



Where Have the Midwives Gone?

Everyday Histories of *Voetvroue* in Johannesburg

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Declaration

I hereby declare that this dissertation is my own original work and has not been submitted before to any institution for assessment purposes.

Further, I have acknowledged all sources used and have cited these in the bibliography.

A handwritten signature in black ink, appearing to be 'TB' with a long horizontal stroke extending to the right.

Tamia Botes

2021/08/27

Date

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Where Have the Midwives Gone?

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Abstract

At the heart of a complex network of knowledge sits the *Voetvrou*—a black autonomous midwife who looks after the health of and nurtures new life in her community. She mentors others in these practices and in this way, shares her knowledge across communal lines. But who is the *Voetvrou*? What is her history? What constitutes being a *Voetvrou*? How does one come to be a *Voetvrou*? Harriet Deacon (1998) identifies a broad shift in power relations between medical men and black autonomous midwives in the nineteenth-century Cape Frontier. These relations were underpinned by growing racialism at legal and institutionalised levels, and effectively squeezed black women out of the practice of midwifery—hence their apparent disappearance from public archives from 1865, onwards. However, these black autonomous midwives have *not* disappeared. This research asks, where have the midwives gone? To this end, I used semi-structured in-depth interviews and archival research to explore where the midwives have gone. I conclude that these women have been part of a living archive, continuing their practices in the margins of power. They are essential to networks of care in Eldorado Park. The *Voetvrou* escapes the discourses of medical anthropology and Indigenous Knowledge systems. My research attempts to re-insert her into these discourses.

Table of Contents

Prologue	6
1. Questions, Context, Concepts	8
2. An Initial Brief History of Midwifery:	
Nineteenth and Twentieth Century United States, and the Cape, South Africa, 1652-1960	13
3. Towards a Living Archive:	
Midwifery in the Nineteenth and Twentieth Century Transvaal, Doulas in Twentieth Century US, and Traditional Birth Attendants in South Africa	23
4. In the Field	41
5. Voetvrouery in Eldorado Park	50
6. ‘In the business of delivering life’: <i>Huis-Hospitale</i>, Emergency Home-Deliveries, and Placental Rituals	61
7. <i>Kruie</i>: Mixtures, Methods, Purpose	71
8. Outside of Voetvrouery: Encounters with the Biomedical Sphere.....	81
9. Conclusion	84
Bibliography	86

Prologue

The sun beamed against my back, cloaking me in a blanket of light and warmth against the cold and dry August air. My toes sunk into the fine, red sand as I leaned forward, ready to be received by Auntie Zee's¹ garden of indigenous medical herbs. I closed my eyes and inhaled, allowing a plethora of aromas—some stronger than others. The *wille-als*² sang a sweet and creamy, yet sharp and sour song; each equally forceful and lulling. Its roots wrapped around my feet, pulling me into the belly of history where it lay in the palm of the “Voetvrou”³.

Warmheartedly and fondly, Nan reflected upon an amusing anecdote about how she understood birthing and care growing up: *Toe ek 'n klientjie was, het my ma hulle gesê dat 'n baba was nou 'n bobbejaantjie*, she laughed. *Die swanger vrou het die bobbejaantjie uitgestoot. Whoops! Daar vlieg die bobbejaantjie uit! En wie was daar om dit te vang? Die Voetvrou. Sy het al die hare van die bobbejaantjie afgesekeer, toe verander dit aan 'n baba*⁴ (6 July 2020).

Auntie Zee's garden is in Eldorado Park, a community of people historically classified “Coloured”. At the heart of a complex network of medical and mythical knowledge sits the *Voetvrou*—an autonomous midwife who looks after the health of and nurtures new life in her community. She mentors others in these practices by sharing her knowledge in ways that create cross-generational knowledge about care. But who is the *Voetvrou*? What is her history? What constitutes being a *Voetvrou*? How does one come to be a *Voetvrou*? All these questions are left unanswered in my prior research. A thick patch of fog falls upon who the *Voetvrou* is. The untold tells its own story.

In her “Midwives and Medical Men in the Cape Colony before 1860”, Harriet Deacon (1998) notes that the nineteenth-century Cape Frontier marks a historically significant shift in power

¹ Auntie Zee is one of four women whom I interviewed in the research prior to this. She is a historically classified “Coloured” woman. According to members of the community, she is often called upon as a ‘healer’. Her garden is where she grows the herbs that form part of her cultural practice of care

² “Wilde Als”, “Wormwood” or “Artemisia” is a tall, grey-green coloured plant that is indigenous to South Africa. I first encountered it in Auntie Zee's garden

³ A “Voetvrou” is the Afrikaans word that women in Lenasia South and Eldorado Park use to describe an autonomous midwife. In other parts, they are also known as “Voedvroue” or “Vroudevroue”

⁴ This Afrikaans anecdote comes from one of my participants, Nan. It loosely translates to “When I was a child, my mother and them said a baby was a small baboon. The pregnant woman pushed out the little baboon and whoops! It went flying out. Who caught it? The Voetvrou. She shaved all the hair off the little baboon and it turned into a baby”

relations between medical men and black autonomous midwives⁵. The relationship between these men and women was underpinned by increasingly racialised legal and institutional regulation of midwives. Training, licensing and supervision programmes for midwives were put in place to undermine and counter traditional, indigenous birthing practices. These programmes actively squeezed poor black women out of midwifery and made room for a “respectable” class of predominantly middle-class white midwives. Hence, the ‘disappearance’ of black autonomous midwives from midwifery registries and public archives from 1865 onwards.

However, as discussed in her work and observed in my own, these black autonomous midwives have not disappeared. Since the nineteenth-century, these women have been part of a *living* archive as they continued their practices in the margins of power. Today, they are essential to networks of care in Eldorado Park. Significantly, the women who talk about *Voetvroue* imagine them to be ‘Coloured’. Regardless of their active presence and practice within these communities, Deacon’s (1998) claims around the ‘disappearance’ of black autonomous midwives stand true—the *Voetvrou* is largely absent from discourses of medical anthropology and Indigenous Knowledge Systems. This research asks: *where have the midwives gone?*

⁵ I specifically refer to them as ‘Black autonomous midwives’ because commonly used words such as ‘untrained’, ‘traditional’ or ‘lay’ hold connotations of hierarchised knowledge with hidden western episteme underpinnings. I also specifically include that they are *Black* midwives to emphasize that the history of midwifery, in South Africa, is a racialised one.

Questions, Context, Concepts

The overarching aim of my dissertation is to explore ways in which one might account for the ‘disappearance’ of black autonomous midwives as a starting point for understanding their existence in the margins of health care related to birthing. A closer look reveals that not much is known about their history. Who are the *Voetvroue*? What are their histories? What are their practices? How is their knowledge acquired? My research aims to a) bring the figure of the *Voetvrou* and her everyday histories to light in the academic world; b) bring to bear on these histories questions about archives, power and epistemic violence; c) locate these histories of midwifery within scholarly, legal and political debates about medical pluralism and indigenous systems of knowledge; and d) challenge common discourses within these debates. To this end, I explore the questions below.

Questions

Central Research Questions

- Which women are seen as *Voetvroue* in these communities?
- What constitutes being a *Voetvrou*?
- How does one become a *Voetvrou*?
- What, for these women, are the sources of their knowledge and practice?
- Why are *Voetvroue* imagined specifically as “Coloured”.
- What, if any, are the connections that *Voetvroue* forge with state health systems?

Corresponding Theory Questions

- Given the long-standing presence and activity of *Voetvroue*, what sustains the notion of their ‘disappearance’? What does this tell us about the relationship between archives, power and epistemic violence? What does this tell us about the *living* archive?
- What does this tell us about indigenous knowledge systems and medical pluralism?
- What do their histories tell us about the relationship between identity and cultural practice in these so-called ‘Coloured’ communities?
- What does this tell us about current state regulation over the practice of autonomous midwifery?

History, ‘the Commons’, and Creolisation

To address these questions, I draw primarily on historical work about midwifery in South Africa. The work of Harriet Deacon (1998), Catherine Burns (1995), and Charlotte Searle (1965) is key to this research report. Deacon and Searle help one understand the history of midwifery during the early years of settlement. Burns (1995) continues this history into the 20th century and draws on archival research to understand the nuances, junctures, and contradictions of midwifery regulation. Furthermore, I attempt to locate this local history in a global context. To this end, I draw on the work of Diedre Owens (2017), Gertrude Fraser (1998), and Craven and Glatzel (2010). Conceptually, I weave together Hardt and Negri's (2009) notion of 'the commons', Dillon's (2019) idea of the plantationocene, and Zimitri Erasmus' (2017) expanded conception of creolisation.

The Commons

Hardt and Negri (2009) explain that the commons are spaces for the marginalised alongside the world of the dominant. They argue that it is not just the earth we share but also the languages we create, the social practices we establish, and the modes of sociality that define our relationships inside a realm that borders power (Hardt & Negri, 2009, p. 139). In a more poetic fashion, Moten and Harney (2007) imagine it as a "wild place", that is not just simply "leftover space" that limns the realm of polite society (Harney & Moten, 2013, p. 7). Rather, "where the commons give refuge, refuge gives commons" (Harney & Moten, 2013, p. 28). Importantly, the commons are not spaces that practice refusal or dissonance against power structures. These spaces do not depend on the realisation of productive forces or any global extension of capitalist relations (Harney & Moten, 2013, p. 8). On the contrary, the commons contend with threats posed by capitalist development. These spaces revalorise locale-specific modes of knowledge and technologies (Federici, 2011, p. 167).

Dillon asserts that the commons are not just an object, entity or thing but a set of relations—a body of people, plants, animals and microbes, systemically dislocated from their natal lands and life-worlds (Dillon, 2019, pp. 84-85). She notes that disentangling life from its natal worlds is ultimately an impossible task because new life-worlds and entanglements emerge in the very sites where older ones were uprooted (Dillon, 2019, p. 87). Dillon uses the example of the plantationocene which depended on the disentanglement and relocation of life. However, on the margins of the plantation, existed the provisional grounds demanded by slaves so that they could grow grain and corn for their own sustenance (Dillon, 2019, p. 84). This was a site of 'commoning' with material, social and spiritual dimensions. It matters that grain and corn were

cultivated for the purpose of sustenance *parallel to* the cultivation of sugarcane for the exchange market (Dillon, 2019, p. 84). Up against the border of this market, slaves enacted a mode of ‘commoning’ *for themselves*, albeit to sustain fungible bodies whose primary function was to serve the broader capitalist market. While *Voetvroue* do not emerge directly out of slavocracy and while their histories cannot be directly compared to histories of midwifery during slavery, there are traces of Dillon’s imagery of the Plantationocene in contemporary Eldorado Park. I elaborate on these in chapters five, six and seven where I illustrate various forms of ‘the commons’ that emerge from *Voetvrouery* as a practice.

Creolisation

Under apartheid, the Group Areas Act of 1950 and the Population Registration Act of the same year, certain areas were designated “Coloured” zones, in which the apartheid government placed racially classified ‘Coloured’ people. In grappling with such debates, unearthing notions “Colouredness” constitutes a turbulent area of research. The term “Coloured” is a stalemate when it comes to cultural and political correctness. To use the term in an official capacity is associated with apartheid eugenics and subsequent racial categorization. However, on the other side of the spectrum, if one surrenders the term in favour of a homogenised conception of Blackness, one runs the risk of glazing over the textures and experiences specific to those historically classified ‘Coloured’. There is no consensus on the meaning or use of the term. Of interest here is how “Colouredness” is (re)invented, (re)shaped and (re)imagined in its expressions over time. One cannot ignore the social experiences and expressions of material culture within these racialised enclaves.

