).

It is important to note that the Compendium formulates its overall goal as "ending mistreatment and achieving respectful care". In doing so, it recognizes that mistreatment and respectful care can coexist, and achieving RMC is not simply the absence of mistreatment, but also the promotion and presence of intentional and proactive respectful care behaviors.

3. Education and Training as Intervention Areas

Actively promoting respectful can take many forms and routes. The Compendium identifies multiple drivers of mistreatment and respectful care across individual, organizational, sociocultural and policy-related levels of the health system as seen in figure 13 (WHO, 2025). Among the proposed strategies to advance RMC is the integration of respectful care into education, training, clinical guidelines and routine practices. Within the framework, gaps in training and education fall under the organizational drivers that enable respectful care or diminish mistreatment. Addressing these gaps by embedding RMC into training material is therefore positioned as a key intervention area.

The implementation of design theory related to the compendium within the design process practice will be marked by this tag throughout the document.

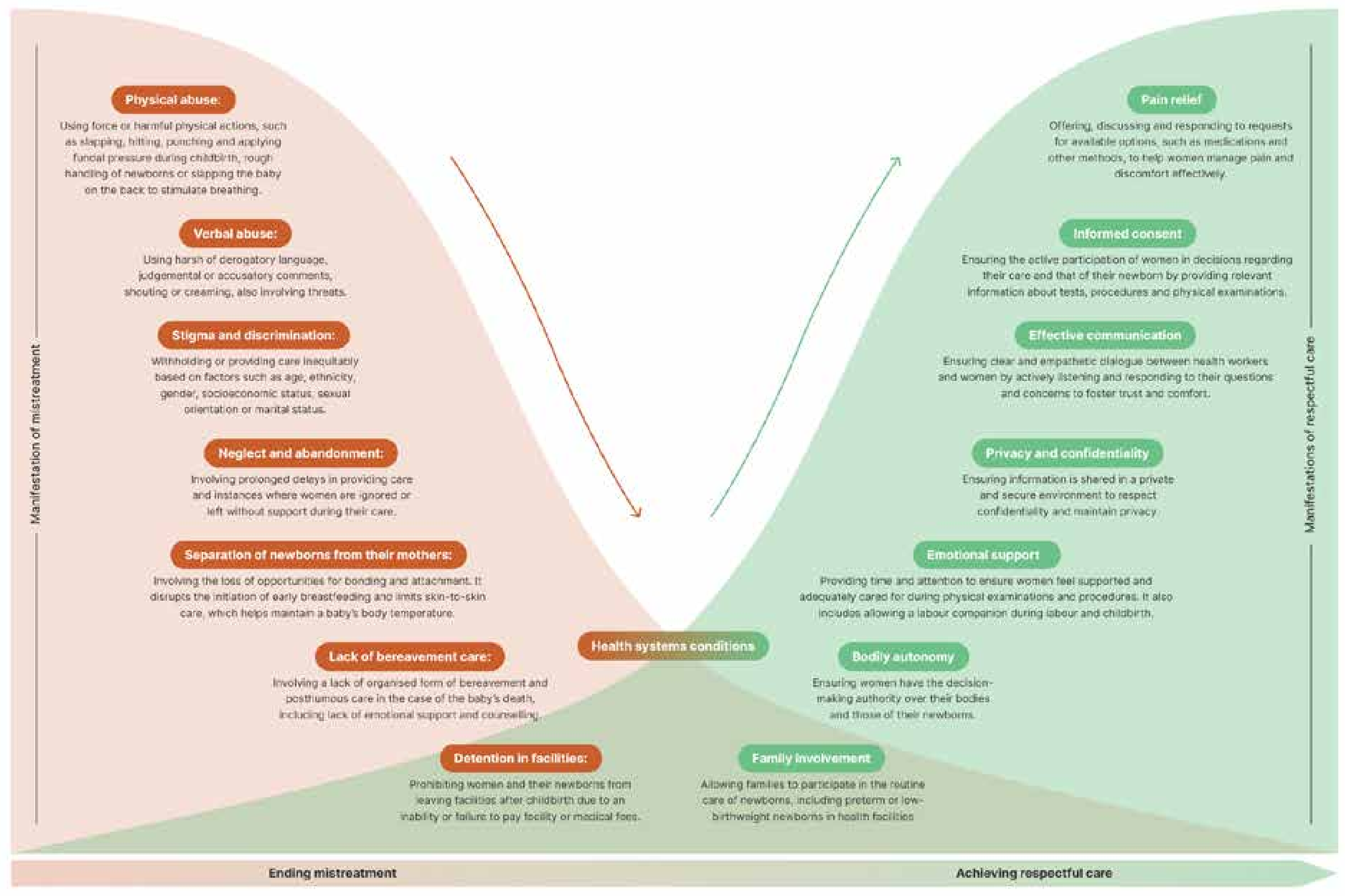
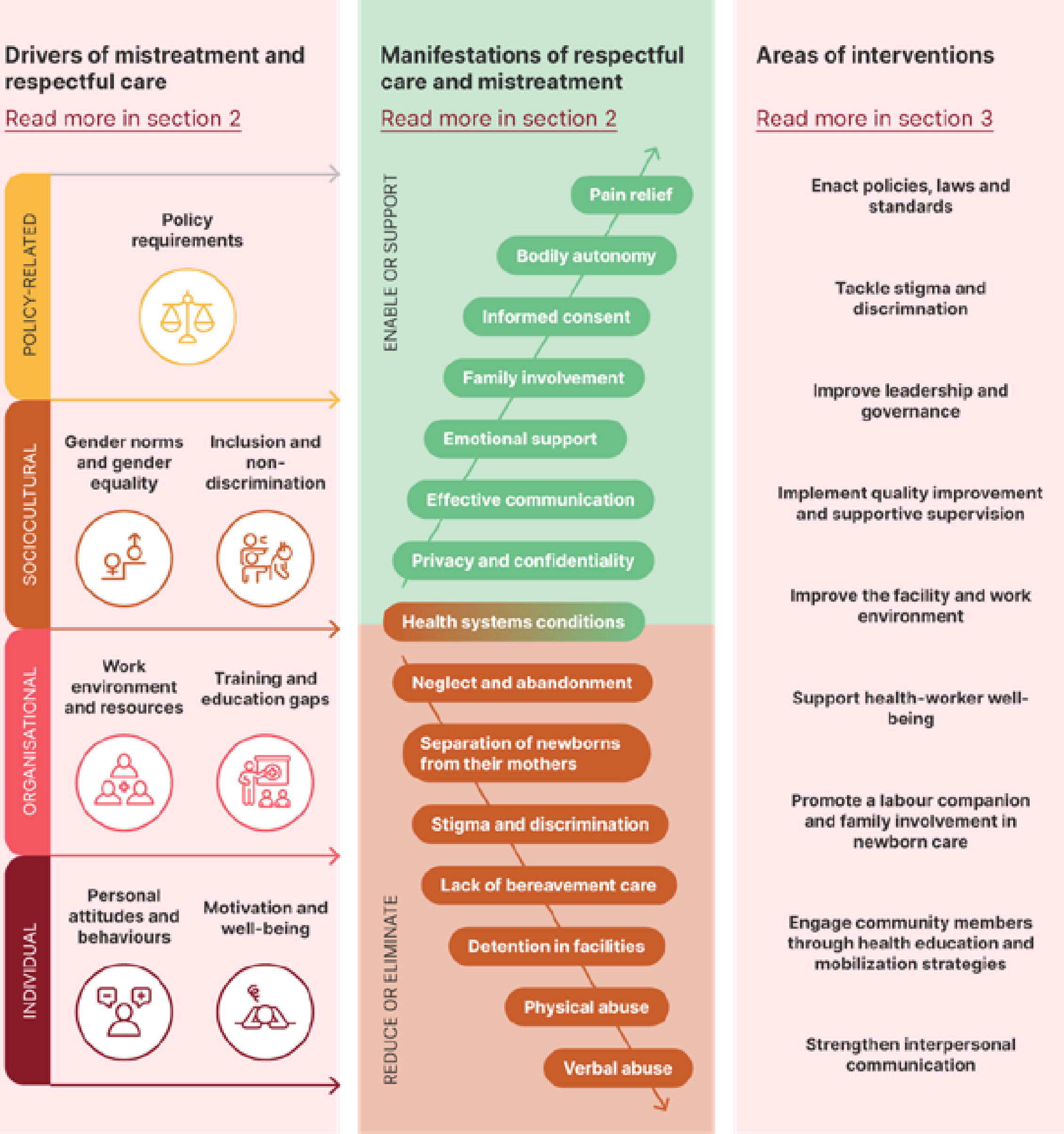


Figure 7: RMC Manifestations according to the Compendium (WHO, 2025)

Figure 8: Results desrciption: magna non sem tempor elit adipiscing convallis massa sit quis dictum justo vitae diam nunc sit accumsan eget magna arcu lorem elementum. (WHO, 2025)



Section Takeaways

Positioning this Thesis Within the Theoretical Framework

This theoretical framework reveals key tensions, opportunities and gaps in how Respectful Maternity Care (RMC) is currently understood, framed and acted upon. While a growing body of literature clearly recognizes the value and consequences of respectful care, RMC remains inconsistently positioned within health systems. Specifically, within emergency maternity contexts and health training. The gaps and opportunities highlighted in the theoretical framework create the entry point for this thesis, as described below.

Re-framing RMC as an Integral Component of Clinical Care

A central gap identified in the literature lies in the constant separation between clinical and psychological or relational dimensions of care. Although evidence demonstrates that psychological elements directly influence health outcomes, experiences and trust in health systems, they continue to be treated as secondary to biomedical and technical procedures. Moreover, RMC if often framed within quality-of-care or patient experience, rather than as an essential component of clinical practice, and therefore continues to be treated as optional or a bonus layer of care.

This thesis seeks to challenge that framing. It takes on the position that RMC is not only clinically consequential but also a fundamental human right, and therefore requires the same level of intentionality, recognition and educational support as technical interventions. In this sense, RMC is not a “soft skill”, but an integral element of clinical care and practice that shapes how care outcomes are delivered, received and remembered.

Emergency Maternity Care Situations as Critical for RMC

The theoretical framework highlights emergency maternity care as a context in which peak tension between clinical urgency and respectful practices is most visible. Time pressure, protocol-driven decision-making and high risks make RMC practices more vulnerable to being deprioritized.

This tension exposes a critical gap in current approaches to RMC: the especially limited guidance on how respectful care can be recognized, practiced, and sustained within emergency maternal care, where both clinical and emotional demands are strongest. Rather than an exceptoin, this thesis positions emergency maternity care as a critical site where the mother is most vulnerable and support for RMC is especially necessary and impactful.

Applying the WHO Compendium through local interpretation

Within this project, the Compendium on Respectful Maternal and Newborn Care is used as a conceptual and analytical framework that provides structure and openness; while it is a global reference for understanding RMC, it explicitly calls for local interpretation and adaptation.

As shown in figure 8, this thesis responds to the Compendium by applying key elements of its framework within a specific local context: Chocó, Colombia.

In particular, this thesis adopts the Compendium’s interpretation and categorization of RMC through positive and negative manifestations as a way to recognize, analyze and support RMC throughout the investigation and analysis phases. While acknowledging the importance of mistreatment, the project deliberatley places emphasis on positive manifestations of care, focusing on opportunities and learn from proactive respectful practices within traditional Colombian midwifery. In doing so, the project moves away from a problem–solution framing and instead focuses on the learning and amplification of existing care practices.

Finally, this thesis situates itself within the Compendium’s organizational drivers of mistreatment and respectful care, specifically addressing the training and education gaps. In this way, design is used as a means to intervene in the area of health education and support RMC through learning processes. Through the use of manifestations to clarify how RMC is understood in the local context, this project seeks to inform the development of training materials that actively support caregivers in recognizing, practicing, and sustaining specific respectful care, particularly within emergency maternity contexts.

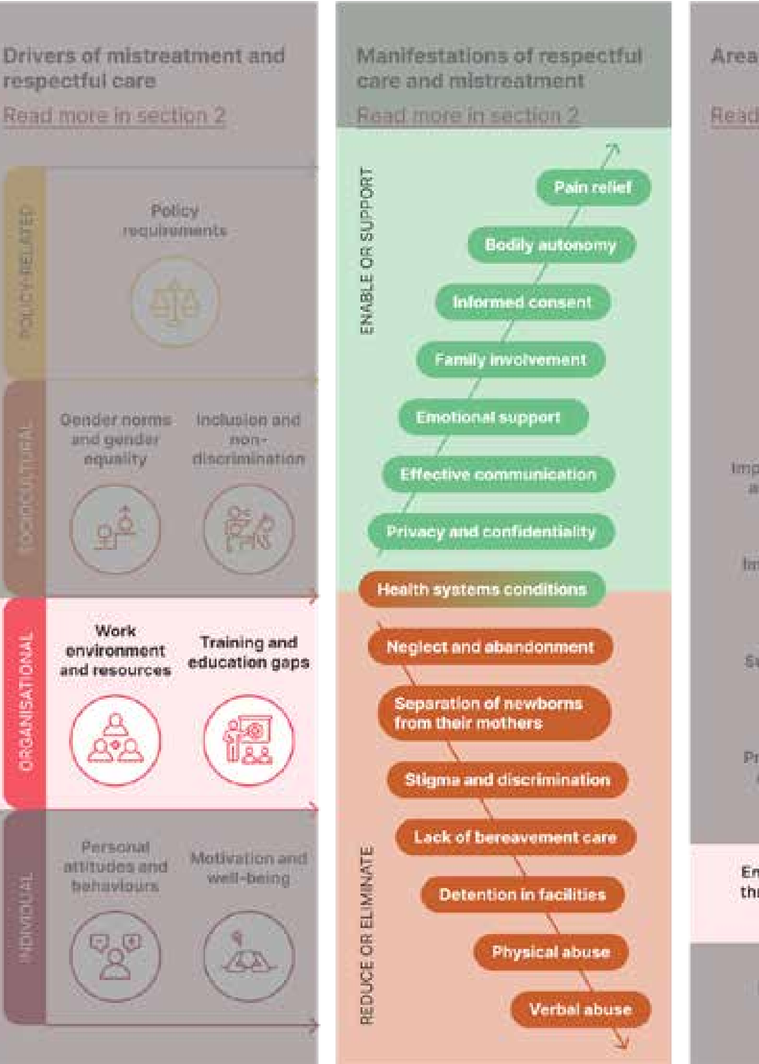


Figure 9: Specific intervention routes chosen as the focus of this thesis project including training and education gaps at an organizational level of drivers, manifestations of respectful care and engaging community memebers through helath education.

03
INVESTIGATION METHODS

How can we ensure we are also prioritizing respect within the design process?
What does the conceptual, political and geographical landscape regarding RMC look like in the Colombian context?
What activities were carried out to approach communities, and how were they implemented?

The following section presents the methodology with which the investigation was carried out, addressing the guiding questions above. It begins with the investigation brief and the initial corresponding investigation questions. This is followed by the design approaches adopted throughout the project, with a focus on embedding respect within the design process itself. This includes the use of Decolonizing and Participatory design as complementary approaches and the Cultura Model to support contextual research with intercultural empathy. The section continues with an overview of the project's Colombian context, introducing relevant policies, concepts, territories and traditional communities connected to RMC. The section concludes with a detailed description of the investigation fieldwork carried out with traditional medical communities in Chocó and Bogotá, outlining how engagements were approached, conducted and reflected upon.

PROJECT DNA

- Investigation Brief
- Investigation Questions

DESIGN APPROACH

- Designing with Respect
- Decolonizing Design
- Participatory Design

DESK RESEARCH

- Respectful Maternity Care in Colombia
- Chocó, Colombia
- Traditional Midwifery

FIELDWORK WITH TRADITIONAL COMMUNITIES

- Collaboration with AFNEMO and Kilombo Yumma in Bogotá
- Fieldwork with Traditional Midwives in Chocó

INVESTIGATION BRIEF

RMC during emergency care with traditional perspectives

How can RMC during emergency situations be supported in Chocó, Colombia, learning and creating along local traditional perspectives, practices and lived experiences to inform and improve emergency training material for future caregivers?

How could training materials respond to the identified opportunities?

INVESTIGATION QUESTIONS

How does Respectful Maternity Care manifest in emergency situations in Chocó, Colombia?

WHO
Who defines what care is?
Who are the main actors involved?
Who assumes which roles and responsibilities in maternity care?

WHAT
What is considered respect or mistreatment in maternity care?
What is considered an emergency in maternity care?
What is defined as maternal care?

WHERE
Where does respect and mistreatment happen?
Where do caregivers obtain their knowledge and skills?
Where is a mother treated during an emergency?

WHEN
When do different actors interact and in which way?
When have actors experienced respect and mistreatment?
When does maternal care begin and end?

WHY
Why is respect considered important?
Why is mistreatment considered an important issue?
Why do western and traditional approaches differ?

HOW
How is RMC translated to concepts and structures in Colombia?
How does respect and mistreatment manifest?
How do caregivers view the ideal relationship with mothers?

Designing with Respect

The design approach adopted in this project is grounded in the understanding that design is not a neutral activity, but a relational, political and cultural practice. Conventional western design has historically been shaped by colonial systems, contributing to the marginalization of non-western knowledge systems by privileging dominant forms of expertise, representation and problem framing (Tunstall & Agi, 2023).

Given the cultural diversity, colonial history and medical epistemic hierarchies present in the project context, this thesis required design approaches that could move beyond extractivist models. Learning alongside ancestral and traditional medical communities demands careful attention not only to how knowledge is used, but also to how it is produced, shared and owned. This consideration extends across the investigation phase, the creative phase, and the design proposal itself. Power operates in design processes, and for this reason, this project draws on Decolonizing and Participatory Design as complementary approaches to guide its development.

DECOLONIZING DESIGN

Decolonizing design is about unlearning dominance and relearning design as a situated and power-aware practice.

According to Tunstall and Agi (2023), decolonizing design is an approach grounded in cultural justice that actively questions and seeks to dismantle the dominance of Western, Eurocentric ways of knowing, making, and deciding. Rather than position design as universal, it centers indigenous peoples, local knowledge, lived experience, and historically marginalized voices throughout the design process. In doing so, decolonizing design seeks to redistribute power in the design process.

Decolonizing design raises questions such as:

- Who defines the problem?
- Whose knowledge counts?
- Who benefits from the design outcomes?
- Who holds power throughout the design process?

In the specific case of universities, Tunstall and Agi (2023) critique how institutions often claim inclusion while continuing extractive practices. Indigenous voices may be invited symbolically, while remaining excluded from structural decision-making and authorship. According to Tunstall & Agi (2023) and Escobar (2018), within institutional research and practice, decolonizing design requires practices such as:

1. Shifting power structurally: ensuring local actors participate structurally rather than only symbolically.
2. Valuing multiple ways of knowing: recognizing embodied, oral, and relational knowledge alongside academic expertise.
3. Designing with, not for: positioning communities as co-creators rather than (end)users or data sources, as in participatory design.
4. Questioning universality: resisting general solutions applied across diverse contexts.
5. Non-extractive research: committing to accountability, reciprocity, and shared ownership of knowledge and outcomes.

PARTICIPATORY DESIGN

While decolonizing design provides an ethical orientation for this project, participatory design offers concrete practices through which these commitments can be implemented.

As mentioned before, participatory design can be understood as designing with people rather than for them. In this sense, it is an approach based on the redistribution of power, roles and responsibilities among those involved within the design process. Within participatory design, partners are recognized as co-creators and experts of their own lived experience, rather than as passive sources and recipients of information and design results (Schuler & Namioka, 1993). Through collaboration, partners actively participate in framing the design situation, ideating, analyzing, prototyping, reflecting, among other design activities. Therefore, participatory design attempts to actively involve all stakeholders or partners throughout the design process (Simonsen and Robertson, 2013;)

With this shift, terminology associated with top-down perspectives—such as (end)users or subjects—is replaced. Participatory design distributes authorship, agency and decision-making across those involved, moving from centralized expertise toward collective knowledge production (Simonsen & Robertson, 2013; Sanders & Stappers, 2008). Within this view, the role of the designer shifts from expert to facilitator. Designers minimize their intervention and the imposition of their view, while supporting collective dialogues and horizontal dynamics. This collective sense-making permits partners' experiential and tacit knowledge to emerge in the process, which allows for context-specific and culturally grounded design (Simonsen & Robertson, 2013).

A relevant case of participatory design aligned with decolonizing principles in the Colombian context is the project EntreVer Con (Kilombo Yumma and Facultad de Arquitectura y Diseño, Universidad de los Andes, 2025). This project, developed in collaboration with the collective Kilombo Yumma*, takes the form of a podcast series that centers traditional midwifery, ancestral knowledge, oral traditions, and community narratives. Concrete participatory practices included granting narrative authority to community members and recognizing oral storytelling as a legitimate epistemic practice and knowledge transfer alongside written knowledge.

* The Kilombo Yumma collective is a collaborator of this thesis project as well, as will be described in following chapters.

The implementation of design theory related to decolonizing and participatory approaches within the design process practice will be marked by this tag throughout the document.

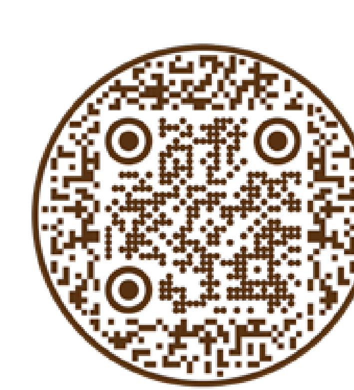


Figure 10: QR to the podcast series EntreVer Con, available on Youtube and Spotify.

Desk Research

Desk research was conducted to establish contextual understanding and inform the focus of subsequent research activities. It draws primarily on academic literature and publicly available policy and institutional documents related to respectful maternity care in Colombia. Where appropriate, it also incorporates contextual information gathered during early project scoping through informal stakeholder engagement. These contextual inputs are included to support background understanding and are not treated as evidence from the academic literature.

Respectful Maternity Care in Colombia

To understand Respectful Maternity Care (RMC) in Colombia, the investigation began with desk research and a literature review of how respectful care is discussed in policies and studies in this context. The literature frequently addresses the equivalent of RMC in Colombia through three key terms and interrelated concepts within maternity care: humanized childbirth, obstetric violence, and intercultural childbirth.

Respectful Maternity Care as Humanized Childbirth

In Colombia, the closest concept to RMC is "Parto Humanizado (Humanized Childbirth). This term was officially established by the law 2244 of 2022, the "law of dignified, respected and humanized birth", which recognizes women's rights during pregnancy, labor, childbirth, and postpartum, among other provisions (Congreso de Colombia, 2022). Additionally, Resolution 3280 of 2018 operationalizes respectful, evidence-based intrapartum care (Ministerio de Salud y Protección Social, 2018).

Despite humanized childbirth having a political presence through policies and laws, studies suggest its understanding and implementation in Colombia is inconsistent across the healthcare system. In a quantitative study, residents and gynecologists in Colombia were surveyed regarding their knowledge of the benefits of respectful care during birth (Farías-Vela et al., 2023). Findings reveal significant gaps in awareness and implementation of humanized childbirth, with more than half of the respondents reporting no education on the topic The study highlights how there is a general disinformation regarding the benefits of humanized childbirth from medical professionals, and that it is necessary to increase and standardize content and protocols for humanized birth within educational programs.

Obstetric violence

Parallel to this body of work, Latin American research frequently addresses humanized birth through the negative construct of respectful care: obstetric violence. Obstetric violence is framed as a form of gender-based violence embedded within biomedical and institutional power structures, encompassing verbal abuse, coercive or non-consensual medical procedures, excessive medicalization, and the systematic disregard of women's preferences during childbirth (Sadler et al., 2016). In this sense, research in this context often focuses on the identification and elimination of mistreatment. Many studies also highlight how the presence and experience of obstetric violence varies depending on women's sociocultural context, described below.

Intercultural childbirth

In Colombia, respectful maternity care is also discussed through the lens of intercultural childbirth, particularly in contexts where birth experiences are shaped by cultural identity, language, and structural marginalization. In this sense, mistreatment during childbirth is not only a general failure of respectful care, but becomes intensified when healthcare systems do not respond to women's cultural needs and knowledge systems.

Research highlights that Indigenous and ethnic minority women in Colombia face disproportionate risks of mistreatment due to the intersection of institutional constraints and sociocultural inequality. Gleason et al. (2022) examine childbirth care among Indigenous women in Colombia, documenting multiple drivers of disrespect and abuse across healthcare levels. Forms of mistreatment include the normalization of mistreatment, prejudice, limited understanding of Indigenous culture, and linguistic/cultural barriers in communication between patients and caregivers. The authors argue that limited institutional support, insufficient training in intercultural competencies, and the absence of national policies contribute to the persistence of non-respectful care practices. They conclude that interventions must be multifaceted and

locally specific, combining community engagement, provider education, and facility-level reforms grounded in respect for Indigenous cultures.

Qualitative work further shows that obstetric violence in intercultural contexts includes an additional layer of harm: a culturally embedded form of mistreatment experienced by Indigenous women, namely the lack of cultural respect or sensitivity. In their earlier ethnographic study "Parir no es un asunto de etnia, es un asunto de humanidad", Gleason et al. (2021) share how Emberá women describe not only authoritarian clinical practices and lack of consent—experienced by many women from different backgrounds—but also repeated microaggressions and the dismissal of ancestral knowledge and traditional practices. This suggests that intercultural childbirth is not only a matter of adapting care to "difference," but of addressing deeper knowledge hierarchies and colonial patterns that shape institutional maternity care.

RMC IN COLOMBIA TAKEAWAYS

Overall, the literature suggests that in Colombia, marginalized populations are especially vulnerable to mistreatment during childbirth, not only through general forms of disrespect and abuse but also through culture-specific harm. Advancing RMC in Colombia therefore requires understandings that bridge knowledge systems and clinical training to ensure care that is clinically safe, but also respectful and culturally responsive. At the same time, this body of work indicates the importance of moving beyond a mistreatment-only perspective by also exploring positive manifestations of intercultural care that already exist in local practices and communities. The following sections therefore introduce Chocó, Colombia as the primary research context and examine traditional midwifery as a key site of knowledge, care, and culturally responsive maternity practices.

Figure 11: Luptat quis sequam quatio tectus et idiat demperumque mi, tem re diciis ullandi tassint re escimus dio quia eos quatibus.

Chocó, Colombia

This project is situated in the Department of Chocó, Colombia, located in the Pacific region of the country (Figure #). Chocó is characterized by a humid tropical climate and predominantly rural, forested terrain that is often difficult to access. The territory's demographic composition is highly diverse, with a majority Afro-descendant population and a significant Indigenous population living in conditions of poverty and extreme poverty (UN SDG Fund, n.d.).

Figure 12: The region of Chocó on Colombia's map.

Figure 13: Chocó has dense tropical rainforest, many rivers, high rainfall, rich biodiversity, and scattered rural communities. Photo taken by the author.

Healthcare in Chocó

Chocó has historically been marginalized and neglected by the Colombian state, resulting in chronic weaknesses in infrastructure, public services, and health system capacity, which in turn undermine both the coverage and quality of healthcare. These structural deficits contribute to disparities in key health outcomes; for example, as seen in figure #, the maternal mortality ratio in Chocó was reported at 330.2 per 100,000 live births in a recent epidemiological period—substantially higher than the national average (about 45 per 100,000 live births) and among the highest in the country (Instituto Nacional de Salud [INS], 2024).

In this context, communities rely on traditional Afro-descendant and Indigenous midwifery as trusted forms of maternal and childbirth care. Traditional midwifery in Chocó consists of a strong and culturally valued practice through which communities sustain ancestral knowledge systems and maintain connections to their roots. At the same time, in remote and rural areas where institutional services are scarce, geographically inaccessible, or limited in capacity, midwifery practices also play an essential role in mitigating gaps in formal healthcare access.

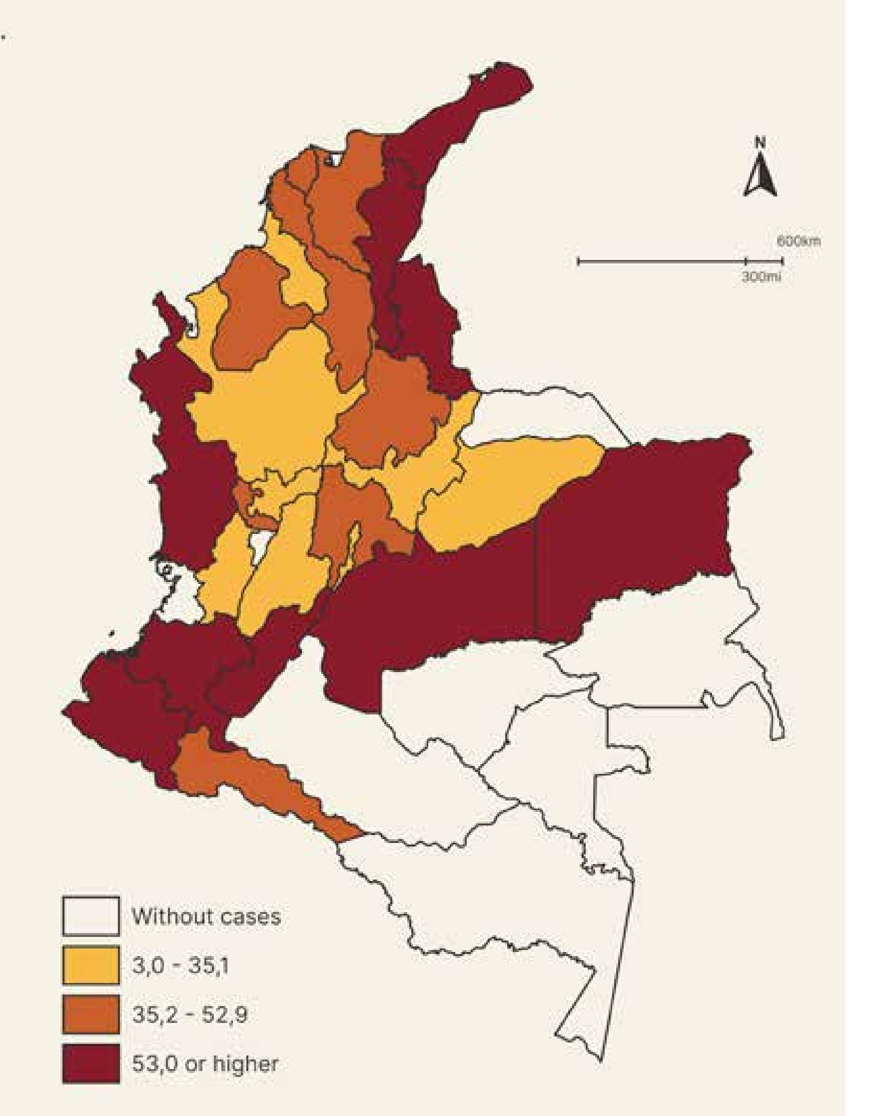


Figure 14: Maternal mortality ratio by department in Colombia (epidemiological period VIII, 2024). Note. Adapted from Mortalidad materna en Colombia: Informe epidemiológico, período VIII de 2024, by Instituto Nacional de Salud, 2024.

Traditional Midwifery

A valued practice

Traditional midwifery in Colombia refers to community-based maternity and reproductive care practices developed and transmitted through Afro-descendant and Indigenous knowledge systems within territories to support care and guidance during pregnancy, childbirth, and postpartum (UNFPA, 2023). Rather than functioning solely as an alternative to biomedical care, traditional midwifery constitutes a culturally valued and enduring form of care that sustains ancestral knowledge, reinforces social bonds, and maintains relationships to territory. In many regions, traditional midwives continue to play a central role in maternal and newborn care, particularly in rural and remote areas where institutional health services are limited, difficult to access, or perceived as culturally misaligned.

Increased Recognition

In recent years, traditional midwifery has gained increased institutional recognition, although it remains an unpaid practice. In Colombia, traditional midwifery has been officially recognized as national cultural heritage and, in 2023, was designated as Intangible Cultural Heritage of Humanity by UNESCO under Midwifery: knowledge, competencies and practices (UNESCO, 2023). National documentation, including DANE's statistical note on traditional midwifery and safeguarding-oriented resources from the Ministry of Culture, further frames traditional midwifery as a cultural and rights-based domain that requires protection, continuity, and visibility (Departamento Administrativo Nacional de Estadística [DANE], 2023). Notably, DANE's note focuses on incorporating traditional midwifery into national vital statistics and birth registration, positioning it as a relevant contributor to maternal and newborn care, particularly in territories with limited access to institutional health services (DANE, 2023).

Traditional Communities

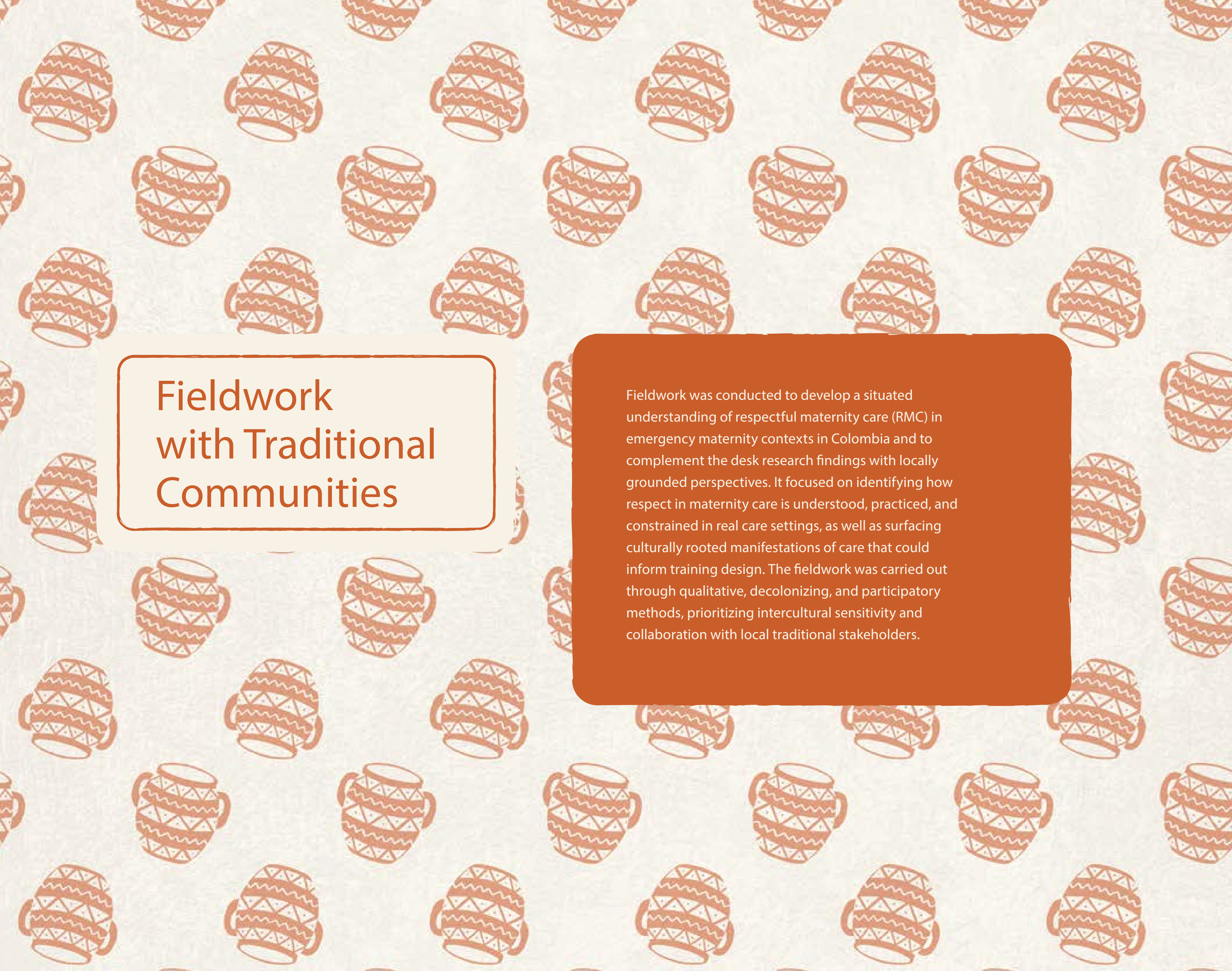
Traditional midwifery is practiced across Afro-descendant and Indigenous communities, which may also integrate through shared spaces, activities, or collective encounters. Importantly, traditional midwives sustain this knowledge beyond rural contexts as well. For example, collectives such as the Kilombo Yumma in Bogotá can be understood as "embassies" of territory and ancestral care practices within urban environments, supporting cultural continuity outside the communities' geographic origins.

The traditional and western coexistence

In Chocó, traditional midwifery and western maternity care coexist within a diverse health landscape in which women and families often navigate between both systems depending on the situation. In practice, this coexistence is not simply a division between "traditional" and "western" care, but a shifting negotiation shaped by local realities. While western approaches tend to prioritize technical knowledge and skills, traditional midwifery takes on a holistic and mother-centered view of maternal care and is often grounded in empirical, practice-based knowledge built through lived experience within the territory.

CHOCÓ AND TRADITIONAL MIDWIFERY TAKEAWAYS

Overall, Colombian literature positions traditional midwifery not only as a maternity care practice, but as a culturally grounded knowledge system with increasing institutional recognition and safeguarding efforts. In regions such as Chocó—where cultural identity, territory, and structural marginalization shape childbirth experiences—traditional midwifery becomes particularly relevant for intercultural approaches to respectful maternity care. This reinforces the need to examine how traditional midwifery is practiced in the region and how it interacts with institutional maternal health services.



Fieldwork with Traditional Communities

Fieldwork was conducted to develop a situated understanding of respectful maternity care (RMC) in emergency maternity contexts in Colombia and to complement the desk research findings with locally grounded perspectives. It focused on identifying how respect in maternity care is understood, practiced, and constrained in real care settings, as well as surfacing culturally rooted manifestations of care that could inform training design. The fieldwork was carried out through qualitative, decolonizing, and participatory methods, prioritizing intercultural sensitivity and collaboration with local traditional stakeholders.

Collaboration with AFNEMO and Kilombo Yumma in Bogotá

The fieldwork stage of this project consisted of engaging with actors who actively integrate ancestral knowledge and traditions into health and wellbeing practices in Colombia. The first strand of fieldwork focused on establishing a collaboration with the Asociación Afrocultural Neftalí Mosquera (AFNEMO) and the Kilombo Yumma collective in the capital city of Bogotá, D.C. This collaboration supported a culturally grounded and intercultural approach to the research. Beyond gathering information, this strand contributed to the investigation through relationship-building, contextual orientation, and the validation of intercultural perspectives relevant to respectful maternity care.

AFNEMO

AFNEMO is an Afro-cultural association that describes itself as "Missionaries of Afro Popular Culture." It is dedicated to empowering Afro-Colombian communities through autonomous ethnic organization, ethno-education, and democratic participation (Asociación Afrocultural Neftalí Mosquera [AFNEMO], n.d.). Its work emphasizes the protection and transmission of ancestral knowledge, fostering sustainable practices that connect community health and wellbeing with environmental conservation. AFNEMO's mission includes supporting economic, social, cultural, and political development that values Colombia's ethnic-racial diversity and environmental wealth.

Kilombo Yuma

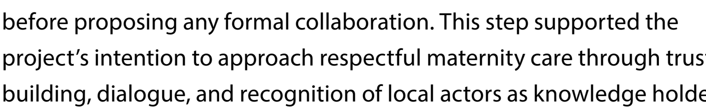
Within AFNEMO, Kilombo Yumma is a collective and community space of resistance focused on the preservation and conservation of women's ancestral and traditional medical knowledge from Colombia's Pacific coast (Figure #). The group brings together women who have experienced violence and displacement and who have settled in Bogotá, sustaining and sharing ancestral practices in an urban setting. It is important to note that the Kilombo is composed of actors from the community including traditional midwives and members with backgrounds in both traditional and academic western medicine. In this sense, AFNEMO and Kilombo Yumma are understood as an "embassy of the territory," sustaining ancestral and cultural care knowledge within an urban environment ("The territory" in this context refers to the geographical region of Chocó, but it also refers to the traditional space, culture and communities that come from it.). The collective operates through two main spaces in Bogotá: El Museo del Viernes Negro, where the community gathers for activities and has established a museum reflecting cultural history, and the Emergency Center, where ancestral medicine is practiced and patients are attended to.

The Kilombo's mission includes (AFNEMO, n.d.): (1) communicating the benefits and opportunities offered by the humanization of healthcare through ancestral knowledge; (2) promoting alternative practices in women's health, including sustainable practices that reduce environmental impact; and (3) creating and consolidating digital media that documents women's knowledge and experiences related to sexual and reproductive health, with particular emphasis on ancestral midwifery.

In addition, Kilombo Yumma has hosted and participated in projects and workshops focused on health, ancestral knowledge, education and dialogue between Western and traditional knowledge systems, including collaborations with universities, public institutions, and international actors. The latest example of this is the podcast Entrever Con mentioned in a previous chapter, where they hosted episodes with western invitees to discuss their different perspectives on health approaches.

Figure 15: Members of the Kilombo Yumma gather in Bogotá celebrating ancestral health knowledge, music, and community traditions. Kilombo's archive.

PERSPECTIVE ON COLLABORATION: LEARN TO UNLEARN



The perspective taken towards collaboration in this project can be summarized as an intention to learn to unlearn—to intentionally challenge Western and academic design assumptions, and instead learn and centre the ways the community organizes and shares knowledge.

To establish the collaboration respectfully, engagement was based on relationship-building and contextual orientation. Initial contact with the Kilombo was facilitated through local personal networks. Throughout the project, communication, invitations, initiatives, and planning were handled through a Kilombo representative, who acted as the primary point of contact for all engagements. All proposals and activities were discussed and revised with the representative before implementation with the group. Additionally, all project activities done with the Kilombo were integrated into workshops planned and hosted by them in their spaces—there were no activities scheduled exclusively for the purposes of this thesis. Instead, project activities were incorporated as a time slot allotted into their existing agenda and workshops. In this sense, the collaboration was meant to be done on their territory and under their terms.

From the beginning, it was agreed that the outcomes of the collaboration would result in materials that the Kilombo, as a co-creator in the design process, would have access to, use, and co-author. Therefore, understanding the Kilombo's practices and forms of knowledge transmission was treated as a key part of the research process.

The First Encounter

Keeping in mind the previous approach, the first encounter consisted of attending and participating in one of the collective's workshops as an initial point of contact. In this sense, no research activities related to this thesis were planned for the encounter. Its purpose was to understand the community's space and practices, and to allow for a mutual introduction before proposing any formal collaboration. This step supported the project's intention to approach respectful maternity care through trust-building, dialogue, and recognition of local actors as knowledge holders.

The Workshop: A Feminist Gathering

The workshop led by the Kilombo in this first encounter took place in the Museo del Viernes Negro and involved 15 participants in a women's gathering supported by an international cooperation initiative, including participants from Germany and Rwanda. The gathering explored themes related to feminism and Afro community perspectives, including the concept of the body as territory, pain, and collective healing as an ancestral and community-based practice. Intersectional themes such as gender, race, peace-building, decolonization and environmental relationships were centred.

Activities were structured through dialogue and story-sharing, followed by reflection. This included paper illustrations representing their bodies, used to externalize experiences of pain and subsequently to visualize self-care and healing practices through images and symbols.

The entire workshop was conducted in a circular dialogue format named Uramba. Uramba consists of a space in which participants sit in a circle and the discussion is characterized by horizontal dialogue where there is no hierarchy, everyone speaks the same language, no one knows more than anyone else, and collective knowledge is created. Uramba includes a rituals such as elders asking permission from the ancestors to open the space at the beginning of the discussion; participants dancing in tribute to thank the ancestors when closing the space, denominated chirimiotherapy; and food as a sacred medium to connect dialogue.

The Community Space

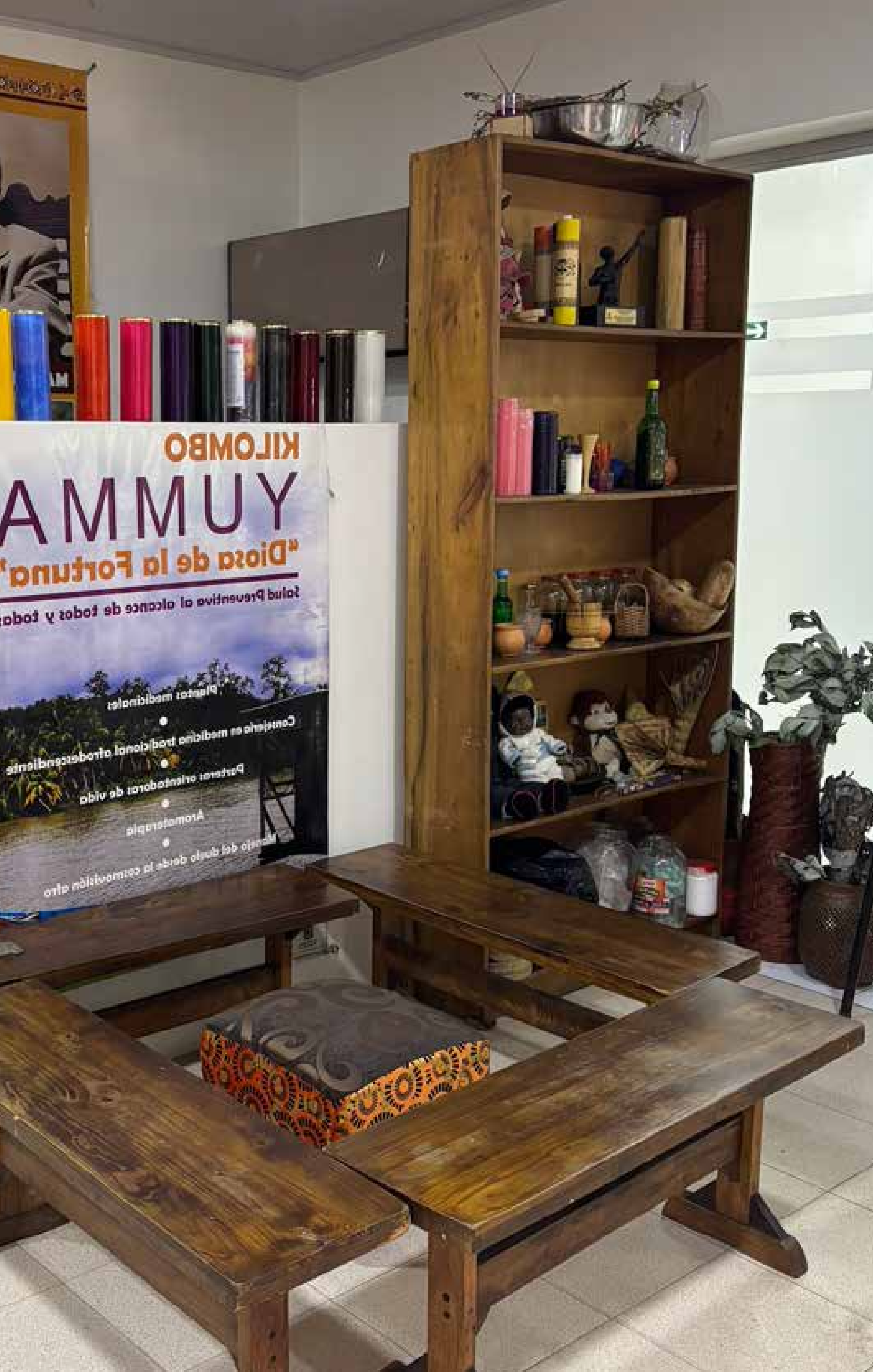
Finally, as part of becoming familiar with the community space, the encounter also included a guided tour through the Kilombo's environments, including:

- The physical "Kilombo", a space for circular dialogue, talks, and workshops (figure #);
- The kitchen, where food is treated as a sacred and integrative part of knowledge exchange;
- The museum, which documents cultural history and the movement from Africa to Colombia (figure #);
- The children's area with games and learning resources;
- The "roof", with samples of medicinal plants used in ancestral practices (figure #);
- And the herbarium, where products are created from these plants.
- The care center, where patients are attended to with traditional medicine.

Figure 17: Cultural objects from the Museum. Kilombo's archive.

Figure 16: Museum's entrance. Photo Taken by the author.

Figure 18: Children's area. Kilombo's archive



FIRST ENCOUNTER TAKEAWAYS

This first encounter served as a foundation for trust-building and opened the door for continued collaboration with Kilombo Yumma throughout the project. It enabled later activities led within the thesis process, including insight confirmation, co-ideation and feedback sessions that supported the development of the design proposal (described in the Ideation & Evaluation chapter).

In addition, the encounter provided practical understanding of how knowledge transfer is facilitated within the collective through structured workshops and specific elements such as circular dialogue, embodied reflection, and the integration of food, space, and symbolic materials. It also supported early familiarization with the Kilombo's actors and profiles, oral traditions, language use, and ways of framing care knowledge. These observations informed the structuring of subsequent design activities, allowing them to be integrated into fieldwork with traditional midwives in Chocó, and existing Kilombo-led workshops in later stages of the project. Overall, this experience shaped both the methodological approach and the final design proposal, which includes a Kilombo-led workshop format grounded in the community's practices of knowledge transmission.

To obtain a situated and deeper understanding of respectful maternal practices in this context, the following fieldwork activity consisted of traveling to the territory and interacting with many traditional midwives.

Figure 19: The Kilombo Care Center in Bogotá. Photo taken by the author.

Fieldwork with Traditional Midwives in Chocó

The second and main strand of fieldwork consisted of supporting and attending a traditional midwife convention in Chocó, where the majority of the design research and investigation activities took place.

Anonymity: To respect participants' privacy and considering the vulnerability of the communities involved, details and visuals that could identify individuals, organizers, or specific communities are edited or not disclosed in this thesis.

FIELDWORK CONTEXT

Fieldwork setting

The convention was hosted in a rural finca (farmhouse) located in the Chocó region, between the city of Quibdó and the town of Yuto. The site was composed of open-air structures used for activities during the day and converted into shared sleeping spaces at night. Facilities included sleeping mats and tents, shared bathrooms and showers, a communal kitchen, and outdoor shared spaces, including access to a nearby river.

Event overview

The event lasted six days and was organized as a convention for traditional midwives in the region. The convention theme centered on care and wellbeing for traditional midwives themselves.

Participants

Over 450 traditional midwives (women and men) from diverse Afro and Indigenous communities from across the region attended the event. Each community had designated representatives. The national federation of midwives also attended the convention, acting as a formal representative body that engages with national and international actors to advocate for recognition, rights, and support for traditional midwifery. Participating midwives represented a range of experience levels, including those who practice exclusively within their communities, those who also practice in institutional medical centers, and some who hold complementary degrees in nursing.

Figure 20: First day of the National Gathering of Traditional Midwives and Male-midwives.

Figure 21: Installations. Photo Taken by the author.

Figure 22: The river where some midwives would meet to wash utensils. Photo taken by the author.

Figure 23: Indigenous midwives crossing event yard. Photo taken by the author.

Figure 24: General medicine appointments. Photo Taken by the author.

Programme and formal activities

The programme included a series of talks and training sessions for the midwives, which were led and delivered by western professionals, including doctors, nurses, and other healthcare practitioners. Trainings focused on clinical and technical skills relevant to maternal and newborn care. In addition to training sessions, midwives were offered health and wellbeing appointments, such as general medical consultations and specialty check-ups. Days generally began at 7:30 a.m. and ended around 6:00 p.m., followed by dinner. The event concluded with festivities.

Figure 25: Respiration training session. Photo taken by the author.

Figure 26: Training on womb massages. Photo taken by the author.

Figure 27: Kangaroo training for premature babies. Photo taken by the author.

Research access and researcher role

Access to the convention was enabled through an invitation extended to a local research support team, of which the researcher was part. The team supported event logistics, organization, documentation, materials, and facilitation during scheduled activities. The researcher contributed to these responsibilities while also conducting research activities for the thesis project during designated free periods. For thesis-related documentation, individual permission and consent was requested through verbal consent and an explanation of how the data would be used.

Informal engagement and immersion

Importantly, the research support team was requested by the organizer to remain on-site for the duration of the event—sharing meals, accommodation, and daily routines with the midwives—as a foundation for trust-building and respectful engagement, rather than staying in nearby towns. This immersion enabled participation in informal community activities beyond formal sessions, including the exchange of artisanal products, storytelling, singing, dancing, and bathing in the river.

Figure 28: Indigenous pattern paintings using jagua, a natural ink, painted by midwives on researcher and organization team. Photo taken by the author.

Figure 29: Lunch on day 5 cooked by the kitchen team of eight staff. Photo taken by the author.

Figure 30: Ice-breaking activity for midwives and organization teams.

RESEARCH ACTIVITIES & METHODS

During the six-day event, multiple qualitative research activities were conducted for this thesis project to develop a situated understanding of traditional midwifery practices related to respectful, intercultural and emergency care dynamics in the region. Research activities were carried out alongside the researcher's logistical support role and took place during moments of availability, always with explicit permission from participants. The methods and their purposes are outlined below.

Active Observation

Observation was conducted during the formal convention training sessions facilitated by western healthcare professionals in which the researcher supported execution. These sessions included role-playing, talks and practical demonstration activities related to Kangaroo care for premature births, neonatal resuscitation, tension-reading and weight assessment.

The purpose was to understand how knowledge and skills were taught, learned, and transmitted between the actors. Particular attention was given to how respectful care practices were shaped through interactions during training scenarios. As the convention included significant moments of knowledge transfer across approaches, observation also provided insight into the exchange between western and traditional perspectives, versus also how traditional representatives then passed it on to their respective communities.

This method resulted in photographs and fieldnotes which were taken for the documentation process. All material was documented with verbal consent from midwives including an explanation that identifiable details—such as faces—would remain or be rendered anonymous in this thesis.

Figure 31: Role-playing activity during weight training. Photo taken by the author.

Figure 32: Role/playing in training on monitoring tension rates. Photo taken by the author.

Guided interviews

Guided interviews were conducted with traditional midwives from different afro and indigenous communities during their free periods throughout the event. Interviews took place in individual and small-group formats, depending on how midwives felt most comfortable. When speaking with Indigenous midwives, a translator from within the community was requested when necessary to ensure an accurate interpretation.

Interviews focused on how traditional midwives in Chocó understand and learn about key concepts and experiences related to:

- The term Humanized Childbirth
- Respect and respectful care in maternity care
- How emergency situations are understood and handled
- Intercultural births

The goal of the interviews was to allow specific manifestations of care to surface. To support this, interview prompts were designed to align with the communities' oral traditions, storytelling practices, and lived-experience-based knowledge, drawing on the Path of Expression in generative research for flow (Sanders & Stappers, 2012). The detailed prompt design and learnings from this integration are presented in the How-To / Learnings box, and the full list of interview questions is provided in Appendix X.

This method resulted in 50 recorded interviews, ranging from 10 minutes to 2 hours in length. Audio recordings were later transcribed and translated for analysis. Photos were captured with permission to support documentation of materials relevant to the discussions. Midwives were reminded that they could stop the interview at any time or opt out of any question.

Figure 33: Traditional male-midwife and medical professional from Chocó. Photo taken by the author.

How-To / Learnings:

Guiding interviews in contexts of oral traditions and lived-experience knowledge

This box summarizes both the interview prompt structure used in this phase of the project and key learnings from the interview sessions.

Interview prompts were designed to align with communities' practices, in which knowledge is predominantly oral, experiential and transmitted through storytelling. The interview flow was informed by the Path of Expression approach in generative research (figure 34), which supports the emergence of tacit knowledge through guided reflection (Sanders & Stappers, 2012). In practice, this involved situating midwives through personal experience- and story-based prompts, moving from present understandings of care, to past experiences of respect and emergencies, reflecting on these in the present, and finally closing with future-oriented advice. This approach aligned with the communities' communication strengths and allowed for specific local care actions and examples to surface.

1. Present: Ground concepts in participants' language / context

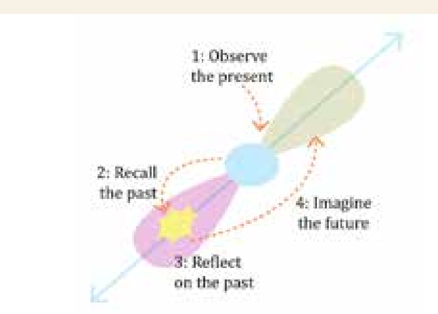


Figure 34: The Path of Expression (Sanders & Stappers, 2012, p. 55)

Interviews began by asking about familiarity with key terms:
- Are you familiar with the term Humanized Childbirth?
- What does it mean to you?

2. Past: Understanding concrete experiences through past memories
Interviews continued through past memories and concrete episodes through stories to generate tacit knowledge:
Emergency Situations
- Describe a past emergency situation you faced.
- How did you support the mother?
Intercultural Births
- Describe a birth you assisted for another community or culture.
- How did you handle their different traditions then?
- How did you know to do so?
Experiences with western medicine
- When was the last time you engaged with a medical center?
- What were interactions with doctors or nurses like?

3. Present Reflection: Moving from "disrespect" to "respect"
In some cases, starting to describe respect directly was challenging. Starting with experiences of disrespect made it easier to define respectful care in contrast:
- What forms of disrespect have you lived or witnessed?
- What would you do differently in that situation?
- What does respect look like, and how do you create it?

4. Closing with the future: hypothetical advice
Interviews closed with forward-looking prompts:
- What advice would you give a future medical student, doctor or nurse who will attend to mothers in these communities to create respect?

Mapping Barriers Workshop

The researcher participated in and supported workshop activities held during the convention. This included federation-led sessions aimed at identifying barriers that traditional midwives face in sustaining their practice within the region.

During a mapping workshop focused on barriers and access, the researcher supported facilitation and led one community in mapping and discussing their access situation and constraints related to healthcare availability, transportation, and regional infrastructure. This activity supported contextual understanding of the broader midwifery landscape, including the effects of local conflict, economic limitations, geographical constraints, and systemic barriers.

Within the scope of this thesis, the purpose of this activity was to illustrate the scenarios and conditions that form the backdrop of emergency situations in the region. This included the decisions, limitations, and logistical struggles midwives and mothers encounter when attempting to reach the nearest institutional medical center during maternity emergencies.

This method resulted in fieldnotes documenting main contextual information surrounding emergency maternity care.

Figure 35: Mapping activity to understand barriers for midwives when commuting to medical centers.

CHOCÓ FIELDWORK TAKEAWAYS

Besides insights on respectful and emergency maternity care, this fieldwork strand generated methodological takeaways that informed the research process and design approach in this context, and offers guidance for replicable intercultural design work.

Trust-building as a core research practice

Remaining onsite and sharing routines with the community showed that trust and knowledge is built through immersion and participation, not interviews and introductions alone. Methodologically, this suggests relational work should be treated as an essential component of fieldwork.

Oral tradition requires experience-based prompting to elicit tacit knowledge

Interviews were most effective when guided through storytelling and lived experience rather than abstract concepts. Using the Path of Expression logic supported the emergence of tacit knowledge and actionable care situations, practices, examples and timelines.

Observation of knowledge transmission is as important as interviews

Observing training, talks and role-play sessions revealed how skills and knowledge are transferred across western and traditional approaches, and among the communities themselves. This highlights the value of combining interviews with observation when informing training design.

Design activities must fit within existing community rhythms

Integrating design activities within community-led activities (rather than creating separate sessions only for the thesis) supported participation. For future replication, design work should be modular and integrated into existing agendas with local partners.

Figure 36: The building functioned both as activity spaces and sleeping areas. Photo taken by the author.

Figure 37: Midwives resting before the afernoon activities, chattting and painting each others' nails. Photo taken by the author.

Figure 38: Group photo with indigenous midwives.

04 ANALYSIS OF FIELDWORK

How can fieldwork data be analyzed and structured to reveal patterns of key Respectful Maternity Care manifestations in emergency maternity care in Chocó?

This chapter answers the guiding question above by mapping and synthesizing fieldwork findings across actors, beliefs, relationships and care moments. It begins with an Actors Map, highlighting how different knowledge systems and care providers in Chocó collaborate, recognize one another, and set the context for care practices. This is followed by a manifestation categorization process, where situated examples from fieldwork are structured into positive and negative manifestations and further classified according to the RMC types defined in the Compendium framework (WHO, 2025). Building on this categorization, a Constellation Mapping process then visualizes care narratives and respect-related manifestations into clusters of value creation to understand how they connect across situations and meanings. Finally, the chapter concludes with a Journey Mapping of emergency maternity care in this context, identifying the key moments in which manifestations of respectful care emerge or break down.

ACTOR MAPPING

- Method Purpose
- Mapping Process
- Actors Map Takeaways

MANIFESTATION CATEGORIZATION

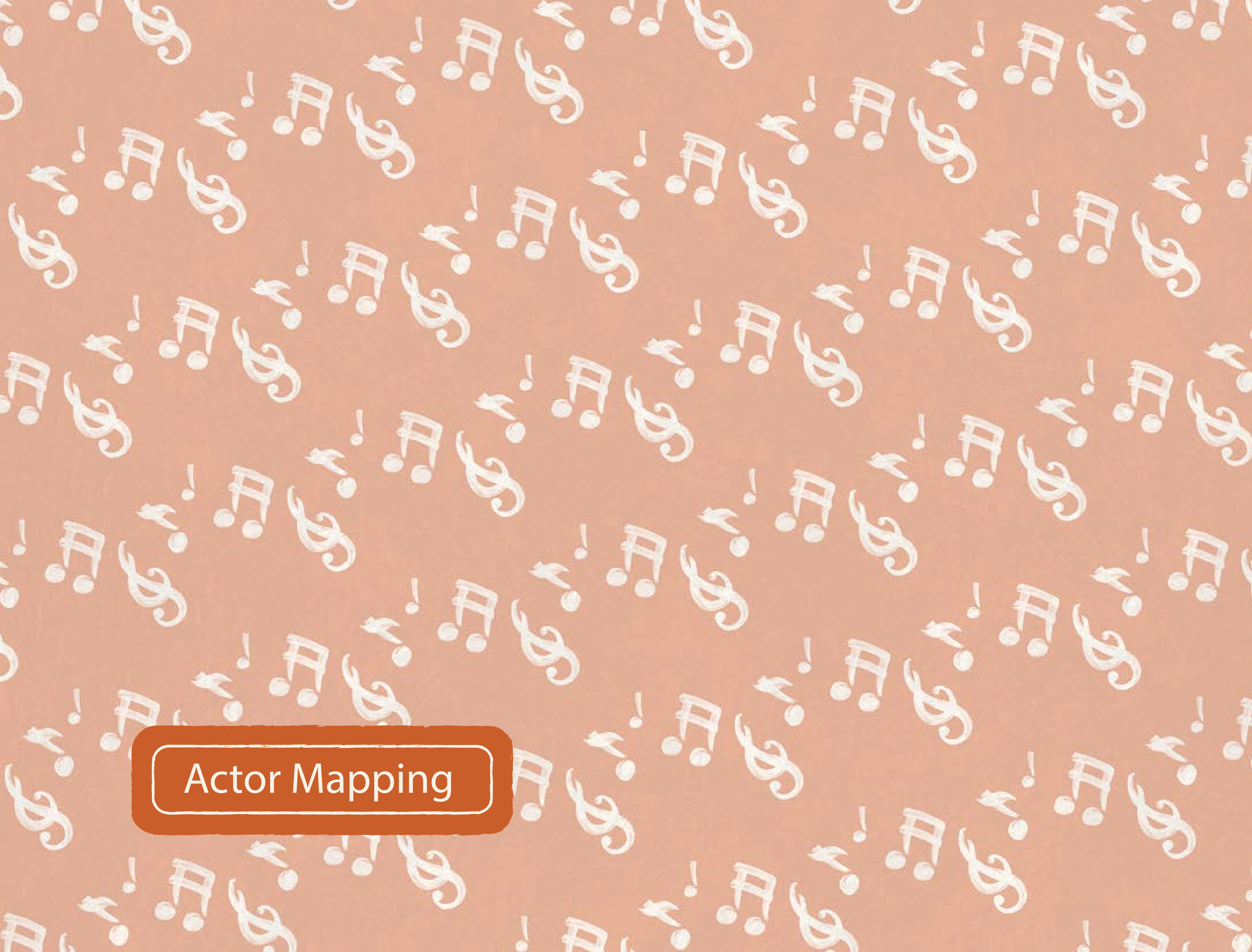
- Method Purpose
- Categorization Process
- Manifestation Categorization Takeaways

CONSTELLATION MAPPING

- Method Purpose
- Constellation Nodes
- Constellation Arenas
- Constellation Mapping Takeaways

JOURNEY MAPPING

- Method Purpose
- Mapping Process
- Journey Mapping Takeaways



Knowledge Systems Collaboration & Recognition

Figure 39: Actor ecosystem map visualizing maternity care actors in Chocó across knowledge system orientation, institutional recognition, and key relational dynamics. Developed by the author, 2026.

Actors Map: Knowledge Systems Collaboration & Recognition

METHOD PURPOSE

This actor mapping process was developed to synthesize fieldwork findings into an overview of the care ecosystem shaping emergency maternity care in Chocó—a big picture or macro-level understanding of the care context. The purpose of the map in figure X is to identify the main actors involved in maternity care practices and visualize how they overlap, interact, and acknowledge one another across traditional/ancestral and biomedical knowledge systems. By making relationships of institutional legitimacy, knowledge transfer, and epistemic tension explicit, the map supports later analysis by highlighting where collaboration is present, where conflict and mistrust emerge, and which actors occupy bridging roles across care systems.

MAPPING PROCESS

1. Positioning Axes & Actors

The creation of axes and positioning of actors was guided by the question: How do different knowledge systems coexist, collide, and how are they valued?

Two axes were established to situate actors within the care ecosystem: institutional recognition in medicine and knowledge system orientation.

- Horizontally (X-axis), actors are positioned according to their degree of institutional recognition, this includes actors whose practices are informal or not currently recognized by the state, as well as actors who are formally institutionalized and regulated. Actors positioned in the middle represent semi- or contextually recognized practices, whose legitimacy depends on the specific context or situation.
- Vertically (Y-axis), actors are positioned according to their knowledge system orientation, ranging from traditional/ancestral medicine to Western/biomedical medicine. Actors placed near the center represent hybrid practices, including actors who operate within, participate in, or frequently interact with both approaches.

- Key actors involved in maternity care were identified and placed on the map based on fieldwork. Actors are represented as colored nodes grouped by type such as mothers, traditional midwives, medical institutions, medical institution actors, associations, and government actors, including mixed actors.

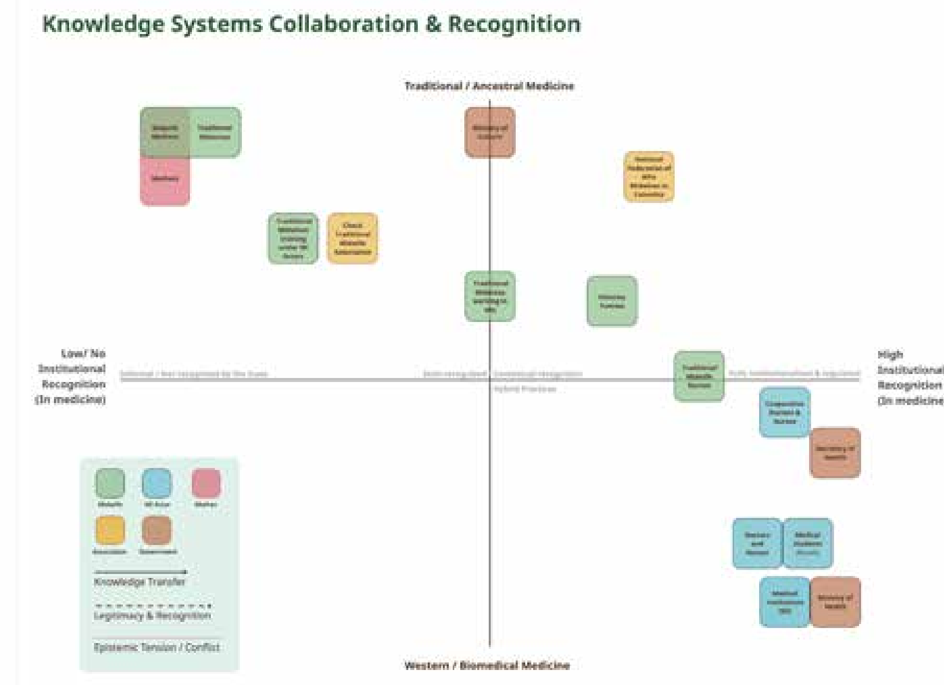
2. Visualizing relationships between Actors

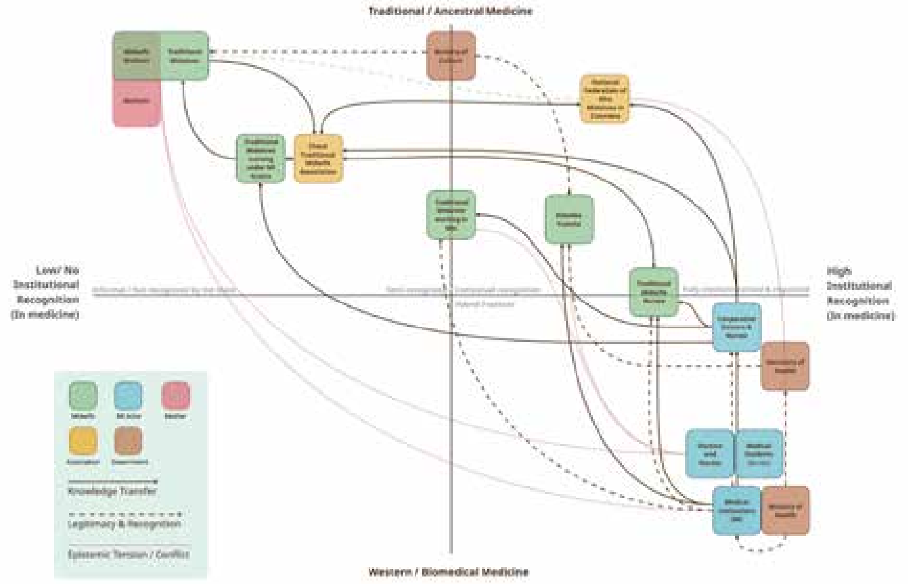
Finally, three types of relationships were mapped to capture how actors interact across the system. The relationships were defined as answers to the following questions:

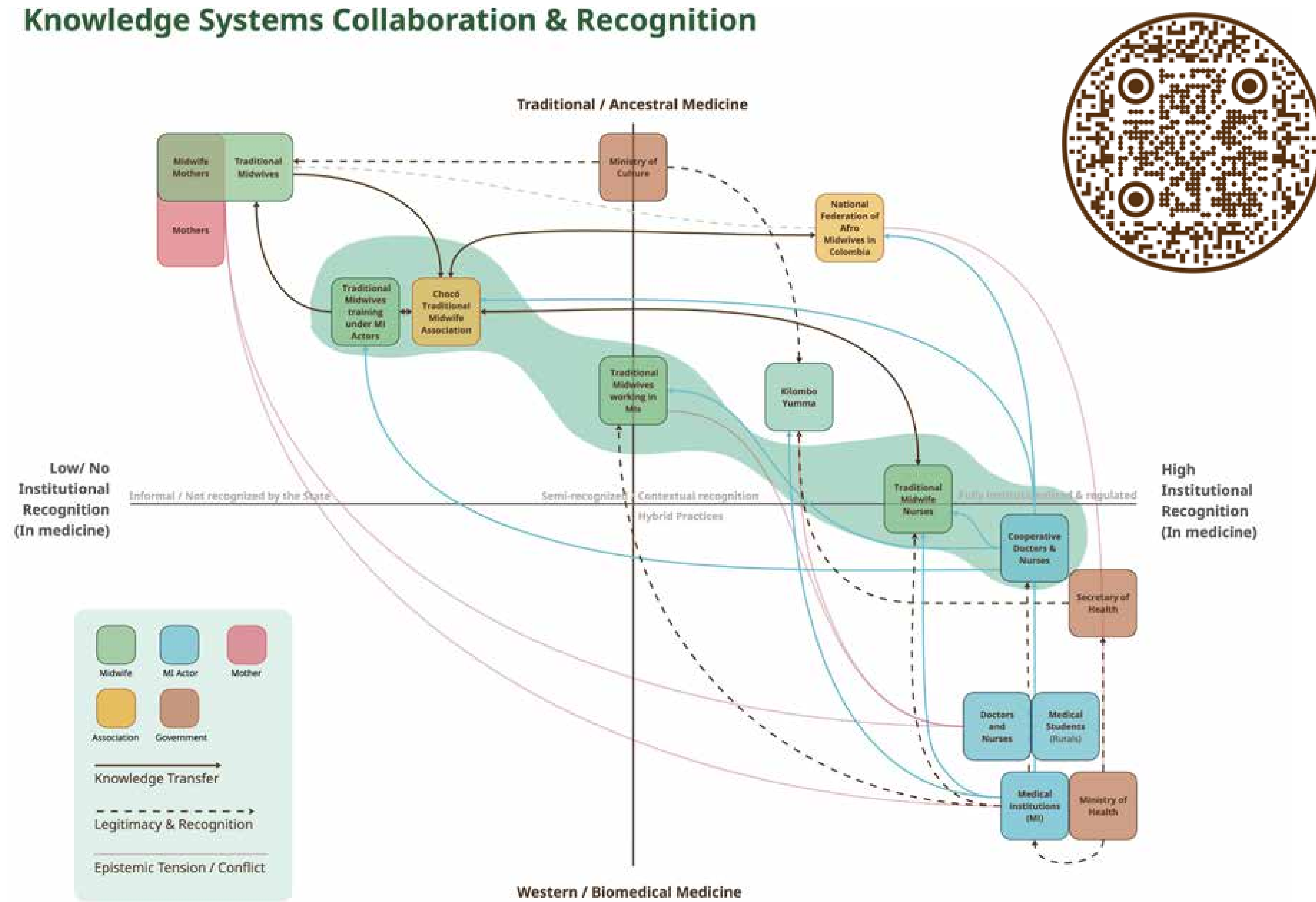
- Legitimacy and recognition: Who validates whose knowledge as "acceptable", and where institutional acceptance is granted or withheld?
- Knowledge transfer: Who teaches, trains and learns from who?
- Epistemic Tension or conflict: Where do knowledge systems clash, compete or undermine each other?

Together, these elements allow the map to function not only as an actor overview but as a tool that makes visible how legitimacy, collaboration, and conflict shape emergency maternity care practices.

Knowledge Systems Collaboration & Recognition







ACTORS MAP TAKEAWAYS

This actors map enabled the identification of the following key insights:

Knowledge transfer is largely a one-sided conversation

Knowledge exchange relationships primarily flow from medical institution (MI) actors within biomedical and western frameworks toward traditional and community actors (highlighted in blue in figure X). This transfer most often takes place through trainings (conventions or workshops) or weekly online classes with cooperative MI actors.

Transferred knowledge is predominantly technical.

The knowledge that is passed from MI actors to traditional midwives through training is largely technical and clinical, complementing the empirical knowledge midwives own from experience in the territory.

Hybrid actors are key bridging roles across systems.

As seen in figure X highlighted in green, the map highlights the presence of actors that operate within, participate in, or frequently interact with both knowledge systems. These actors enable collaboration and translation across care systems.

Hybrid roles should be supported, but not positioned as the "ideal."

In the context of this project, it is important to clarify that hybrid actors are seen as valuable bridge-builders, yet not as the desired end state for all actors. In this sense, supporting hybrid actors should not imply an assimilation for all traditional actors into biomedical standards, rather , all actors' expertise should be recognized, respected and alongside the collaboration of diverse care experts.

Kilombo Yumma is considered a hybrid actor ecosystem.

As an embassy, the traditional collective is grounded in traditional experts and perspectives while including members with academic biomedical training and, in some cases, formal degrees. Additionally, the Kilombo lead many events in which they share and exchange medical perspectives, often being invited to educate on the traditional perspective at conferences, universities and classrooms.