But it is essential that one does not get caught up in what Zimitri Erasmus calls the trap of “cultivating purity” by using stringent markers such as the racial category of “Coloured” (Erasmus, 2017, p. 84). What are some of the conceptual resources in reach for coming to know and see in ways that do not depend on racial classification, politics, and that do not fall into the trap of “cultivating purity” but simultaneously account for the effects of such politics and classification? Erasmus posits that “*creolisation*” is a starting point for challenging the normative practices of race classification and the normative ideals presented by a “politics of cultivating purity” (Erasmus, 2017, p. 97).

Important to Erasmus’s argument is the distinction between ‘Creole’ as a category, the imagined property of creoleness, and creolisation, a process. The term begins its life as a

classification traced back to the Spanish word “criollo”, which referred to Spanish Americans born in the colonies. The term referred to Europeans born and settled in the colony and consequently considered to have “gone native and fallen from European grace” (Erasmus, 2017, p. 85). As early as the 1700’s, it was associated with people considered to be of mixed ancestry; a marker of dishonour, illegitimacy and shame (Erasmus, 2017, p. 85). Like ‘Creole’, the category ‘Coloured’ is embedded in similar discourses of shame and, for Zoe Wicomb, “miscegenation” (Erasmus, 2017, p. 85). These categories imply political meanings of a “type of people” defined as culturally or biologically ‘mixed’ (Erasmus, 2017, p. 97). “Creoleness”, implies a severance or disentanglement from culturally embedded practices that existed in former life-worlds that emanated from people’s movements and interactions. Erasmus notes that “the politics that produce these cultural practices arise from interconnected histories that precipitate processes of absorption, partnering, domination, dissolution and cultural borrowing among social formations marked by changing power relations and by changing historical conditions” (Erasmus, 2017, p. 97). These “interconnections” propel cultural change, enable multiple belongings, and render identifications fluid. These practices, politics and histories make creolisation a “method by which identifications are continuously transformed and extended into new possibilities of seeing the Self and Other, with no intention to universalise any particular possibility.” (Erasmus, 2017, p. 98). Important to this research report, it accounts for histories of conquest, disentanglement and severance that necessitate invention. Creolisation is thus the process of coming to belong that emerges out of histories marked by entanglement, disentanglement, co-production and interdependence, and unequal power dynamics (Erasmus, 2017, p. 98). In the South African context of dominance and racial categorization, creolisation serves as a conceptual tool of opening up how we see people who have been forced to forge new ways of living in order to survive and to “remake histories”. Erasmus beautifully describes these as histories of a meshwork of “multiple, mostly unknown elsewheres: historic, geographic, religious, cultural and epistemic elsewheres” (Erasmus, 2017, p. 3).

In sum, there are four pillars to my research report. First, a substantive account of the historical context in both its local and global iterations. Second, ‘the commons’ as manifested in the world of the *Voetvrou*: medicinal herb gardens as ‘a commons’; a knowledge commons of *Voetvrouery*; and a ‘commons of care’ in the form of *huis-hospitale* or home-hospitals. Third, processes of creolisation in the healing practices and rituals of the *Voetvrou*. And fourth, the primary research – archival and in the field – on which this report is based.

An Initial Brief History of Midwifery: Nineteenth and Twentieth Century United States, and the Cape, South Africa, 1652-1960

The history of midwifery is steeped in the racialised and gendered violence of colonial knowledge and western medicine; in colonial hierarchies of culture and knowledge, and in its regulation of the Self and the Other. Nineteenth-century Antebellum slavery serves as a landscape for understanding the socio-cultural climate of early midwifery. White men with stakes in slavery relied heavily on racialised medical language, narrative and practice to maintain what they saw as a ‘reproductively sound’ female slave labour force. This era saw multiple groups of men competing for control over the birthing process. Medicine became an important site of race-making particularly because the bodies of black female slaves were used to generate new theories of race based on the anatomy of black women (Owens, 2017, p. 46). Gynaecology presented one of the largest sexual encroachments black women faced at the hands of white men. Despite this violence, black midwives were prevalent and extremely important amongst slave communities. In a time where enslaved black women were defined and exploited by how well they reproduced, their reproductive power became a site of agency, in which the black midwife played an important role. Enslaved women resisted the efforts of their slave masters ‘laying claim to their souls’ by sharing long-held traditional beliefs and practices that were embedded within their indigenous African homelands from which they were captured (Owens, 2017, p. 50). The model of the African midwife that took effect on the plantations was seen as the bearer of African culture. However, the turn of the twentieth-century inaugurates a racialised, gendered, and hierarchal system of medical knowledge, enforced by law and leading to the subsequent ‘disappearance’ of the black autonomous midwife.

The Regulation of Midwifery in the Twentieth Century US

“In the first half of the twentieth century, American midwifery did not disappear, it was racialized.” (Craven & Glatzel, 2010, p. 335)

The history of midwifery is complex. Craven and Glatzel (2010, 331-332) emphasise the racial politics of public health initiatives in the twentieth-century that sought to eliminate the poor black midwife through licensing, regulation and supervision. They observe that at the turn of

the twentieth-century, efforts to improve maternal and child health care practices came under public scrutiny. As preferences for medicalised births in hospitals over traditional midwifery grew, so did the institutionalised defamation of black midwives (Craven & Glatzel, 2010, pp. 336-337). Fraser (1998, p. 221) notes that laws, regulations, and supervision during the twentieth-century cared more about bolstering a specific racial, gendered social order within the medical realm, than about maternal and child. The black midwife was generally perceived as 'filthy', 'unhygienic', 'superstitious' and both racially and professionally inferior to white male doctors (Craven & Glatzel, 2010, p. 338). License and regulation campaigns conspired with local law to enforce new training and registration requirements for previously autonomous midwives, specifically aimed at squeezing out poor black midwives.

The Sheppard-Towner Act of 1921 was one of the key laws for regulation and supervision, aimed at standardising midwifery practices in the US South. Although a few black midwives were permitted to undergo training, they were subject to narrow, male-centred, western notions of midwifery which further marginalised their traditional practices (Craven & Glatzel, 2010, p. 339). Alicia Bonaparte (2015) notes that this era of professionalisation - through the establishment of an institutionalised, patriarchal medical hierarchy – represented black autonomous midwives as the Other of the normative, predominantly white, male-led sector of obstetrics and midwifery. This process bolstered the formation of a white middle-class cohort of midwives who were subordinate to and discriminated against by white male doctors. Bonaparte examines the language that physicians in the South used to express anti-midwife advocacy in their writings and journal articles. She concludes that physicians' advocacy for regulation was underpinned by a desire to uphold "their medical authoritative knowledge and simultaneously discrediting granny midwifery" (2015, p. 4), and it actively weeded out black autonomous midwives.

Craven and Glatzel (2010) argue that despite these regulations, traditional practices did not cease, but instead carefully continued to circulate. Keeping silent about traditional herbs and practices protected black midwives and their patients from the gaze of health officials (Craven & Glatzel, 2010, p. 340). Thus, a parallel realm of midwifery and health care came into being. Efforts to erase these women from history simultaneously allowed for their more careful and organic existence 'underground'. This prompts questions about how these realms of care in the margins of power operated from then on.

Midwifery during twentieth-century US reveals the racialised politics of western medicine and the labour divide in care, specific to birthing and antenatal care. Racialised laws and regulations sought deliberately to exclude black autonomous midwives, hence the apparent 'disappearance' of autonomous black midwives. The history of midwifery at the Cape frontier of nineteenth-century South Africa reveals parallels with nineteenth- and twentieth-century America.

Midwifery at the Cape Frontier

Harriet Deacon (1998) provides an initial understanding of the history of midwifery in South Africa that, like its American counterpart, is entangled in similar kinds of racial and gendered histories. She begins by stating that the paucity of research on this matter is due to the relative absence of the black autonomous, traditional midwife of the nineteenth century from public archives and centres her argument mainly around *accoucheurs* and the relation they had to midwives (Deacon, 1998, p. 271).

Deacon notes that the nineteenth century is a pivotal moment. Globally, there is a large shift with men gaining greater power over female bodies through the channels of gynaecology and midwifery, which saw the rise of the male-midwife or the *accoucheur*. This period identifies a broad shift in power relations between medical men and black autonomous midwives at legal and institutionalised levels (Deacon, 1998, p. 272). Like in the US, training, licensing and supervision programmes for midwives were put in place to counter traditional, indigenous healing practices among black midwives. Khoisan midwives were perceived as immoral, primitive, dirty, uncivilised and superstitious "pretenders of great skill in herbs and plants" (Deacon, 1998, p. 275). Deacon notes that "Khoisan women bore the brunt of discrimination and racism and were blamed for the source of diseases because of their filthy and unhygienic lifestyles" (Deacon, 1998, p. 275). Racial ideas about black midwives bolstered laws for regulation and training. Not only would this disrupt the flow of traditional knowledge, but it shifted the sphere of care and of knowledge to white male-centred practices.

Training and regulation sought to mould a "respectable", subordinate class of middle-class white midwives from which black autonomous midwives were subsequently excluded (Deacon, 1998, p. 279). However, Deacon notes that the white *accoucheurs* were not as socially overarching amongst white mothers in South Africa. Khoisan women were often the only assistance preferred by Dutch Afrikaans women during childbirth. Deacon mentions how they

shared "the intimate world of the home" and encouraged the use of shared language and culture (Deacon, 1998, p. 287). She gives the example of Dutch-speaking women adopting the use of tobacco-filled pipes from Khoisan midwives to induce labour as well as the adoption of Khoisan herbs such as *Pelargonium Anceps* to procure abortions (Deacon, 1998, p. 289). These shared practices produced and sustained a degree of cross-class and cross-cultural links between Khoisan midwives and white women (Deacon, 1998, p. 289).

However, Deacon makes this sound like a harmonious process of cross-cultural exchange and sisterhood untouched by the racism that shaped settler-colonial society. She does not account for the power dynamics between white Dutch Afrikaans women and Khoisan midwives and the effects what she refers to as the "cross-cultural closeness" between them. Regardless, there remained a realm in which Khoisan midwives operated despite attempts by the white medical world to marginalise them. However, despite these regional and cultural preferences of midwifery, by 1865, Deacon notes that black women 'disappeared' from midwifery registries, and public archives (Deacon, 1998, p. 287). She does not explain where these black autonomous midwives disappeared to after 1865. It is perhaps not that Deacon did not account for this, but as she noted at the beginning of her piece, she observes a general absence of black autonomous midwives within *public archives*. Although the aim of my research is to explore who or what exists beyond colonial structures of knowledge, along margins of power, and within the *living archive* of black communities in contemporary SA, it is vital that one analyses the public archive and assess Deacon's claim of 'disappearance'.

My analysis of a fraction of South Africa's medical and health archives, suggests that Deacon's argument about the 'disappearance' of black autonomous midwives might be valid but too simplistic. If these women 'disappeared' from the public archive, what does it mean to 'appear' within the public archive? What is a 'public' archive to begin with?

Mbembe notes that an archive "refers to a building, a symbol of a public institution, which is one of the organs of a constituted state. However, 'archives' is also understood as a collection of documents- normally written documents - kept in this building" (Mbembe 2002, 19). Archival research is then defined as an interrogation of said documents in understanding its language, construction and content. Mbembe also notes that the archive is a product of judgement; a result of an exercising of power, which involves simultaneously placing certain documents in the archive while others are discarded (Mbembe 2002, 20). "The archive, therefore, is fundamentally a matter of discrimination and of selection" (Mbembe 2002, 21).