> "So, yes, we want traditional medicine to be recognized in Western medicine, for us to be one and one."
>
> TRADITIONAL AFRO MIDWIFE

Manifestation Categorization

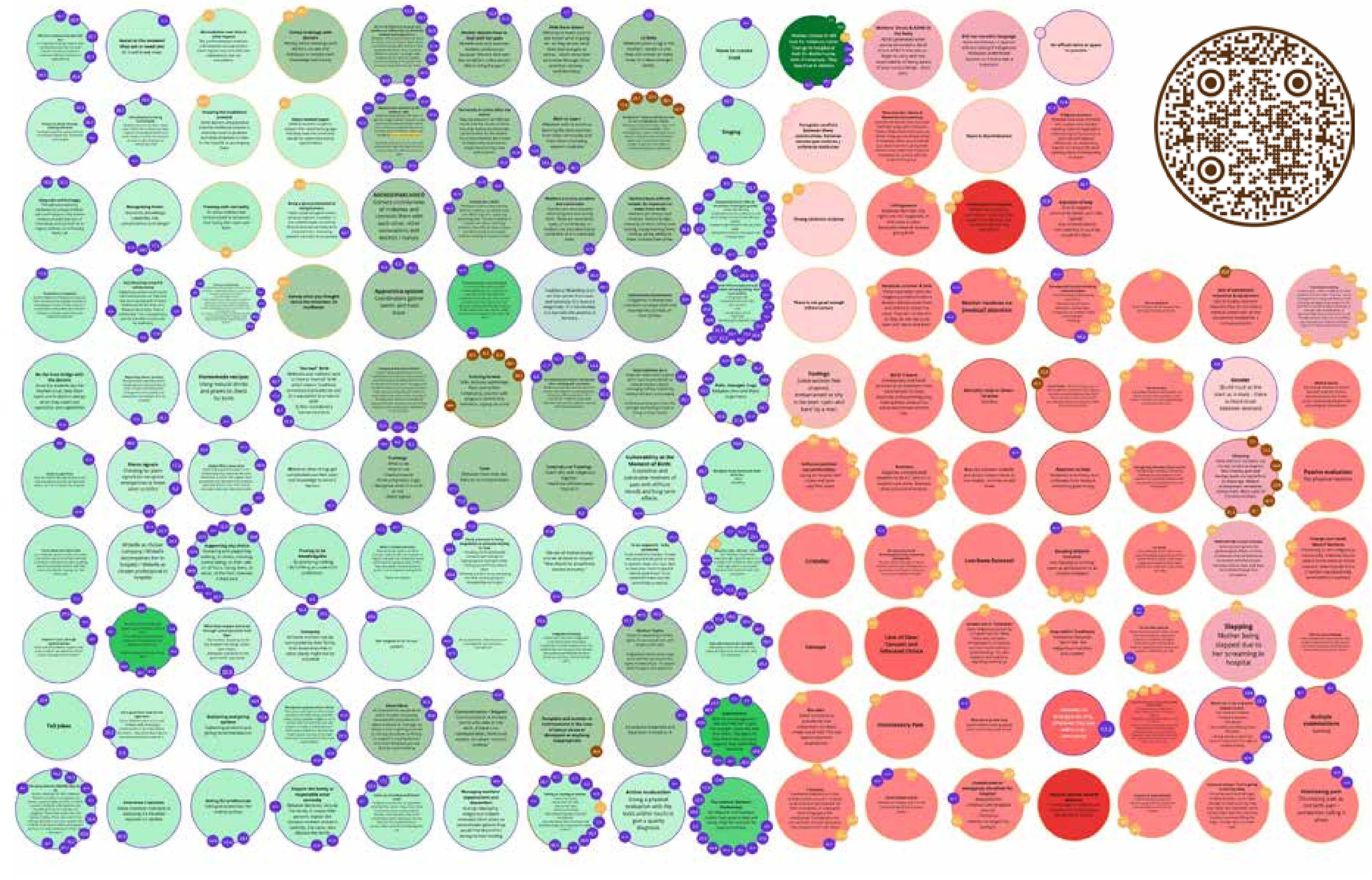


Figure 40: Manifestation Categorization map where green indicates postivie manifestations and red negative.

Manifestation Categorization: Positive, Negative and Where

METHOD PURPOSE

This categorization process was developed to translate fieldwork data into a structured overview of RMC manifestations. Using the Compendium framework (WHO, 2025) as the base, the method allows for the identification of specific and recurring positive manifestations of respectful care as well as negative manifestations of mistreatment in the context.

CATEGORIZATION PROCESS

Manifestations of RMC as concrete Concepts and Actions

To generate manifestations, fieldwork data was reviewed to extract concrete examples of respectful care concepts and actions, both positive and negative. Each circle or unit of information is treated as a manifestation, with numbers that allow for the manifestation to be traced back to the supporting evidence, as is seen in figure 1.

Figure 41: The manifestation on the right is considered a positive RMC-related concept with four supporting quotes form the fieldwork. The manifestation on the right is considered a negative RMC-related action based on one evidence note.

Positive or Negative, and in which context

As seen in figure 2, each manifestation unit was categorized as either a positive manifestation with the color green (actions or concepts that shape what respectful care is in the context) or a negative manifestation with the color red (mistreatment or concepts that undermine respectful care in the context). Manifestation units were further categorized based on the color of its outer ring: (1) Purple indicates the manifestation exists within the traditional community ; (2) yellow indicates the manifestation exists within medical institutions; and (3) brown indicates it occurs in both contexts.

Figure 42: Manifestation categorization based on the inner color for positive or negative, and the outer ring for the context in which it occurs.

Without context, some manifestation units seem like they may be negative when they are actually positive, or vice versa. This is where constellation mapping, the method described in the following section, allows for the determination, as it situates the manifestation for a better understanding of its interpretation according to the context. Figure 3 is an example of this phenomenon.

Compendium Categories (WHO, 2025)

Finally, manifestations were further classified according to the Compendium's RMC manifestation types, allowing each manifestation to be situated within broader categories of respectful maternity care. This was to, as suggested by the WHO (2025), facilitate the understanding of which type held the most value in the context at hand, to then use it as a focus lens for the continuation of the project.

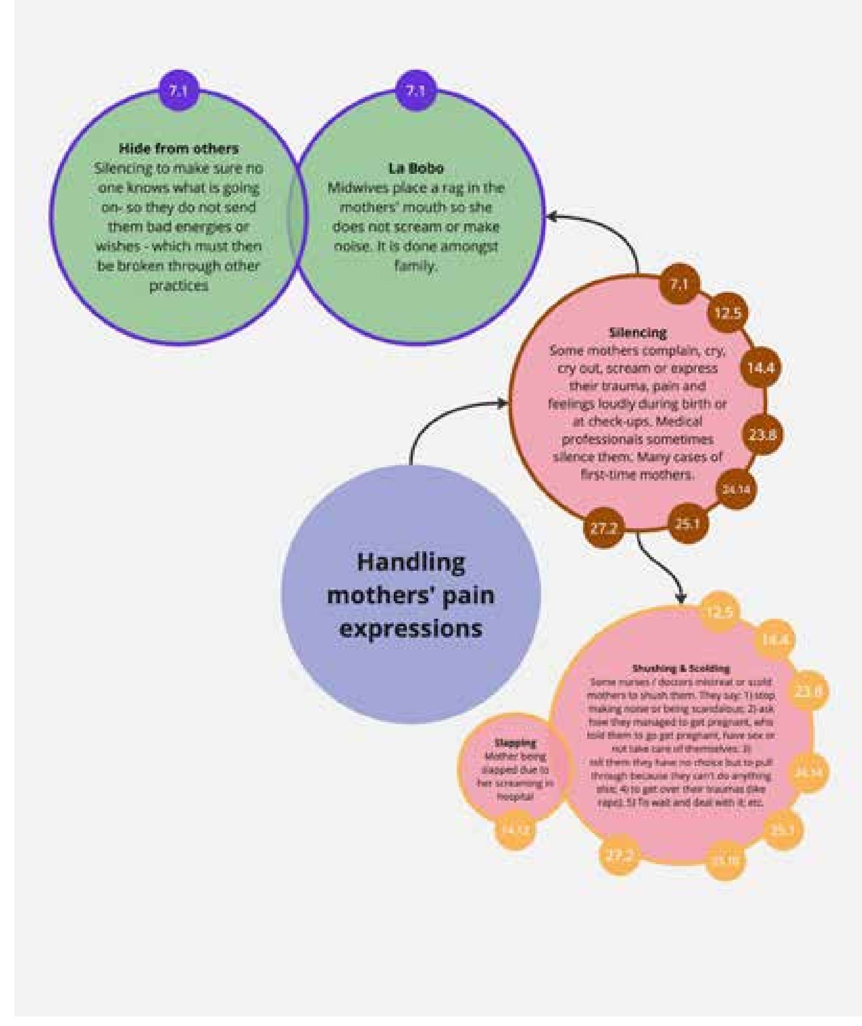


Figure 43: Silencing the mother can be thought as a negative action. In the context of a medical center it is, as explained in the negative manifestation unit. However, in the traditional community, it can have a positive intent based on the belief of protection from negative energies in the local context.

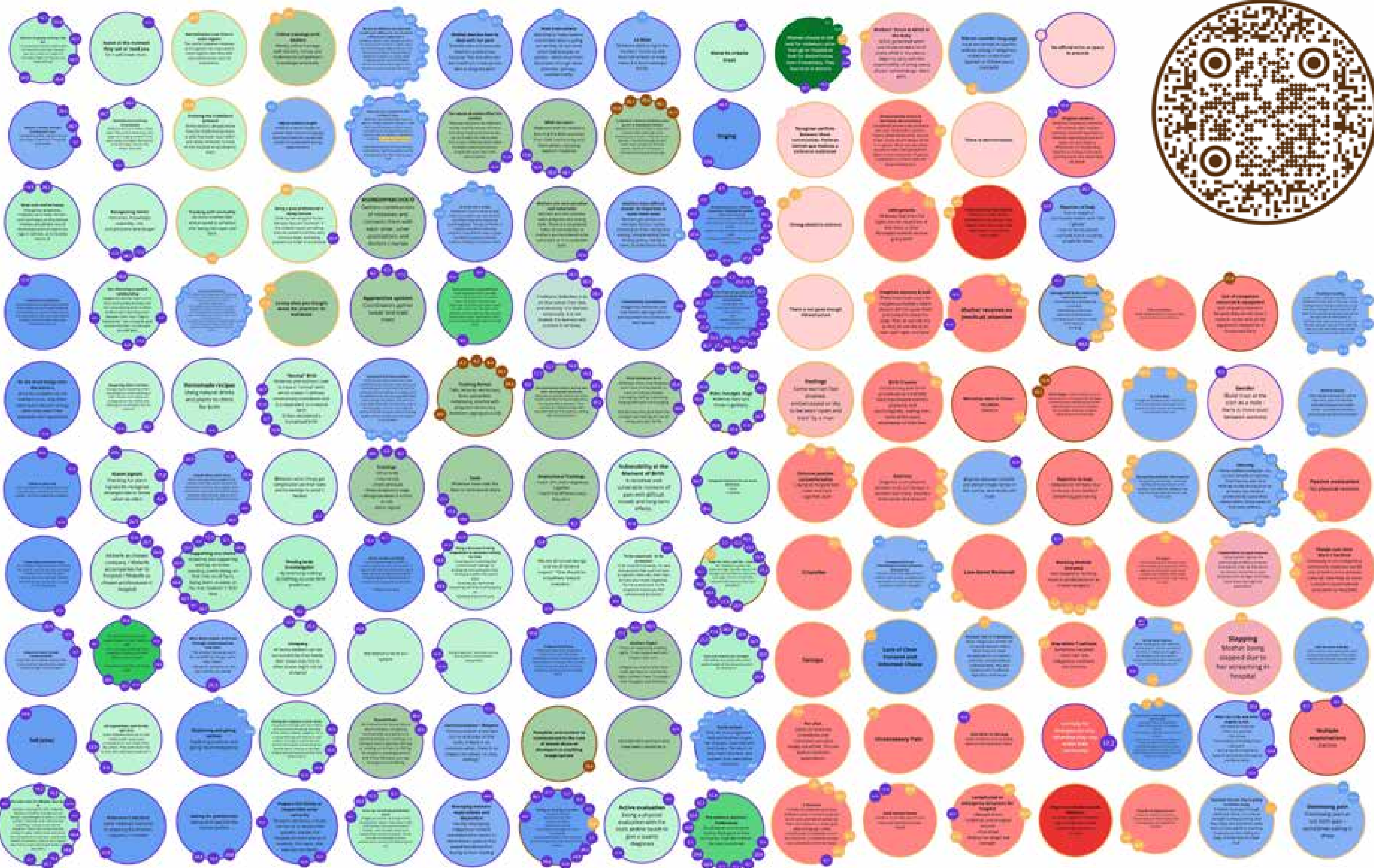


Figure 44: Manifestation units related to communication highlighted in blue.

MANIFESTATION CATEGORIZATION TAKEAWAYS

The manifestation categorization process allowed for the understanding of key insights regarding how RMC is interpreted in Chocó, and it provided a structured foundation for later analysis and design methods.

ANALYSIS TAKEAWAYS

Some manifestations required local contextualization to interpret their shade

Certain actions or concepts could not be categorized as positive or negative without understanding the local situation, intention, and relational meaning. This led to the need for simultaneous constellation mapping as a complementary method to locate manifestations within local situations.

Concrete examples create analysis and design readiness

The categorization produced concrete and context-specific examples of actions and concepts that generate respectful care or contribute to mistreatment. This step therefore enabled the translation of qualitative narratives into a structured set of design-relevant inputs that could be integrated into later analysis methods and design proposals.

Design decision to focus on traditional proactive respectful care

Despite analyzing forms of mistreatment, the project prioritizes a focus on manifestation types in the purple rings with green centers; this centers proactive positive manifestations and respectful actions grounded in the traditional/community perspective. With this decision, the project seeks to emphasize an opportunity-based approach that supports existing care knowledge rather than focusing on deficits.

INSIGHT TAKEAWAYS

Ring categorization revealed a stronger presence of respectful care in traditional community practices

From the perspective of traditional midwives, positive manifestations were more frequently associated with community-based care practices, while negative manifestations appeared more frequently in medical institution settings.

Communication emerged as the most transversal and valued manifestation type in this context

Across the fieldwork, respect was repeatedly related to acts and concepts of communication within maternal care. Given the region's strong oral tradition, communication practices were found to touch multiple dimensions of care simultaneously and appeared as one of the most frequent categories in both positive and negative manifestations, as seen in figure 4.

Constellation Mapping

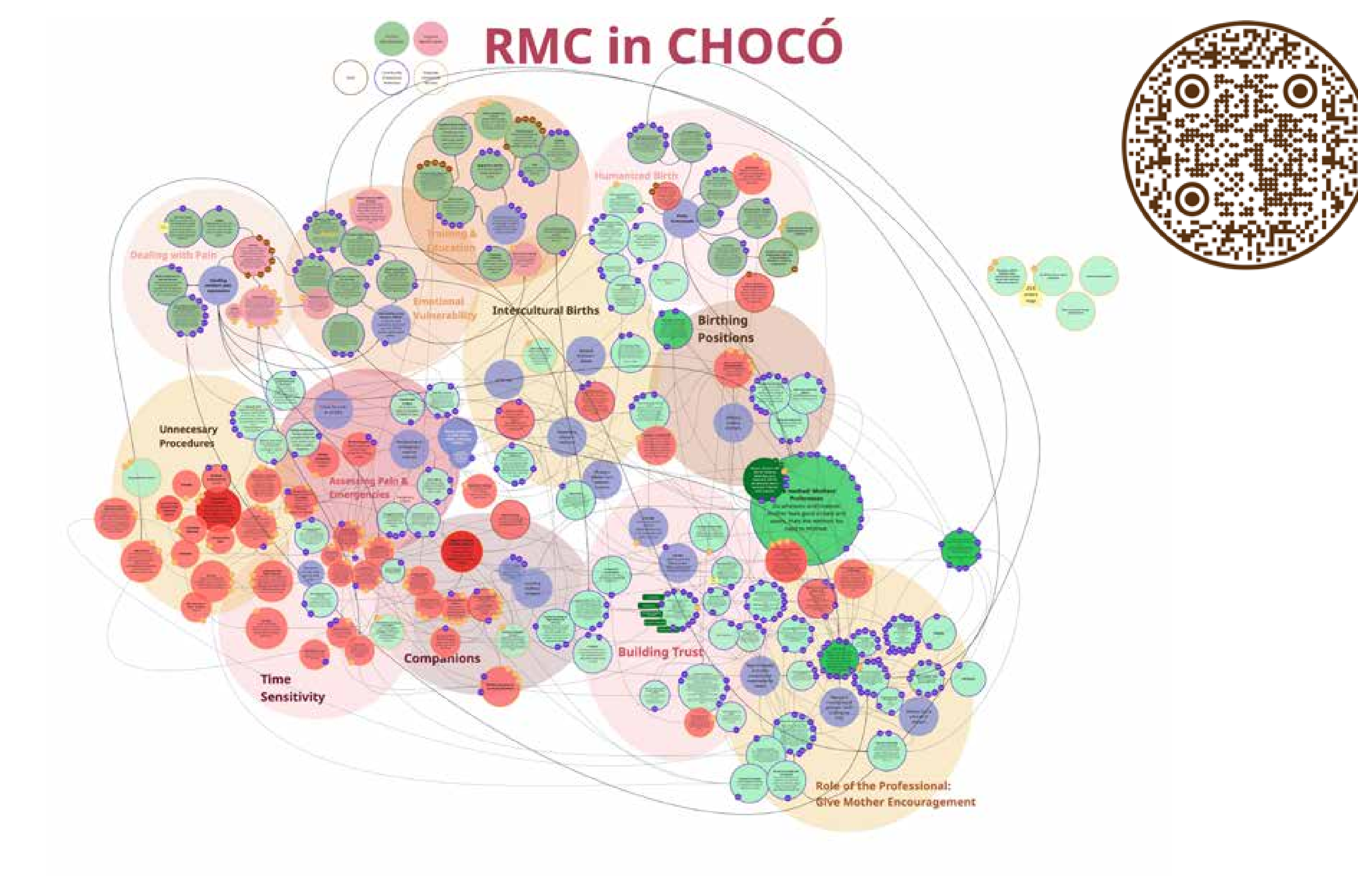


Figure 45: Constellation map.

Constellation Map: understanding value relationships

METHOD PURPOSE

This activity-based mapping process was developed to translate fieldwork narratives into a micro-level understanding of situated RMC concepts and manifestations in emergency maternity care in Chocó. Conducted in parallel and building on the manifestation categorization method described in the previous section, constellation mapping reveals how specific actions and manifestations are embedded within concrete situations, activities, and concepts rather than occurring in isolation. By "knitting together" actions and examples into the narrative situations in which they were described, this method connects, contextualizes and visualizes relationships between manifestations and concepts, identifying clusters of value-creating activities that shape emergency maternity care.

What is Constellation Mapping?

According to De Los Reyes Victoria (2020), Constellation maps are methods that analyze how different social actors cooperate and compete in situated processes of value construction. Constellation mapping is done in two layers: first by identifying and structuring Constellation Nodes or activity clusters, and then by identifying Arenas, zones of value cooperation and competition.

Nodes: activity clusters / literal narrative
Arenas: higher-order conceptual dynamics within and across nodes

CONSTELLATION NODES

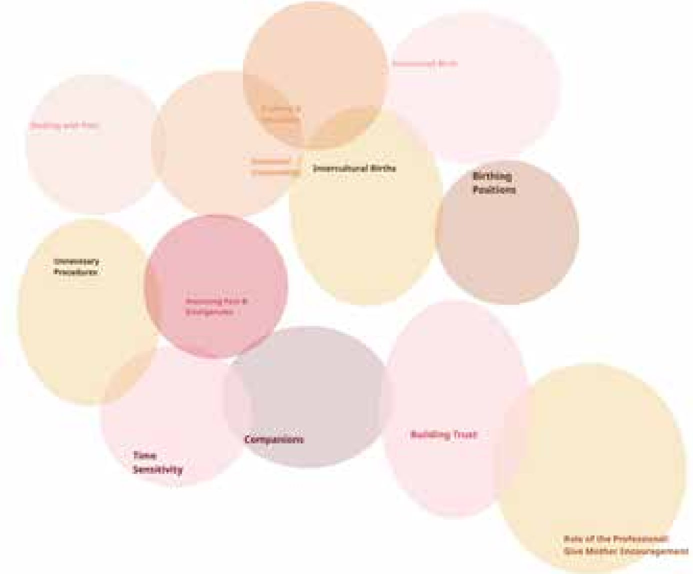
In accordance with De Los Reyes Victoria (2020), each constellation node is a type of general activity that produces value. It can be represented as a large molecule of sub-activities, or as a black box; however, what defines its boundary is the shared meaning around the value being produced. The outcome (value) can then be used in a new activity, but there is always a process of translation in which, by definition, some information is lost (An example of this analysis concept can be read in the author's note box).

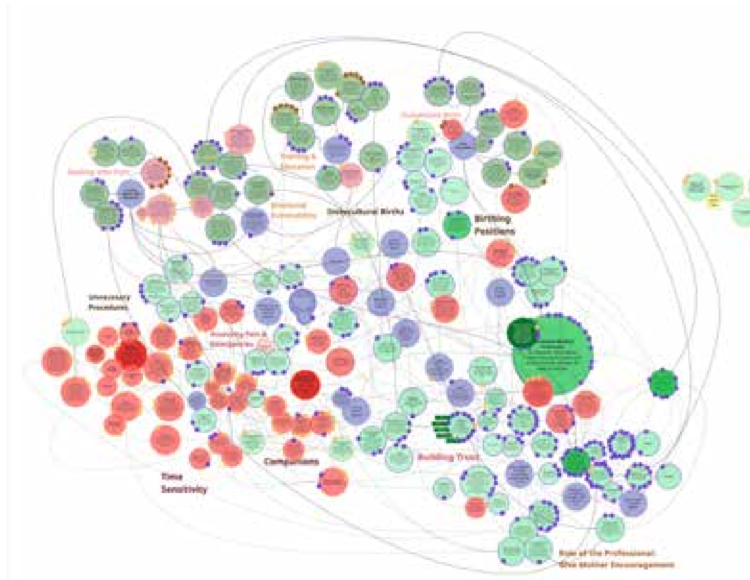
Author's Note: Example of Constellation Nodes - Sports Edition

NODE 1: An athlete is preparing for a competition in the gym, they train and accumulate biological value, which they measure through gym-specific metrics.

NODE 2: When moving into the competition, however, they must also mobilize symbolic and affective forms of value (their jersey, their charisma), and succeed within the meaning-making dynamics of the competition in order to translate their training into competition-specific value.

NODE 3: Value from node 2 then allows them to accumulate further value in other nodes (prestige, recognition, monetary reward, etc.).





Constellation Nodes Process: Generating Activity Clusters

The process began by connecting different manifestations to understand general activities (nodes) composed by sub-activities. Connections between manifestations were drawn according to literal narrative relationships including shared situations, sequential actions, overlapping concepts or linked consequences.

To facilitate mapping, initial base themes were used as large background clusters (figure x). These themes functioned as preliminary anchors for organizing manifestations and the emerging connections. The base themes included: birthing positions, dealing with pain, assessing pain and emergencies, emotional vulnerability, training and education, humanized birth, unnecessary procedures, time sensitivity, companions, building trust, intercultural births, and the role of the professional. Over time, these general themes held multiple clusters of manifestations or constellation nodes (figure x). As seen in figure x, solid activity units in grey were used to help cluster manifestations into sub and general activities within base themes.

This process supports a systems view of Respectful Maternity Care in Chocó, where constellation nodes are interconnected and the outputs of one node influence others. As described in the theory, value is continuously translated and transformed across activities, meaning that the outcomes of one node (e.g., trust, intercultural education, uncertainty, collaboration, delay, birthing preferences, cultural beliefs) shape the conditions under which subsequent care practices unfold. This process laid the ground for the identification of Arenas.

CONSTELLATION ARENAS

As explained by De Los Reyes Victoria (2020), since activities are situated (they run through time, artefacts, systems and infrastructures), different actors compete or cooperate to access and benefit from them. When particular nodes of the constellation consistently attract cooperation and competition dynamics, they become arenas. An arena can be understood as a situated dynamic or ecosystem involving particular actors, in which it is possible to identify how they cooperate or compete around a topic within the constellation.

Arenas Process: Identifying Conceptual Dynamics

Upon understanding the situations, relationships, and thematic connections between manifestations and nodes—including the context in which they occurred—it became possible to interpret how actors from different medical approaches in Chocó cooperate or compete to generate or undermine RMC through specific concepts and actions. Unlike constellation nodes, which are grounded in concrete narratives and activity sequences, arenas operate at a more abstract interpretive level and highlight cross-cutting dynamics that influence multiple care moments. This analysis therefore revealed "invisible" connections between value activities, elements, actors, and concepts that could not be captured through literal storyline connections alone.

To identify arenas, connections were drawn across constellation nodes and manifestations by recognizing patterns of cooperative and competitive relationships. These arena-level connections represent larger belief systems, value transitions, and recurrent situated tensions or alignments throughout activity sequences. This process enabled deeper insights into why certain care actions take the forms and meanings they do in this context, and how situated meanings define whether actions are experienced as respectful or harmful.

"So when I came in with the hemorrhage, he told me there was nothing he could do, that if it was going to come out, it would come out. It's traumatic for a mother who wants her child. That's not the way to talk to a mother who longs to have her child."

TRADITIONAL AFRO MIDWIVES

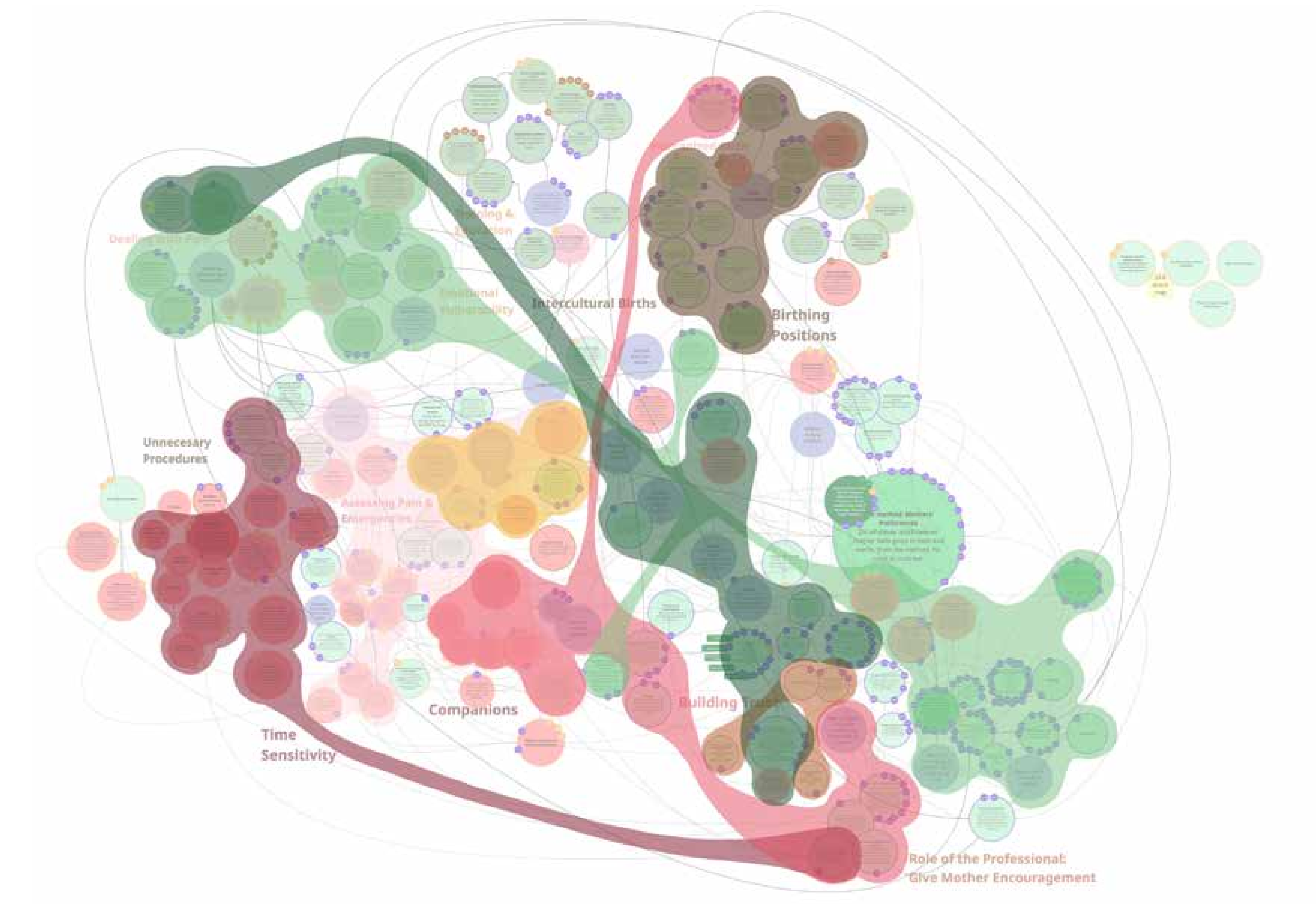


Figure 46: Constellation arenas.

For example, confidentiality may be understood as a universal protocol, yet arena mapping supported an understanding of what confidentiality looks like locally, why it carries particular weight, and how it can be shaped through communication elements. In this sense, arenas support interpretation by revealing how manifestations are negotiated across traditional and biomedical approaches and by identifying where trust has the opportunity to be created—or undermined.

CONSTELLATION MAPPING TAKEAWAYS

Analysis takeaways: How did this method help the design process?

Translating narrative fieldwork into structured analysis
Constellation mapping proved to be an effective analysis tool for translating qualitative, story-like fieldwork data into structured relationships between actions, concepts, situations, actors, and meanings. The method makes visible how care practices are built both literally (through activity sequences) and conceptually (through beliefs, values, and interpretations).

Explaining why actions become respectful or harmful
The method supports situated interpretation by showing how manifestations become respectful or harmful depending on context. It reveals how value is constructed through recurring dynamics of cooperation and competition between actors, local beliefs, and knowledge systems. This enables the analysis of not only what occurs, but why it takes the forms and meanings it does in this setting.

A method suited for RMC and context-defined concepts
Constellation mapping is particularly appropriate for analyzing Respectful Maternity Care, a concept that is inherently defined through local meaning and lived experience. Rather than treating care as the application of universal protocols, the method highlights that when context is understood, care actions are understood as responses to situated realities.

Design outputs for further analysis
Finally, constellation mapping generates design-relevant outputs by revealing key activities, manifestations and value transitions. These are then elements that serve as inputs for subsequent analysis tools such as journey mapping to identify concrete care moments where interventions can strengthen respectful care.

> "[...] there shouldn't be a barrier- I am a doctor and I worked for five years, and I don't want to be with a midwife who hasn't studied and comes to compete with me- It's not about competing, it's about learning and doing things better every day so that things always turn out well. That's what it's all about."
>
> TRADITIONAL AFRO MIDWIFE

Insight takeaways: What insights regarding RMC related to communication in Chocó did this process yield?

Defining Respect & Humanized Birth

Humanized Birth = Being Humane and Building Trust

Humanized birth, and being a good maternal caregiver, is defined as "being humane" and creating trust. According to midwives, trust is experienced through feelings of protection, safety, love, affection, belonging, empathy, and presence, all of which could be generated through communication practices.

> "We are all human and we all deserve respect."
>
> TRADITIONAL AFRO MIDWIFE

Respectful Care = Building Trust through Communication

In this context, respect in maternity care is primarily understood as creating and sustaining trust through communication. When describing how trust is created in interactions, midwives emphasized communication practices, and many acts of respectful care or mistreatment were rooted in communication elements. Given the oral and relational nature of the community, respect is further reinforced through reputation: "good care" becomes known through community talk, and acceptance or rejection of medical support is often shaped through these shared narratives.

> "Communication is the best tool to articulate all this work. If there is no communication, there is no respect, no values, no trust, nothing."
>
> TRADITIONAL AFRO MIDWIFE (MALE) & DOCTOR

The Midwife Perspective in Emergency Contexts

Mothers stay with Traditional Midwives unless its an Emergency

Traditional midwifery is the default and trusted care pathway, while institutional care is largely emergency-driven. Mothers in these communities primarily seek traditional midwives within their communities whenever possible, rather than go to medical institutions, even when advised otherwise. Medical institutions are typically only sought out when a high-risk emergency arises that exceeds community-based care. This is reinforced by the perception that community customs or preferences are often not accepted or respected within medical institutions.

"[...] too much danger, we bring them to the hospital. But if there is no danger, we indigenous attend to them. We use traditional culture- our customs- sometimes hospitals don't like that."

TRADITIONAL INDIGENOUS MIDWIFE

Different Complexity Definitions: Natural Births vs Unnecessary Procedures

Midwives and mothers explained how they value and prioritize having natural births, equating it with "normal" and humanized birth. C-sections and other procedures are avoided whenever possible, often considered unnecessary and perceived as the default response to complex situations in medical institutions driven by protocol, time pressures and incentives. Midwives described delivering natural births despite complications, while feeling most medical institutions would defer to C-sections in these same cases (e.g., firsts-time births, breech positioning, and umbilical cord complications).

"What's the deal? I diagnose that this mother is at serious risk and a C-section must be performed. That's where we bring in the midwife, who isn't involved in that. But we have to bring her in. The midwife just has to do the maneuver."

TRADITIONAL AFRO MIDWIFE

Midwives have multiple (informal) roles in maternity care

Midwives describe taking on multiple roles throughout the maternity process, adapting to whatever the mother needs (e.g., mother, companion, advisor, psychologist, doctor, friend, sister, etc.) Within maternity and emergency care, this includes four key roles:

- Bridge of trust: Midwives often act as bridges of trust between mothers and medical institutions, being the first indirect point of contact and encouraging mothers to seek check-ups and other exams when needed.
- Translator: Midwives act as translators for indigenous mothers who do not speak Spanish, helping prevent uninformed consent or misunderstandings regarding unwanted emergency procedures.
- Chosen companion: Midwives frequently become the mothers' chosen companion during birth, providing emotional support while continuing their role as responsible caregiver.
- Educator: Midwives maintain a holistic approach to maternity care that extends beyond pregnancy and birth. Midwives begin with educating their communities on sexual, reproductive, and feminine health.

"And then I arrive and I say, 'Mami, your life and your baby's life depend on these checkups."

TRADITIONAL AFRO MIDWIVES

"Since the women sometimes don't understand Spanish, they perform a C-section right away. [...] Thats when I bring myself to the hospital. [To make sure that they translate and don't do a C-section]."

TRADITIONAL AFRO MIDWIVES

"Midwives there don't just attend births; no, there, they generally dedicate themselves to education, health, and prevention."

TRADITIONAL AFRO MIDWIVES

> "[...] the midwife is clear about this, and she knows how far she can go as a midwife."
>
> TRADITIONAL AFRO MIDWIVES

Assessing Emergencies: Recognizing Limits, Expertise and Listening

Midwives defined emergency situations through the identification of "alarm signals", used to recognize when to refer mothers to institutional care as the result of an active examination. They explained how they were taught to recognize and communicate transparently with mothers about limits in resources, technology, knowledge, capacity and risk during births and check-ups.

However, when midwives accompany mothers to medical institutions, they describe an unequal recognition. They report being met with negative attitudes when arriving to medical institutions, including being blocked from entering facilities, ignored during emergency situations, or having their perspectives dismissed, including experiences of discrimination. Despite holding detailed contextual knowledge about the mother's situation, midwives feel their input or opinion—as well as the mothers'—is not consistently listened to or valued during institutional emergency care. This includes the dismissal of mothers' pain and urgency, such as being sent home, being told to "sit and wait" or "it is not time", sometimes based on a passive evaluation.

Figure 47: Traditional indigenous midwife during an interview holding a pamphlet on signs to refer mother to a doctor. Photo taken by the author.

Communication-based RMC practices

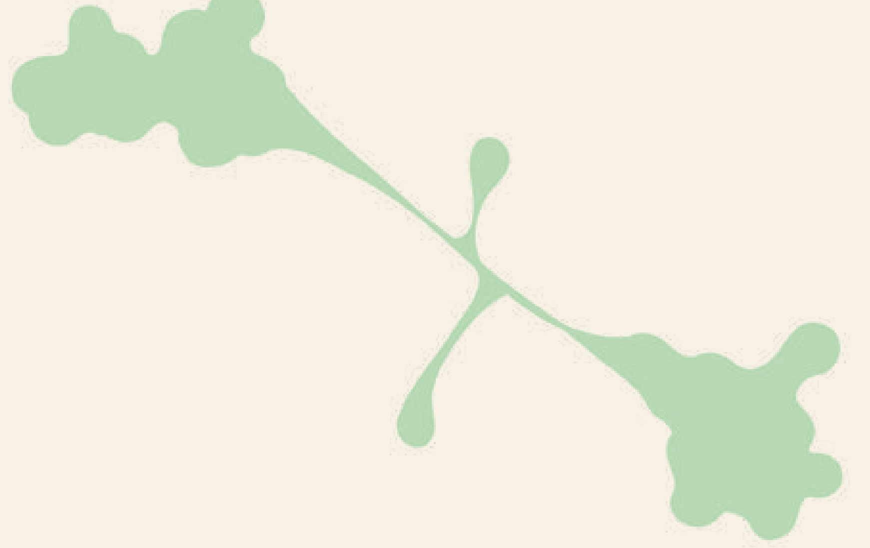
Regulating the Emotional Climate during Emergency Births

Midwives described birth as a sensitive moment in which women are physically and emotionally vulnerable, and where the care experience can have long-term impacts on wellbeing. They mentioned being especially careful with young and first-time mothers, who are simultaneously confronting bodily change, pain, uncertainty, and at times even denial toward pregnancy. Within this arena, three recurring practices were highlighted:

- Keep Calm and Encourage vs Threaten
  Midwives explained how birth often requires mothers to have and use a lot of strength. When labor is prolonged and mothers feel they are running out of strength, midwives described keeping the mother calm and encouraged as key for regaining confidence and pushing through complications. They highlighted communication strategies to support relaxation and self-trust, including singing, telling jokes, talking, and praying. This approach was contrasted with situations witnessed by midwives and volunteer doctors in which mothers were threatened or blamed when expressing that they could not continue, including accusations such as "you're killing the baby."

- Supporting vs Silencing Pain
  Midwives emphasized that respectful care requires allowing mothers to express pain in their own way and supporting them through it. In contrast, midwives and volunteer doctors described witnessing moments in which women were verbally or physically silenced during labor, including harmful comments, which they interpreted as abusive and as a contributor to birth trauma. A key concept within this situation is the need to separate caregiver stress from the mother's calm: caregivers were described as having a responsibility to regulate their own emotions, as stress can undermine trust relationships and lead to complications in the birth and baby.

- Delivering Difficult Information
  Finally, respectful maternity care extends into how difficult information is communicated, such as in high-risk situations or moments of death. Midwives described the need for sensitive explanation and gentle communication so that mothers can make complex decisions and emotionally process what is happening; whereas blunt or unempathic delivery of such news was repeatedly associated with lasting harm for mothers and their loved ones.



Intercultural Respect through Cultural Awareness and Compromise

Midwives in Chocó often attend to multiple communities beyond their own, including Afro midwives supporting Indigenous mothers. As a result, they described developing awareness of diverse cultural practices and adapting to different traditions and preferences. In this sense, midwives repeatedly practiced intercultural respectful care. Midwives also acknowledged that they often build trust through long-term relationships, enabled by time and one-on-one continuity of care. However, they emphasized that respectful care does not rely only on long-term trust; it can also be generated quickly "on the spot". The following practices illustrate this adaptation:

- Building Trust as a New or Male Caregiver: Talk & Listen before Touch
  Midwives emphasized cultivating trust and respect—particularly in cases involving new or male caregivers—by talking before touching the mother. This includes asking and listening to how the mother feels, explaining what will be done, how and why, communicating reassurance, and building rapport through conversation (e.g., asking about family). They also emphasized touching only where instructed by the mother and seeking explicit permission before initiating intimate examinations. In contrast, institutional care was described as sometimes moving directly into physical examination.

- Indigenous preferences: Cover up and touch only when necessary
  Midwives described how during check-ups and birth, Indigenous mothers cover intimate areas with cloth, minimizing exposure as they prefer not to be seen or lay open and bare. Midwives are aware of this preference and accommodate it by avoiding looking, and with limited touch examinations when necessary. In contrast, institutional contexts were described as sometimes violating these boundaries, such as uncovering mothers or visually examining them. This was attributed to a lack of knowledge, consent and communication, as described in talk & listen before touch.

- Intercultural Negotiation: middle point between traditional and clinical concerns
  Respectful care was also described as emerging through intercultural negotiation and shared decision-making, in which space is created for both knowledge systems. Midwives and volunteer doctors described reaching middle points between traditional practices and biomedical concerns. For example, Indigenous communities may paint newborns immediately after birth as a traditional practice, while medical staff may prefer delaying this for clinical reasons. In one case, compromise was reached (painting the baby a few days later), illustrating how cultural awareness and dialogue can enable mutually acceptable care.

- Confidentiality and privacy as culturally grounded protection
  Privacy and confidentiality emerged as a culturally grounded care practices that protect pregnancy and birth. In a context where talk and communication strongly shape community life, midwives and mothers emphasized being wary of gossip and protecting confidentiality during birth—to the point of limiting information within the birthing space (e.g. preventing others from knowing by placing a rag in the mother's mouth so others would not hear or lying to keep children away from spying). This emphasis on privacy and confidentiality as protection is shaped by local beliefs in which exposure may attract negative external influences during birth (e.g., negative energies, bad omens, or "evil eye"), which may require rituals to amend. In this sense, confidentiality and privacy function as both social and energetic protection. Importantly, some mothers described worrying about visiting specific caregivers if they heard they "talk too much," illustrating how confidentiality directly impacts trust and care-seeking.

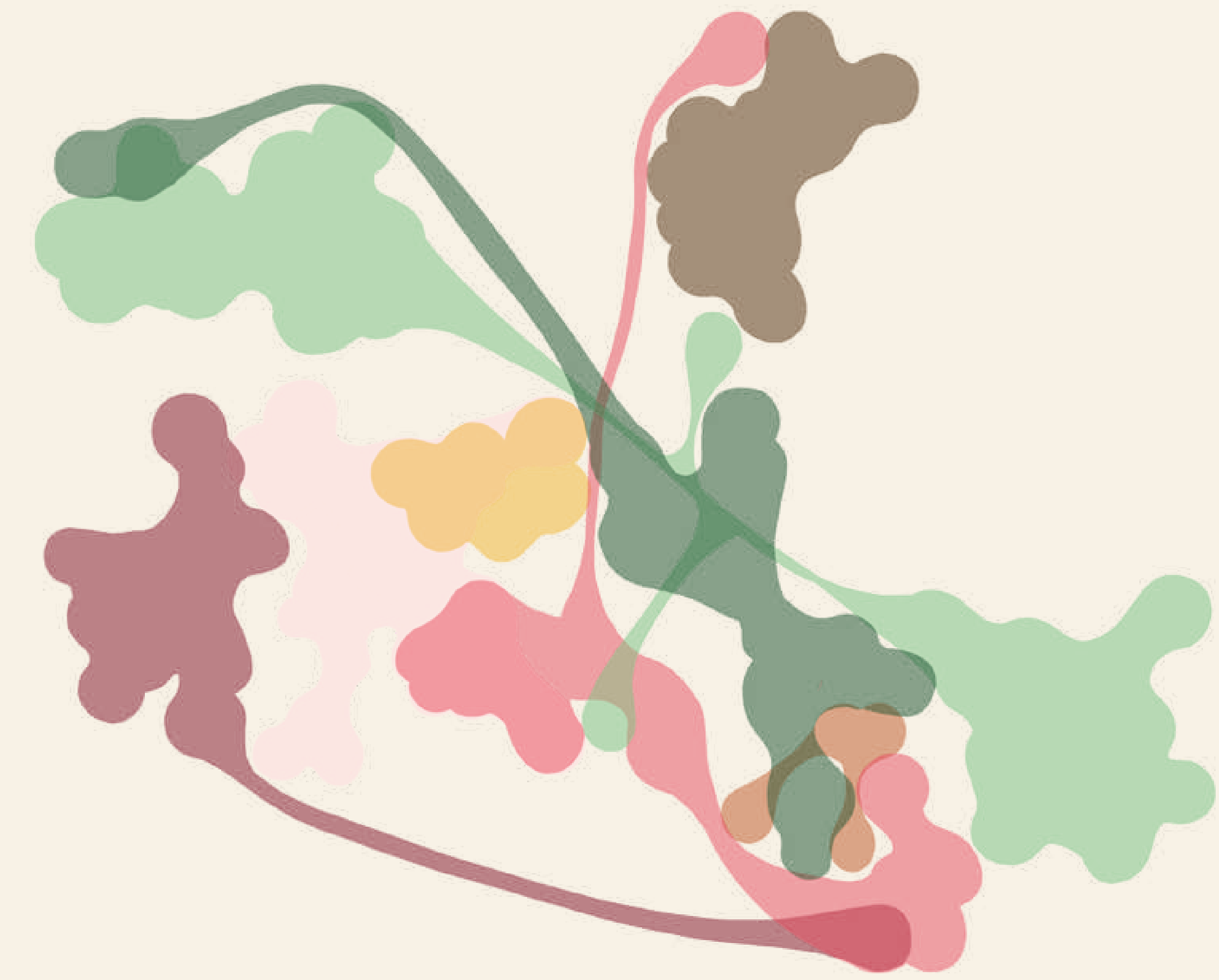


Figure 48: Arenas' silouhettes.

Journey Mapping

Click or scan here to view the full size map digitally

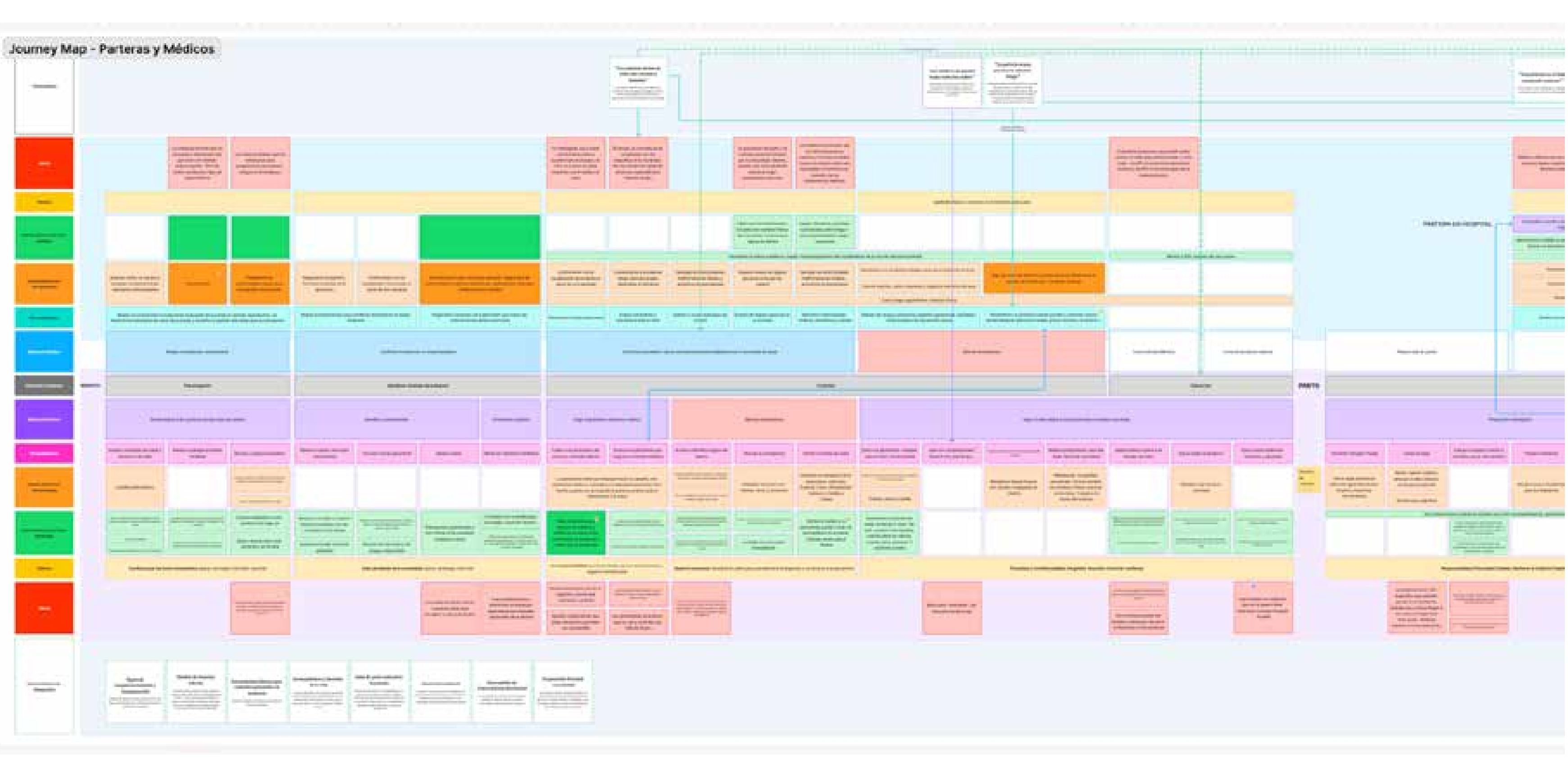


Figure 49: Journey map elaborated by the author, along with Silvi Loaiza, Angie Henriquez and Valentina Martínez.

Journey Map: Key Moments of RMC in Emergencies

METHOD PURPOSE

This journey mapping process was developed to create a temporal overview of emergency maternity care in Chocó. Building on the actor mapping, manifestation categorization, and constellation mapping analysis, the purpose of the journey map is to locate where key manifestations of Respectful Maternity Care emerge or break down across the emergency care pathway. By structuring the experience into stages and care moments, the journey map reveals where trust is built or undermined, and how respectful communication practices influence both immediate care interactions and future trust in the system.

MAPPING PROCESS

Defining Emergency Phases and Actors (Worst-Case Pathway)

Based on fieldwork narratives, a sequence of events was constructed to represent a "worst-case scenario" emergency maternity care pathway. This was developed to reflect the widest range of context and local-specific situations described by participants and to capture the full spectrum of care moments where trust could be built or broken. It is important to note that no specific clinical emergency types, terms, or procedures were used; instead, the pathway focuses on general moments that can apply across different emergency scenarios.

The mapping includes key moments occurring both before and after the emergency itself. It outlines pregnancy and birth phases, emergency events and transitions, involved actors, and points of interaction between caregivers and mothers.

Placing Communication Manifestations and Roles

Following the "worst-case scenario" pathway, all possible moments of low trust were identified across phases. This began by mapping negative manifestations within each moment. In parallel, corresponding positive manifestations and respectful communication-based practices were identified to visualize how trust could be built or restored within each phase in response to mistreatment risks.

Manifestations were mapped not only as actions, but also through the actors, roles, and key concepts shaping each moment (e.g., the midwife as bridge of trust or translator). This enabled the map to capture how trust is influenced not only by what is done, but also by who performs it, when and how it is communicated, and how its effects unfold over time. In this sense, the mapping also considered how respectful practices can influence trust across phases—either by preparing trust earlier in the pathway or by shaping future willingness to seek care.

This process continued until an "ideal" care path could be visualized, grounded in proactive respectful communication practices.

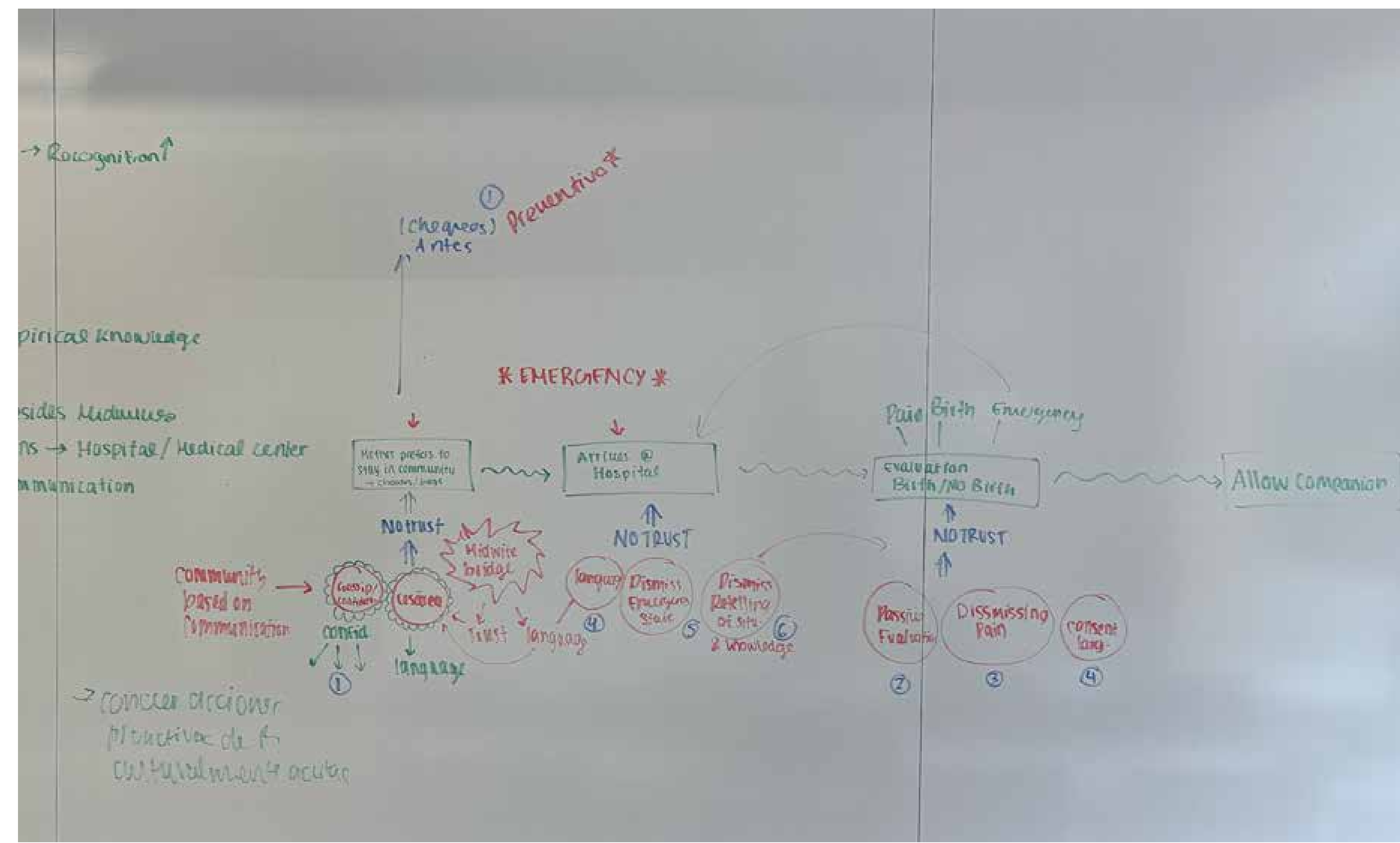


Figure 50: Example of rough mapping and elements.

JOURNEY MAPPING TAKEAWAYS

Analysis takeaways: How did this method help the design process?

The journey mapping method supported the design process by translating fieldwork findings into a temporal structure. This enabled the project to:

- Locate key manifestations and value-creating practices in time, connecting constellation mapping insights (relational activities and trust dynamics) to specific phases of the emergency care pathway.
- Identify key leverage moments, revealing which phases carry the strongest influence on trust, decision-making, and future care-seeking.
- Highlight intervention and prevention opportunities, including moments where proactive trust-building earlier in care can prevent escalation into emergency harm later in the pathway.
- Shift focus toward proactive trust-building, by identifying opportunities to generate trust rather than centering analysis only on mistreatment.
- Inform training content through sequence, supporting educational material that reflects realistic emergency timelines rather than isolated tips.

Insight takeaways: What insights regarding RMC related to communication in Chocó did this process yield?

The journey map revealed that although emergencies include many detailed micro-moments, three phases consistently concentrate the most influential manifestations of Respectful Maternity Care:

1. Check-ups and appointments before birth (preventive trust-building)
   Trust built during prenatal check-ups influences whether mothers seek care, including their willingness to attend institutional services when emergency referral becomes necessary.
2. Arrival and emergency assessment at the medical institution
   The first institutional contact during an emergency emerges as a critical trust threshold, where communication, recognition and consent practices strongly influence how mothers perceive care.
3. During birth
   The birth itself remains an intense and vulnerable stage, where respectful communication and emotional regulation practices have strong influence on both immediate wellbeing and long-term trust outcomes.

For the scope of this project, these three phases were selected as the primary focal points for intervention.

05 DESIGN OPPORTUNITY

How might an educational intervention, facilitated through hybrid spaces, enable two-sided knowledge exchange between traditional midwives and biomedical caregivers—so that respectful and locally grounded intercultural communication practices can be applied in emergency maternity care to build trust and improve mothers' wellbeing?

This section translates key findings from the analysis chapter into a concrete design direction. It defines the intervention situation and the project's value proposition, positioning locally grounded intercultural communication practices—held by traditional midwives—as a key resource for strengthening trust in emergency maternity care in Chocó.

INTERVENTION SITUATION

VALUE PROPOSITION

Intervention Situation

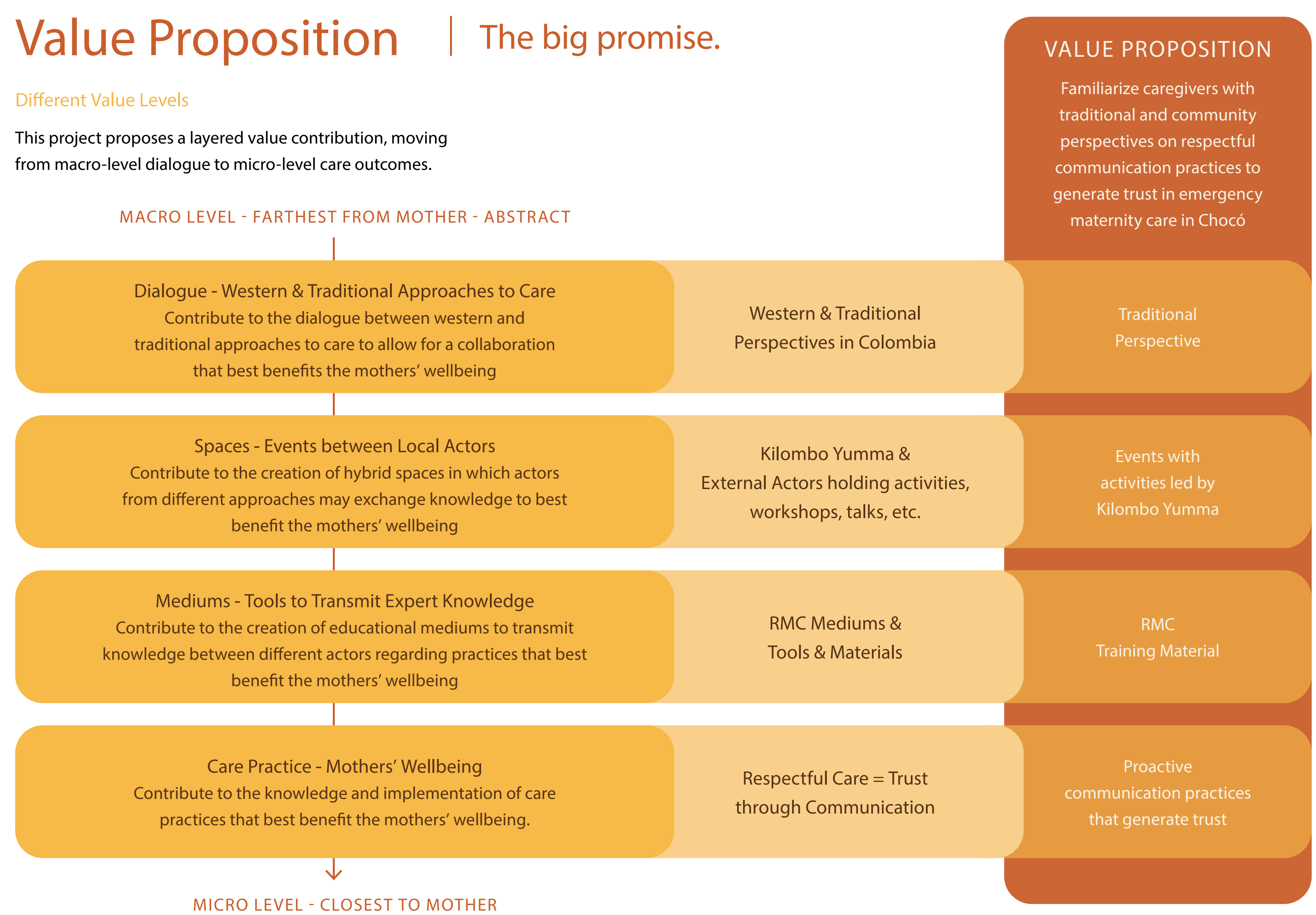
The analysis highlights that Respectful Maternity Care (RMC) in Chocó is strongly shaped by trust, and that trust is primarily created or undermined through communication—especially in emergency moments. While traditional midwives maintain community-based trust through culturally grounded practices, emergency situations often require mothers to engage with medical institutions where intercultural preferences may not be understood, and trust can quickly break down.

The intervention situation therefore lies at the intersection between traditional midwifery systems and institutional emergency maternity care, where intercultural tensions, unequal recognition, and lack of trust shape maternal experiences and outcomes. Importantly, this opportunity space is not only about strengthening general RMC principles. It also involves familiarizing caregivers with locally grounded, context-specific intercultural care practices—including cultural traditions, bodily boundary preferences, consent rituals (e.g., "talk before touch"), privacy norms, and trust-building communication patterns—in which traditional midwives are experts, yet which are frequently invisible or undervalued within institutional care.

Several actors are particularly relevant to this design opportunity. First, hybrid actors (such as Kilombo Yumma) already function as bridge-builders between knowledge systems through their role as an "embassy" and through ongoing workshops and events with external actors. Their current practice positions them as key facilitators of intercultural exchange. Second, midwives hold situated expertise in respectful communication and intercultural care navigation, and already play strong educational roles within their communities. Third, medical students and early-career healthcare professionals represent an urgent target group, particularly those who later carry out rural placements ("rurals") and may enter intercultural contexts with limited preparation in cultural safety and respectful communication in emergencies.

The intervention opportunity is therefore framed as a two-sided knowledge exchange: complementing technical biomedical knowledge with empirical, relational, and culturally situated expertise. Rather than introducing additional burdens, the intervention focuses on proactive communication practices that can function even under emergency time pressure—enabling caregivers to rapidly generate trust, reduce harm, and recognize midwives as part of the local expert care system. Ultimately, this approach aims to strengthen collaboration across approaches, improve emergency care experiences, and support maternal wellbeing in high-stress and intercultural situations.

Value Proposition | The big promise.



06 IDEATION PROCESS

How were fieldwork insights and RMC findings translated into design concepts through collaborative ideation?

This chapter documents the creative process through which insights were translated into design concepts. It describes the co-ideation work conducted with Kilombo Yumma and the individual ideation process informed by framing imperatives and collecting design references.

CO-IDEATION

- Introduction Session with the Kilombo
- Co-Ideation Session at the Kilombo

INDIVIDUAL IDEATION

- Frame for Individual Ideation
- Collected Design References
- Individual Ideation

Introduction Session with the Kilombo

PRE-MEETING COORDINATION AND PARTICIPATION INVITATION

Before conducting the introductory session, project updates and the proposal for co-ideation were shared with the Kilombo Yumma representative as part of the ongoing collaboration. The representative then introduced the project intentions and planned ideation activities to the broader collective, inviting those interested to participate in the sessions.

Prior to the in-person introduction session, a digital meeting was held with interested Kilombo members. During this call, the researcher formally presented the project, explained the proposed ideation activities, and clarified the purpose of participation. The group then coordinated and planned the following meetings.

SESSION PURPOSE & SETUP

Purpose: Sensitizing and Insight Validation

The purpose of the introduction meeting was to sensitize Kilombo Yumma members to the fieldwork findings and to create a shared foundation for later ideation activities. Importantly, this meeting also functioned as an insight validation space, enabling the researcher to check whether the emerging analysis and design direction resonated with the Kilombo's lived experience and positioning.

Format & Dynamic: Uramba

Based on previous workshop experiences with Kilombo Yumma and guidance from the representative, the meeting was facilitated in a typical circular-dialogue format (Uramba), prioritizing horizontal conversation, shared reflection, and collective meaning-making. Six members were invited to the care center where the collective often works, and the two hour session was hosted around a table with snacks to create a welcoming atmosphere.

Supporting Medium: Dialogue through Hand Weaving

Because the session was primarily discussion-based, a complementary medium was introduced to support engagement and materialize reflection: hand weaving. The "How-To" box included in this section describes why and how hand weaving can be implemented as a supportive medium in discussion activities.

SESSION IMPLEMENTATION

Collective Reflection

During the session, the researcher began by welcoming the group, explaining the space, and teaching the collective how to hand weave. As everyone wove, the researcher presented a recount of the Chocó fieldwork, highlighting key insights and situations, as well as the resulting design opportunity.

As Kilombo members listened and wove, they were invited to reflect on the findings considering their own lived and professional experiences. They then shared parallels between narratives from the fieldwork and their experiences in Bogotá, in the territory, and in the case of members with formal medical training (e.g., nursing), reflections also emerged from their experiences during rurals.

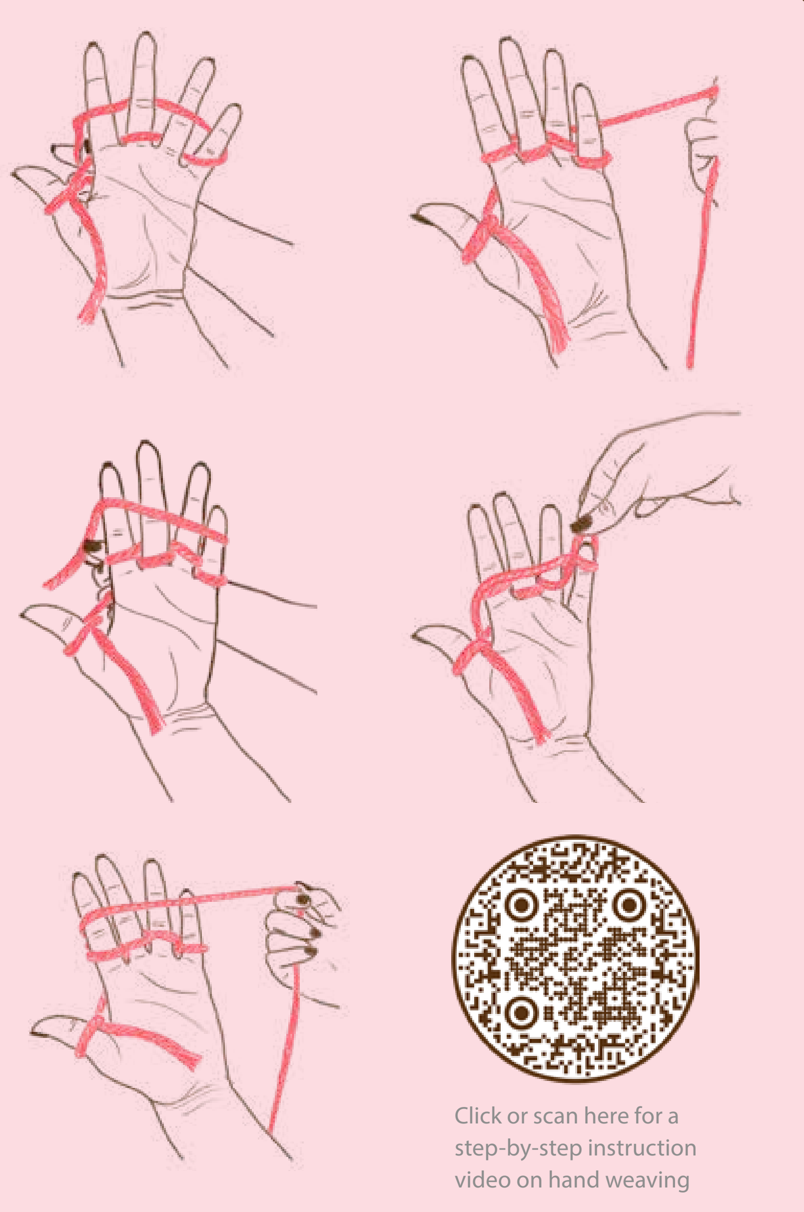
To end the session, members reflected on their woven pieces (figures XXX), and on the following session's question: what format could respectful care be taught in?

How-To: Hand Weaving for Dialogue

This box explains how to hand weave, and how to subsequently understand this skill as a medium for dialogue in design activities.

Hand weaving is a technique described by Pitta (2023) that can be used to support dialogic and reflective activities, enabling the textile to function as a material record of the discussion being "woven" through it. The material "speaks" in the sense that it can reflect physcial traces of the conversation—such as tension, relaxation, different voices and the passage of time:

- When participants are stressed or they feel unsafe, stitches may become noticeably tighter, making it harder for fingers to move through. In these cases, the dialogue can help "loosen" the hands and set a calmer pace.
- When participants weave while speaking, the conversation often slows down and becomes more relaxed. Because attention is partially directed toward the material, participants may share more openly and organically.
- Each woven piece becomes the persons' body situated in the textile: Each piece will be different according to the hand—its size, shape, movement and rhythm—producing variations across participants.
- Similarly, as conversations are woven and built together, so can the woven pieces. At the end of the activity, pieces can be stitched together to illustrate the conversation and how different voices, like the material, interacted. This also creates a tangible artifact connected to the session that participants can take away.



Click or scan here for a step-by-step instruction video on hand weaving

Figure 51: Hand weaving 1. Photo Taken by the author.

Figure 52: Hand weaving 2. Photo Taken by the author.

Figure 53: Hand weaving 3. Photo Taken by the author.

INTRODUCTION SESSION TAKEAWAYS

The introduction meeting functioned as both validation of fieldwork findings and a space to expand insights into ideation through collective reflection. Four key takeaways emerged:

1. Validation of Analysis Insights
   Kilombo members confirmed that many fieldwork dynamics resonated with their own lived and professional experiences, both in Chocó and in Bogotá.
2. Confirmation of Communication as the Focus
   The discussion reinforced the project's core insight that trust is primarily built or broken through communication practices, especially in moments of urgency and intercultural interaction.
3. Early design implications for training format: Role-Playing
   Participants with academic medical formation backgrounds emphasized that respect-based education remains a gap in institutional healthcare formation, including through experiences during rurals. They highlighted the need for training material usable across caregiver types, and supported roleplaying formats as effective learning tools in institutional formation.
4. Hand Weaving as a Tool for Dialogue
   Hand weaving served as an ice breaker in the activity, allowing for moments not only to connect in the discussion at hand but also personally.

Once the discussion began, most woven pieces appeared initially tight and difficult to manage across participants. However, as the conversation flowed, many pieces gradually loosened along with the dialogue-Personal stories began to emerge more easily after some time.

Figure 54: Hand weaving 4. Photo Taken by the author.

One participant continued to struggle with the textile and contributed less verbally throughout the session. While this may relate to individual preference or comfort, it also suggests that the difficulty of the weaving process can influence participation and should therefore be considered as part of facilitation planning.

Finally, participants valued producing a tangible artifact to document the discussion, requesting that the woven outcomes be refined and returned as part of the collaboration.

Co-Ideation Session at the Kilombo

SESSION PURPOSE

Forming future caregivers

The purpose of the co-ideation session was to create a space in which the Kilombo Yumma could collectively imagine what the next generation of maternity caregivers should be like in terms of Respectful Care, and to ideate ways of teaching and transmitting those qualities. The session was designed to support community authorship, not only by involving community memebers in concept generation, but by enabling them to define what education around their knowledge should look like—including the content, format, dynamic, and learning tools. In this sense, the session aimed to support the Kilombo Yumma in shaping an educational tool they could potentially use in practice, in a way that felt appropriate and legitimate from their own perspective.

SESSION SETUP

Integrated into a Kilombo Workshop

The co-ideation session was integrated into an existing scheduled Kilombo workshop, forming the second part of the feminist workshop program that the researcher had previously attended. The session plan was discussed with the Kilombo representative prior to implementation.

The ideation activity lasted approximately two hours within the overall workshop program. Approximately 15 participants attended, including Afro Kilombo members and invited Indigenous participants. Participants included mothers, a young girl, traditional midwives, community knowledge holders, and caregivers with both traditional expertise and institutional healthcare formation. The session was held in the Kilombo's dialogue space at the Viernes Negro museum.

Format & Dynamic: Uramba

In alignment with Kilombo Yumma's established workshop practices, the session followed an Uramba-based facilitation dynamic, emphasizing horizontal dialogue, collective reflection, and shared meaning-making. The Kilombo representative guided the opening activity, connecting it to the first feminist workshop session. The researcher facilitated the co-ideation activity framed around respectful maternity care. An Indigenous representative guided the closing of the session.

Supporting Medium: Playdough

To support the activity and discussion, playdough was introduced as the complementary medium. Because the key concept of the session was to "form" or shape future caregivers, playdough provided a direct embodied metaphor: participants could physically mold the caregiver they envisioned. Playdough was also selected as a medium that is less technically demanding than weaving, reducing the risk of distractions.

Figure 55: Co-ideation session with Kilombo in Uramba format with playdough. Photo Taken by the author.

SESSION IMPLEMENTATION

Introduction

As new participants were present in the space, the session began with a brief introduction to contextualize the activity. The researcher provided a short recount of the project, fieldwork, and key findings, and explained the purpose of the co-ideation session.

Shaping future caregivers through playdough

Each participant received playdough in a color of their choice. The first instruction was that the playdough represented a future maternity caregiver, and that participants were responsible for molding and shaping that person. To guide this activity, participants were given reflective prompts such as:

> What qualities will you give them? What knowledge? What should they be like? How should they treat a mother?

Approximately 30 minutes were allocated for participants to form their playdough caregivers and reflect on the prompts. Paper and markers were also provided as optional tools to support the creation or explanation process.

After the making phase, each participant was invited to present their caregiver to the group and explain what they had formed and why. This sharing phase generated a dialogue as participants added perspectives, questions, and reflections to one another's contributions.

Hypothetical Scenario: How would you train your caregiver?

Following the sharing phase, the researcher introduced a second co-ideation prompt:

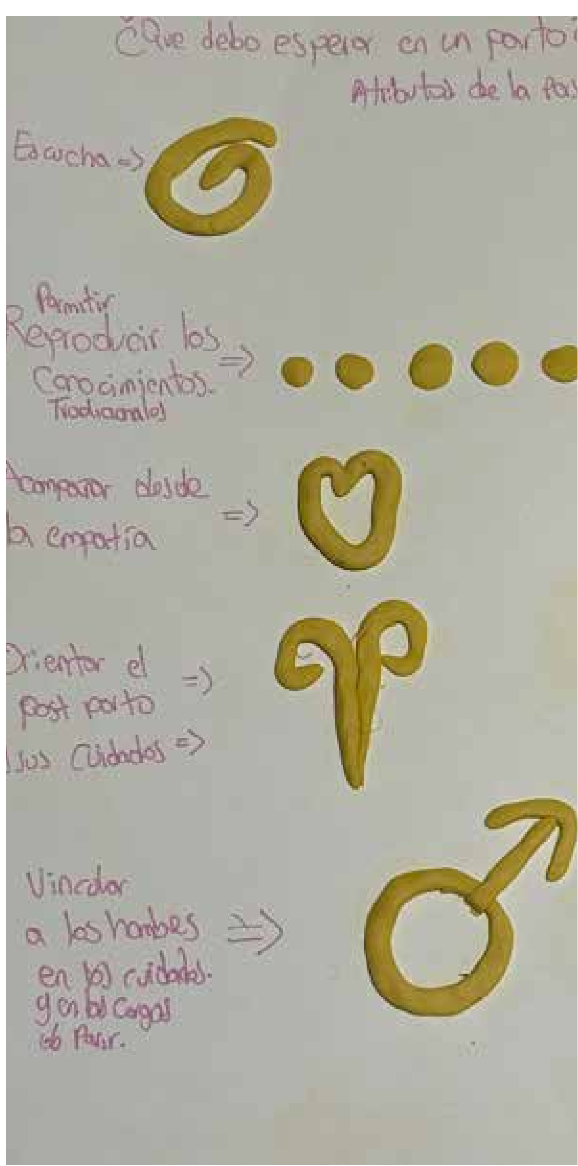
> Now that we know how we want future caregivers to be, how would we teach them to become that way?