The use of archival materials is never innocent nor transparent. Rather, the condition of their production often involves contradictory or partial evidence, laden with inherent political residue. The archive is thus not neutral, but a breeding ground for power relations, which both include and exclude certain types of documents, produced by certain types of people. This is perhaps seen as a limitation of the archive; however, it is its epistemically violent nature that is of value in this study. The epistemic violence of the colonial archive is central to this study. What picture does the archive paint about black autonomous midwives from 1865 onwards? How does it help our understanding of *Voetvroue* today? My analysis of the extremely limited, literature and archival resources⁶ (covering the period 1904 to 1960) on black autonomous midwives' challenges Deacon's claim. I doubt that the black autonomous midwife ever held weighable, independent words and representation within the public archive, even prior to 1865. I argue that the black autonomous midwife has always been represented as a secondary, voiceless, statistical subject; viewed only from the gaze of the white official— a footnote, albeit with very few exceptions. My analysis is spurred by Catherine Burns' (1995) work on midwifery, nursing, and the interactions between black women and the apartheid healthcare system. I tracked a reference to untrained slave midwives in one of her footnotes (Burns 1995, p. 72). This led to the work of Charlotte Searle (1965) which deals with a period earlier than that studied by Deacon.

Cape Midwifery between the Seventeenth and Nineteenth Century

“Who did the delivery of the first white South African?... Vrouw de Jager being a married woman and more experienced in such matters probably did the delivery, though she probably had the assistance of the two young women” (Searle, 1965, p. 28).

Charlotte Searle's (1965) *The History of the Development of Nursing in South Africa, 1652-1960*, is one of the few pieces of literature that sought to trace the development of nursing and midwifery in South Africa. Her genealogy of midwifery is one of the oldest and most revealing of the erasure of black autonomous midwives from the colonial archive. She credits the first delivery and act of midwifery to Vrouw de Jager, whom we can assume based on her work, is

⁶ This research has drawn on several archives: the Wits Historical Papers Society with specific reference to the SAIRR collections; several journal articles published by the South African Medical Record between 1909 and 1950; the Intermediary Archive Depot, Johannesburg containing the Johannesburg Public Health Department collection, 1904 to 1960; and the Government Gazette 1909-1919.

white and Dutch. However, she proceeds to note that Jan Van Riebeeck's 1654 journal reads: *Yesterday, a Hottentot woman was delivered of a child close to the fort, on the bank of the river, beneath the branches which were piled, without assistance from man or woman, just as if she were an irrational animal*⁷ (Searle, 1965, p. 28). This juxtaposition of events frames Searle's genealogy of midwifery in South Africa. Searle's work is of concern, not necessarily for what she says, but more for how she says it.

During the early years of settlement, nursing at the Cape revolved around women and childbirth. It appears to have been the policy of the Dutch East India Company to appoint official midwives to trading stations. Regulations were in fact prepared for the appointment and control of midwives (Searle, 1965, p. 29). Searle notes how "the principles which they embodied are as valid today as they were three centuries ago... Modern maternal and child care requires that the midwife should be certificated and licensed and that a doctor, with his superior knowledge of midwifery matters should be associated with the preservation of the health of the nation" (Searle, 1965, p. 29). Despite these acclaimed "enlightened" regulations, sworn midwives were not appointed at the Cape for many years, therefore leaving women to fend for themselves and each other.

On the one hand, Searle argues that their spirit of "self-reliance" was crucial to the settlement and survival of the new burgers. Their medical practice was based on imported French Huguenot knowledge, skills and medicine. These practices were kept alive by the women of their households who were well-versed in the family remedies and medicines of home nursing (Searle, 1965, p. 54). Key to this was their "*Huis Apotheek*", a box of medicine kept in each household, generally stocked, used, and safeguarded by elderly women. Searle notes that this 'box' was especially important in the hinterlands where Company midwives could not reach (Searle, 1965, p. 55). The limited Company midwives who were appointed much later, in 1807, could not provide for all who required birth attendants and midwives. As the boundaries of settlement extended, more women were in secluded villages. Thus, the figure of the "*ou-tante*" was important in these villages (Searle, 1965, p. 93).

Searle's neatly crafted story of the downtrodden, poor yet resilient and skilled settlers elevate the "*ou-tante*" above elderly slave women who "occasionally acquired skills" in midwifery and acted as a midwife to their owner's wife and other female slaves (Searle, 1965, p. 56). I also

⁷ Searle draws directly upon primary texts taken from the Jan van Riebeeck Society.

find it puzzling that while no sworn midwives were appointed, yet available, in South Africa during this time, it was in fact the job of the slave to accompany their owner on long trips abroad in the capacity of a midwife. Searle writes about Hon. Pieter van Helsdingen who took his slave, Claasje, to Batavia to attend to his wife during the trip. Slave owners were responsible for the costs of transit as well as a security sum in the event that the slave died (Searle, 1965, p. 56). Furthermore, she mentions that further on in the sixteenth century, the first known private nurses were slaves. With the rising deaths of colonist physicians and a severe shortage of Company midwives, slaves who survived the smallpox epidemic were used as nurses to assist the ill (Searle, 1965, p. 59). She also writes at length about the named, official midwives who did not come from the Netherlands, but rather were longer-settled, white elderly women who were certified and paid as midwives by the Company. Among these women, she names Wilhelmina van Zijl (1751), Agetha Bloom (1763) and Catherine Visagie, who were qualified midwives “drawn from a stable social class” and commends their professionalism, decorum and behaviour (Searle, 1965, p. 77). Searle does not name the slaves whose contributions are just as important and valid. Deacon (1998) acknowledges the cultural and proximate closeness of the slave midwives with the white home, whereas Searle completely erases it. Searle gives credence to struggling white settlers who sourced their own medicine and kept their new-born and pregnant settlers alive. While she notes the significance of slaves to settlers’ survival, slaves who were midwives remain nameless and their resourcefulness is not valued. This colonial discourse frames her entire book. Searle presents the reader with named, white heroines, who appear in the archive, but leaves slaves who were key to settler women’s survival before, during and after birthing, as nameless and voiceless. These slaves have no place in the colonial archive other than behind and between its pages. Deacon (1998) argues that black autonomous midwives ‘disappeared’ from the public archive. I argue that one needs to look between the public archival lines, as it were, to get a sense of the place of these women who were not considered to be part of ‘the public’ and thus not worthy of being named.

Searle notes that while midwifery was initially practiced at home, the nineteenth century saw its development into a profession. She argues that British colonial administration at the Cape was considerably disorganised and did not pay much attention to matters concerning midwifery practice. In contrast, the Batavian Republic’s colonial authorities realised the severe shortage of certified midwives at the Cape and planned to establish general policy and facilities to make up for this shortfall (Searle, 1965, p. 93). In 1807, the Supreme Medical Committee was constituted to undertake the examination, qualification and licensure of midwives. A prominent

figure that headed the ‘development’ of the profession was Johann Wehr. He was concerned with the “inadequate and often dangerous midwifery which was practised by unlicensed persons in the Cape” (Searle, 1965, p. 93). In July of 1808, he wrote to the Governor of the Cape claiming that it would serve the administration if he were appointed as Colonial Accoucheur and thus authorised to train midwives for certification:

“... these several years, there has existed a great want of proper and able midwives in this Colony, and that at present there is an aged woman only excepted, not one midwife professionally or legally, instructed and sworn, only Hottentot woman, Free women of colour and even Slaves, presuming to act as midwives, therefore practise freely and the consequence that must arise therefrom both for mothers and children are obvious... THAT convinced by many proofs of your Excellency’s philanthropy and paternal care for the welfare of the Colony, your memorialist further begs leave to pray, that it may graciously please your Excellency to appoint him as Colonial Accoucheur and thus to authorize him to instruct an adequate number of midwives for the town and each district—whence of course would flow the duty for him to assist gratis all the wives and the slaves of poor Inhabitants, in cases where knowledge and strength of a midwife are insufficient” (Searle, 1965, p. 93)

Johann Wehr’s self-assurance was affirmed when the Supreme Medical Committee recommended that he be appointed as ‘Colonial Instructor of Midwifery’. In 1810, his preparation for the training of midwives commenced (Searle, 1965, p. 94). Wehr submitted his regulations to the committee: the place of instruction would be his private home (11 Kasteel Street); the Slave Lodges would serve as the Practical School; no person would be considered a midwife unless [she] attended all three courses of lectures was and deemed qualified by Dr Wehr; the total number of women to be instructed would be limited to six, four of whom shall be white Christians and two of whom shall be Malay (Searle, 1965, p. 94). The first qualified were five white women and two Malay and Free Black women. While Non-white midwives were allowed to train alongside white midwives, once certified, they were only allowed to treat Non-white people (Searle, 1965, p. 97).

Before certification, midwives had to take an oath of office against Dr Wehr’s code of ethics. It sought to mould a respectable and dependable doctor’s assistant that would not stray too far out of her line or duty. A midwife was expected to “Obtain immediate assistance from a doctor or an *accoucheur* when such assistance was indicated... Ensure that she was not too venturesome on the one hand and too difficult on the other and had to guard against becoming

confused” (Searle, 1965, p. 96). For Searle, these expectations were as true in the mid-1960s, when she wrote, as they were in the early 1800s (Searle, 1965, p. 97).

Despite Wehr’s regulations for the Cape, untrained midwives continued to practice in the hinterlands. Searle notes that women were forced to fall back on “*ou-tantes*”, monthly nurses and “Hottentot women who had gained some measure of midwifery experience by serving their own tribal women and white women”, while “*ou-tantes* and monthly nurses acquired considerable diagnostic skill and midwifery experience as the years of their practiced lengthened. This specialised knowledge and the traditions of their art were handed down from mother to daughter or daughter in-law, for the knowledge was not to die with the midwife” (Searle, 1965, pp. 98-99). For Searle, “what the *ou-tantes* and monthly nurses lacked in technical and scientific skill they made up in humanity, in empathy and in the observation of their unwritten code”; whereas Hottentot women were in her view, “ignorant, depraved, and dirty” (Searle, 1965, p. 99). Like medical officials of the time, Searle demonises black autonomous midwifery, on the one hand and on the other, valorises midwifery practised by white women. This resonates with Deacon’s argument. These colonial narratives frame midwifery for the foreseeable future. Deacon’s key moment—1865—marks the establishment of a midwifery register as midwives became more regarded in professional circles. Only certified midwives were listed here. Registered midwives would be struck off the register in the event that they violated the code of ethics. No black autonomous midwife was listed here and this is perhaps where Deacon draws her argument from. However, uncertified and untrained midwives *are* well documented by private and state facilities in later years. This is discussed at length by Catherine Burns (1995). In sum, while Deacon notes a ‘disappearance’ of black autonomous midwives in the archives from 1865 onwards, what does it mean to belong to an archive? What does it mean to ‘appear’ or ‘disappear’ in an archive? Is being statistically noted enough to consider it an “appearance”? If it is that we hold adequate representation and weighable words to the standard of “appearance” in an archive, Searle’s work explicitly shows that since the dawn of settlement, black autonomous midwives are for colonists, nameless, worthless and medically dangerous because they are ‘ignorant, depraved and dirty’. Their contributions have been snubbed. Their practices have been demonised. But, as records of later years show, these midwives continued their practice on the margins of power.