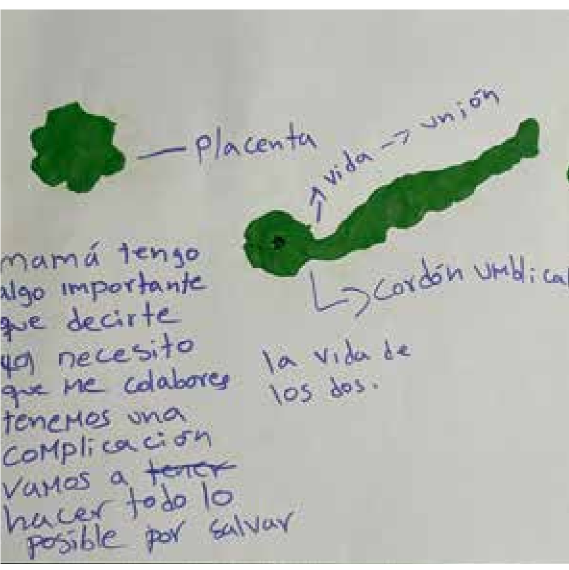
A hypothetical scenario was presented, asking members how they would train a future generation of caregivers if they were to arrive tomorrow, including what tools, materials, learning formats, and spaces they would use. This prompt initiated a final discussion focused on educational and training possibilities.

Personal stories and lived experiences were frequently used to illustrate or support the members' ideas, thoughts and choices.

Figure 56: Playdough activity 1. Photo Taken by the author.

Figure 57: Playdough activity 2. Photo Taken by the author.





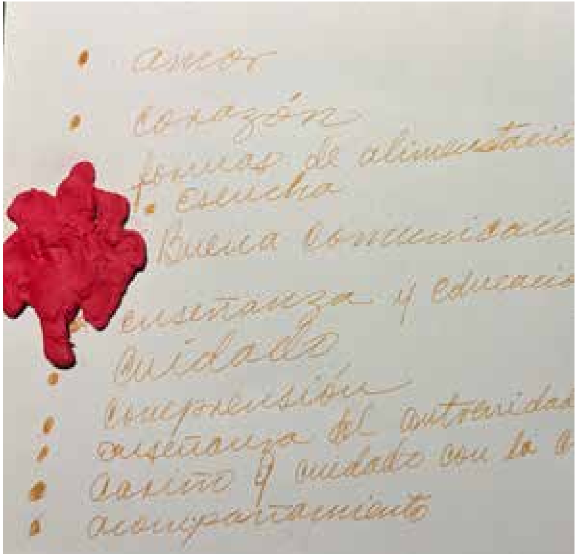


Figure 58: Co-Ideation activitiy results and reflections. Photo Taken by the author.

CO-IDEATION SESSION TAKEAWAYS

This co-ideation session concluded with four main ideas that the Kilombo felt were strongest for the creation of future training activities:

Circular Dialogue

First, members emphasized collective action and learning, specifically through circular dialogue. Knowledge was described as something that circulates and is not imposed, privileging listening, mutual respect, and horizontality. Circular dialogue spaces with collective oral, situated, and relational modes of knowledge transmission—such as Uramba, Malocas or Mingas—were identified as culturally aligned ways of learning and teaching care.

Role-Playing

Second, roleplaying emerged as a central learning mechanism shared in both traditional and biomedical learning approaches. Members valued roleplay as a way to embody perspectives, allowing caregivers to experience situations emotionally, relationally, and ethically rather than only technically. Additionally, they felt it was easy to execute in circular dialogue formats.

Approach Collaboration

Third, the collective highlighted the importance of collaboration between traditional and biomedical methods and perspectives. Education was imagined as a space where both forms of knowledge could coexist and complement each other for the best of the mother. They highlighted how pride had to be put down and that they could not continue separately.

Interactive Elements

Finally, participants expressed an interest for interactive and innovative elements, including digital or AI-based components, as long as these tools supported interaction, reflection, and human connection rather than replacing them.

Note on the Kilombo's reaction to the Session:

During reflections, members highlighted that future knowledge sharing activities, including care training, should be like this session: uramba format and with interactive elements that allow for deep discussions and reflection. They mentioned how more sessions like this one should be done, and that they had a very good discussion that day.

At the end of the session, the researcher recieved much gratitude from the members. When asked if they would like to keep their creations, they collectively decided to keep all the figurines and written reflections and donate it to the museum, to start a documentation of the discussions and knowledge-creation they had in the Kilombo space and workshops.

This reaction brought to light the value that supporting material gave to discussion spaces, not as the focus or protagonist, but as detonating mediums of collective reflection, creation and documentation of word.

Frame for Individual Ideation

The "frame" is understood as the space in which the design proposal will inhabit—the space in which the researcher can propose ideas. This frame is shaped by the requirements, constraints and conditions imposed by the project's context including the value proposition, investigation and visions expressed during ideation with the Kilombo. In this sense, the frame establishes the boundaries of ideation, ensuring that individual ideation remains grounded in the contexts' findings.

Actors & Roles

- Kilombo: The proposal is meant for the Kilombo's use to familiarize caregivers with traditional and community perspectives regarding trust through communication in emergency maternity care in their territory. Through the proposal, and as an embassy for their territory, Kilombo members help form caregivers in intercultural care.
- Caregivers: In this proposal, caregivers include hybrid actors who are unfamiliar with intercultural care or the care perspectives in Chocó, yet are open to learning. This includes medical professionals, such as doctors and nurses, medical students or others, particularly from external, biomedical or western approaches and academia. As participants, they are meant to explore the proposal under the Kilombo's guidance.

Space

The proposal is intended for implementation in hybrid spaces or events where Kilombo leads structured activities. These may take place:

- within Kilombo spaces (e.g., museum or care center), or
- within academic or institutional settings (e.g., classrooms, event rooms).

Time

The intervention should last a few hours (3-6) to half a day.

Transportation

The intervention should be simple and portable, allowing easy transportation and implementation in different locations.

Resources

Resources should remain low and accessible, with minimal technology requirements. If technology is used, it should rely on widely available tools (e.g., cell phones).

Content

The intervention should provide:

- clear guidance on implementing proactive and positive manifestations of respectful communication that generate trust in emergency maternity care,
- exposure to traditional and locally grounded manifestations of care,
- an introduction to community perspectives on childbirth and emergency care,
- familiarity with the diverse actors and roles involved in local care practices,

Avoid

The intervention should avoid:

- stereotyping,
- framing any actor group as "a problem" or doing something wrong,
- relying on negative framing such as "what not to do" as the primary learning mechanism.

KILOMBO VISIONS

Co-ideation highlighted the following preferred directions:

- Uramba format: horizontal dialogue without hierarchy and shared language, where the voice and lived experience function as key learning mediums.
- Roleplay dynamics: embodied learning as a central mechanism
- Interactive and multisensory elements: including possible video-based tools, possible AI elements, and other formats supporting engagement.
- Collaboration across knowledge systems: a collaborative approach between traditional and biomedical perspectives.

Collected Design References

Based on the ideation frame described previously, a set of design references was collected to support individual ideation. References were selected to explore: (1) traditional knowledge transference, (2) interactive storytelling as an educational method, and (3) roleplaying dynamics across contexts such as therapy, games, and simulation-based training. To assess each reference and inform the ideation process, key and transferable elements were extracted and highlighted.

TRADITIONAL KNOWLEDGE SHARING FORMATS

Through observations and experiences with traditional communities across design activities, traditional knowledge sharing became a central reference area. References particularly included Uramba dynamics as central dialogue formats and roleplaying as a key training tool. The main characteristics observed included:

- Circular Dialogue: Uramba or Minga as horizontal dialogue structures where sessions are facilitated in circular formats in which there is no hierarchy, dialogue occurs in shared language (Spanish), no participant is positioned as knowing more than others, and knowledge is collectively generated through discussion.
- Voice as a primary medium: in line with oral traditions, knowledge is transmitted through spoken narratives, collective reflection, and situated or lived experiences rather than formal instruction.
- Opening and permission-based facilitation: sessions may be opened by a senior community member through a short word, prayer or gratitude, followed by requesting permission from the ancestors.
- Ice-breaking presentation: each person present presents themselves including an explanation of why they are there that day.
- Roleplay elements: role-based dynamics are commonly used to teach and rehearse care interactions in traditional and biomedical approaches. Elements include imagined space, activity or procedure, mother and caregiver roles, including observers.
- Supporting Mediums: while voice remains central, interactive and supporting mediums such as creative materials (e.g. papers, markers, images, playdough) and explanatory or contextual objects can be used to support discussions.

Figure 60: Role-playing training session in Chocó.

Figure 59: A Kilombo workshop in Uramba forrmat for circular dialogue.

Figure 61: Discussion among traditional midwives in Chocó to transmit learnings from group leaders to seedling midwives.

ROLE-PLAYING IN SIMULATION TRAININGS & GAMES

Laerdal Simulation Training

Simulation-Based Learning (SBL) is widely used in healthcare training for medical professionals and students. Its purpose is to rehearse real-life clinical situations in a controlled and safe environment, allowing caregivers to make mistakes without direct consequences. The effectiveness of simulation training depends on the selection of scenarios, facilitator quality, and the ability to recreate credible and realistic situations (Wahlqvist, 2025).

KEY TAKEAWAYS FROM LAERDAL'S SBL INCLUDE:

Structured Reflection in Parts (with emphasis on Debriefing):

- Briefing: learning objectives and explanation of roles and scenarios.
- Simulation: acting out the scenario in real time.
- Assessment: observation of performance (formal or informal).
- Debriefing: guided reflection exploring learning outcomes, including an understanding of events, relationships, actions, thoughts, feelings, and dynamics that emerged during the scenario.
  - According to Wahlqvist (2025), debriefing is considered one of the most influential phases, as it enables participants to interpret what occurred, articulate underlying dynamics, and connect experiences to actionable improvement in future practice.

Facilitator for Roles & Reflection:

Each phase is guided by a facilitator who supports role clarity and structures reflection to translate the roleplay experience into learning.

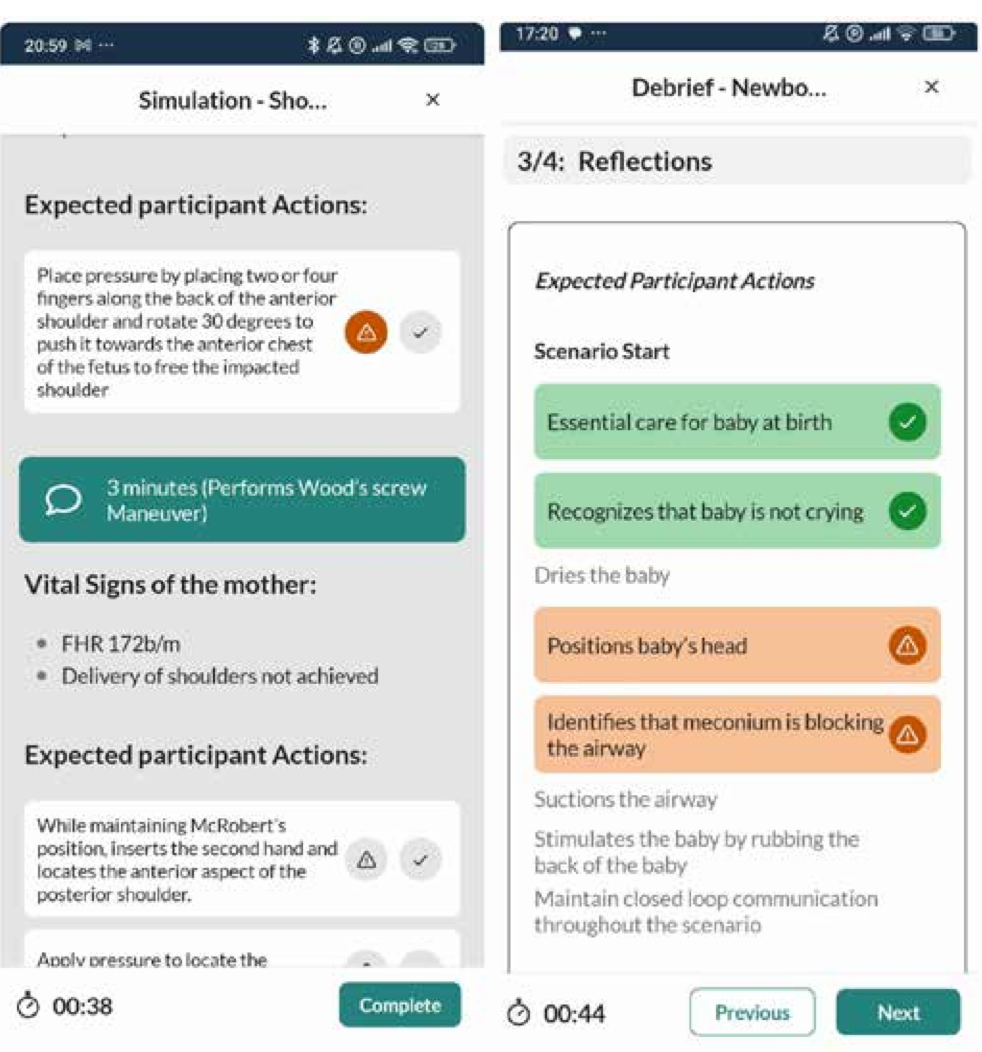


Figure 62: Laerdal Simulation training app (Lift Scenarios) including debriefing section.

Dungeons and Dragons Game

Dungeons & Dragons (D&D) is a highly-structured role-playing game based on complex character creation and scenario-driven interaction, where participants embody roles through defined backgrounds, abilities, and narrative constraints.

Scenarios, Conditions & Perspectives over Personality Traits:

Roleplay does not rely on fixed personality traits or labels. Instead, characters are defined through situated perspectives, scenario conditions and character backstories or origins that describe dilemmas.

Recognition over Correction:

Rather than relying on prescriptive "don'ts," learning emerges through exploration, consequences, and reflection. This supports a non-punitive dynamic in which participants uncover insights through interaction.

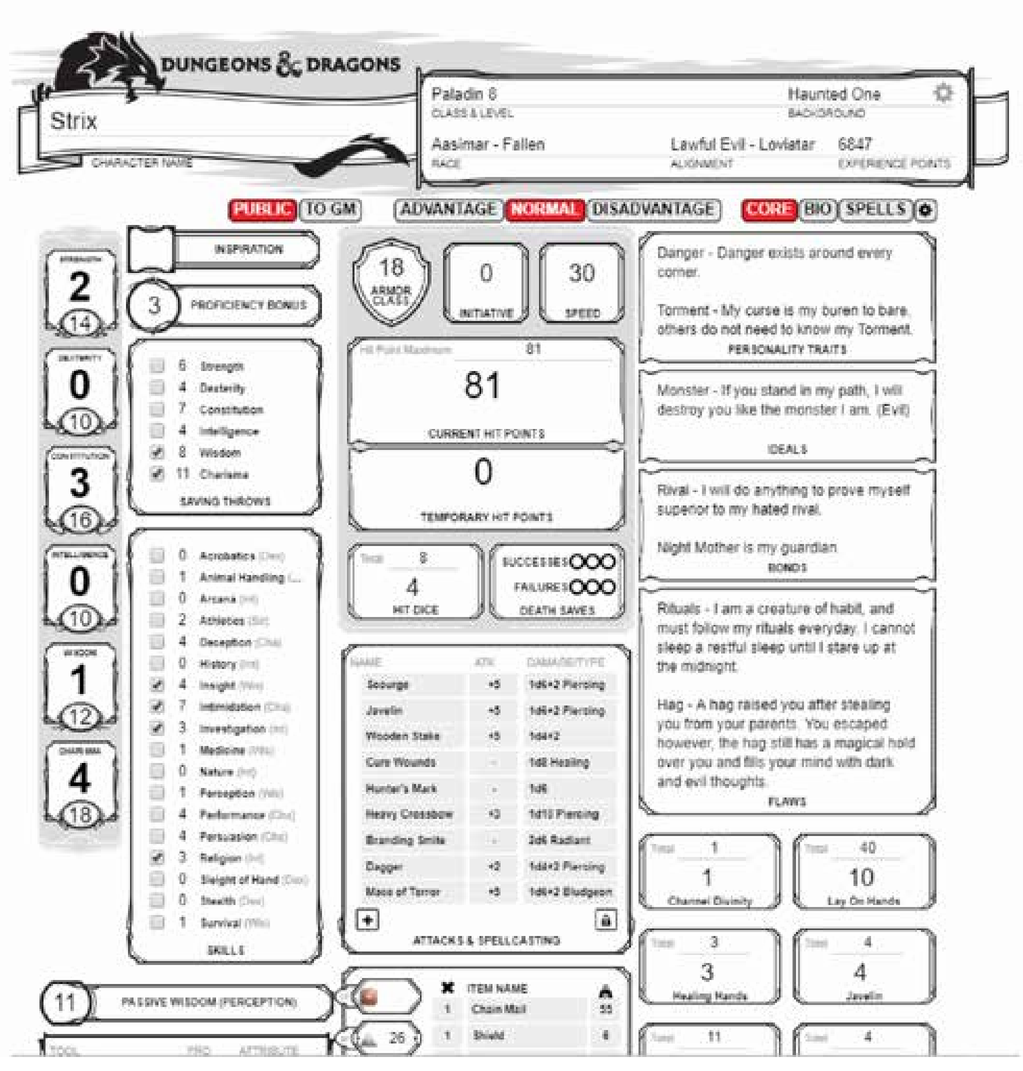


Figure 63: Dungeaons and Dragons character sheet.

INTERACTIVE TOOLS

The Tiny Prince AR App for iPad

The Little Prince AR iPad application was a reference given by the Kilombo during co-ideation to illustrate multi-sensory storytelling and interaction.This design interactive elements to enhance the experience.

Simple Technology: Scanning & Interface: through a simple scanning-based interface, the app expands the original narrative.

Multi-sensory and Digital Interaction: the narrative is expanded through augmented reality, music, animations, and touch-based mini-games.

Volvelles

Volvelles are paper-based interactive devices composed of rotating and layered discs. By turning the discs, different pieces of visual or written information are aligned and revealed. Historically, volvelles have been used in fields such as astronomy, medicine, mathematics, and navigation to represent sequences, calculate outcomes, and visualize relationships within complex systems.

Circular narrative (conceptual and literal): information is explored and unveiled through rotation, supporting cyclical or non-linear knowledge generation. This narrative aligns literally and conceptually with circular dialogue dynamics where there is no hierarchy.

Low-tech and hands-on: interaction is requires no or limited technology, yet is not too distracting.

Explorative and progressive interaction: The interaction feels explorative, as an invitation to discover new options. In this sense, users actively reveal multiple options, conditions, or outcomes, supporting comparison and discovery.

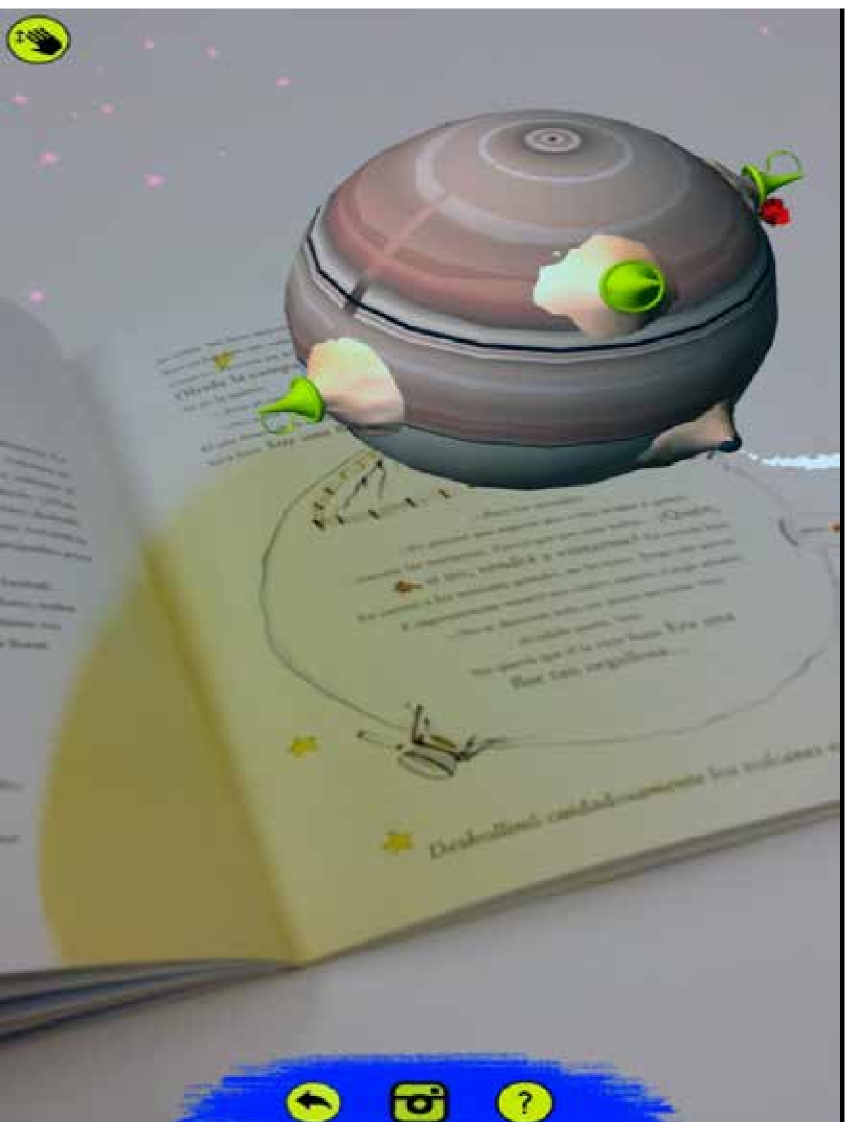


Figure 64: Little Prince AR iPad application featuring interactive planet animation on screen.

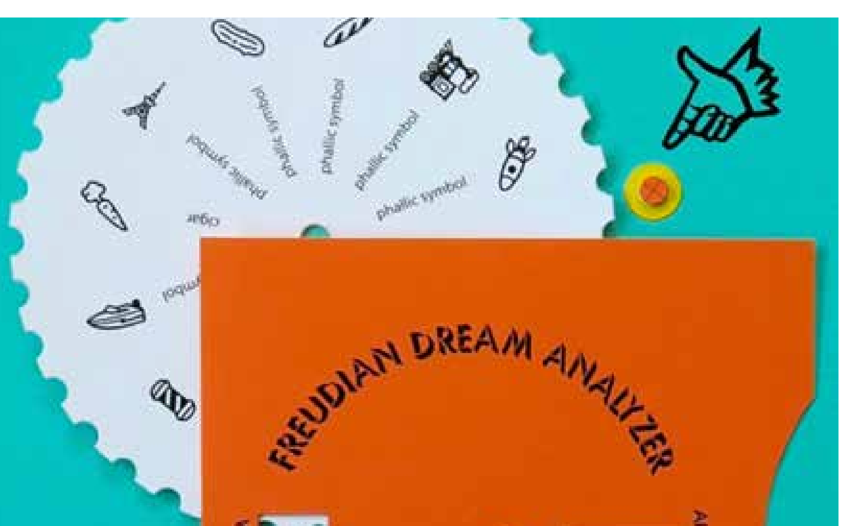


Figure 65: Volvelle references from open Pinterest boards.

Individual Ideation

The individual ideation process was developed according to the value proposition, within the frame proposed, and with input from the collected design references. Ideation was done through brainstorming sketch sessions focused on the activity space and training material dynamic and content.

Figure 66: Invidual ideation for activity space through sketch brainstorming.

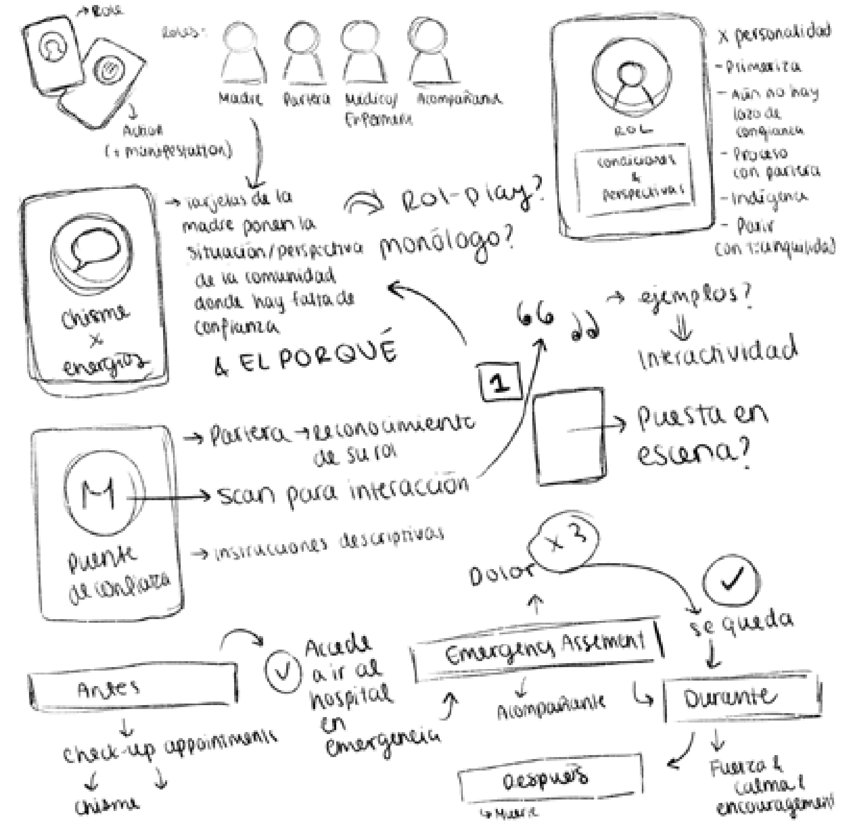


Figure 67: Sketch brainstorming for training material dynamic.

Activity Space

Sketches of the activity space were developed considering Kilombo workshop experiences and their reference elements. The activity space was designed around the concept of the training material, as the material was to inhabit a particular workshop regarding RMC.

Training Material Dynamic

Sketches of the training material dynamic included roles, phases, rules, instructions and materials.

Training Material Format

Once the ideation for the activity space and training material dynamic were documented, they were visualized into an initial card format. This format allowed for a first understanding of how the training dynamic would be applied in terms of information and roles. Once the role-playing dynamic was made more understandable through the card format, different formats were proposed that could manifest the same dynamic but considering specific forms of interaction with the participants.

The ideation phase ended here as the format chosen, the volvelle, took on the card dynamics and was then designed as the first prototype.

Figure 68: Initial card visualization for the training material dynamic including four roles and different manifestation cards.

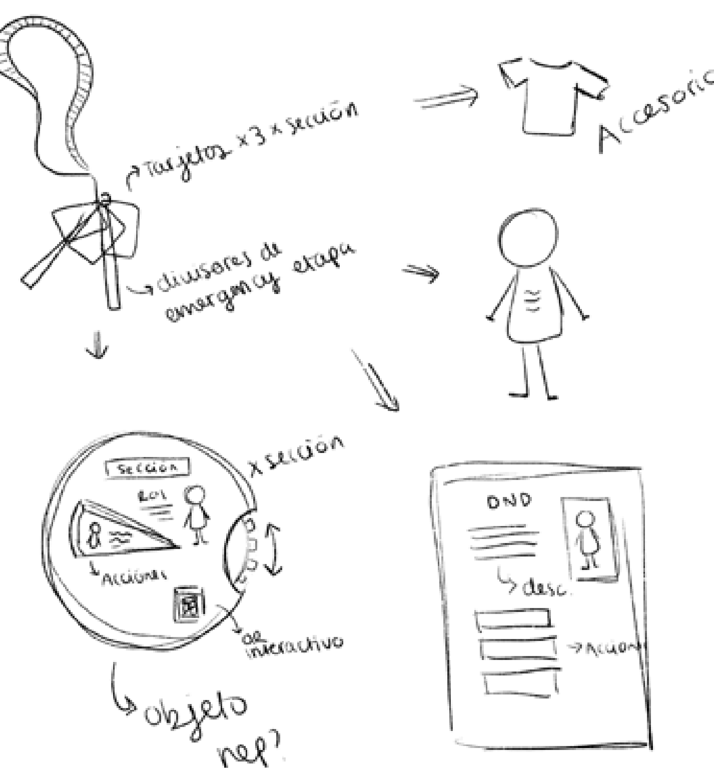


Figure 69: Sketch brainstorming for different material formats that could adopt and simplify the card dynamic including lanyards, volvelles, accessories and shirts.

07
PROTOTYPES & EVALUATION

How were design concepts evaluated and tested through iterative prototypes?

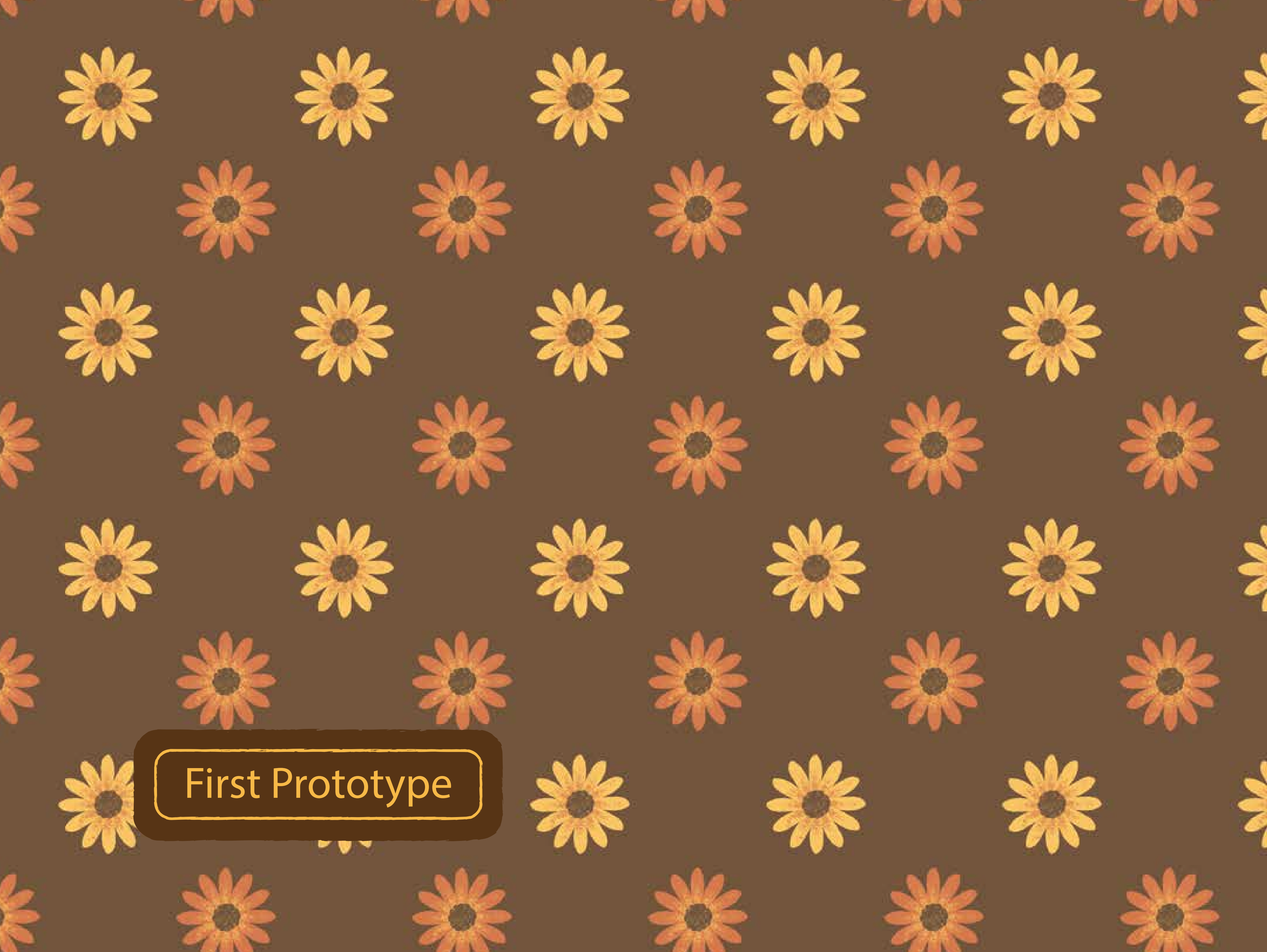
This chapter documents the process through which design concepts were iteratively developed into testable prototypes. It describes the evaluation and testing cycles used to refine prototypes with both community actors and medical partners.

FIRST PROTOTYPE

- Prototype Design
- Kilombo Yumma Representative Evaluation
- Medical Student Testing

PROTOTYPE ITERATION

- Iterated Prototype Design
- Kilombo Yumma Evaluation
- Medical Professional Evaluation



Prototype Design

The following pages describe the first prototype developed from the individual ideation process and the insights gathered during co-ideation with the Kilombo Yumma. This initial prototype explored two core elements of the intervention: (1) the event in which the training would take place, and (2) the training material itself, including interaction dynamics, material format, and key Respectful Maternity Care scenarios.

THE EVENT: TALLER DE PARTO HUMANIZADO
(Humanized Birth Workshop)

At the event level, the prototype proposed a Kilombo-led workshop designed for medical students and healthcare professionals.

The workshop was envisioned as a structured training space focused on communication practices that generate trust in emergency maternity care.

The workshop format is illustrated in the storyboard below (Figure X), detailing the before, during, and after of the event. The proposed setting situates the workshop within the Kilombo space at the Viernes Negro Museum. The session was designed to last half a day and include shared moments such as lunch and snacks to support informal connection.

Within the event, Uramba formats, presentation dynamics, material use and closings activities are scheduled and clarified to adjust to a typical Kilombo workshop.

1
Call for participation: Social Media Publication

2
Uramba Format: Circular Discussion Space

3
Opening the space: Elder gives a few words

4
Presentations: Present yourself and why you have come

5
Snacks: Snack and drink to begin

6
Humanized Birth: Present theme, what we know about it, and what we will learn and why

7
Exercise Explanation: Objectives, dynamics, rules.

8
Divide First Roles: Explore Roles

9
Explain & Explore Material

10
Simulation: Role Playing in 3+ rounds

11
Reflections: collective discussion or debriefing after each round

12
Lunch

13
Final Reflection: Through materialization

14
Chirimiotherapy

15
Close

THE TRAINING MATERIAL: VOLVELLE ROLE-PLAY

The training material was developed as a low-fi, paper-based prototype using a volvelle format, integrating key insights on Respectful Maternity Care (RMC) derived from fieldwork and analysis. The prototype brings together three emergency phases, three roles, and a total of nine care scenarios—three distinct scenarios per emergency phase—allowing participants to explore communication-based trust-building practices from different perspectives in a structured yet exploratory way (Figure X).

3 Emergency Phases

The three emergency phases selected were those identified in the journey mapping analysis as containing the most influential manifestations of communication-based RMC (pg. X): Check-Up Appointments, Emergency Evaluations, and During the Birth. On each volvelle, the main title indicates the emergency phase in which the role and scenario occur (Figure X).

3 Roles to Role-Play

Throughout the role-play activity, participants embody one of three roles: Mother (M), Traditional Midwife (TM), and Doctor (D). Each participant receives a set of three volvelles—one per emergency phase—specific to their assigned role and perspective. The actor icon and title on each volvelle indicate the embodied role (Figure X).

9 Care Scenarios

Within each emergency phase, three specific care scenarios are embedded, resulting in a total of nine scenarios across the system. Each volvelle's roulette contains the three scenarios corresponding to both the emergency phase and the role's perspective.

The scenarios were adapted from personal stories and lived experiences shared by traditional midwives during fieldwork. They are constructed as key situations in which trust is needed and can be built through communication-related manifestations identified in the analysis (pg. X).