Towards a Living Archive:

Midwifery in the Nineteenth and Twentieth Century Transvaal,

Doulas in Twentieth Century US,

and Traditional Birth Attendants in South Africa

Midwifery in the Nineteenth and Twentieth Century Transvaal

The history of South Africa shows that prescriptive, normative discourse operates alongside and is often strengthened by blurry, contradictory legislation and practical leaks and fissures. Catherine Burns challenges Foucauldian notions of homogenous master narratives in a South African context. Medical institutions in colonial SA were simultaneously totalising and riddled with internal contradictions (Burns, 1995, pp. 20-21). From the early twentieth century, the state attempts to tighten its agenda on women's health. This period is saturated with internal debates which simultaneously consolidates and presents deep cleavages between different levels of state and organizations regarding women's health. Burns draws extensively on the Rand Daily Mail archives, the South African Institute of Race Relations archives, found in the Wits Historical Papers Society, the Intermediary Archive Depot with specific reference to the Public Health Department and West Rand Administration Board as well as the Central Archives Depot in Pretoria.

Burns (1995) argues that the pinnacle of midwifery is characterised by the establishment of the Bridgman Memorial Hospital, a space of cross-cultural knowledge and practice. From its inception in 1928, the Bridgman envisioned an “ambitious program of midwifery training” which served as a blueprint for programs launched in the forthcoming decades (Burns, 1995, p. 2). The hospital was established in between Sophiatown and Vrededorp for the purpose of serving black women's maternal health (Burns, 1995, p. 2). Before its establishment, no maternal hospital served black women. However, this is not to say that black autonomous midwives were able to freely practise. The hospital served as a locus for ‘civilising’ both midwife and patient into the productive, clean, ideal Christian motherhood (Burns, 1995, p. 2).

Despite this, both registered and unregistered midwives were recorded. Louisa Mvemve, a well-known autonomous midwife, actively challenged the racialised boundaries of policy and legislation that shaped registration and the construct of midwifery.

The formation of the Bridgman Memorial Hospital was a material manifestation of debates and anxieties about race, sanitation, the “black peril”, and the “betterment of poor whites” (Burns, 1995, pp. 31-33). These anxieties were expressed in the white supremacist state’s obsessions over the sexualised and immoral dangers of black women who began moving into the city and surrounding areas at the time. Swanson writes: “Medical officials and other public authorities in South Africa at the turn of the century were imbued with the imagery of infectious disease as a social metaphor... this metaphor interacted with British and South African racial attitudes to influence the policies and shape the institutions of segregation... urban public health administration was of considerable importance in accounting for the ‘racial ecology’ of South Africa...” (Swanson, 1997, p. 387). Swanson elaborates on the “interconnections between local state health formation, racial segregation and the representational power of disease and contagion”, otherwise aptly named by him as the “sanitation syndrome” (Swanson, 1997, p. 387). A piecemeal public health system was built upon the “sanitation syndrome” which had its roots in nineteenth century health initiatives.

By the 1910s, black women were seen as the main vectors of contagion, both venereal and non-venereal. For the white supremacist state and its white citizens, black women threatened the fabric of the desired social order and jeopardised the strength of the labouring male workforce by ‘infiltrating’ pure white elite homes (Burns, 1995, pp. 30-31). As more black women moved to segregated cities which did not cater for their homely and health needs, many lived illegally in cramped yards. In addition, influx control laws meant that black women were forced to avoid official detection. Thus, these women had no option but to work as undocumented domestic helpers in white homes (Burns, 1995, pp. 30-31). The advantages to white families of the exploitation of these black women’s labour meant that officials became increasingly concerned with the emerging crisis of black health in the city (Burns, 1995, p. 33). Central hospital records indicated alarmingly high rates of morbidity and mortality for black city dwellers, with a particular focus on infant and child mortality (Burns, 1995, p. 47). Alongside continued racialised concerns about contagion, public health shifted to black maternal and child health, due to the new configuration of the city. This shift manifested in a focus on hygiene, health and motherhood. Race, gender and urbanisation conveyed to press officials to link black and white maternal and child mortality and morbidity (Burns, 1995, p. 48). Burns notes that this link

opened up a non-racial space in public health. This extended to a concern for black reproductive bodies, and consequently for midwives.

My examination of the University of Pretoria's digital repository shows that the twentieth century saw the Transvaal passing an Ordinance⁸, modelled on its Cape counterpart, which regulated the work of midwives and nurses, and set up a midwifery register. Charlotte Searle notes that the 1891 Medical and Pharmacy Act made provisions for the regulation of midwives and nurses from the school established by Wehr (Searle, 1965, p. 104). The Transvaal Ordinance originally stated that unregistered midwives who had been practising at least a year prior to the passing of the Ordinance, in theory, could continue practising subject to licensure and registration (Lucas, 1979, p. 690). However, with the state in a flurry over infant and maternal mortality and morbidity rates, at a more central and organizational level, the Transvaal Medical Council opposed the promulgation of new measures to register and investigate midwifery practice (Burns, 1995, p. 102). From the top, it was opposed on the grounds that it would take away medical control from physicians and Medical Councils who currently had the authority over licensure and registration, extracting fines from untrained and unregistered midwives and exerting legal punishment over them (Burns, 1995, p. 102).

Physicians' Views

Articles and journals of the time outline physician anxieties agitated by three facets of midwifery reforms. Burns records these facets as follows:

Physicians argued first that "Medical authorities needed to clamp down on armies of so-called 'gamps' whose unsanitary and unlearned techniques were causing infection... Second, they demanded full control over the examination and licensing of midwives in the hands of physician controlled Medical Councils. Third, they insisted that women found guilty of misdemeanours under new laws, should pay fines of the Medical Council" (Burns, 1995, p. 107).

None of these articles and publications called for the complete outlaw of unregistered and untrained midwives but the general muscle of their argument was that even competent midwives were technically untrained and underqualified to perform surgical assistance. Furthermore, physicians, especially those emerging from specialised fields such as obstetrics

⁸ This item appears in the collection of Statutes of the old South African Colonies: 1714-1910

and gynaecology, were concerned that they should not find themselves outnumbered and outcompeted by midwives charging cheaper rates (South African Pharmacy Record, 1915).

My impression from reading professional journals and physician letters⁹ published in the South African Medical Record (1909-1950) is that physicians imagined a city overrun and dominated by untrained midwives, whose patients refused physician care and left physicians, especially those newly specialised in the field of obstetrics and gynaecology, unemployed (South African Medical Record, 1920, p. 139). Burns notes that, in fact, most of the urban, black poor turned to their local herbalists, neighbours and distinguished community women elders to help them through birth in the context of extremely poor and cramped city conditions (Burns, 1995, p. 104). Little is written about these herbalists and elders except that physicians thought that modern science and the urban populace would be lost to the grip of “all forms of quacks” (Burns, 1995, p. 108). This idea persists into the late 1920s and 1930s and underpins laws concerning midwifery, registration, and maternal health (South African Medical Record, 1920). While my reading of these professional journals paints a picture as to where regulation stems from, it also reveals a gap between professionals’ perceptions on the one hand, and the reality of midwifery in the everyday lives of ordinary people.

Health Visitors’ Views

A more comprehensive view of midwifery and maternal health on the ground can be gleaned from female health visitors. Contrary to journals, letters and articles, health visitors presented a different view of local circumstances to that of physicians. Health visitors such as, Morisse and Sistertson, presented overwhelming evidence of a grave shortage of maternal beds and pressing need for better trained and equipped midwives. The evidence presented pushed the 1913 complaints of physicians off the front pages of journals and articles (Burns, 1995, p. 104). Health visitors were a small group of government-funded female employees who worked under tightly constrained central state organizations among the urban poor, both black and white. During the late 1920s, the 1919 Public Health Act stipulated that female health visitors were to regularize birth and death notifications (Burns, 1995, p. 119). They were to track birth and deaths through registered midwives, both trained and untrained, nursing homes, hospitals, clinics and word of mouth (Burns, 1995, p. 104). They were also responsible for ensuring

⁹ The archival sources drawn from here are journal articles published in the South African Medical Record from 1909-1950.

midwife compliance with aspects of legal duties, patient care, equipment and cleanliness. They were charged with enumerating and investigating hundreds of births, deaths and midwives per year (Burns, 1995, p. 115). It is through their reports and findings that one gathers a sense of how many, where, who and how midwives (trained, untrained, registered and unregistered) existed on the ground. Burns provides a detailed analysis of investigations and summaries of Health visitor reports in June of 1926 (Burns, 1995, p. 116).

Health visitors reported 410 births by trained midwives and 389 births by untrained midwives. Interestingly, the data was not broken up into race or language group. However, district reports allowed for a comment on the increasing number of black midwives in particular non-white areas. It is estimated that “there were 136 “European” midwives practising in Johannesburg, of whom 34 were untrained, and 147 “non-European” midwives, of whom 44 were untrained and unregistered, and 103 of whom were registered but not necessarily trained”¹⁰. She notes that upon surveying the Government Gazette, she counted 190 white and ‘Coloured’ trained and registered midwives operating in Johannesburg, but no African women held midwifery certificates as of 1926 (Burns, 1995, p. 123). Health visitor reports provide one with a quantitative picture of midwifery during the early to late 1920s of who held registration and certification and from what district. However, their correspondence also provides intimate details of their interactions with particularly untrained midwives. Burns provides an extract from such correspondence:

“On visiting Mrs Evan, 40a Terrace Road, Fordsburg.... This morning, I found that her new born baby had discharge in each eye, and on enquiry found that she was attended to at her confinement up to today, by Nurse Greyling – untrained—of 68 Avenue Road, Fordsburg. The nurse did not call in a Medical Practitioner nor has she notified this Department of the condition of the baby’s eyes. I would like to draw your attention to the fact that I have previously warned Nurse Greyling that it is her duty to comply with the act, (Ophthalmia Neonatorum) (Burns, 1995, p. 120)”

Apart from the numerical data and reports from investigations, these records also contain brief letters, minutes, memoranda, which are more qualitative in form and suggestive of the daily politics that the work of health visitors involved¹¹. Significantly, health visitor reports provide

¹⁰ This primary data is taken from the IAD/JPHD 48: 3233 “Health Visitors”, Report, June 1926

¹¹ IAD/JPHD 48: 3233 “Health Visitors” August 1926 and IAD/JPHD 48: 3233 “Health Visitors”, Report, June 1926.

a picture of communities' lived experiences of health. It is important to consider the day-to-day work of these small numbers of individuals whose explicit task was to enumerate, regulate and investigate health and welfare. The implications of their work provide a basis for reconsidering the formation of the South African state and suggest a concern on the part of central and local government with the influx of black women as well how to subsequently interpret, formulate and manage the reproduction of a desired order wherein the black woman's body played a central role.

However, the overwhelming evidence of a severe lack of maternal services took centre stage at various state levels towards the late 1920s, both before and during the establishment of the Bridgman Memorial Hospital. Government officials, missionaries, medical councillors and directors, concern themselves with the apparent maternal health crisis. They agreed that maternal and child welfare was a medical problem hence the need for more medical specialists and the allocation of more resources (Burns, 1995, p. 126). What I find particularly interesting is further investigations, on the part of the government in 1927, dedicated to tracking black midwives. While they list 1 qualified, yet 10 registered black midwives, they list that the number of untrained and unregistered midwives are unknown. Despite their reservations towards midwifery, in his 1926 speech, McGibbons, a professor in obstetrics at the University of the Witwatersrand addressed the Medical Council and asserted that "The days in which midwifery is regarded as an inferior sort of art as compared with medicine or surgery should be gone, and midwifery in South Africa must take its seat in the front row of clinical education" (McGibbons, 1927). Subsequently, four conferences were held to determine further training and licensure for untrained midwives. This is reflected in the 1928 amendment of the 1919 Dental and Pharmacy Act of 1919¹². The Act provided for the local supervision of midwives and the regulation of maternity homes. A compromise was reached and it was agreed that the Queen Victoria Maternity Hospital would remain the primary site of maternity institutional care for white women and district midwives would be trained in larger cohort by the institution, in conjunction with various medical schools (Burns, 1995, pp. 131-132). However, the Queen Victoria Maternity Hospital only accepted white midwife and nurse trainees. This shaped the establishment of the Bridgman (Burns, 1995, p. 132).

¹² Government Gazette 2: 9801, June, 1919.

The Establishment of the Bridgman

The Bridgman Memorial Hospital, opened in 1928, on the western edge of the city, adjacent to both white suburbs such as Melville, Westdene and Brixton and poorer, more racially mixed communities, such as Fordsburg and Vrededorp. This hospital was closely affiliated to the freehold community of Sophiatown which was seen as a site of a growing black bourgeois and professional elite. The Xuma, Rathebe and Sita families. Historians such as Ben Magubane name Sophiatown as “an amalgam of ethnic, social and cultural groups, a cosmopolitan centre of intellectuals, radical politics, jazz and gangsters” (Magubane, 1989). However, it was also home to ordinary, working class people such as small scale garment makers, beer brewers, hawkers and domestic workers (Burns, 1995, p. 109). As Burns argues, the Bridgman was inextricably tied to Sophiatown, whose forced removals under the Group Areas Act coincided with the forced closer of the Bridgman around the same time¹³ (Burns, 1995, p. 195).

The Bridgman’s founders dreamed of establishing a space which was ordered by Christian values. They sought to craft young women into good mothers and midwives. They called for sobriety dignity, adherence to Christian values and the scientific management of the body (Burns, 1995, p. 195). Following on from anxieties of contamination in the years before 1928, the establishment of the Bridgman sought to draw the iron curtains between the economic and social lives of black and white women, hence the motive to establish a maternal welfare institution that catered for black women specifically (Burns, 1995, p. 197). The overwhelming majority of missionaries, medical practitioners, philanthropists and social activists, at the heart of the Bridgman, were women. A smaller group of black women were drawn into the planning and discussions of the institution but they never held central positions of authority (Burns, 1995, p. 198). Important figures in the establishment of the institution were that of Clara Bridgman and Edith Reinhalt-Jones (Burns, 1995, p. 198). Despite its constricting and somewhat paternalistic ideology, the Bridgman prided itself on being a space to train black midwives and nurses. It found inspiration in programmes such as the Helping Hand Club (Burns, 1995, p. 266). Its emphasis was on midwifery training. They accepted young black, unmarried women, who were drawn to the Bridgman because they were welcomed as *women*

¹³ It is important to note that along with forced removals came the closure of the Bridgman Memorial Hospital in the 1963. Following racial segregationist policies, the training of midwifery and nursing was structured along racial barriers. Baragwanath Hospital became the new site of nursing and midwifery with training in the latter reduced to a single course in a broader nursing qualification (Burns, 1995, p. 195).

(Burns, 1995, p. 199). The Bridgman was the first, and for a long time the only site of large-scale midwifery training for black women.

Burns notes that in 1928, *Umteteli wa Bantu* heralded the appointment of Poppy Mbele as one of the first accepted midwife-trainees of the Bridgman (Burns, 1995, p. 265). Applicants were accepted on the recommendation of white missionary educators. The Bridgman required excellent 'character testimonials. The age range of twenty to twenty-five was preferred and the first trainees were unmarried and childless (Burns, 1995, p. 268). At first, the Bridgman intended to admit women with no prior nurse training because it intended to follow a British model of midwifery which saw midwifery as a separate profession to nursing. But with massive nursing programmes in the 1920s and 1930s, male midwifery applicants had already obtained a nursing qualification. However, the Bridgman, from the start, provided women with full qualifications, equivalent to that of white candidates at other institutions (Burns, 1995, p. 278).

Despite the Bridgman's commitment to moulding disciplined Christian midwives and mothers, Burns beautifully notes that "the will and subjectivity of black women at prenatal classes, in examination rooms, and on birthing tables, arrested the full implications of scientific inquiry based on racial taxonomies and interrupted easy dichotomies between notions of civilization and primitivity so present in expert discourse across South Africa in the first half of the century" (Burns, 1995, p. 2). Hence Burns' argument that constructs of "western" and "indigenous" as we anthropologically know it to be, aren't as fixed as they appear to be (Burns, 1995, p. 4). Women who assisted births at the Bridgman undermined simplistic assertions that discourses of science created totalising institutions or dioramas out of the lives of black women in Johannesburg (Burns, 1995, p. 4).

An important figure to Burns' argument is the Port Alfred born midwife, Dr Louisa Mvemve. "As a midwife and herbalist, Dr Louisa Mvemve brought together in one person the skill, knowledge and networks of nineteenth century practitioners, but she adapted her expertise and developed her range of services with a canny sense of the needs of her fellow twentieth century South African" (Burns, 1995, pp. 140-141). Dr Mvemve bore witness to the shift from British Colonial rule to a white settler Government; a world of African communities competing on the frontiers of the Eastern Cape, on the one hand, to the migration of members of these very same communities to the city of gold, on the other (Burns, 1995, p. 141). Burns notes that she aspired to live like a Victorian woman and was not a part of radical movements that sought to change

the status quo. However, her individual actions actively challenged the boundaries of urban legislation and the very fabrics of the medical Acts passed. Burns notes how “as a woman without formal education, the social world within she moved was largely of her own making” (Burns, 1995, p. 142).

Dr Mvemve presented herself as a midwife, “healer, herbalist, diagnostician, and innovator of cures” (Burns, 1995, pp. 142-143). She also claimed to store and safeguard the practices of past generations and importantly, the nursing skill of her grandmother and the medical knowledge of her maternal grandfather (Burns, 1995, pp. 142-143). At the same time, she viewed herself as the company of scientists, and while respecting western science, saw herself as a doctor when “Doctors had given up the case” (Burns, 1995, p. 143). She explained herself and her practice through both Christianity and Witchcraft. Dr Mvemve is an anomaly within the archive. Burns notes that she single-handedly holds more weight in the archive than some doctors of her time— “I could trace myself if anyone wants to know”, Mvemve writes (Burns, 1995, p. 158). She wrote a booklet entitled “A Woman’s Advice: A Woman’s Advice to the Public on the Cure of Various Diseases”, which detailed how to mix herbal remedies, how to bathe, how to tend to wounds. It pre-dated many first-aid booklets. The booklet had a section on the ways in which to comport oneself during pregnancy. Her booklet, along with her name, reached high-ranking officials of the National Health Department (Burns, 1995, p. 170). However, the 1923 Urban Areas Act and the 1928 Medical, Dental and Pharmacy Act, resulted in her expulsion from Johannesburg, for acting without certification. She was allegedly involved in the murder of a Greek man for treating him (Burns, 1995, p. 178). She retreated to the Eastern Cape where she re-established herself on a farm and cultivated a large herbarium (Burns, 1995, p. 181). Dr Mvemve’s story is a powerful one. The decades leading up to the formation of the Bridgman saw policies that sought to heavily control the reproductive lives of women. Discourse on midwifery, at the time, used conventional and narrow language of ‘trained’ and ‘untrained’, ‘certified’ and ‘uncertified’, dictated by no one other than the state’s medical boards. However, Dr Mvemve’s story provides an account of a woman who forged her own path and practice. While she was eventually subject to state laws, she pushed the boundaries of legislation and the definitions of care and medicine. She maintains a lone and individual presence within the archive. In terms of the broader argument of my research report, Louisa Mvemve embodies “appearance” within an archive. In relation to the figure of the *Voetvrou*, Mvemve stands out as one who speaks for herself in literature and the archive.

However, it is unfortunate that the public archive begins and ends with her. But what possibly lies within the *living archive*?

Towards a Living Archive: Where are the midwives now?

Albeit a necessary inquiry into the claimed ‘disappearance’ of black autonomous midwives from the public archives, it is important to note the connotations that this claim brings with it. Holding such an assumption denotes a continual separation of black autonomous midwives from the biomedical sphere which furthers an over-determined association between black autonomous midwives and tradition. Such an assumption misses the complex set of negotiations that black autonomous midwives, or ‘traditional’ midwives, find themselves in globally. Theoretically, Davis-Floyd et al (2001) note how debates that pit “medicalised childbirth” against “traditional midwifery” simplify the matter and make it difficult to understand midwifery in a way that avoids these value-laden polarities (Davis-Floyd, et al., 2001, pp. 106-107). These authors argue that midwifery is neither the evil twin to its western biomedical counterpart, nor is it a neutral profession. Instead, black autonomous midwifery emerges as an ever-changing practice within contexts that are themselves dynamic (Davis-Floyd, et al., 2001, p. 109). That said, it is important to note the conditions which precipitate changes in this practice. Although midwifery today is not necessarily relegated to the margins of power, its interaction with structures of power is vital for understanding midwifery today. Again, this argument is emphasised by the work of Catherine Burns and the story of Dr Louisa Mvemve.

Davis-Floyd et al observe what they call a “lay midwifery renaissance” in the US and Canada during the 1970s. This was generated mostly by white middle-class women responding to the growing demand for alternative forms of birth and older “folk-midwifery”, which had largely served marginalised women (Davis-Floyd, et al., 2001, p. 106). They give the case of Gladys Milton who, with the lobbying of the women leading this ‘renaissance’, became the first licensed *traditional* midwife in Florida, that has since set up conferences and a weekly television show promoting the use of alternative forms of medicine (Davis-Floyd, et al., 2001, p. 106). This landscape reveals the fluidity of midwifery over time. However, Davis-Floyd et al (2001), in their attempt to de-romanticize so-called ‘traditional’ midwifery, end up romanticizing a “post-modern” midwifery where certain circumstances of agency are highlighted and praised but various intersections of race, class and gender, while alluded to,

are seldom spoken of. This is perhaps where Davis-Floyd may not necessarily fit within certain contexts, namely that of Doulas, in the US and Traditional Birth Attendants (TBA's), in South African. Various case studies, in both, contexts provide some examples.

Doulas in the US

Both Craven and Glatzel posit the idea that from the 20th century US onwards, the black and indigenous autonomous midwife has "disappeared". However, heralded by Davis-Floyd et al, the figure of the "Doula" exemplifies similar histories to that of the 20th century.

Mitchell (2010) defines a "Doula" as an experienced "birthing assistant" who provides continuous emotional support before, during and after childbirth. Mitchell notes that Doulas tend to come from diverse ethnic backgrounds and are well-rooted within their communities (Mitchell, 2010, pp. 1-6). Lantz et al (2005) discusses that Doulas were initially a family member or friend in their community who volunteered her knowledge and experience, but has since been professionalised by DONA (Doulas of North America), an organisation founded in 1992 that sought to acknowledge unique child birthing practices that catered for the psychological and emotional needs of women, in attempts to "humanize and demedicalize" birthing practices (Lantz, et al., 2005, p. 110). The institution thus provided a certification process to already experienced Doula and allow them to work based on a fee-for-service to both public and private clients. Mitchell extensively, divulges into how Doulas are particularly preferred amongst more affluent communities and how this further links to the growing commodification of indigenous or alternative practices as niches for the white, middle class rich. While giving a comprehensive view of what Doulas are in the mainstream imagination, Mitchell's work is thin on the history of Doulas before the establishment of DONA. These histories, as articulated by Ireland et al (2019) and Gilpin (2017) who place Doulas within larger entanglements of colonialism and institutionalised racism, as seen within the 20th century US.