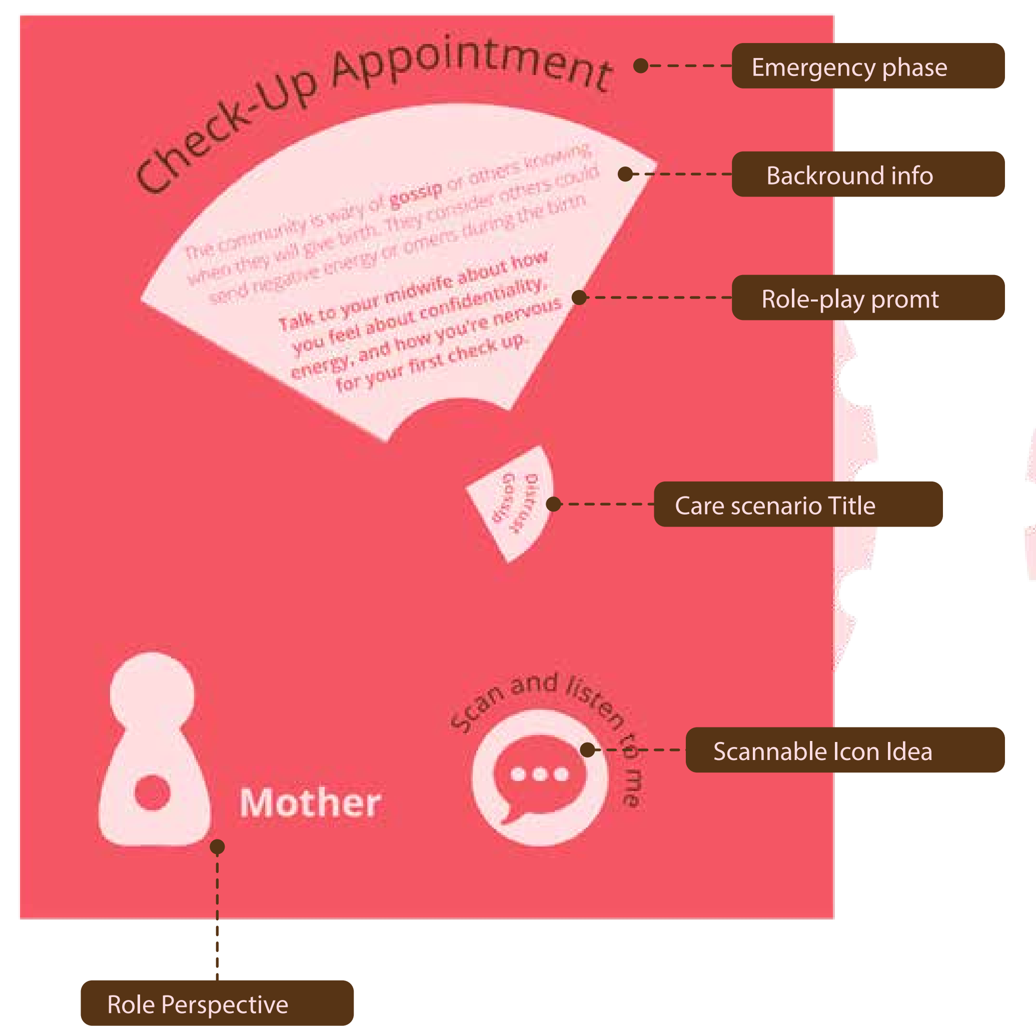
Each care scenario includes:

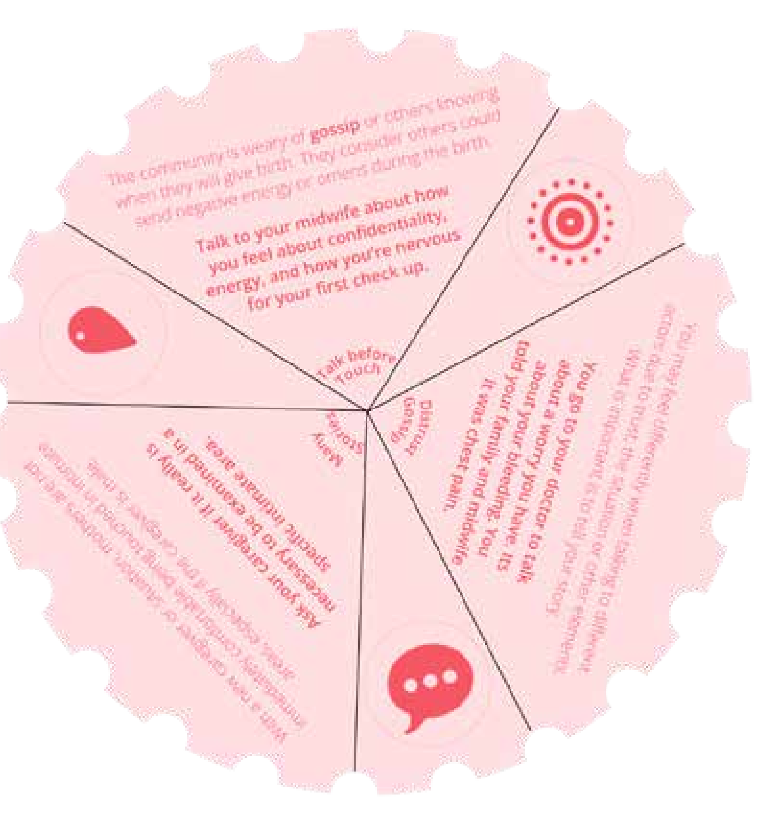
- Background information situating the context.
- A role-play prompt guiding the participant's response.
- A scannable icon containing supplementary audio-visual material that further illustrates the scenario.

When a care scenario is selected for a given emergency phase, all three actors can align their corresponding volvelle to the same scenario. In this way, participants respond to the same care scenario within the selected phase, but from different embodied perspectives.

Volevelle Format

The volvelle format allows participants to physically hold the role and emergency phase they are enacting, while the rotating disc facilitates exploration between three possible care scenarios within that phase. This circular dynamic supports discovery, encouraging participants to consider multiple ways in which respectful communication can be generated and multiple situations in which trust may be challenged.

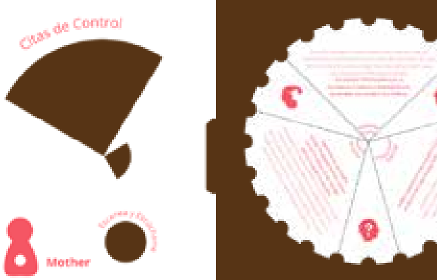
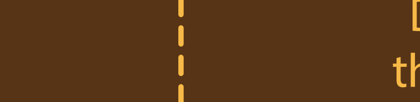
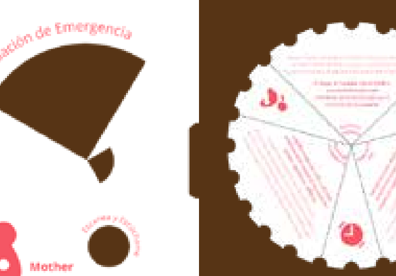




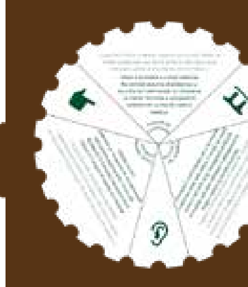
Roulette with 3 care scenarios during check-ups from the Mothers' perspective

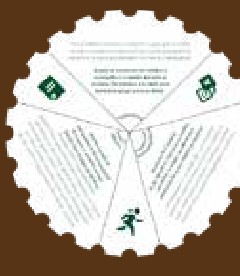
Check-Up Appointments | Emergency Evaluations | During the Birth

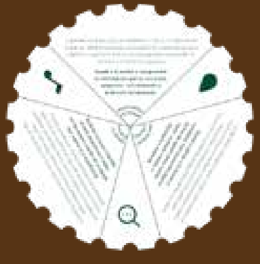
MOTHER

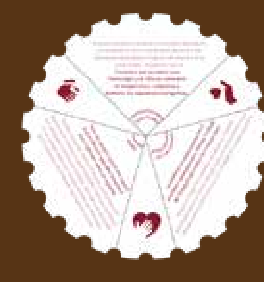
TRADITIONAL MIDWIFE

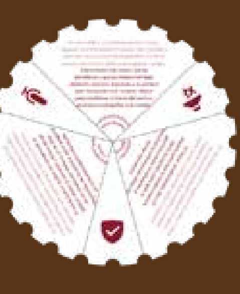


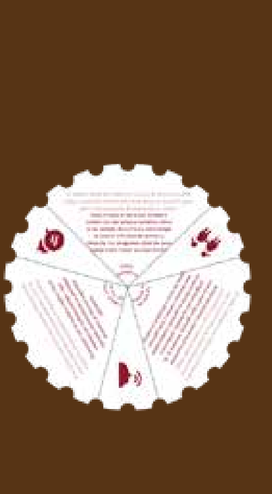


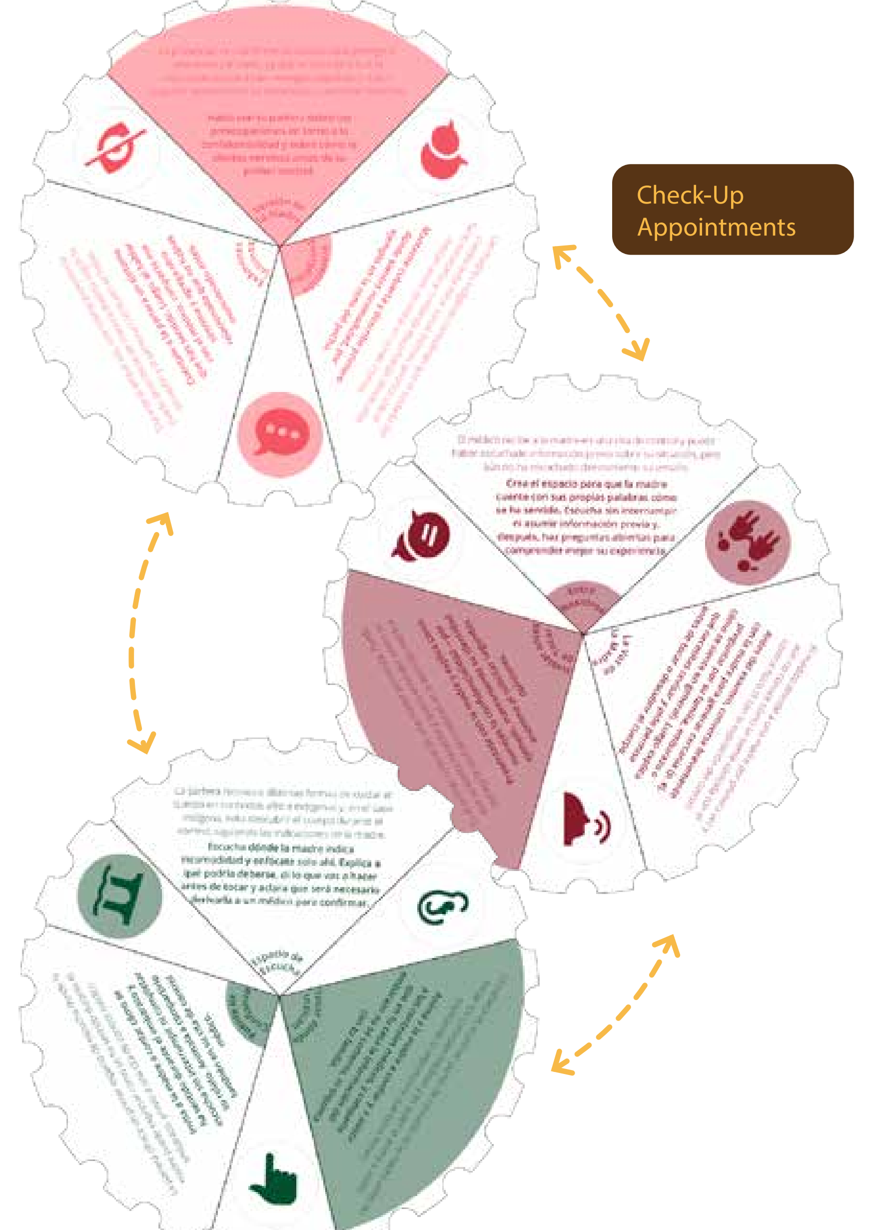


DOCTOR









Role-Play Dynamic

Participants are gathered in a circular format and the activity is explained by the facilitator. The role-play is divided across three chronological emergency phases, each containing distinct care scenarios. For each scenario practiced, three different participants are selected to role-play the roles of Mother, Traditional Midwife, and Doctor, while the remaining participants take on the role of observers.

For each round, the participant role-playing as the Mother begins by selecting and reading one of the three available care scenarios from her volvelle. This scenario establishes the situation to be enacted.

The participants role-playing the Traditional Midwife and Doctor must identify which of the three scenarios on their volvelle corresponds to the situation she has introduced, as the scenarios are written from perspective-specific angles rather than as identical descriptions.

Once each actor identifies the scenario that aligns with the Mother's account, the role-play begins. Participants enact the scene through improvised dialogue, guided by the contextual background and communication prompts embedded within their volvelle.

After each scenario, a collective reflection discussion or debriefing is guided by the facilitator. Questions are directed both to the participants who embodied roles and to the observers, encouraging multiple perspectives on the communication dynamics that unfolded. After going through all the emergency phases, a general reflection or de-briefing is also conducted.

Kilombo Yumma Representative Evaluation

EVALUATION SESSION

The first evaluation of the prototype was conducted with the Kilombo Yumma representative (hereafter referred to as Rep). A dedicated meeting was organized in which the prototype was presented in detail, including the event structure, the volvelle material, and the role-play dynamic. The session created a space for the Rep to ask questions, provide feedback, and suggest modifications. It was clarified that this session functioned as a preliminary evaluation prior to evaluation and testing with the Kilombo collective and medical students/professionals.

EVALUATION RESULTS

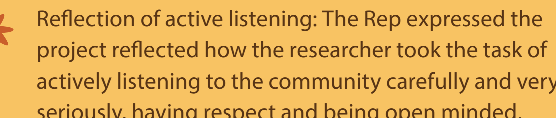
The feedback provided by the Rep is documented in the following boxes, categorized by visual symbols which distinguish between confirmations of design decisions and information, suggestions for future iterations, and highlights of aspects deemed important or meaningful.

Insights from Investigation

Only during emergencies: The Rep highlighted the understanding that traditional communities typically do not want to go to hospitals—they only do so in emergency cases—as a strong point of the thesis.

Confirmation Highlight Suggestion

Design Process

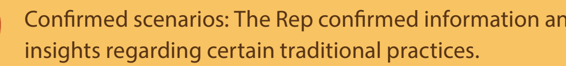


- Reflection of active listening: The Rep expressed the project reflected how the researcher took the task of actively listening to the community carefully and very seriously, having respect and being open minded.
- "Own epistemology": The Rep felt the design process enforces the idea of an "own epistemology"—the understanding that people hold their own form of knowledge and value equal to that of academia—as the information came directly from the source: the community.

Humanized Birth Workshop

- Fitting for workshops: The Rep felt the prototype idea and material fits well in a Kilombo knowledge exchange or workshop.
- Always Uramba format: The Rep underlined the consideration that anything that is taught will always be in Uramba format.
- Materializing dialogue with creation is potent: The Rep explained how something is always born or created from this process of dialogue and that processes of understanding always generate or create new things.
- Explaining food's role: The Rep mentioned the reason for involving food must be made clear—food is sacred and connects and maintains dialogue.
- Explaining Chirimioterapia: The Rep commented Chirimioterapia must also be explained as a dance that represents a close where they thank the ancestors for the space through a tribute.

Volvelle Training Material



- Confirmed scenarios: The Rep confirmed information and insights regarding certain traditional practices.
- Any general emergency: The Rep appreciated how material focuses on transmitting RMC practices that can be applied to any general emergency situation.
- Division into emergency phases and scenarios: The Rep appreciated the divisions that impact Respectful Maternity Care and trust in key ways.
- New learnings: The Rep mentioned how she learned from the material herself about interesting traditions from different traditional communities she did not know about.
- Interactive icons: The Rep appreciated the chance to add information about the scenario through the scannable icon.
- Belief systems as context: For the Rep it was important to have connected belief systems to the material to understand the context of care practices, including the understanding that birth can be viewed in many perspectives or ways.
- Specific emergencies: The Rep suggested future material could focus on specific emergency types and their particular needs.

EVALUATION TAKEAWAYS

Overall, the Rep expressed appreciation for the project and noted that the concept was thoughtfully and carefully developed.

- Regarding research insights, the Rep emphasized several key learnings that the project should continue to highlight and center.
- In relation to the workshop structure, all phases were validated, with the recommendation to more explicitly explain the importance and meaning of each Uramba element and its outcomes.
- In terms of the training material, the information was confirmed and deemed relevant. In some cases, the Rep noted that she also learned something new about other traditional communities' care practices. Additionally, it was highlighted how incorporating contextual belief systems was key to understanding care practices.
- The interactive format, which allows participants to discover and unveil different emergency phases and scenarios, was also positively received.
- Finally, the Rep commended the design process itself as a significant strength. She acknowledged how the work reflected a commitment to seeking and engaging directly with the community, actively listening to their perspectives, and recognizing their lived experience as a valid and valuable form of knowledge.

Medical Student Testing

TESTING SET-UP

Location & Participants

A prototype testing session was conducted in person at the University of La Sabana in Bogotá, Colombia. The session involved four female medical students in their fourth semester of medicine, who had already had an introduction to gynecology.

The session took place in an empty restaurant on campus space, where participants were seated around a circular table with snacks. This spatial configuration, including the presence of food, was intentionally chosen to promote horizontal interaction and encourage open dialogue as in an Uramba format.

*Testing Questions

To assess both prior knowledge and the impact of the prototype, participants were asked a series of questions before and after the activity.

Before the activity, questions aimed to understand participants' existing exposure to RMC and related practices, such as:

- What experience or training they had received regarding respectful maternity care or humanized birth in their education until now.
- Whether they had any knowledge or experience with traditional medicine including contact with traditional midwives or mothers.
- Whether they were familiar with role-playing learning methods in their education.

After the activity, questions focused on evaluating the prototype's impact and participant experience, including:

- What new information they had learned.
- What new perspectives they had gained.
- How they felt during the role-play activity, including interacting with the prototype material.
- What reflections or insights they took away from the experience.
- How the activity might influence their future clinical practice if placed in contact with traditional communities.

TESTING SESSION

The testing session lasted approximately one hour and consisted of three main phases: introduction, activity, and feedback.

Introduction

During the introduction, participants were briefed on the researcher's and project's background, the purpose of the session, and the structure and dynamic of the prototype and activity. The participants were then asked the initial testing questions listed previously*.

Activity

The prototype activity was carried out by the students role-playing one scenario from each emergency phase, for a total of three role-playing rounds. Despite only role-playing three scenarios, all scenarios were read and discussed afterwards. For each round, the students changed roles.

At the beginning of each round, time was given for the students to simply read, explore and interact with that phase's training content before selecting and acting the chosen scenario out. At the end of each round, a collective reflection on the scenario was carried out.

Feedback

Following the activity and ending the session, an open discussion was conducted to gather participant reflections, feedback, and suggestions for improvement. This included the closing testing questions described previously*.

Figures 70, 71 & 72: Medical students exploring protoype material to prepare and embody their designated roles including making up props for the mother, studying the script and discussing past role-playing experiences.

Figure 73, 74 & 75: Medical students during debriefing, discussing the contextual information, reflecting on their acting and considering other options they could have done.

TESTING RESULTS

The learnings and reflections students had from the testing are documented in the following boxes, divided into student reflections and feedback and researcher observations. Visual symbols distinguish between opportunities for design interventions, student learnings and elements to consider for future iterations based on the students' experiences and perspectives.

Opportunity Learning Future consideration

STUDENT REFLECTIONS AND FEEDBACK

Previous Experience

- A learning gap: During their introduction to Gynecology, students had not yet been educated on respectful protocols, the term humanized birth or the subject of intercultural births. The closest example was that of a teacher who shared their personal experience in one case.
- Normalized mistreatment and focus on technical: Students mentioned they had been shown videos of births in which mistreatment was evident yet professors stated it was normal and focused on the technical aspect.
- Inexperienced with traditional practices and communities: Students mentioned they did not have knowledge or experience regarding traditional medicine or communities.

Role-Playing

- Difficulty improving traditional perspectives: Students found that improving in traditional perspectives—including the midwife and mother—was the most difficult aspect of the activity, as they were not deeply knowledgeable or experienced with these communities' practices or preferences.

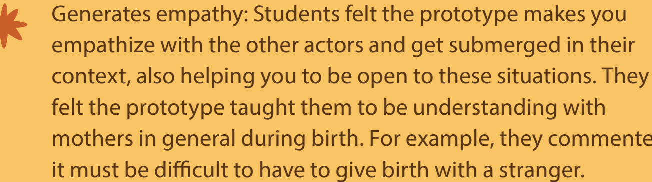
The Medical Student Perspective

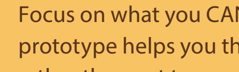
- Rushing against systematic pressures: Students reflected on how they can be invasive. They explained how they're taught to ask and inform mothers, but due to the time pressure and amount of mothers, they rush through steps in day-to-day practice. They become used to the goal being to make it as fast and simple as possible.
- Mistreatment due to lack of knowledge: Students recognize that they are not prepared to receive intercultural cases and can therefore mistreat mothers simply because they have not been formed considering different belief systems. Therefore, they consider it an important topic for doctors to learn.
- Prejudice complicates info exchange despite beneficial view: Students feel there's prejudice towards traditional medicine as it is not considered scientifically supported. They feel this generates a barrier that complicates info exchange despite viewing it as an opportunity with many benefits for maternal care.
- Predisposed to not try: Students commented on the specific scenario where they are confronted with language barriers with indigenous mothers. They explained how normally if there was a language barrier they would already be predisposed to not trying, rather that looking for strategies that could help.
- Considered these situations for distant rurals only: Students mentioned they only think of these situations regarding intercultural births for their rurals. They do not prepare for them throughout their normal education. However, with they acknowledged that this could be needed anywhere, as traditional communities inhabit the city and are not a distant reality.

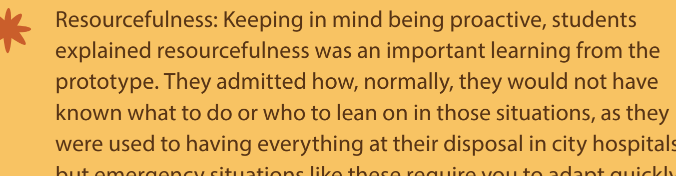
Lone wolf vs. teamwork perspective: Students reflected how they would have not considered midwives as supportive roles before, as they feel doctors tend to think they can manage by themselves. Additionally, during emergencies, they reflected that they tend to focus on what they can do rather than how others can contribute.

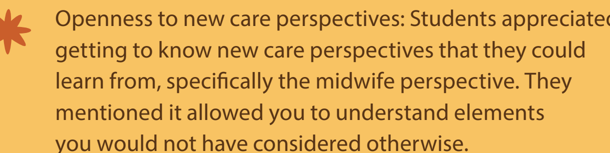
Holistic and continued vs. department division care: Students reflected on how traditional midwives provide a holistic care and point of view—connecting and accompanying different moments of care—whereas doctors have different roles, divisions and departments that divide the care experience amongst different actors.

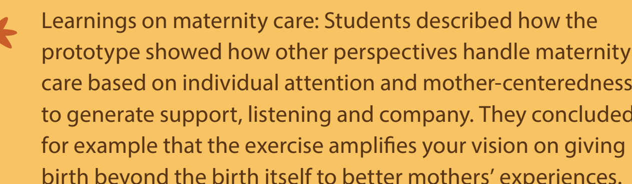
Prototype Benefits


Generates empathy: Students felt the prototype makes you empathize with the other actors and get submerged in their context, also helping you to be open to these situations. They felt the prototype taught them to be understanding with mothers in general during birth. For example, they commented it must be difficult to have to give birth with a stranger.


Focus on what you CAN do: Students highlighted how the prototype helps you think about what you can do to help, rather than not try or not respond to the situation.


Resourcefulness: Keeping in mind being proactive, students explained resourcefulness was an important learning from the prototype. They admitted how, normally, they would not have known what to do or who to lean on in those situations, as they were used to having everything at their disposal in city hospitals, but emergency situations like these require you to adapt quickly.


Openness to new care perspectives: Students appreciated getting to know new care perspectives that they could learn from, specifically the midwife perspective. They mentioned it allowed you to understand elements you would not have considered otherwise.


Learnings on maternity care: Students described how the prototype showed how other perspectives handle maternity care based on individual attention and mother-centeredness to generate support, listening and company. They concluded for example that the exercise amplifies your vision on giving birth beyond the birth itself to better mothers' experiences.

Understanding context to empathize and provide better care: Students admitted sometimes they do not comprehend their patients. Although they know patients have personal beliefs, they felt those beliefs were not relevant unless it affected how they acted. Through the prototype, students explained they realized that if you take the time to comprehend patients' context, it allows for better care.

"Knowing how to treat a person based on their beliefs and everything that surrounds that is a big advantage."

MEDICAL STUDENT

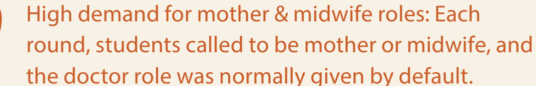
"It would be a great topic to see in class. How would it work? Do you know if we can ask the director about it?"

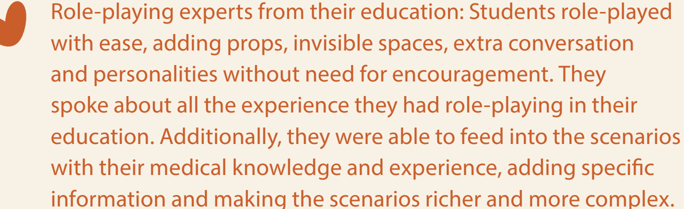
MEDICAL STUDENT

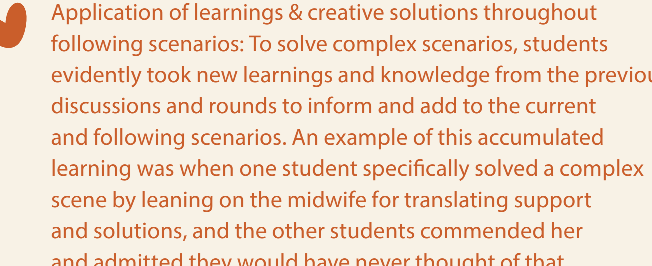
RESEARCHER OBSERVATIONS

Role-Playing

High demand for mother & midwife roles: Each round, students called to be mother or midwife, and the doctor role was normally given by default.


Role-playing experts from their education: Students role-played with ease, adding props, invisible spaces, extra conversation and personalities without need for encouragement. They spoke about all the experience they had role-playing in their education. Additionally, they were able to feed into the scenarios with their medical knowledge and experience, adding specific information and making the scenarios richer and more complex.


Application of learnings & creative solutions throughout following scenarios: To solve complex scenarios, students evidently took new learnings and knowledge from the previous discussions and rounds to inform and add to the current and following scenarios. An example of this accumulated learning was when one student specifically solved a complex scene by leaning on the midwife for translating support and solutions, and the other students commended her and admitted they would have never thought of that.


Enjoyable: Students laughed in some occasions due to the high effort being placed into the roles. At the end they mentioned the exercise was enjoyable, cool and fun.

Unclear situation combination: When the midwife and doctors roles had to choose the corresponding scenario to that of the mother, it was not clear which was the correct scenario, leading to a mixing of care scenarios in one round. Although the situation still worked, it did not come to a conclusion naturally.

Debriefing

- Interest in better understanding traditional world: Students focused their questions on understanding the difference between midwives, doulas and matronas, or simply understanding traditional care perspectives.
- Understanding mistreatment to understand respect: When discussing the care scenarios during de-briefing, students understood respectful care practices best when they understood the possible mistreatment that would occur in its place otherwise.
- Great topic for class: After the activity and among themselves, students expressed they felt intercultural and respectful care would be great to see in class and wondered if they would see it in the future. They then asked how they could go about introducing the idea to the director of their program as part of the curriculum. Finally, they concluded respectful and intercultural care is not only pertinent in gynecology but in every care department.

TESTING TAKEAWAYS

Positive reception of the prototype

Overall, the medical students responded positively to the prototype, describing it as well thought out and valuable as a learning tool.

Confirmation of an educational gap and opportunity

Testing confirmed the existence of a gap in medical education regarding respectful and intercultural maternity care, and a focus on efficiency and technical aspects of care. Students reported limited exposure to these topics and reflected on the value, benefits, and opportunities to introduce this knowledge into their curriculum soon.

Conversation and reflection starter supported by traditional actors

Role-playing traditional perspectives confirmed that the workshops regarding this training should be led by traditional actors who can guide students, answer questions, and fill in the knowledge background and lived experiences that are not provided by the training material. In this sense, the prototype functions primarily as a conversation and reflection support rather than a stand-alone tool.

Revealing the biomedical perspective and its limitations

Debriefing revealed aspects of the biomedical perspective, including existing knowledge gaps, external limitations, standing points, and current perspectives on traditional care from the medical student perspective.

Clear evidence of student learning and perspective shifts

Students explained how the exercise generated empathy toward the mother's perspective and expanded their vision on the midwife's role as part of their care team. Students reflected on the importance of mother-centered care, listening, and accompaniment, and expressed interest in learning from alternative maternity care perspectives with the purpose of improving the mothers' care and experience.

Role-play and debriefing as effective educational tools

Role-playing was confirmed as a familiar and effective learning method within medical education. Students applied their own medical knowledge and new learnings across scenarios, demonstrating accumulated learning. The debriefing phase was particularly valuable for digesting, sharing, and reflecting on these learnings and perspectives.

Understanding mistreatment to understand respectful care

The debriefing confirmed that understanding mistreatment situations helps students better comprehend why respectful care is needed in practice and how it could look like.

Importance of contextual and community understanding

Consistent with the Kilombo evaluation, this session emphasized that students felt that understanding the community and cultural context was valuable and essential to provide better care.

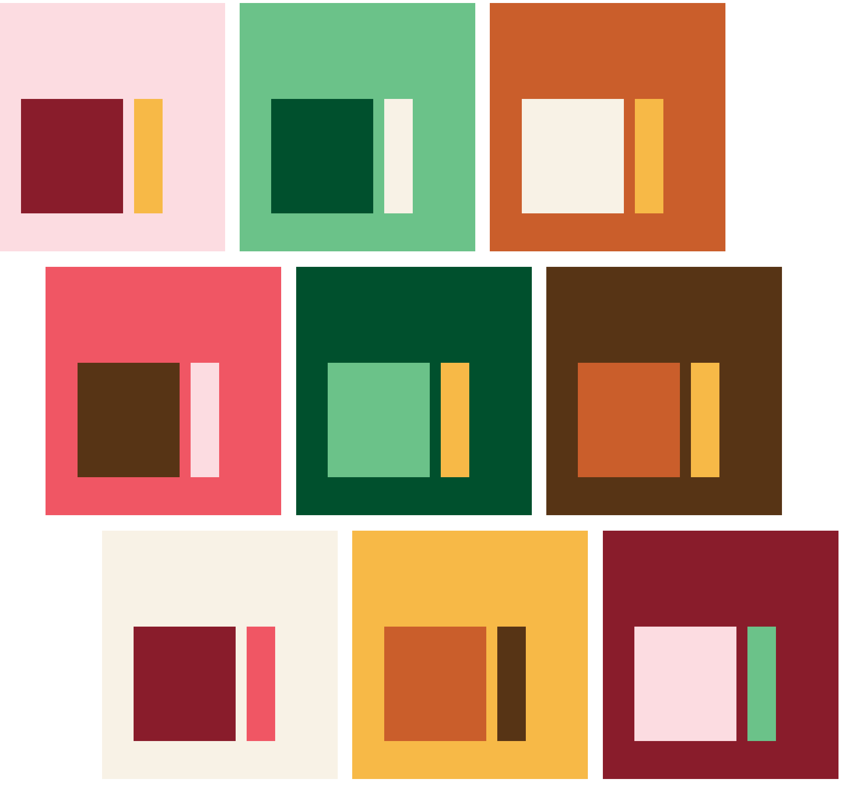
Scenario mix-ups to improve

Some scenario combinations and their intended learnings were unclear, leading to a mix of scenarios when role-playing. This led to intricate scenarios but no clear learning that unified the perspectives.

First Prototype

Iterated Prototype Design

The following pages describe the iteration of the prototype based on the observations and feedback collected in the first Kilombo evaluation and medical student testing. This second prototype explored various adjustments of the training material including: (1) the visual identity of the material, (2) the target user group, (3) the RMC material with changes to the scenarios, the information structure and content purpose.

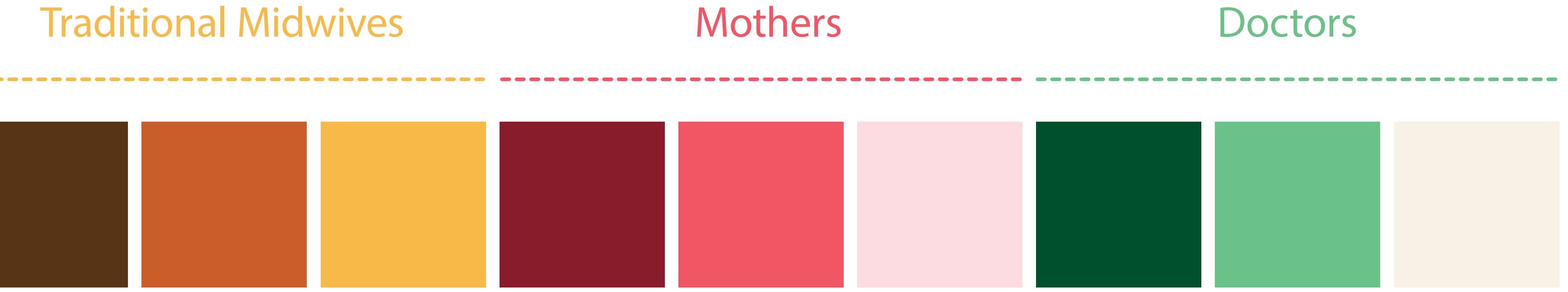


VISUAL IDENTITY: TRADITIONAL AND BIOMEDICAL COLLAB

Considering the recognized importance of understanding and being submerged in the local context, the visual identity was adapted to embrace the idea of a collaboration with traditional perspectives.
All following visual elements were executed by Silvia Loaiza Niño.

Chocó Care Color Palette

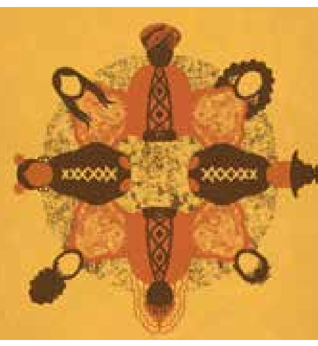
The colors chosen for the project were based on a colorful and tropical Chocó context, taking from key aspects of the region and assigning them to the three main actors and perspectives in this care conversation.



Hand-Drawn Illustrations

The following 20 hand-drawn illustrations were created and chosen based on elements in the investigation, including the stories, actors and materials that were deemed central to the traditional midwifery narrative in Chocó, COL.

CHACHAJO TREE
Native species from Chocó


URAMBA FORMATION
Traditional Midwives
in circular dialogue

HEARTS
Love and care in the
form of hearts

STETHOSCOPES
Traditional (Pinard)
and biomedica

MOTHER

CARING HANDS
Symbols of traditional
midwifery

CALÉNDULA
Medicinal plant

MUSIC NOTES
Symbols of verbal
knowledge and chants

NECKLACE
Hand crafted beaded necklace
of indigenous communities

MANZANILLA & RUDA
Medicinal plants

UTERUS

ARTISANAL VESSEL
Objects for the midwifery
practice during birth

BIOMEDICAL SYMBOLS
Asclepius staff

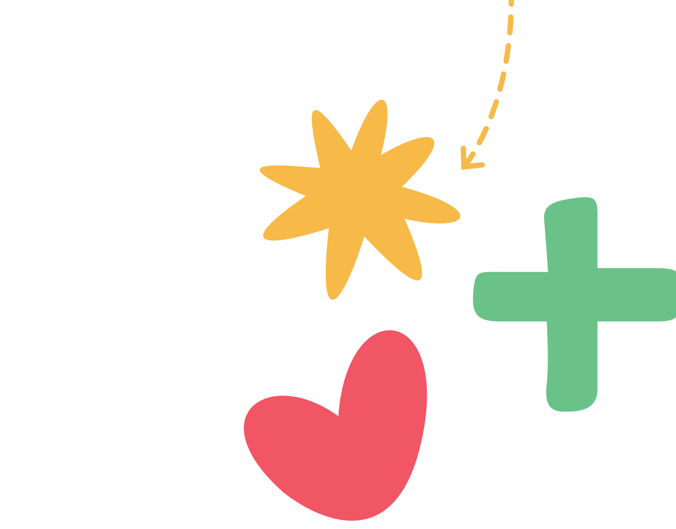
SCISSORS
Objects for the midwifery
practice during birth

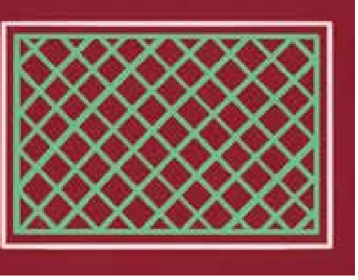
MOTHER, MIDWIFE AND
MEDIC SILOHUETTES

CANDLE
Native species from Chocó

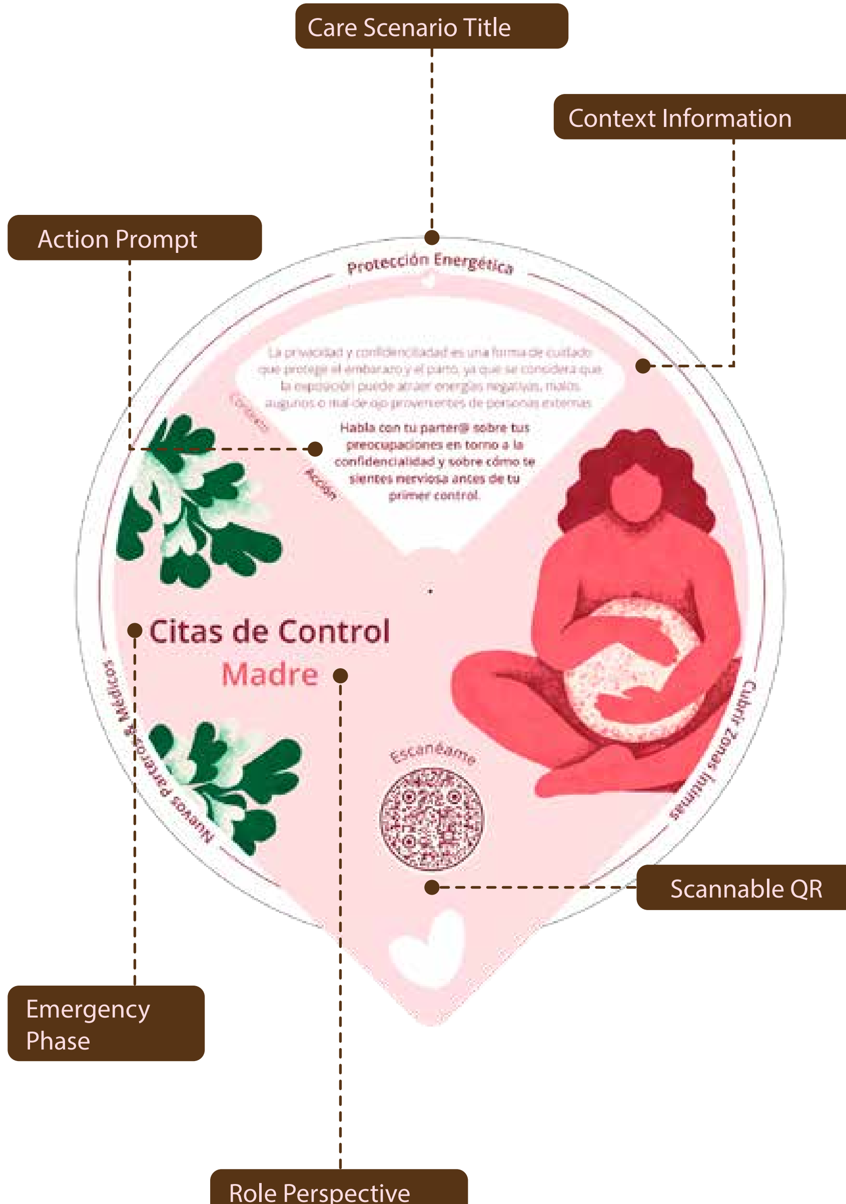
URAMBA FORMATION
Traditional Midwives
in circular dialogue

HEARTS
Love and care in the
form of hearts


Three visual elements for various applications including the visual identification of roles or perspectives on the training material: mother (heart), midwife (star) and medic (plus)



INDIGENOUS PATTERNS
Taken from the Chocó fieldwork
- painted on researchers' skin
by indigenous community



TRAINING MATERIAL & CONTENT ITERATIONS

Based on the initial prototype results and takeaways, a series of design decisions were taken to adjust the training material format and content.