Ireland et al (2019) posits that the modern discourse on Doulas places them within an ahistorical, acultural slot and apolitical slot. In contrast, these authors locate Doulas within broader struggles of 'indigenous' practices being subject to commodification and neo-colonialism at the hands of the rich. They begin by indicating that Doulas have deeper historical connections to communities and indigenous knowledge practices and that their services go

beyond child birthing practices. Indigenous Doula work is positioned and based within a plethora of different cultural practices (Ireland, et al., 2019, pp. 54-55). Ireland et al (2019) emphasize that indigenous Doula practices seek to re-centre the spiritual reverence of childbirth while emphasizing the sacred in addition to healthy and safe childbirth (Ireland, et al., 2019, p. 55). In addition, Doulas practices are a political tool that maintains sovereignty and resists the ongoing neo-colonial management of the bodies of women (Ireland, et al., 2019, p. 54).

Ireland et al claim that the training and certification process, of which DONA holds the monopoly, is unrepresentative of poor, indigenous Doulas. They assert that training is still structured along western biomedical lines of what 'alternative' childbirth entails. The training assumes a standard level of functional English, marginalizing Doulas who aren't English home language speakers, and while there are other programmes available, in order to practice as a Doula, one would need to be certified through DONA (Ireland, et al., 2019, p. 56). Training thus narrowly defines the Doula as a privatised, "individualised birth worker" (Gilpin 2017). This scope effectively marginalizes many indigenous Doulas from their practice. However, Ireland et al do mention that within this space of marginalization, poorer women can gain access to traditional training and that traditional processes and practices can happen organically without intervention and standardization. In this way, the Doula pedagogy found here disrupts and challenges the epistemological racism experienced by Doulas that engage in western training (Ireland, et al. 2019).

Gilpin (2017) states that examining the everyday challenges of Doulas, reveals the ongoing effects of colonialism against the bodies and practices of indigenous people (Gilpin 2017). The experiences of Doulas, especially under the harsh and skewed regulation of DONA, illustrates a replication of colonial and racist regulatory laws imposed upon marginalised women in the 20th century US and the 19th century Cape. Moreover, the Doula emerges, not as a wholly autonomous midwife, but a monolithic "birthing attendant" that can only serve in a limited capacity. This heralds back to the gendered partitioning of medical labour in the 20th century US and the 19th century Cape. This is where Davis-Floyd et al (2001) argument is lacking—midwives do exist in ever-changing contexts, forging new relationships at different junctions of power. However, this does not necessarily mean that they escape the grips of power and the regulation of the state. Similar processes are seen in South Africa, a highly unequal society, with both a past of racialised reproductive governance and a current high HIV/AIDS

prevalence, all coupled with poor accessibility to healthcare facilities. What does midwifery look like here?

Traditional Birth Attendants during Apartheid and Post-Apartheid South Africa

Dududu clinic, in what was Natal during the apartheid era, had considerable difficulty accessing conventional maternal and child health care. Larsen et al (1983) examine the role of traditional birth attendants (TBAs) at this rural clinic who supplemented medical care for rural women. Part of their study was to introduce the “*Umphambinyoni*” pilot scheme, a low-level training scheme, initiated by government health services and medical schools (Larsen, et al., 1983, p. 543). Significantly, the pattern in studies aimed at intervening in poor access to health care and at understanding the role of TBAs tend to end up being attached to a state-administered training scheme. In this study the only definition it provides of a TBA is a “rural obstetric service” and an “arm of an over-extended health service” (Larsen, et al., 1983, p. 545).

These researchers conducted house-to-house surveys of 100 women in the vicinity of the Dududu clinic and provided training sessions for four TBAs in the area. They report mostly on procedures and recommendations that follow the TBA training. These include that TBAs were advised to consult the newly pregnant woman at her home, where health education is administered and to stray from encouraging the use of “*ishihlambezo*” or an herbal infusion (Larsen, et al., 1983, p. 545). Attendants were required to capture the health history of the women for clinic documentation, and then refer women to the nearest clinic for antenatal treatment. At clinics, TBA’s were only to assist in health education, the weighing of babies and following up on patients in their respective communities (Larsen, et al., 1983, p. 545). The content of the education they administered was limited to encouraging and monitoring regular antenatal attendance at clinics, 3-year family spacing and contraception, the physiology of labour in the process of birthing, and the signs of danger and risk during this period (Larsen, et al., 1983, p. 545). Upon delivery of a baby, TBAs were allowed to conduct home births as per their cultural procedures but “deliveries are to be conducted without the use of herbal infusions”, and only with the use of instruments provided to them by clinics (Larsen, et al., 1983, p. 545). Post-partum care required the TBA to visit the new mother and her infant for check-ups. During that visit, the TBA was required to focus on whether or not the woman had attended a clinic regularly and on providing contraception. Complications during both birth

and post-partum required that the TBA refer the woman to the nearest clinic (Larsen, et al., 1983, p. 545).

Larsen et al's (1983) study claimed to be concerned about unequal access to healthcare but it quickly morphed into a report on outcomes of the *Umphambinyoni* pilot scheme. Instead of addressing the racialisation of inequities in access to healthcare, TBAs were mobilised as an "extension" of the state healthcare system. In essence, the state outsourced its responsibility for healthcare in rural black communities to TBAs and researchers were complicit in facilitating this process. Furthermore, the training offered to TBAs was limited to a western understanding of obstetrics which made its tools and medicines the norm, over cultural and indigenous herbs. In part, the growing dominance of western obstetrics as expressed in the discourse that appealed to TBAs to 'stray away from "herbal infusions"'. Similarly, clinics were held as totalizing healthcare facilities where TBAs were required to continually refer pregnant mothers to clinics for treatment, over administering the treatments they had come to know as their own.

The shift away from these treatments eroded the reproductive rights of poor rural women who were previously free to choose where they wanted to give birth and what kind of treatment they wanted to receive before and after birth. The emphasis on the TBA providing pre- and post-partum education which prioritised encouragement of contraception and family planning reproduced tropes of western models of the nuclear family. What the results of the pilot scheme illustrate is an engulfing of traditional midwives into the model of a TBA, forced to adhere to a western mode of obstetrics and then marketed or represented as a process by which the state and the communities it oppressed worked together to ensure their access to healthcare. This echoed colonial schemes of indirect rule. What is concerning is that even post-1994, parallels from this era can be seen in studies on midwifery today.

Since the dawn of its democracy, South Africa has been engaged in general societal transformation aimed at alleviating inequality and rectifying the ills of the past. Most studies about TBAs in a post-apartheid setting are located in a time of concern over high maternal mortality rates and a high prevalence of HIV/AIDS. Programmes around this are led by the 'Safe Motherhood' initiative, launched by the World Health Organization (WHO) in 1988. WHO claims that maternal mortality is a violation of women's rights and therefore urges governments to ensure "necessary political and financial resources are dedicated to this effort" because "Safe motherhood is a vital, compelling and cost-effective economic and social

investment” (World Health Organization, 1998, p. 7). Coupled with a high prevalence of HIV/AIDS, the female body [more specifically, the infected reproductive female body] becomes a sight of regulation, surveillance and organization by states that take on ‘humanitarian’ reproductive initiatives. What is seen are ploys by the state to get a better hold on the reproductive governance of poor black women, who are mainly viewed as HIV/AIDS proxies.

Similarly, Peltzer and Henda’s (2006) study operates under the concern of a high maternal mortality rate and a high HIV/AIDS prevalence. They assert that TBA’s are ill-trained to deal with the complications that arise here and “have poor HIV/AIDS knowledge and poor hygiene practices and may be at risk of occupationally acquiring HIV” (Peltzer & Henda, 2006, p. 140). The study is deployed to evaluate a training programme pilot for TBA’s on safe deliveries, within a noted paradigm of emergency obstetrics. They have used 50 TBA’s from two unmentioned clinics in the Eastern Cape over a four-day training period that focused on HIV/AIDS prevention, antenatal and post-partum care, the status and role of the TBA, traditional medicine and rituals, and monitoring follow-ups (Peltzer & Henda, 2006, p. 142). Their results state that after the training, more TBA’s conducted prenatal check-ups and referred mothers to clinics for the administration of nevirapine. During labour, women with risk signs were referred to nearby healthcare facilities (Peltzer & Henda, 2006, p. 145).

What is concerning is that the study begins with an immediate assumption that TBA’s are ill-trained, ‘unhygienic’, and in need of training with a western obstetric model as normative. This echoes old tropes for the regulation of midwifery. Furthermore, the training has offered nothing more than a ‘how to’ guide on referrals. In that vein, there has been no discussion regarding traditional medicine and rituals, albeit a focus on it—the silence around this tells a larger story of a marginalization of traditional practices, over normative western ones. What this study also seeks to do is outsource responsibility on to available TBA’s, rather than addressing macro structures of inequality leading to a high maternal mortality rate and poor access to healthcare—yet again, the TBA becomes an extension of the state’s healthcare system, but in a way that assimilates them into this said system, rather than offering fair collaboration. As an extension of this idea, the TBA is reduced to a monolithic, acultural appendage of the state. Furthermore, TBA’s are assumed to only exist within rural areas [as most studies done, both pre-and-post apartheid, only look at TBA’s in relation to rurality], further entrenching the harsh, stereotypical binary between biomedical and urban versus TBA/traditional and rural.

The reduction of the TBA to an acultural expendable tool of the healthcare system by the researchers is also telling of their pre-conceived ideas of what a TBA is. The mere use of the word itself is problematic in its homogenization.

An interesting juxtaposition to this narrative arises out of study done by Tlebere et al (2007) that also concerns itself with a high maternal mortality rate, attributed to HIV/AIDS related deaths. They aimed to understand underlying factors that lead to maternal deaths. The study focused on factors that influence the utilization and barriers of maternal health services experienced by women, both HIV positive and negative, in Paarl, Rietvlei and Umlazi. What is interesting is that their results illustrate mainly socio-economic barriers to maternal healthcare services. “Stated barriers to care were examined specifically. Women indicated that they had problems attending antenatal care in Paarl (27%), Umlazi (28%), and Rietvlei (38%). A lack of financial resources for transport was the barrier most often cited” (Tlebere, et al., 2007, p. 346). Regarding home births, they note that “transport, attitudes of nurses, and nurses not recognizing labour were the predominant health systems issues that prevented them from getting to the hospital or clinic for delivery” (Tlebere, et al., 2007, p. 349). What is interesting is their discussion around traditional healer’s supplementation for the short-falls of the healthcare system- when clinics did not have medicine, or women have simply lost faith in the healthcare system, they turned to traditional healers for care and treatment (Tlebere, et al., 2007, p. 349).

Similarly, a study done by Abrahams et al (2001) reports on how the experiences of Coloured and Xhosa women in the Western Cape impact their decision to seek care. They note that both groups felt that their needs were not met by said services: “They were given very little information regarding when they will deliver, the status of the baby after each palpation, and test results; this, undoubtedly, contributed to their ambiguous views on the value of antenatal care” (Abrahams, et al., 2001, p. 244). They also note that most women expected to be treated badly by nurses upon arrival for their bookings; they expected scolding, negligence and even beating. This was all based on prior experience or an experience of a friend or family member, hence their preference for traditional midwives (Abrahams, et al., 2001, p. 245). These studies decentre the black autonomous midwife, or TBA, from issues around maternal mortality, HIV/AIDS and poor access to healthcare. Rather, their results reflect the true nature of barriers to healthcare—socio-economic inequality coupled with other social factors. This actively challenges narratives around supposed ill-trained TBA’s as the cause of maternal mortality. It

further relinquishes motive for the state to roll out training programmes, and rather directs our attention to the material conditions these women find themselves in. Why then the need for constant regulation and training of TBA's?

This chapter provides a brief history of midwifery in the US and in South Africa. Both histories produce common tropes. The history of midwifery is rooted in ideas of sexual violence, in colonial hierarchies of culture and knowledge and in its regulation of the Self and the Other. It is entangled in the politics of medical regulation and domination by the western biomedical sphere. Regulation and control have explicitly run along the lines of race, gender and class. Significantly, despite these narrow and conservative legislative parameters, the western biomedical sphere is not as totalizing as it appears to be. Figures emerging from the archive, such as Dr Louisa Mvemve, are indicative of this. The archive projects a picture of strong-muscled physicians and medical boards wrangling 'untrained' and 'uncertified' midwives, moulding those deemed acceptable into a palatable class of subordinate birthing assistants, and maintaining further control over midwifery as the sole voices of practice. However, reported statistics show that the 'untrained' midwife has always stood in opposition to the state. This brings into question Deacon's argument around the claimed "disappearance" of black autonomous midwives from the public archive as of 1865. As Burns' work shows, 'untrained' and 'uncertified' midwives are well documented and discussed by both private and public archives, well past 1865. This begs the question as to what then characterizes "disappearance" and "appearance" in the archive. If these 'untrained' and 'uncertified' midwives were statistically recorded even after 1865, is Deacon's argument of "disappearance" correct? A figure such as Louisa Mvemve, closely characteristic of a "*Voetvrou*", is one of the very few independent voices that holds as much weight in the archive as the physicians and doctors of her time. Can we characterize this as "appearance" in the archive? If we hold Louisa Mvemve to the standard of "appearance" in the archive, have black autonomous midwives ever appeared in order to disappear from the public archive? As the aforementioned literature has shown, black autonomous midwives, since settlement, have never held weighable words in the archives. They have been painted as voiceless, nameless, contribution-less silhouettes along the periphery of care. However, they have not disappeared altogether. The archive, while epistemically violent, has left traces of them in statistical values, in health visitor accounts, in correspondence between physicians. While it is debatable as to whether they ever "appeared" [in order to "disappear"] in the archive, their

existence is well documented by the archive. It is this existence that is further explored in this thesis. An existence, not in the public archive but in the *living archive*.

In the Field

Leaning against the robot, I hail a taxi at the top of Main Road, Eldorado Park, commonly known as ‘Eldos’. More affluent parts of the city are desolate and barren, their residents engulfed in a pandemic-panic. Wedged between the corner of Turf Avenue and the Golden Highway, people without the means to ‘shelter in place’ wait for minibus-taxis to transport them to work. The corner is bustling despite Lockdown Level 3. We are rushed into Siyaya’s rusty taxi which is held together by threads. It creaks in response to each step onto its body. My thoughts of claustrophobia, contagion and personal space momentarily set aside, sitting shoulder to shoulder with other passengers felt snug in the dry cold of August. I cannot smell through my mask, so, I imagine an agglomeration of perfumes, colognes, and soap. Soon, I panic as passengers begin to cough and sniffle. Everyone is quietly on edge. Nevertheless, we had places to go so no one uttered a word relating to the matter.

In the refreshing light of early day, the streets had hues of artistic dreamtime—a mixture between soft pastel paints, lively greenery and red, dusty sand. Without romanticizing it, Eldos had a beauty to it. Eldos came to life in the early morning sun. Each beautiful little scene, fleeting as the taxi rode past it. My eyes were pulled to one thing after the other, unable to fully capture it in the moving vehicle. But straight ahead, Main road grew sky-forward. We passed Eldomaine Primary and then bent towards what use to be Shoprite. Upon waiting for pedestrians to cross, I was able to look upon a space that was once so vibrant and busy. The smell of hot, oily potato chips, hair relaxer and burnt hair flooded back into my mind when peering upon a local takeaway and a hair salon I visited when I was younger. My hips swayed as the taxi abruptly went over the speed bump and the moment passed. We passed the power station and headed towards Blue School. To my right lay the institution determinant of life and death in this community—the police station. The institution which bred the murderer of Nathaniel Julies. The community’s mourning is still palpable. Not far across from it was his home. The Hilbrow flats. Each yellow flat had a satellite as an appendage which advertised the commonly known brand of medicine, “Lennon’s”. At the foot of the flats, colourful laundry waved. I couldn’t help but to wonder about the people who put on, took off and washed these clothes every day; who slept in these clothes and in them, ran down, in and around these flats. What were their lives like?

As we drove further down Main road, the sand became dryer and the trees barer. The stands became smaller, yet more populated by different families. Situated in houses that were already built shoulder to shoulder, were smaller houses made of corrugated steel. Next to it a cemetery of old cars. Number 16 had what looked to be a blue, rusty 1950s ford in the yard. It was parked right in front of one of four steel rooms, encapsulated in one stand.

Finally, the taxi stopped in the right lane, on the corner of Turf Avenue and John Scot road and I stepped out into a busy, bustling scene. The street was a marriage of sounds, from hooting taxis to chattering and hollering. I crossed Main road and stood at the foot of John Scot road. My destination lay at the end of it. The street was full—not just with people but with sounds, smells and sights. The street is the most private of public places—a nook of the communal intimate positioned well within the public. All around were mixtures of moments of kind gestures, fleeting smiles, suspicious looks and sharp stares. Such moments reminded me of both my inclusion and exclusion to the space. At the neck of the street, right across an unkept park, lay nestled Ouma Yvette's house. It was still inside. The curtains were drawn but the washing machine shook and rattled outside the kitchen door. That was the only indication that she was home. Her house belonged to neither Extensions. It sat on the back end of Extension 8 but on the very cusp of Extension 9—what used to be Kliptown.

History of Kliptown and Eldorado Park

“The leftover, back ends of nothing” (Bremnar, 2004, p. 319)

Cramped shacks and old ramshackle farmhouses compete for space, all reminders that Kliptown used to be occupied by white dairy and fruit farmers, amongst many other residents. The rural label stood in place for areas that were once known as Vaalkamers, Geelkamers, Paddavlei and Tamatievlei. The area leaks into current Pimville, Dlamini, Moroka and Eldorado Park (Roux, 2009). In the middle of the area today, lay Freedom Square, or now known as Walter Sisulu Square. Kliptown is located 25km from the centre of Johannesburg and today forms a part of Soweto. The area is best known as being a place where the seminal document of the liberation movement, the Freedom Charter, was signed. *“The People Shall Share in the Country's Wealth!”*, *“There Shall be Houses, Security and Comfort!”*, *“The Doors of Learning and Culture Shall be Open!”* (Roux, 2009, p. 12). These words are the marrow of Kliptown. Despite a history of resistance that preludes 1955, the “Congress of the

People” and the signing of the Freedom Charter is the historical event that Kliptown is remembered for. Johannesburg Development Agency (JDA) developments, have literally carved an official version of the area’s heritage in stone. In this sense, Kliptown acts as a repository of ‘official memory’, one designed as a part of a larger project of nation building in the new democratic era (Roux, 2009, p. 34). Writings about Kliptown outside of this etching is limited and scarce. The history of resistance before 1955 has largely been ignored and omitted in writings on the area. While the events of 1955 deserve to be commemorated, the area carries with it a deeper, richer history; one that made it possible for the Congress of the People and the signing of the Freedom Charter to take place in Kliptown. It is a unique place with a multi-layered political, social and spatial history.

In 1903, Alfred Milner, the British High Commissioner in South Africa, was appointed to lead the “Johannesburg Insanitary Area Improvement Scheme”. The Commission’s enquiry was sparked by fears of the spread of bubonic plague outbreaks as a result of “overcrowding and unsanitary conditions” (Roux, 2009, p. 13). Reports at the time detail the “slop-sodden” and “filth-bestrewn” ‘Coolie’ location that engendered a sense of fear in the minds of the commissioners (Roux, 2009, p. 13). Their primary concern was not that the area was unsuitable and sanitarily uninhabitable, but rather that the plague would lead to further contamination of the rest of the city. The ‘Coolie’ location and the adjacent areas were seen as a contagious lesion on the face of an emerging, prosperous city; a marker of “pestilence and rot” that festered amidst the blooming mining hub (Roux, et al., 2014, p. 13). The need for segregation was therefore driven by containment and sanitation metaphors. The commission concluded that the area was “past praying for” and should be dealt with by rehousing occupants and razoring down the area (Roux, 2009, p. 14). At this time, the area next to the Klipspruit river, now occupied by Kliptown, Nancefield, and Eldorado Park, consisted of scrubby farmland located well outside of municipal and city borders. It was occupied mostly by white dairy farmers. In the wake of the commission, it was decided that the inhabitants of the former ‘Coolie’ location were to be moved to an “Accommodation Camp” built on the banks of the Klipspruit river. This was the official beginning of the area known today as “Kliptown” (Roux, et al., 2014, pp. 14-15). It was proclaimed in 1903, with its most early inhabitants transported in 1904. The township was particularly interesting because it was outside of the city’s boundaries and therefore did not fall under City Council jurisdiction. In this way, Kliptown was shrouded in territorial mystery. For a long time, Kliptown was not charted on municipal records but was

instead known as spaces between Klipspruit, Klipriviersoog farms, and the south-eastern edge of Soweto.



Figure 1 presents a map of the space that characterised Kiptown. Kiptown was not charted on municipal records but was rather made up of spaces between Klipspruit, Klipriviersoog Estate, Soweto and Eldorado Park.

Source: (Roux, et al., 2014)

(Roux, et al., 2014, pp. 319-320).

Bremner (2004) asserts that Kiptown has always been conceived by the state as a community of “surplus people living in leftover space” (Bremnar, 2004, p. 522). Removing people out of the ‘Coolie’ location and into Kiptown was a convenient means of forgetting that they were there, deflecting the supposed danger of their presence in the city (Bremnar, 2004, p. 523). From its inception, Kiptown has officially and physically been distant from the administration of the city. As a consequence, it served as a freehold area, similar to that of Sophiatown and Alexandra, pre-Group Areas Act. Kiptown’s freehold roots have arguably contributed to the sense of autonomy and independence still felt over a century later (Roux, 2009, p. 15). Due to the relative freedom of the area, Kiptown became an attractive place for people all over the country. It grew into a thriving cosmopolitan with a bustling informal and formal commercial centre, home to a diverse group of people (Roux, 2009, p. 15). Roux (2009) notes how since, at least, the 1920s, Kiptown has been a centre of commercial activity. This has contributed to its atmosphere of a small, self-sufficient town, rather than a domiciliary suburb of the city. It was a thriving commercial centre in its own right—this is heralded by many residents (Roux, 2009, p. 42).