Volvelle Format

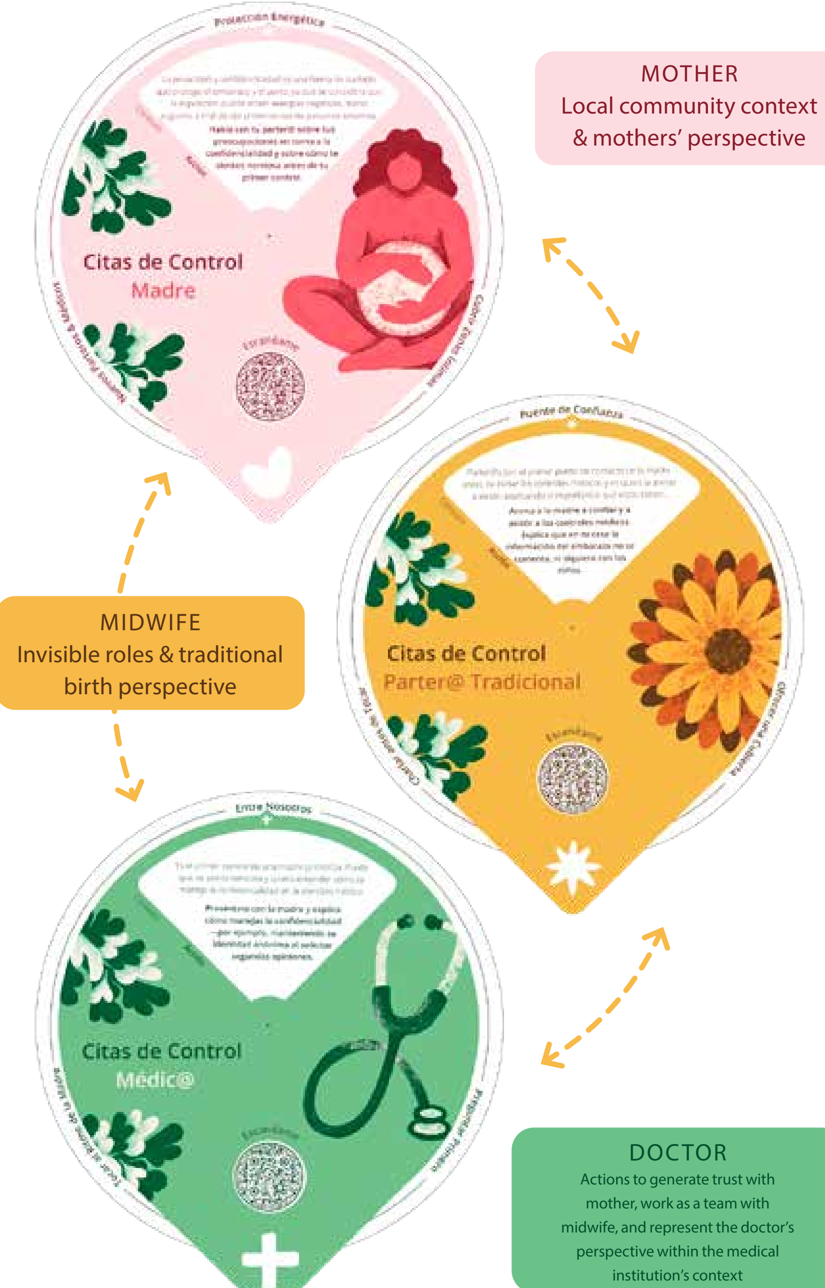
The volvelle design and overall format was adjusted for a smoother physical interaction and a stronger connection and immersion into the context with the integration of the new visual identity (Figure x).

Solidifying Role Purposes & Dynamics

Besides the three different roles representing the mother, midwife and doctor perspectives, the roles in this prototype iteration were designated specific purposes and dynamics aligning with the investigation insights and prototype learnings.

Mother's volvelles: Considering the mothers' wellbeing is the goal and center of maternity care, this role was given the starting position in role-playing. In this sense, the mother chooses the scenario to be played out. Additionally, all other roles focus on tending to her needs, according to her context, perspective and background. Therefore, the mother's volvelles represent the local community, its context, belief systems, preferences and perspectives. The information was adjusted to highlight this.

Traditional midwife's volvelles: These volvelles wew based on the first prototype learnings that doctors tend to focus on what they as individuals can do, yet the prototype allowed students to view midwives as a team with roles they had not considered before. Due to this, these volvelles were adjusted to name, highlight and focus on those invisible roles from the investigation that midwives offer and add to the collaboration for mothers' wellbeing.



Doctor's volvelles: These volvelle focus on providing communication actions doctors can take to generate trust directly with the mother, but also to work as a collaborative team with the midwife. Additionally, it provides the perspective of doctors within their context of medical institutions.

Adjusting and changing scenarios for no mix-ups

The scenarios were revised, adjusted or changed completely in some cases to avoid future participants mixing-up unclear corresponding scenarios and acting out different ones. To make the scenarios clear, they were redacted again to make sure they (1) fulfilled the new volvelle purposes described previously, (2) were very clearly distinguished (3) focused on illustrating the key insights from the investigation, with concrete learnings and using specific lived experiences.

QR Code to Kilombo Podcast

The scannable icon idea was transformed into a QR code that when scanned, leads to the Kilombo Yumma podcast ,where users can begin to learn more about the traditional community, their perspective, and the current dialogue with biomedical approaches.

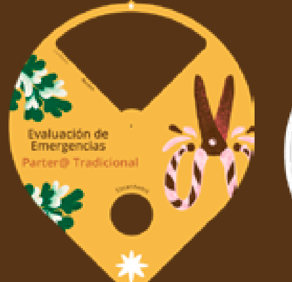
Target Group

The target group after the first prototype was narrowed down to western or biomedical professionals in formation, such as student or professionals undergoing more education. This was due to the specific dynamics of the workshop and the opportunity to make an impact from the initial formation of caregivers.

Check-Up Appointments | Emergency Evaluations | During the Birth

MOTHER

TRADITIONAL MIDWIFE



DOCTOR

Kilombo Yumma Evaluation

COLLECTIVE EVALUATION SESSION

The second evaluation of the prototype with the Kilombo Yumma was conducted with the collective at the Care Center, including 6 members. A dedicated meeting was organized in which the prototype was presented in detail and a space was given for the collective to interact with the material, ask questions, provide feedback, and suggest modifications.

Figure 76: Researcher explaining and answering questions about the prototype while sharing it for evaluation with the Kilombo at the care center.

Figure 77: Kilombo member reading a check-up appointment volvelle, as they were particularly interested in this phase due to their role at the Kilombo.

Figures 78, 79 & 80: Grandma Pilar, the traditional midwife among the group, listening to the care scenarios and sharing her personal experience with those situations. And her grandaughter scanning the QR to find the podcast.

EVALUATION RESULTS

The feedback provided by the collective is documented in the following boxes, categorized by visual symbols which distinguish between confirmations of design decisions and information, suggestions for future iterations, and highlights of aspects deemed important or meaningful.

Confirmation Highlight Suggestion

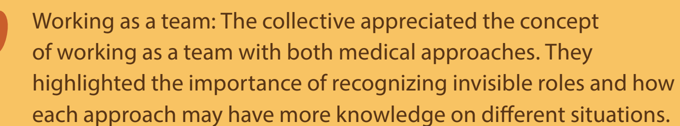
Design Process

Recognized as an expert: The collective explained they felt that the researcher interpreted the topic very well and was now an expert.

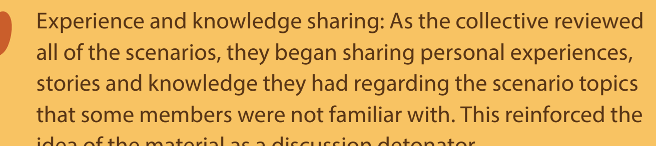
> “And she’s [researcher] an expert, because if she ends up becoming a doctor, then births will be better.”

GRANDMA PILAR
(KILOMBO’S LEAD TRADITIONAL MIDWIFE)

Generated Dynamics



Working as a team: The collective appreciated the concept of working as a team with both medical approaches. They highlighted the importance of recognizing invisible roles and how each approach may have more knowledge on different situations.



Experience and knowledge sharing: As the collective reviewed all of the scenarios, they began sharing personal experiences, stories and knowledge they had regarding the scenario topics that some members were not familiar with. This reinforced the idea of the material as a discussion detonator.

Umbrella categories: The collective was able to connect and categorize all of their specific stories regarding respectful care to the different scenarios. In this sense, the scenarios seemed general enough to discuss many specific and common situations.

Future Iterations

Creating material for the QR: The collective was very keen on creating supporting material for the QR that could illustrate each scenario through, videos, audios or pictures for future iterations.

Templates for more emergency phases and practices: The collective contemplated creating more emergency phases including other practices besides communication-based ones. They asked to have templates to transform their own experiences into scenarios and material.

Incorporating traditional terminology: The collective reflected on emergency communication between midwives and doctors. They wondered how specific terms would translate, as the traditional community has names for certain situations or symptoms that doctors do not have, whereas they have been taught technical terms.

Different Applications

- Nursing students: One of the members said they would like to have this material for nursing students that sometimes come to the care center. They would like to use it to show them the traditional perspective and compare how the team is formed between the ancestral and western approach.
- Workshops with other Kilombos: Members also suggested they could use it when they meet with other Kilombos to share different traditional practices or material. They find it especially important to focus on the recognition of traditional roles and practices because they felt that lately all the presentations have focused more on biomedical knowledge.
- Hang material in the care center: The collective considered hanging the volvelles in the care center for others to learn simply based on curiosity.
- Asked to keep specific volvelles: At the end of the session, the collective asked to keep the check-up appointment volvelles and all of the traditional midwife ones across all phases, as they felt these were the ones that best applied to their current practices and opportunities in their day-to-day encounters.
- Volvelles as a toolbox: The way the collective understood the volvelles' value was in the form of a toolbox of actions that could be taken from ancestral perspectives during emergency births.
- The adaptability of the volvelle format: Some members appreciated the circular form and dynamic of the volvelle. They felt it was practical and an appropriate format to sensitize other people on the topics they work with.

SESSION TAKEAWAYS

During this evaluation, the collective expressed an appreciation for the material, sharing many ideas, considerations and adaptations for its use now and in the future.

- In terms of the design process, the collective felt that the topics were interpreted with care and expertise.
- In terms of dynamics generated, the collective appreciated the ongoing dialogue with western or biomedical approaches in the form of teamwork. Additionally, the material served as a discussion detonator among the collective itself.
- For future iterations, the collective seemed keen on developing future audio-visual material, working on their own scenarios and incorporating specific emergency terminology from the traditional perspective to facilitate team communication with doctors.
- Finally, their contemplation of different applications and uses of the material opened many alternatives for current uses and understandings, leading to them keeping the material immediately.

Figures 81, 82 & 83: Members posing with the specific volvelles they asked to keep including all the chek-ups appointment volvelles and those of the traditional midwife perspective.

Medical Professional Evaluation

EVALUATION SESSION

The last evaluation of the prototype was conducted with two medical professionals including a man and woman who had already graduated from general medicine and were seeking their specialization. A one-hour meeting was organized online to present the prototype in detail and discuss the material through questions, feedback and suggestions.

EVALUATION RESULTS

The feedback provided by the doctors is documented in the following boxes, categorized by visual symbols that distinguish between opportunities for interventions, learnings and elements to consider for future iterations based on the doctors' experiences and perspectives.

Opportunity Learning Future consideration

Previous Experience

Education focus on technical rather than respectful care: Doctors explained they only learned how to treat patients when they became conflictive, but not in emergencies. Additionally, their education focused more on technical skills.

Respect is ideal but not protocol: Many respectful practices are considered an ideal but are not really considered protocols during birth.

The Doctor's Perspective

Difficult to automatize this behavior, even if it seems logical, so it must be taught: The doctors explained how they consider it difficult to automatize this type of behaviors, especially when you have seconds to respond. In terms of effectiveness, they explained that the more technical your mind works when making decisions, the better the result. Therefore they confirmed that they schematize their way of thinking and it is valid and necessary to place these behaviors on the scheme to learn, as things are not automatic or obvious no matter how logical they seem.

Better doctor if humane: The doctors mentioned that you are a better doctor the more human you are in emergency situations, and that humanity should not be left aside.

Bias, prejudice and ego in terms of recognition: The doctors explained how there is bias against traditional birth due to the perception of a lower success rate. Additionally, they feel there is prejudice and an aspect of ego, as they compare their intense and formal education that required specific and satisfactory results to the idea that midwives received an informal education. This comparison leads to barriers where they doubted midwives knowledge or experience. In this same sense, the doctors had many questions and assumptions on how midwives work.

Different faces of the same coin: The doctors gave many examples of their perspectives on the care practices shown in the material. Upon explaining their perspectives it was clear that that both the midwife and doctors perspectives agreed on many goals and ideals, they simply viewed or explained it differently.

Topics such as gender consideration, c-sections, listening to the mother and handling pain expressions were explained from the doctors emotional, logical and technical perspective, leading to new understandings of the same goals yet with different approaches in different contexts.

References of respectful care among doctors: The doctors mentioned how they admired very few other medical professionals they worked with for their handling of respectful, empathetic and effective communication to patients compared to most. They took their skills in handling communication as examples of good practice and were able to explain exactly what it sounded like.

"You have to recognize that the one who knows, knows."

EVALUATING DOCTOR

Material Reflections

New learnings: The doctors mentioned how the material taught them a lot. Specifically about different traditional communities and perspectives they would have never contemplated or imagined.

Recognize limits and lean on who knows: Upon reflection, the doctors recognized that during birth complications, it is important that a rural doctor recognize that their experience curve is not as large as that of a midwife, and that they must lean much more on her. In this sense, one must recognize their limits and know when others know best and that it is ok to say you do not know.

Sensitizing is necessary: The doctors highlighted how this sensitizing exercise is necessary, considering obstetric violence is very real and they feel it is a very important topic. They also focused on the idea of sensitizing actors towards different perspectives and actors with positive attitudes as a key aspect of the material.

Overall well-thought tool: The doctors concluded that the scenarios are well introduced—not too technical or so specific—showing clearly difficult and real situations that you must deal with eventually. They also mentioned they liked the dynamic as it felt didactic and easy to learn.

Missing the doctor's perspective: Upon reflecting on their own experiences, the doctors concluded that the investigation and material is lacking more of their own perspective, especially if the idea is to create a two-sided dialogue.

Debate detonator: The material began sparking debates and discussions between the doctors themselves regarding perspectives, barriers and difficulties in working with maternity care.

Understanding mistreatment and the context helps: As in previous testing and evaluation, the doctors seemed to engage best with the idea of respectful care after understanding examples of mistreatment and the context background.

TESTING TAKEAWAYS

Positive reception as sensitizing tool

Overall, the doctors responded positively to the prototype, describing it as well thought-out and valuable as a sensitizing tool.

Focus on integrating schematic, automatic and technical actions

Discussion with the doctors highlighted their way of viewing their work. This included taking learnings and seeking to automatize them for better effectiveness and results during decision-making in emergencies. In this sense, they tended to prioritize technical procedures. However, they recognize the importance of making humanized behaviors a learned part of their mental scheme and integrating it into their automatic responses. They highlighted that education and training regarding this material was necessary, as it is not obvious despite seeming logical.

Biases, assumptions and barriers:

The doctors discussed the reasons for which they may have barriers in accepting more traditional perspectives, making these recogition decisions conscious to change.

Same coin, different face:

In terms of biomedical perspectives, the doctors also made it clear that they had similar goals to midwives, simply different ways of viewing and explaining it among themselves, medically and to their patients.

Opportunities for the doctor perspective:

Considering the proactive and positive focus of this project, the doctors mentioned how among themselves they referenced a few doctors as ideal caregivers in terms of their communication practices with patients. In this sense, they also mentioned how perhaps a deeper doctors' perspective was missing from te prototype.

Recognizing and respecting limits:

Finally, doctors highlighted the need to recognize their own limits and understand when to lean more on midwives in terms of experience and teamwork.

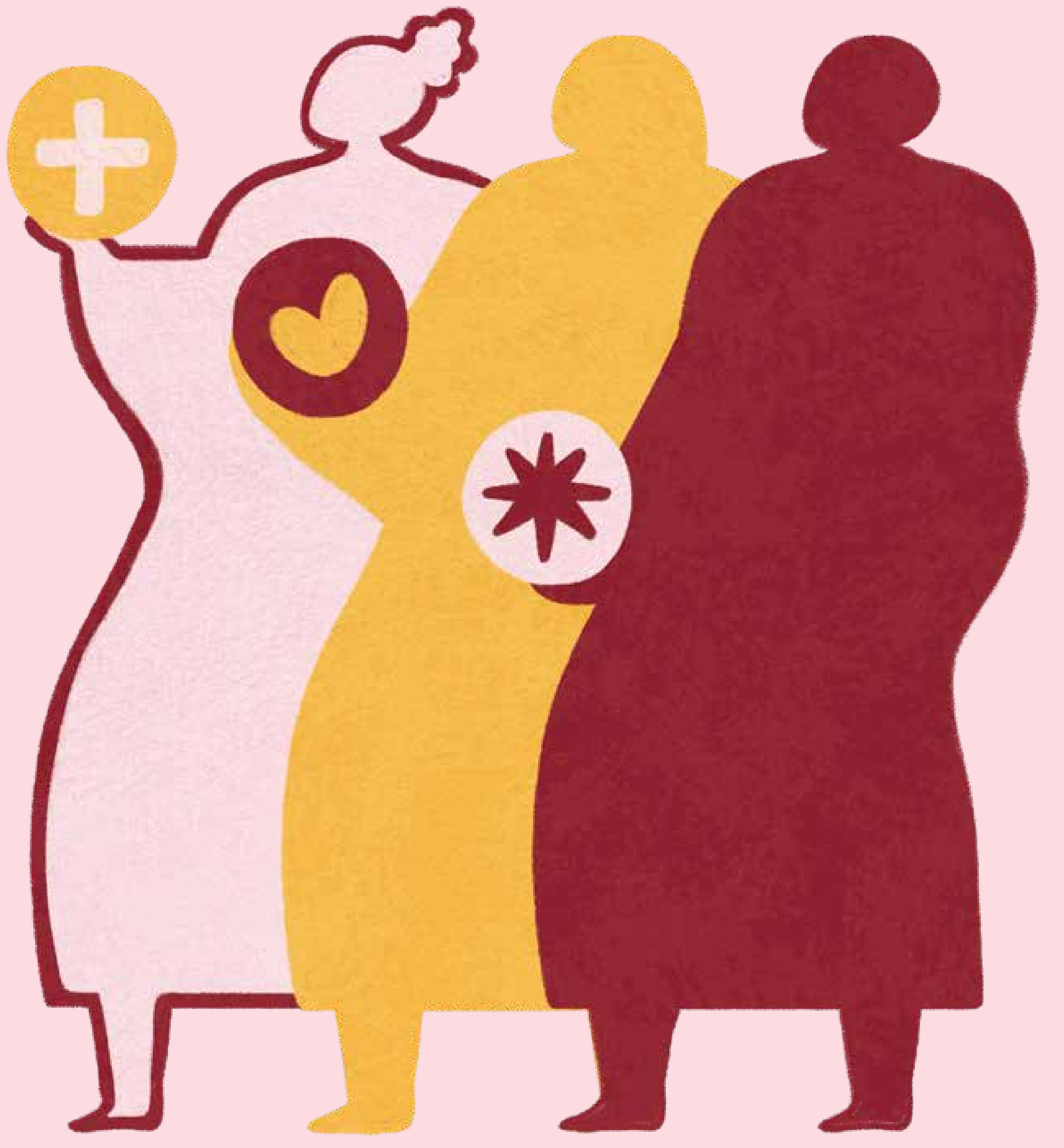
08 DESIGN PROPOSAL

How were project learnings translated into a final design proposal?

This chapter presents the final design proposal resulting from this thesis project. The proposal is the outcome of an iterative design process informed by literature, fieldwork, ideation, prototyping, and evaluation sessions with traditional care and medical actors. These learnings shaped the development of a training approach aimed at fostering respectful communication and intercultural understanding in emergency maternity care. This chapter outlines the proposal and its key components.

HUMANIZED BIRTH WORKSHOP

RESPECTFUL MATERNITY COMMUNICATION VOLVELLES (RMCV)



Humanized Birth Workshop

A space for intercultural knowledge exchange

A workshop where traditional and biomedical care perspectives generate collective learning, adding to the ongoing conversation between the two.

Embedded in medical education

Integrated into medical students' curriculum as part of their formation as future care providers. It takes on the form of a half-day activity within the classroom.

Guided by traditional care experts

Facilitated by the Kilombo Yumma, a collective dedicated to preserving and transmitting traditional medicinal knowledge and practices.

Introducing respectful and intercultural maternity care

Guiding medical students in understanding traditional care perspectives and respectful communication practices from Chocó, Colombia.

Preparing students for diverse care contexts

Equipping students to engage with traditional communities, both during rural service and urban encounters with diverse populations.

Cultivating empathy and openness

Familiarizing students with different care perspectives, experiences, roles, and community contexts that surround birth.

Reframing care as collaboration

Fostering collaboration between both approaches through the recognition of traditional midwives and diverse care roles as part of the maternal care team.

Defining respect as trust through communication

Exploring communication practices that can cultivate trust and best shape the mothers' wellbeing and care experience in emergency maternity care situations.

Collective knowledge exchanges regarding traditional practices and perspectives is held in the traditional Uramba format based on circular dialogue.

Respectful Maternity Communication Volvelles (RMCV)

A role-play training tool

Interactive volvelles support experiential learning through guided role-play and dialogue, detonating embodied reflection and discussion.

Circular narrative structure

A rotating disc format reveals care scenarios progressively, supporting an exploratory dynamic while also representing circular dialogue.

Three emergency care phases

- Volvelles are situated in three key emergency maternity phases:
- Check-up appointments, where trust relationships begin and influence mothers' decisions to seek out future care.
- Emergency evaluations, focusing on the moment when mothers and midwives arrive at medical institutions seeking attention.
- During birth, where attitudes taken on during and after birth generate most impact.

Three care actors, roles and perspectives

Roles to be acted out represent the mother, traditional midwife, and doctor as interconnected members of the care team with their own perspectives, responsibilities and lived context regarding each care situation.

Nine care scenarios

A total set of nine scenarios—three per phase—illustrate diverse emergency situations in which communication plays a key role in breaking or creating trust.

Proactive communication actions that generate trust

Volevelles provide proactive communication prompts or actions that foster respectful interaction and mother-centered care.

Figure 84: Final design proposal for Respectful Maternity Communication Volvelles (RMCV).

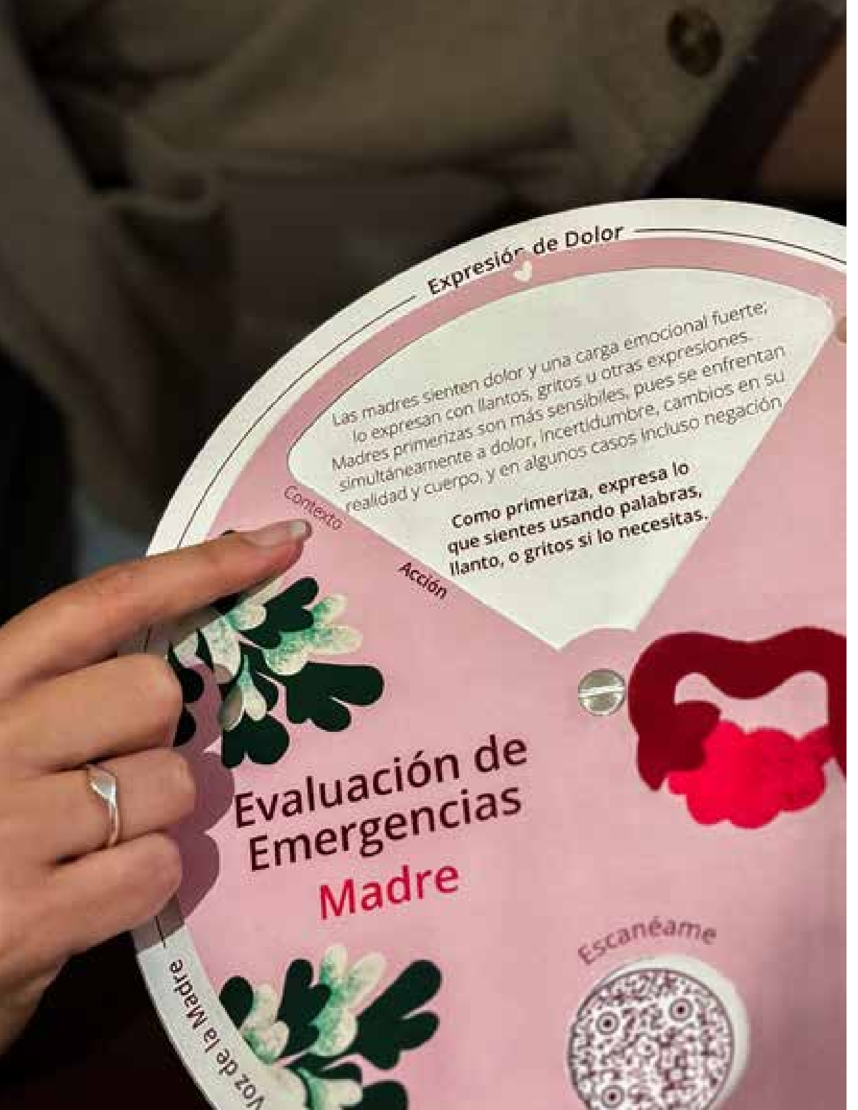


Figure 85: The mother's emergency evaluation volvelle showcasing the local community context and communication action prompt.

The Mother

As the center of respectful maternity care, the mother initiates the activity by selecting a care scenario. Her volvelle represents the local community's mindset, context or belief system that shapes her experience, alongside action prompts that guide the enactment from her perspective.

The Midwife

The midwife seeks the corresponding scenario through the traditional care perspective. Her volvelle highlights traditional communication birth practices and the often invisible roles midwives take on to support the mother's wellbeing.

The Doctor

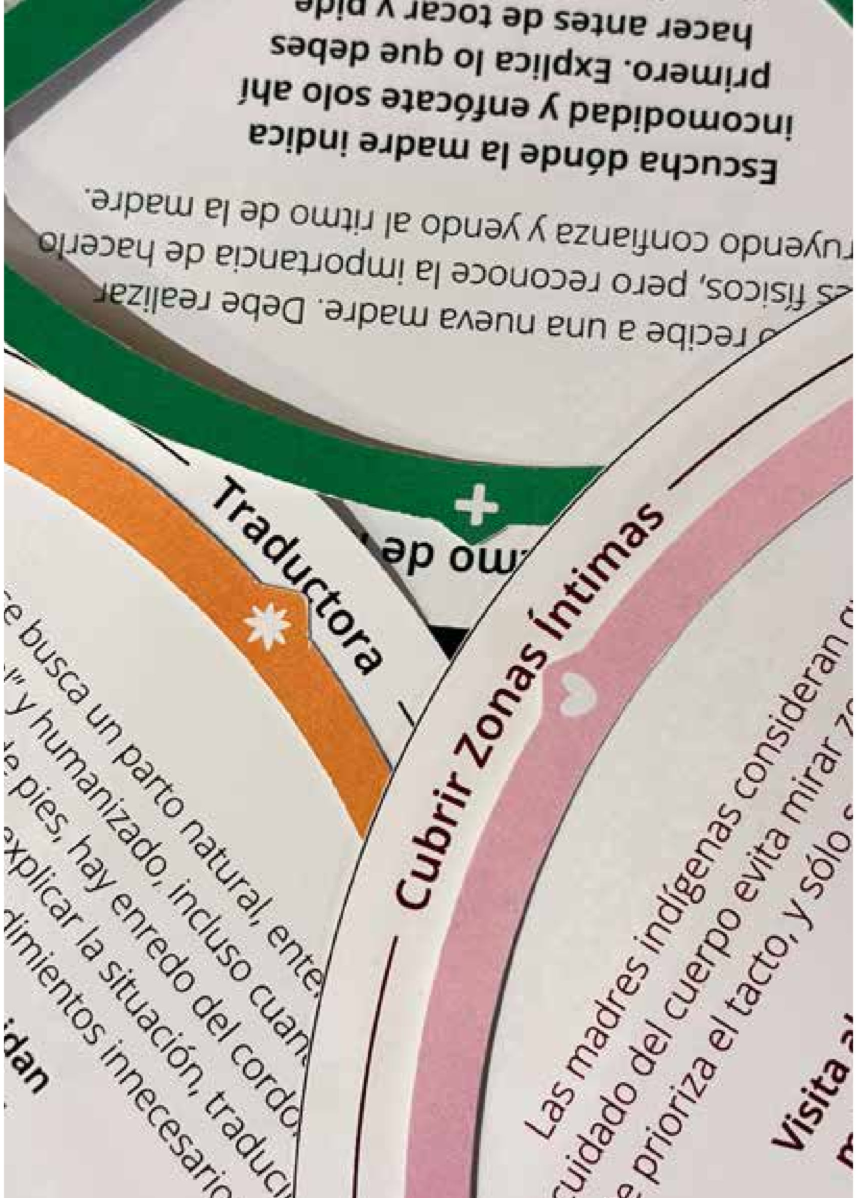
The doctor identifies the same scenario from the biomedical perspective. Their volvelle presents the institutional context alongside communication actions that focus on generating trust, collaborating with the midwife, and engaging respectfully with the mother.

The Observers

Observers witness the interaction as members of the broader care environment. They listen, reflect, and identify how communication shapes trust, relationships, and care outcomes. Their role is to support collective reflection and shared learning during the debriefing phase.

Figure 86: The traditional midwife volvelle for the during birth phase, highlighting the midwife's role in sharinng difficult news with the mother's loved ones.

Figure 87: The doctor volvelle for the emergency evaluation phase, highlight how the doctor explains to the mother that she must conserve her strength.



Figures 88 & 89: Symbols designated to the mother, midwife and doctor as a care team with different but complementary perspectives.

Additional audio-visual material

Each scenario includes a QR code that provides access to audio-visual content, offering a deeper understanding of the care situation and communication actions from the specific embodied perspective.

Figures 90 & 91: Scannable QR codess with audio-visual material made by the Kilombo that illustrate the perspective and situation at hand.

The material is created by community actors, including the Kilombo Yumma and biomedical professionals, ensuring representation from both traditional and institutional care perspectives. The content ranges from images, illustrations, and videos to podcasts, songs, and recorded testimonies.

Figure 92: Final design material.

RESPECTFUL CARE SCENARIOS & PRACTICES

The nine care scenarios include the following communication topics from the perspectives of the mother (M), traditional midwife (TM) and doctor (D).

CHECK-UP APPOINTMENTS

1. Building trust across genders: Distrust during check-ups with new midwives or doctors who are male (M), addressed by chatting before touching (TM) and following the mother's emotional and physical rhythm during examination (D).
2. Covering intimate areas: Indigenous preferences for covering intimate areas during examinations (M), addressed by offering cloth coverings and examining through limited touch without looking (TM), and asking about body exposure preferences and permission before intimate examinations (D).
3. Confidentiality as energy protection: Concerns for privacy and confidentiality due to beliefs around negative energies, bad omens, or the evil eye (M), addressed by encouraging mothers to attend doctor check-ups (TM) and clearly discussing confidentiality and privacy measures (TM & D).

EMERGENCY EVALUATIONS

1. Responding to pain expressions: First-time mothers expressing intense physical pain and emotional distress through screams, cries and denial (M), addressed by recognizing the vulnerable state of the mother and providing emotional support (TM), and separating personal stress to maintain a calm composure while explaining how to preserve strength for birth (D).
2. Listening to act: Creating space to ask and listen (D) to the mother's physical and emotional state (M) ,and to the midwife's knowledge on the situation (TM), to better orient following care decisions and actions.
3. Informed consent in different languages: An indigenous mother who does not speak Spanish (M), supported by the midwife translating her preference for a natural birth despite complications (TM), and the doctor translation and other support to discuss options and ensure informed consent (D).

DURING BIRTH

1. Delivering difficult news: Receiving and processing difficult news, such as the loss of the baby (M), addressed by supporting communication with the mothers' loved ones (TM), and sharing the news with the mother herself in a compassionate and respectful manner (D).
2. Running out of strength: The mother experiencing exhaustion during birth (M), addressed by communicating with the mother to calm her (TM), and encouraging her (D) to regain confidence and strength to continue.
3. Intercultural negotiations: The mother wishing to perform a cultural practice, such as painting the baby a few hours after birth with natural dye for protection from mosquitoes (M), addressed by explaining the practice or seeking a middle point (TM), and negotiating a safe compromise within hospital protocols (D).

Scan to view final design material

Figure 93: Final design for the emergency evaluation phase from all three perspectives.

09 DISCUSSION & CONCLUSIONS

How can respectful maternity care be understood and translated into training within this context?

This chapter presents the discussion and conclusion of this thesis. It interprets the key findings of the project, reflecting on how respectful maternity care was understood within the specific local context and how these insights informed the design proposal. The chapter discusses the role of communication, collaboration between care systems, and contextual approaches to teaching and learning respectful care. It then presents the overall conclusions of the project, followed by its limitations and future considerations. Together, these sections outline the design, methodological, and research contributions of the project to respectful maternity care training.

DISCUSSION

CONCLUSION

PROJECT LIMITATIONS

FUTURE CONSIDERATIONS

Discussion

1. Respectful maternity care as a contextual and locally defined practice

A central outcome of this thesis was understanding respectful maternity care (RMC) as a locally defined and context-dependent practice, and how to identify and interpret it within a specific context. While the WHO Compendium global framework provided structure for identifying respectful care manifestations and recommended adapting them to local contexts, this project demonstrated how respect can be recognized and enacted through culturally situated practices shaped by community beliefs, relationships, and care systems. Through careful engagement with different care actors in Chocó and Bogotá, Colombia, a local understanding of respectful care emerged, along with unique manifestations that reflect the lived realities of these communities.

This aligns with the project's participatory and decolonizing design approach, which positioned local actors such as traditional midwives as holders of valuable care knowledge. Rather than identifying deficits through mistreatment frameworks, the project focused on learning from care systems that already sustain respectful and mother-centered practices as integral parts of care. An important early step was understanding what respectful maternity care translated to within this context. RMC is not a universally used or directly translatable term, and no single equivalent existed among participants. Instead, related concepts such as intercultural birth and humanized childbirth were used to describe similar values and practices. In this project, the working definition of respectful maternity care was adapted from midwives' explanations and lived practices, with communication emerging as a defining manifestation.

Context also emerged as essential not only for the researcher's understanding, but for participants engaging with the training material. During prototyping and evaluation, medical students relied on information about the mother's community, beliefs, and care environment to interpret scenarios and role-play appropriately. Without this grounding, respectful communication practices were harder to understand and imagine. This reinforced the importance of embedding contextual information within the training material itself, ensuring that respectful care is taught as a situated and relational practice rather than a generic protocol.

Finally, this project also recognized how respectful care in this context took place within an ongoing dialogue between traditional and western or biomedical care systems in Colombia. Navigating this space highlighted that respectful maternity care cannot be understood independently of these broader cultural and systemic dynamics. Instead, it emerges at the intersection of care systems that shape how care is delivered and experienced.

2. Respectful care as trust through communication

Within this specific context, communication emerged as a defining manifestation of RMC. Traditional midwives consistently described respect as the building or weakening of trust through the way care actors spoke, listened, explained, reassured, and responded to mothers. In emergency recounts, communication shaped whether care was perceived as respectful or mistreating, and collaborative or imposed. Therefore, in this project, respectful care was defined as the building of a trusting relationship with the mother through communication. Communication therefore became the primary manifestation identified and translated into the design proposal.

This decision was both contextual and strategic. RMC encompasses many manifestations, such as emotional support, informed consent, privacy, and confidentiality. However, communication practices emerged as a horizontal element that intersected and enabled other manifestations, becoming a central element and medium for respect and mistreatment overall. At the same time, communication emerged as the most accessible and actionable intervention within biomedical contexts. Unlike structural changes that require additional time, staffing, or infrastructure, communication can be integrated into existing care interactions without increasing workload. This was particularly important given the structural constraints identified by participants, including overwork, fatigue, and limited time per patient. Focusing on communication allowed the proposal to introduce respectful care practices without adding new tasks, but by simply reshaping how existing care is delivered.

Finally, this project challenged the perception of respectful care as an "immaterial" dimension of care. Participants demonstrated that communication has observable and actionable manifestations with direct and material consequences for care outcomes. For example, how care actors respond to mothers during moments of pain, fear, or uncertainty can influence whether mothers feel supported or not, which in turn affects their ability to remain calm, preserve strength, and continue through the birthing process without complications. Communication therefore shapes both the emotional experience of care and its clinical effectiveness. Within this context, respectful communication cannot be separated from clinical care, but must be understood as one of its operational components.

3. Bridging traditional and biomedical care: two faces of the same coin

This project revealed that respectful maternity care in Chocó exists within an ongoing conversation between traditional and biomedical care systems. While these systems are often positioned in opposition or experienced as competing, prototype evaluations in this project found that they share the same fundamental goal: the wellbeing of the mother. They can be understood as two faces of the same coin, approaching the same care outcomes through different viewpoints, explanations and forms of knowledge. Due to their contexts of practice, traditional midwives emphasize emotional grounding, accompaniment, and relational trust, while biomedical actors often frame care through technical reasoning, efficiency, and physiological outcomes. Despite these differences, both approaches seek to support the mother through the birthing process and achieve safe births with similar milestones.

An example of this alignment can be seen in how both traditional midwives and doctors respond to mothers' expressions of pain based on seeking to generate or conserve strength. From a traditional perspective, midwives accompany mothers emotionally, reassuring them, singing to them and helping them remain calm, as calmness is believed to preserve strength and self confidence. From a biomedical perspective, doctors may also seek to regulate pain expressions and conserve strength, but through technical explanations—for example, by explaining to the mother that although they know it is painful, screaming drains strength in the wrong place—their throats—when they really need to save it for pushing to be able to give birth. While the explanations differ, both approaches aim to help the mother conserve strength and successfully give birth. This illustrates that both approaches have complimentary goals, but their

way of communicating to the mother emerges through different views.Keeping the previous idea in mind, integrating respectful communication practices into biomedical care requires understanding how biomedical professionals work. Doctor participants described their decision-making as structured around speed, efficiency, and clinical effectiveness, particularly in emergency situations. Their thinking becomes automatic, schematized into structured decision frameworks that guide rapid action. Within this context, respectful care practices must be integrated into these existing schemas in order to be adopted and eventually automatized—raising the challenge of how to get between doctors' ears. For example, framing respectful communication as contributing to physiological stability, patient trust, and smoother interventions, allows it to align with biomedical priorities rather than be perceived as separate from them.

A key learning from this project was also the importance of supporting caregivers, particularly doctors, in recognizing their own limits and viewing other care actors as complementary members of the care team. Traditional midwives naturally operate within collaborative care frameworks, where roles are shared and adapted based on the mother's needs. In contrast, biomedical training often emphasizes individual responsibility and technical autonomy, which can unintentionally position other care actors as external or competing rather than supportive. This project highlighted the need to create educational experiences that help doctors recognize traditional midwives as collaborators with distinct and valuable expertise. This does not require doctors to adopt the role of midwives, nor midwives to adopt biomedical roles, but rather to understand how each perspective contributes differently to the same care process. Supporting this recognition allows caregivers to rely on one another's strengths while maintaining their own expertise and responsibilities. By supporting this mentality shift, the project contributes to bridging care systems not by merging them, but by enabling collaboration between distinct forms of knowledge that work together toward the shared goal of the mother's wellbeing.In this sense, the project proposal actively reframed traditional and biomedical actors as members of the same care team. Through role-play, scenario alignment, and facilitated reflection, participants engaged with one another's perspectives and experienced how care situations could be navigated collaboratively. This shifted the focus from isolated decision-making toward shared responsibility and mutual support.

4. Teaching and learning RMC as a contextual and epistemological practice

This project also revealed that not only respectful maternity care itself, but the ways in which it is taught and learned should be deeply contextual. Traditional communities do not transmit their knowledge through standardized protocols or formal instruction, but through storytelling, shared experiences, demonstrations, and collective dialogue in horizontal formats such as Uramba. Knowledge is communicated through their own epistemology. In contrast, biomedical training often relies on written guidelines, procedural instruction, and hierarchical teaching structures. These differences highlight that knowledge exchange regarding RMC can exist within distinct epistemologies—different ways of knowing, learning, and transmitting care practices.

This understanding directly informed the design proposal, which sought not only to translate traditional respectful care practices into training content, but to do so in a way that reflects and respects how this knowledge is normally shared and understood by the community. The workshop adopted the Uramba format, facilitated by traditional care actors, creating a space for knowledge exchange that is already used by the community and recognizing this epistemological method as equally valid. This approach supported learning about respect through a respectful format, where all participating care actors were placed in a horizontal structure that allowed them to collectively exchange and construct knowledge.The material format and visual identity of the proposal were also intentionally developed in response to this contextual understanding. The circular volvelle structure reflected Uramba dynamics and presented scenarios as equally important, rather than presenting knowledge as linear or prescriptive. Additionally, the visual elements and color palettes created further immersion into the context, allowing traditional midwives to feel initially identified with the tool itself. The inclusion of QR codes linking to audio-visual material created by care actors allowed participants to engage directly with voices and representations from the communities where these practices originate. These design decisions moved away from standardized biomedical training formats and instead aligned the material with the relational and experiential ways in which respectful care knowledge is shared in the context where it thrives.

In this sense, the design proposal does not only communicate respectful maternity care practices, but reflects the epistemological conditions in which this knowledge exists. By aligning both content and format with contextual ways of learning, the proposal supports a more meaningful and grounded integration of respectful care into training. This positions design not only as a tool for transmitting information, but as a mediator between knowledge systems, supporting the recognition, exchange, and learning of care practices across traditional and biomedical contexts.

5. Methodological design contributions

Beyond the final design proposal, this project contributes a methodological approach for identifying, understanding, and translating respectful maternity care practices from local contexts into training material.

Through participatory and decolonizing design approaches, traditional midwives and community actors were positioned not as subjects of research, but as knowledge holders and active contributors to defining respectful care. This allowed the project to move beyond abstract or externally defined frameworks and instead identify respectful care manifestations grounded in local lived experiences.A key methodological contribution was the use of specific analysis methods. The use of actor mapping led to an understanding of how care knowledge is recognized or not recognized across different actors. Actor mapping also made visible how respectful care emerges through relationships between mothers, midwives, medical institutions, the government, and independent organizations, highlighting who influences whom and how to identify key actors to engage with or learn from.

To interpret respectful care practices within their context, manifestation categorization and constellation mapping processes were key. Constellation mapping proved to be an effective analysis tool for translating qualitative, story-based fieldwork data into structured relationships between actions, actors, situations, and meanings. This approach was particularly valuable in contexts where different care actors interpret the same situation differently, allowing competing perspectives to be analyzed. When combined with manifestation categorization, it allowed the project to determine whether a particular manifestation was considered respectful or a form of mistreatment according to the specific context and belief system.

Journey mapping was also used to identify key moments in the care process where respectful care is built, negotiated, or weakened. This helped identify critical intervention points for trust-building in maternity care, with impacts across different phases of the care journey.

In addition to the aforementioned analytical tools, this project contributed methodological insights into conducting participatory design within communities with strong oral and relational knowledge traditions

Design activities were intentionally adapted to align with existing community practices and forms of knowledge exchange, such as dialogue-based gatherings and collective reflection spaces. Rather than imposing external workshop structures, the design process adjusted to the rhythms, formats, and leadership of the community. This included integrating dialogue-based sessions and using design support materials such as playdough and hand weaving during ideation activities. These materials supported embodied expression and facilitated dialogue, allowing participants to express relational and experiential knowledge in ways that aligned with their existing modes of communication.

Finally, this project also demonstrates how relational and experiential knowledge can be translated into tangible training material while preserving its contextual meaning. The translation of care practices into role-play scenarios, communication prompts, and perspective-based volvelles maintained the situated nature of the knowledge rather than reducing it to abstract instruction.

Conclusion

This thesis explored how respectful maternity care (RMC) practices from traditional midwifery in Colombia could inform emergency maternity care training. Through participatory engagement with traditional midwives, medical students, and biomedical professionals, the project developed a contextual understanding of respectful maternity care and translated these insights into a training proposal aimed at fostering respectful communication and intercultural collaboration. Rather than applying externally defined standards, the project focused on understanding how respect is locally defined, practiced, and transmitted.

A central finding was that respectful maternity care in this context is primarily enacted through communication. Respect emerged as the building of trust between care actors and mothers through how information is shared, emotions are acknowledged, and decisions are communicated. Communication functioned as a horizontal manifestation that enabled other respectful care practices, and was therefore selected as the primary entry point for intervention. This allowed respectful care to be integrated into training without requiring additional infrastructure, but by reshaping how existing care interactions are carried out.

The project also demonstrated that respectful maternity care exists within an ongoing relationship between traditional and biomedical care systems that share the same goal: the wellbeing of the mother. By framing these perspectives as complementary rather than competing, the design proposal supported a shift toward collaborative care and role recognition. Through workshops and role-play material, relational and experiential care knowledge was translated into training tools while preserving its contextual meaning.

Finally, this thesis contributes a methodological approach for identifying and translating respectful care practices into training interventions. The use of participatory design and relational analysis methods demonstrates how locally grounded care knowledge can be integrated into biomedical training in ways that are context-sensitive and actionable. By embedding respectful communication into training as an operational component of care, this project contributes to preparing future care providers to deliver more respectful and context-responsive maternity care.

Project Limitations

This project was conducted within a specific local and relational context, and its findings should be understood within those boundaries. The respectful maternity care practices identified in this thesis emerged through engagement with traditional midwives and care actors connected to communities in Chocó and Bogotá, Colombia. Traditional midwifery practices vary significantly across regions, communities, and individual practitioners, and therefore the manifestations of respectful care identified in this project should not be generalized as universal. Instead, they reflect situated practices and interpretations grounded in the specific cultural, social, and care contexts explored.

Another limitation lies in the scope of perspectives engaged throughout the project. While traditional midwives were central contributors to defining respectful care, and medical students and biomedical professionals participated in prototype evaluation, the biomedical perspective was not explored to the same depth as traditional midwifery knowledge.

Similarly, while mothers were represented within scenarios and through midwives' experiences, the project did not directly engage a wide range of mothers without prior care knowledge as primary participants. Further research could expand engagement with biomedical professionals and mothers to deepen the understanding of respectful care across all care roles.

This project also focused primarily on communication as a strategic entry point for intervention. While respectful maternity care encompasses many manifestations, including structural, environmental, and systemic factors, communication was selected because it emerged as a defining manifestation in this context and could be integrated into training without requiring structural change. However, respectful care is also influenced by broader systemic conditions such as workload, institutional policies, resource availability, and staffing constraints. These structural factors were outside the scope of this design intervention, which focused specifically on educational and behavioral dimensions of care.

Finally, the design proposal remains at the level of a tested prototype and has not yet been implemented longitudinally within a formal medical curriculum or evaluated in real clinical environments. While prototype testing demonstrated its potential to support perspective-taking and reflection, longer-term implementation would be necessary to evaluate its impact on sustained behavioral change and clinical practice. Future work could focus on integrating the proposal into formal training structures and assessing its effectiveness over time.

Future Considerations

This project opens opportunities for further development, both in refining the design proposal and expanding the methodological approach to other contexts. Future work could deepen engagement with biomedical professionals and mothers to further develop respectful maternity care practices from their perspectives. While communication was identified as a strategic entry point, additional manifestations of respectful care, such as decision-making processes, emotional support, and institutional dynamics, could also be explored. Incorporating biomedical examples of respectful care may further support the integration of these practices into clinical training.

This project also highlights the potential for developing a localized respectful maternity care toolbox grounded in participatory and decolonizing design approaches. Such a toolbox could support the identification of locally meaningful care manifestations and guide the translation of these practices into training material. This includes understanding how care knowledge is transmitted within each community—whether through oral dialogue, visual representation, or embodied practices—and aligning training formats with these epistemological conditions. The methodological framework developed in this thesis, including actor mapping, constellation mapping, manifestation categorization, and participatory co-creation, provides foundational tools for designing context-sensitive training interventions across different communities.

An important finding was the validation of role-play and simulation as effective methods for teaching respectful maternity care. Through prototyping and testing, role-play enabled participants to engage with different care perspectives and reflect on their own practices. Participants began questioning how such training could be integrated into their formal education, suggesting a shift toward readiness for implementation. This indicates that experiential learning methods can support perspective change and facilitate the integration of respectful care into biomedical training.

Finally, this project also offers insight into how respectful maternity care interventions can be evaluated. A key indicator of effectiveness is whether participants recognize the relevance of the material and express interest in integrating it into their training or practice. Future work could build on this by implementing and evaluating the proposal longitudinally. For organizations such as Laerdal, this project provides a framework for developing respectful maternity care training that is locally grounded, scalable, and aligned with both community epistemologies and biomedical education systems.

10 APPENDIX

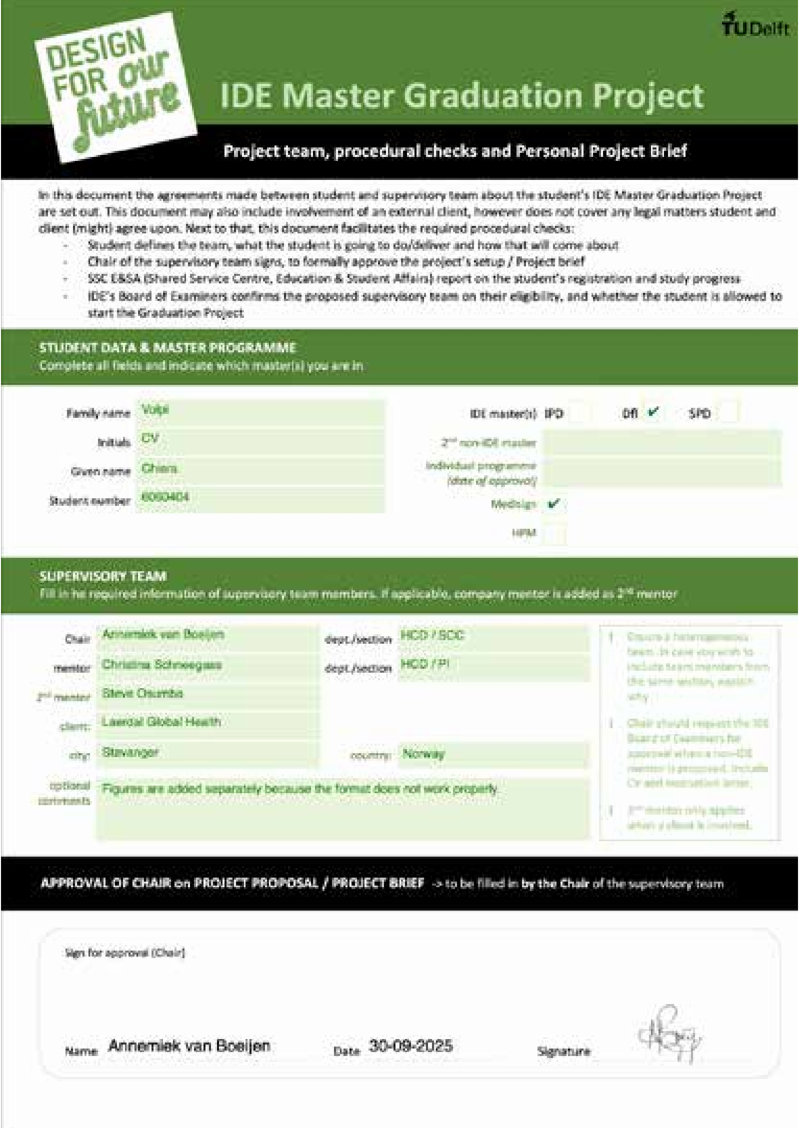
What materials make up the back end of this thesis?

The following section contains the main supporting and supplementary material used and referenced throughout the project.

APPENDIX

- Appendix A: Original Project Brief

Appendix A: Original Project Brief



DESIGN FOR our future

TU Delft

IDE Master Graduation Project

Project team, procedural checks and Personal Project Brief

In this document the agreements made between student and supervisory team about the student's IDE Master Graduation Project are set out. This document may also include involvement of an external client, however does not cover any legal matters student and client (might) agree upon. Next to that, this document facilitates the required procedural checks:

- Student defines the team, what the student is going to do/deliver and how that will come about
- Chair of the supervisory team signs, to formally approve the project's setup / Project brief
- SSC E&SA (Shared Service Centre, Education & Student Affairs) report on the student's registration and study progress
- IDE's Board of Examiners confirms the proposed supervisory team on their eligibility, and whether the student is allowed to start the Graduation Project

STUDENT DATA & MASTER PROGRAMME
Complete all fields and indicate which master(s) you are in

Family name: Volpi
Initials: CV
Given name: Chiara
Student number: 6060404

IDE master(s): IPD [ ] DfI [✔] SPD [ ]
2nd non-IDE master:
Individual programme (date of approval):
Medisign [✔]
HPM [ ]

SUPERVISORY TEAM
Fill in he required information of supervisory team members. If applicable, company mentor is added as 2nd mentor

Chair: Annemiek van Boeijen — dept./section: HCD / SDC
mentor: Christina Schneegass — dept./section: HCD / PI
2nd mentor: Steve Osumba
client: Laerdal Global Health
city: Stavanger — country: Norway
optional comments: Figures are added separately because the format does not work properly.

! Ensure a heterogeneous team. In case you wish to include team members from the same section, explain why.

! Chair should request the IDE Board of Examiners for approval when a non-IDE mentor is proposed. Include CV and motivation letter.

! 2nd mentor only applies when a client is involved.

APPROVAL OF CHAIR on PROJECT PROPOSAL / PROJECT BRIEF -> to be filled in **by the Chair** of the supervisory team

Sign for approval (Chair)

Name: Annemiek van Boeijen — Date: 30-09-2025 — Signature

CHECK ON STUDY PROGRESS
To be filled in **by SSC E&SA** (Shared Service Centre, Education & Student Affairs), after approval of the project brief by the chair.
The study progress will be checked for a 2nd time just before the green light meeting.

Master electives no. of EC accumulated in total ______ EC

Of which, taking conditional requirements into account, can be part of the exam programme ______ EC

	YES	all 1st year master courses passed
	NO	missing 1st year courses

Comments:

Sign for approval (SSC E&SA)

Name ______ Date ______ Signature ______

APPROVAL OF BOARD OF EXAMINERS IDE on SUPERVISORY TEAM -> to be checked and filled in by IDE's Board of Examiners

Does the composition of the Supervisory Team comply with regulations?

YES		Supervisory Team approved
NO		Supervisory Team not approved

Comments:

Based on study progress, students is ...

	ALLOWED to start the graduation project
	NOT allowed to start the graduation project

Comments:

Sign for approval (BoEx)

Name ______ Date ______ Signature ______

DESIGN FOR our future

TU Delft

Personal Project Brief – IDE Master Graduation Project

Name student: Chiara Volpi — Student number: 6060404

PROJECT TITLE, INTRODUCTION, PROBLEM DEFINITION and ASSIGNMENT
Complete all fields, keep information clear, specific and concise

Project title: Respectful maternity care in Colombia - A case study on traditional birthing practices to improve

Please state the title of your graduation project (above). Keep the title compact and simple. Do not use abbreviations. The remainder of this document allows you to define and clarify your graduation project.

Introduction

Describe the context of your project here; What is the domain in which your project takes place? Who are the main stakeholders and what interests are at stake? Describe the opportunities (and limitations) in this domain to better serve the stakeholder interests. (max 250 words)

This project is situated in the domain of Respectful Maternity Care (RMC). RMC, as described by the International Confederation of Midwives (ICM), concerns resources and practices such as guidelines, tools, and educational materials that ensure pregnancy, childbirth, and postnatal care is provided with dignity, compassion, and respect.

This project was proposed with Laerdal Global Health (LGH), a Norwegian organization dedicated to helping save the lives of mothers and newborns through collaborations in low-medium income countries. LGH develops training material for medical professionals to practice emergency maternal protocols, with a heavy focus on survival and physiological perspectives. However, LGH also wishes to address immaterial and overall wellbeing in emergencies, focusing on how RMC can be promoted. Currently, LGH lacks a clear protocol for integrating RMC into their training material [figure 1].

As a master thesis, the project runs from September 2025 to February 2026 in Colombia. Colombia recognizes traditional afro-colombian midwifery as national cultural heritage and, since 2023, as Intangible Cultural Heritage of Humanity by UNESCO. Colombia is also among the countries LGH seeks to support with pilot products.

The project proposes working with Colombian communities experienced in practicing and teaching traditional birthing practices with mother-centered visions: [redacted] where birthing wellbeing research provides community access; [redacted], preserving Afro-Colombian ancestral midwifery; and [redacted], combining indigenous traditions with biomedical care [figure 2]. These communities seek to document and give value to their practices. This includes creating educational material inside and outside of academic publications.

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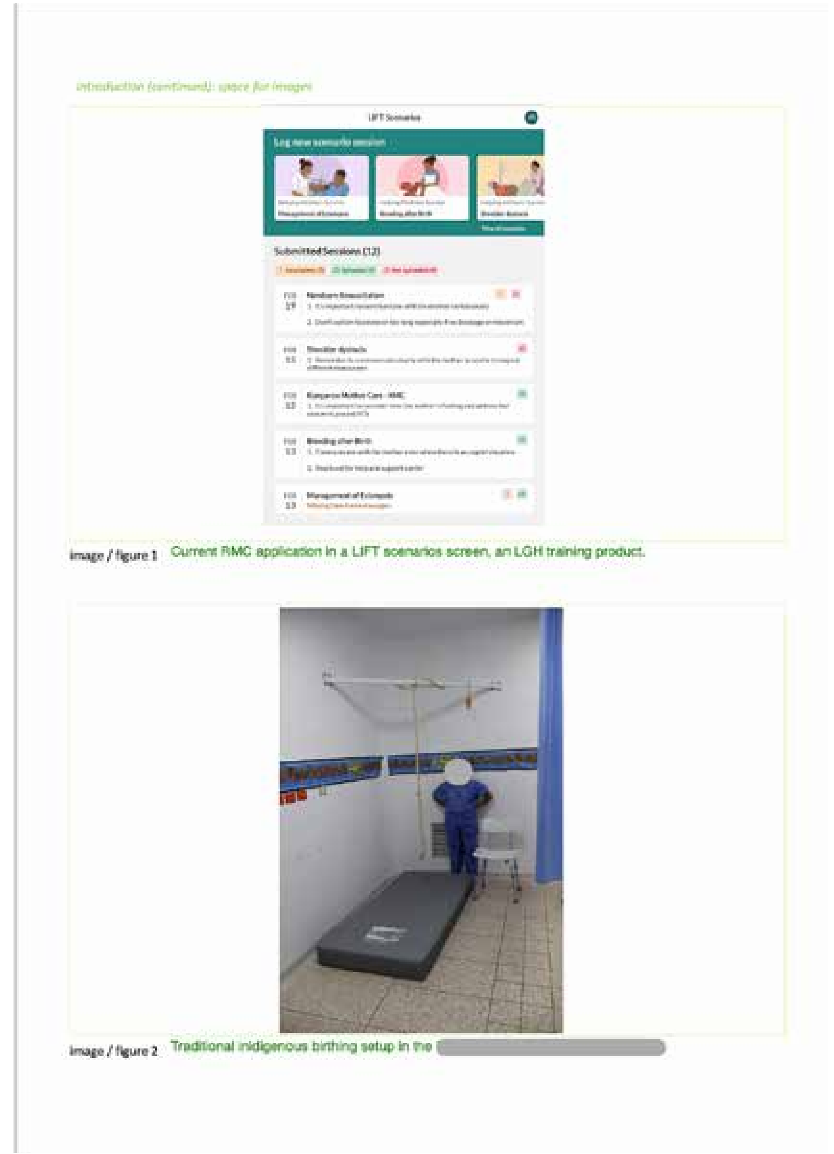

introduction (continued): space for images

image / figure 1 Current RMC application in a LIFT scenarios screen, an LGH training product.

image / figure 2 Traditional indigenous birthing setup in the [redacted]

TU Delft

Personal Project Brief – IDE Master Graduation Project

Problem Definition

What problem do you want to solve in the context described in the introduction, and within the available time frame of 100 working days? (= Master Graduation Project of 30 EC). What opportunities do you see to create added value for the described stakeholders? Substantiate your choice.
(max 200 words)

I want my thesis to take on the challenge of: understanding, defining, and translating traditional Colombian mother-centered care into RMC-related educational material that complements LGH training products, to better transmit how to generate RMC in medical practices.

- Understand Colombian communities as experts for RMC: I want to understand and learn from the Colombian communities as experts in holistic mother-centered practices and the transmission of these.
- Generate and define clear RMC elements: I want to identify and define the key manifestations of RMC in Colombian practices. This is a base to create clear/ comparable/ replicable/ actionable elements that are applicable and complementary to LGH's products and global cause. I would like to do this keeping in mind LGH's experience with RMC in Tanzania and the base elements of RMC chosen for this research.
- Translate and integrate RMC elements into a proposed LGH product: I want to propose an ideal medium or way of integrating and transmitting the RMC elements into, or complementary to, LGH training materials.
- Transmit key learnings to trainees: I want to clarify what RMC is, specifically in how it can be recognized, assessed, promoted, implemented, or supported, so it is clear to trainees how to guarantee its presence in their medical practice.

Assignment

This is the most important part of the project brief because it will give a clear direction of what you are heading for. Formulate an assignment to yourself regarding what you expect to deliver as result at the end of your project. (1 sentence) As you graduate as an industrial design engineer, your assignment will start with a verb (Design/Investigate/Validate/Create), and you may use the green text format:

Design an educational insert/ piece/ guideline prototype that complements LGH's training material to provide actionable RMC assessment or implementation elements, and therefore improve the educational transmission of mother-centered care for trainees in LGH emergency training products.

Then explain your project approach to carrying out your graduation project and what research and design methods you plan to use to generate your design solution (max 150 words)

Design approach: Culture-sensitive and participatory approach built upon the Cultura research framework.
•Research:
(I) Analysis through a literature review of LGH Tanzania projects, Kilombo Yumma's podcast on their traditional care, ICM's RMC guidelines, and current RMC application in LGH products.
(II) Observation through interviews / listening sessions at the Kilombo, Hospital RPL, national midwife events, and with independent experts in the field, including doctors, midwives, researchers, and mothers.
(III) Generative sessions as a series of in-person and online workshops with doctors, midwives, researchers, and/ or mothers using selected design tools
(IV) Observation through guided tours of the spaces and practices with communities.
*Research outcomes will be visualized in different mediums to facilitate the understanding of key information. This includes visual theoretical frameworks and context / insight mapping (constellations, arenas, moodboards).
•Design methods:
(I) Co-creation workshops with the actors involved. (II) Brainstorming sessions. (III) Insight evaluation with actors involved. (IV) Prototyping & evaluating design.

Project planning and key moments

To make visible how you plan to spend your time, you must make a planning for the full project. You are advised to use a Gantt chart format to show the different phases of your project, deliverables you have in mind, meetings and in-between deadlines. Keep in mind that all activities should fit within the given run time of 100 working days. Your planning should include a ***kick-off meeting, mid-term evaluation meeting, green light meeting*** *and* ***graduation ceremony****. Please indicate periods of part-time activities and/or periods of not spending time on your graduation project, if any (for instance because of holidays or parallel course activities).*

Make sure to attach the full plan to this project brief.
The four key moment dates must be filled in below

Motivation and personal ambitions

Explain why you wish to start this project, what competencies you want to prove or develop (e.g. competencies acquired in your MSc programme, electives, extra-curricular activities or other).

Optionally, describe whether you have some personal learning ambitions which you explicitly want to address in this project, on top of the learning objectives of the Graduation Project itself. You might think of e.g. acquiring in depth knowledge on a specific subject, broadening your competencies or experimenting with a specific tool or methodology. Personal learning ambitions are limited to a maximum number of five.
(200 words max)

I am a designer looking to specialize in Medisign, to add to healthcare in a creative way.

I want to use my skills to add to the well-being in Colombia, my home country. Through this project, I wish to highlight Colombia's particular and specialized knowledge in healthcare and add to the dialogues surrounding it. I wish to form new alliances between the actors involved. Therefore, this thesis is the first of many projects with which I seek to build a bridge between my roots and my master's.

I want this to be a demonstration of the culmination of my studies and their combination. It is my way of finding inspiration and learning from the organic knowledge I gained in Colombian design; and infusing it with the methodical and structured methods of TU Delft design I gained abroad.

I want to acquire knowledge on maternity care, a new field for me, and reflect on how to create knowledge without simply extracting it when working with communities like these. I want to experiment in creating my own research tools appropriate to the context. Finally, I want to put the skills I learned from my medisign electives to the test.

References 1

Asociación Afrocultural Neftalí Mosquera (AFNEMO). (n.d.). Neftalí Mosquera [Website]. https://neftalimosquera.org/

Bohren, M. A., Hunter, E. C., Munthe-Kaas, H. M., Souza, J. P., Vogel, J. P., & Gülmezoglu, A. M. (2014). Facilitators and barriers to facility-based delivery in low- and middle-income countries: a qualitative evidence synthesis. Reproductive Health, 11(1), Article 71. https://doi.org/10.1186/1742-4755-11-71

Bohren, M. A., Mehrtash, H., Fawole, B., Maung, T. M., Balde, M. D., Maya, E., Thwin, S. S., Aderoba, A. K., Vogel, J. P., Irinyenikan, T. A., Adeyanju, A. O., Mon, N. O., Adu-Bonsaffoh, K., Landoulsi, S., Guure, C., Adanu, R., Diallo, B. A., Gülmezoglu, A. M., Soumah, A.-M., … Tunçalp, Ö. (2019). How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys. The Lancet (British Edition), 394(10210), 1750–1763. https://doi.org/10.1016/S0140-6736(19)31992-0

Bohren, M. A., Tunçalp, Ö., & Miller, S. (2020). Transforming intrapartum care: Respectful maternity care. Best Practice & Research. Clinical Obstetrics & Gynaecology, 67, 113126. https://doi.org/10.1016/j.bpobgyn.2020.02.005

Congreso de Colombia. (2022, July 11). Ley 2244 de 2022: Por medio de la cual se reconocen los derechos de la mujer en embarazo, trabajo de parto, parto y posparto y se dictan otras disposiciones o "Ley de parto digno, respetado y humanizado". Diario Oficial No. 52.157. https://www.funcionpublica.gov.co/eva/gestornormativo/norma.php?i=189347

De Los Reyes Victoria, D. P. (2020, September 3). Constelaciones de valor [Lecture recording]. Universidad de Los Andes, Estudio 5: Producción Creativa.

Departamento Administrativo Nacional de Estadística. (2023). Nota estadística: Partería tradicional en eventos vitales en Colombia. DANE. https://www.dane.gov.co/files/investigaciones/notas-estadisticas/06022023-NotaEstadistica-ParteraTradi-EVColombia.pdf

Engel, G. L. (1977). The Need for a New Medical Model: A Challenge for Biomedicine. Science (American Association for the Advancement of Science), 196(4286), 129–136. https://doi.org/10.1126/science.847460

Epstein, R. M., & Street, R. L. (2011). The Values and Value of Patient-Centered Care. Annals of Family Medicine, 9(2), 100–103. https://doi.org/10.1370/afm.1239

Escobar, A. (2018). Designs for the pluriverse: Radical interdependence, autonomy, and the making of worlds. Duke University Press.

Farías-Vela, A. P., Capera-López, L. F., Díaz-Quijano, D. M., Ortiz-Zornosa, S., Restrepo-Guarnizo, M. C., & Restrepo-Castro, O. I. (2023). Conocimiento del parto humanizado en Colombia en residentes y ginecólogos. Ginecologia y obstetricia de Mexico, 91(5), 299–306. https://doi.org/10.24245/gom.v91i5.8430

Fondo de Población de las Naciones Unidas (UNFPA). (2023). Análisis de la partería tradicional y su incorporación en estadísticas vitales. UNFPA Colombia. https://colombia.unfpa.org/es/publications/analisis-de-parteria-tradicional-y-su-incorporacion-en-estadisticas-vitales

Gleason, E. G., López Ríos, J. M., Molina Berrío, D. P., & 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), Article 197. https://doi.org/10.1186/s12884-022-04495-4

Gleason, E. G., Molina Berrío, D. P., López Ríos, J. M., & Mejía Merino, C. M. (2021). "Parir no es un asunto de etnia, es un asunto de humanidad": experiencias frente a la violencia obstétrica durante la atención al parto en mujeres indígenas. Salud Colectiva, 17, e3727. https://doi.org/10.18294/sc.2021.3727

International Confederation of Midwives. (n.d.). Respectful care. https://internationalmidwives.org/category/respectful-care/

International Confederation of Midwives. (2024). ICM statement: Obstetric violence and mistreatment and violence against women in reproductive health services. https://internationalmidwives.org/resources/obstetric-violence-and-mistreatment-and-violence-against-women-in-reproductive-health-services/

Instituto Nacional de Salud. (2024). Mortalidad materna en Colombia: Informe epidemiológico, período VIII de 2024. Instituto Nacional de Salud. https://www.ins.gov.co/buscador-eventos/Informesdeevento/MORTALIDAD%20MATERNA%20PE%20VIII%202024.pdf

Kamala, I. I. (2024). Healthcare providers' positive and challenging experiences in implementing the non-medical elements of respectful maternity care at Nyamagana District Hospital in Tanzania (Unpublished master's thesis). Muhimbili University of Health and Allied Sciences.

Kasaye, H., Scarf, V., Sheehy, A., & Baird, K. (2024). Women's narratives of experiences, drivers and consequences of mistreatment during maternity care in western Ethiopia. PloS One, 19(12), Article 0313217. https://doi.org/10.1371/journal.pone.0313217

Kilombo Yumma & Facultad de Arquitectura y Diseño, Universidad de los Andes. (2025). EntreVer Con [Audio podcast]. Spotify. https://open.spotify.com/show/7tL3nC5T96z9yoYjoUZk3l

Kruk, M. E., Gage, A. D., Arsenault, C., Jordan, K., Leslie, H. H., Roder-DeWan, S., Adeyi, O., Barker, P., Daelmans, B., Doubova, S. V., English, M., García-Elorrio, E., Guanais, F., Gureje, O., Hirschhorn, L. R., Jiang, L., Kelley, E., Lemango, E. T., Liljestrand, J., … Pate, M. (2018). High-quality health systems in the Sustainable Development Goals era: time for a revolution. The Lancet Global Health, 6(11), e1196–e1252. https://doi.org/10.1016S2214-109X(18)30386-3

Medicine, I. of, & America, C. on Q. of H. C. in. (2001). Crossing the Quality Chasm: A New Health System for the 21st Century (1st ed.). National Academies Press. https:/ doi.org/10.17226/10027

Ministerio de Salud y Protección Social. (2018, August 2). Resolución 3280 de 2018: Por medio de la cual se adoptan los lineamientos técnicos y operativos de la Ruta Integral de Atención para la Promoción y Mantenimiento de la Salud y la Ruta Integral de Atención en Salud para la Población Materno Perinatal y se establecen las directrices para su operación [PDF]. https://www.minsalud.gov.co/sites/rid/lists/bibliotecadigital/ride/de/dij/resolucion-3280-de-2018.pdf

Raoust, G. M., Bergström, J., Bolin, M., & Hansson, S. R. (2022). Decision-making during obstetric emergencies: A narrative approach. PloS One, 17(1), Article 0260277. https://doi.org/10.1371/journal.pone.0260277

Reed, R., Sharman, R., & Inglis, C. (2017). Women's descriptions of childbirth trauma relating to care provider actions and interactions. BMC Pregnancy and Childbirth, 17(1), Article 21. https://doi.org/10.1186/s12884-016-1197-0

Sadler, M., Santos, M. J., Ruiz-Berdún, D., Rojas, G. L., Skoko, E., Gillen, P., & Clausen, J. A. (2016). Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence. Reproductive Health Matters, 24(47), 47–55. https://doi.org/10.1016/j.rhm.2016.04.002

Sanders, E. B.-N., & Stappers, P. J. (2008). Co-creation and the new landscapes of design. CoDesign, 4(1), 5–18. https://doi.org/10.1080/15710880701875068

Sanders, E. B.-N., & Stappers, P. J. (2012). Convivial toolbox : generative research for the front end of design. BIS.

Schuler, D., & Namioka, A. (1993). Participatory design : principles and practices. CRC Press ; Taylor & Francis Group.

Simonsen, J., & Robertson, T. (2013). Routledge international handbook of participatory design. Routledge.

Tunstall, E., & Agi, E. (2023). Decolonizing design : a cultural justice guidebook. The MIT Press.

UNESCO. (2023). Midwifery knowledge, skills and practices. Intangible Cultural Heritage Lists. https://ich.unesco.org/en/RL/midwifery-knowledge-skills-and-practices-01968

United Nations General Assembly. (2019). Report of the Special Rapporteur on violence against women, its causes and consequences: A human rights-based approach to mistreatment and violence against women in reproductive health services, with a focus on childbirth and obstetric violence (A/74/137). https://docs.un.org/en/A/74/137

UN SDG Fund. (n.d.). Indigenous and Afro-Colombian communities in the Chocó Department promote their food security. United Nations SDG Fund.

World Health Organization. (2016). Standards for improving quality of maternal and newborncare in health facilities. World Health Organization. https://www.who.int/publications/i/item/9789241511216

World Health Organization (WHO), HRP, UNICEF, UNFPA, & Jhpiego. (2025). Compendium on respectful maternal and newborn care. World Health Organization. https://www.who.int/publications/i/item/9789240110939

White Ribbon Alliance. (2020). Respectful maternity care charter: The universal rights of women and newborns. https://www.whiteribbonalliance.org/respectful-maternity-care-charter/

Image References

Figure 1. Visualization of the design process within the thesis project. Developed by the author, 2026.

Figure 2. Final prototype of the RMC training material. Design by the author; photograph by Lucy Díaz, 2026.

Figure 3. Three base elements of the project proposal. Illustrated by the author, 2026.

Figure 6. Example of current RMC integration in LGH training material. Page excerpt from the Bleeding After Birth: Emergency Action Plans. Source: World Health Organization, United Nations Population Fund, UNICEF, Laerdal Global Health, Jhpiego, International Confederation of Midwives, & FIGO. (2025). Retrieved from https://cdn.who.int/media/docs/default-source/reproductive-health/maternal-health/bleeding-after-birth-action-plans.pdf

Figure 7. Example of current RMC integration in LGH training material. Page excerpt from the Bleeding After Birth: Flipchart. Source: World Health Organization, Jhpiego, Laerdal Global Health, UNICEF, & United Nations Population Fund. (2025). Retrieved from https://www.who.int/publications/i/item/9789240115835