It was particularly known as a safe haven for inter-racial couples who were able to evade apartheid legislation that would have otherwise hindered them to live together in other parts of

the city. Thanks to Kliptown's 'Peri-urban' status, it slipped under the radar of the apartheid state to a limited extent. Many apartheid era edicts were simply ignored or flouted (Roux, 2009, p. 15). An example of this is how the Group Areas Act mandated that the area be classified as a white zone [and soon after a Coloured zone], leaving residents to sell their land and move but many residents illegally stayed in Kliptown. This was possible because unlike in Sophiatown, forced removals did not occur here to the same extent (Roux, 2009, p. 16). The geography and spatiality of Kliptown posed a challenge to the apartheid state's need for strict control over the categorisation and dispersal of people; so, as a place where people could somewhat bypass apartheid's-imposed boundaries, Kliptown was characterised a space where apartheid's ideology of racial segregation could, to some degree, be subverted and challenged (Roux, 2009, p. 37). It is its very unfettered nature that grounds the Congress of the People (CoP) and the signing of the Freedom Charter.

Despite its history of resistance and independence, Kliptown was not entirely able to escape the machinery of apartheid. Although many evaded residential laws, many were relocated to areas such as Eldorado Park. People were not necessarily forcibly removed but offered homes in nearby Eldorado Park. This happened at the same time that certain areas in Kliptown were razed down due to them being designated as "slum areas", hence the move of people from Kliptown to Eldorado Park (Roux, et al., 2014, p. 325).

An even deeper dearth of writing exists on the history of Eldorado Park. What is written on the formation of Eldorado Park is written from the economically dogmatic viewpoint of Malcom Lupton. Lupton credits the "Environment Planning Act of 1967" to the development of Eldorado Park. Lupton notes that a significant aspect of this legislation was defining the term "factory extension", referring to the increase in the number of a firm's black African employees. "The Act required ministerial permission to be granted before any new factory extensions could occur" (Lupton, 1993, p. 37). The Act did however create new employment opportunities for people classified Coloured in the Johannesburg region. Unhindered by influx control measures and pass laws, Coloured labourers flocked to the city in search of new opportunity. What this created was a housing crisis for Coloured people (Lupton, 1993, p. 37). Therefore, provisions for Coloured housing in Johannesburg assumed top priority at a local state level and a working-class suburb was designed, built and managed as a Coloured zone under the Group Areas Act. Development of Eldorado Park commenced in 1963 (Lupton, 1993, p. 37).

The department of Commercial Development acquired 148 hectares of cheap farming land which was expropriated from white farmers. The isolation of the land made it unattractive to private investors and therefore, 697 white properties were purchased and proclaimed by the state as a Coloured zone and were purchased (Lupton, 1993, pp. 37-39). By 1965, the first 200 sub-economic houses were built. The lowest possible costs were spent on housing people. The suburb was not necessarily planned as a whole but rather extended when needed, to alleviate the mounting housing crisis—hence, the progressive development of Eldorado Park Extension 1-10 and Klipspruit 1 and 2 (Lupton, 1993, p. 38). As aforementioned, when Kliptown came under the management of Community Development Board, their tenure was known for periodic shack and slum clearances, leaving residents with no option but to move to Eldorado Park. This process is laden with pain for many, pain very scarcely documented (Roux, et al., 2014, p. 325). As Judin, Roux and Zack note,

“They started moving us to Eldorado Park in the 60s. Little by little. It wasn’t a big mass like Sophiatown. They started moving but there was a date on which it was finally expropriated because we were amongst the last to leave and (we were) paid peanuts – for our massive house and big stand. Our neighbour was put into one of those flats there and because she was not used to living in a flat with lots of children, she committed suicide” (Roux, et al., 2014, p. 325).

Many families still speak of Kliptown as a familial home with a connection to both the people that live there and the space, despite physical distance. “We were a family. Whenever we meet at funerals, we know that we are old Kliptonians” (Roux, et al., 2014, p. 326). Thus, Eldorado Park, a community which not only consisted of flocking workers but families moved from Kliptown; carries with it remnants of a Kliptonian spirit. It is not necessarily an extension of Kliptown, and rather a community in its own respect; but it still carries with it interconnections between its people and Kliptown. Exploring these interconnected histories is very important in situating the stories of *Voetvroue*. It helps further contextualise why Ouma Koekie was trained by a nurse in Kliptown and why Ouma Cummings consulted a Chinese doctor in Kliptown, stories that will later be discussed. Therefore, although Eldorado Park is the field site of this research report, its attachment to Kliptown is an extension of the field site, as *Voetvroue* moved between both areas and interacted with players from both areas.

Fieldwork During a Pandemic

Faeenza was one of the very first *Voetvroue* I was introduced to. At first, she played off who she was upon answering the phone. She stated that she was instead, Faeenza's sister. Once I revealed my reason for call, only then did she introduce herself. Our video call took place a few days after that. What I realised was that I had pages and pages of stories but no detail to contextualise them in.

How does one gather rich data during a pandemic? How does one capture the sounds, smells and sights of places while trying to maintain a safe distance from the rest of society? How does one capture the happiness, contempt, joy, anguish or sadness on one's face when they're recalling a childhood memory? Doing ethnographic research via a Whatsapp call cannot replace immersing one's self into their field site. These are commensurate methods. Pivoting to Whatsapp requires new questions. This is not to say that virtual methodologies are not feasible and effective in their own right but they demand different kind of questions and provides different kinds of data. Questions are required to be as intimate but without being brash or inappropriate so that one can squeeze out as much ethnographic detail possible. Such a pivot involves loss and grief for one's research. What does this look like in a final write-up? I missed out on spending time with my participants in a meaningful, warm way. It robbed my participant of the comfort of their own space and means of communication. It reduced conversations to cold and almost fatiguing online interactions that had to be cut short because no one enjoys prolonged periods of harsh blue light or issues with connectivity. While a bulk of the data was gathered, we were robbed of happenstance encounters and spontaneous trips to family or friends they believed could help better. It must also be made clear that the issue of access has been an insurmountable hurdle for my participants. This goes beyond just access to cellular data but as far as cellular devices. Altering one's field site to a virtual one did not necessarily raise questions of "how am I going to do this project?", but rather questions about what data looks and feels like, what the absence of such data creates and how does one go about harnessing the texture of online data. How do we write the environment by watching it from the opposite end of a screen?

Faeenza invited me to collect something outside of her house upon our second interview. I took this opportunity to walk from the top of Eldos, through to Extension 2, where she lived. Upon arriving at her house, a brown paper bag with a bottle inside awaited outside for me. It was still warm. She left a note reading that it was freshly boiled *Kruie*, good for overall general health

and wellbeing. While she did not include the ingredients, this was a powerful gesture that required effective rapport grafting before we got to this point. It required addressing her in Afrikaans, addressing her as “Aunty Faeza”, many phone calls prior to formal interviews and opening up myself to personal questions so that she could assure I was not there with ill-intent.

Despite my reservations, I drank a sip of it. It was bitter. It did not taste like overall wellbeing but sure tasted like health. I took the rest of time to peer into Faeza’s yard and explore her street, trying to imagine the routes she’d walk, the friends she’d visit and the taxis she’d catch. In subverting the loss and grief pivoting to Whatsapp audio and video calls has created, a combination of telephonic semi-structured interviews, observation or “walk-about” were employed. My telephonic semi-structured interviews, or non-directive interviews (SSIs) were conducted using a prearranged initial set of open-ended questions. I interviewed eleven *Voetvroue*; Aunty Faeza and Aunt Rose, Mimi and Aunty Zee, Aunty Lorrel and Ma, Ouma Koekie, Ouma Yvette, Aunty Lola, Aunty Ivy and Mrs Basson; most of whom either lived in Eldorado Park or grew up in and around Eldorado Park. They all were between the ages of forty-five to eighty-seven. Each woman acts, or has acted, as a *Voetvrou* throughout their lives. While they may not have called themselves *Voetvroue*, they are called *Voetvroue* by others. This is how I came to my sample group—being recommended to them by those who call them *Voetvroue*. My previous research has allowed me to enter into a network of healers and seekers. It is through my previous participants that these *Voetvroue* were both recommended and introduced to me.

Considering the recent and long-lasting pandemic as well as the age of my participants, face-to-face interviews would have been far too risky and could have presented many ethical and legal dilemmas. Therefore, I opted for telephonic and WhatsApp video call interviews. I was able to contact younger relatives of the *Voetvroue* who did not have access to a smartphone or a landline. Although my participant information sheet and consent form were sent prior to the interview, each interview began with me reading out the two forms. After clarifying what everything meant and gaining verbal consent from the *Voetvroue*, I began the interview. Each interview began with a pre-arranged set of questions that was centred around their roles as a *Voetvroue*, their sources of knowledge and their methods and recipes. Although there were set questions, conversations branched out into many different directions, deepening their narratives and providing extra information, apart from the information that the questions sought to collect. From these interviews, I learnt about the histories of these *Voetvroue* and their

encounters with healing—how healing was done, who healing is learned from, their own personal encounters with healing and care, the recipes they brewed, the *Kruie* they used and their overall experience of *Voetvrouery*. Each interview lasted for 30 minutes to an hour. A follow-up interview was done in most cases. The general length of the interview was kept short due to fatigue that being in front of a screen created. In total, I conducted two to three formal interviews with each participant. This is aside from pre- and post-interview calls, which were necessary for establishing rapport and maintaining relationships with these participants during and beyond this research.

Accompanied by the interviews, I obtained permission from *Voetvroue* to walk around the area that they lived in. I had asked permission to walk in and around their street as a part of contextualizing their setting. In each case, verbal consent was given, however, street names and numbers have been changed from the onset of note-taking for purposes of anonymity. In the case of Aunty Faeza, a bottle of brewed *Kruie* was left outside of her gate for me to try. What do we call this? Socially distant participant-observation?

The collected data from interviews and walk-about were used in tandem with a small degree of auto-ethnography, as well as archival research to co-create rich and thick descriptive field notes. However, the feeling of loss is very evident in the work produced. Online interviews and walk-about have provided surface-level texture but they don't begin to capture the intimate spheres *Voetvroue* have existed in. There is a lack of an 'unspoken' element to fieldwork—the awkward silences, the moments of joy and laughter and how these emotions revealed themselves in different parts of the body was uncapturable. The field notes that came out of field work descriptively detail the environment *Voetvroue* are wrapped in, but not what their cocoon looks, feels, smells and sounds like. Nevertheless, after a process of coding and memo'ing were done, themes from these fieldnotes were drawn. These themes include *Voetvrouery*; the “when”, “who” and “why” of care; *Kruie*; the “how” of care. My research report centres around these themes.

Voetvrouery in Eldorado Park

The blocks of flats in Eldorado Park rise in monotonous similarity from patches of green, soggy land that separate them from the stand-alone houses. Rows of trash border the identical buildings. Their main entrances are indistinguishable. They are a trace of apartheid's racialised 'sub-economic' housing in which residents are left to create some measure of functionality. The drainage system is held together by an old Clover milk bottle, fashioned into a pipe that is crudely attached with wire. Each block of flats carves a trail of its own, much like the people who live in it. With feet sunken into one such sandy trail I follow the pathway to Aunt Rose's ground floor unit of a three-story building. Like the main entrances, each unit is fitted with an identical front door. "*Sien jy die deur met die kruis op? Daai's my huis*"¹⁴. Behind the front door adorned with the Christian symbol of the cross is the home of Aunt Rose. She sat perched on a red velvet couch, a common item of furniture in working class households. I think to myself, "*Jinne, wie het die rusbanke gemaak? Hulle't mos klom geld uit Coloured families tydens die 70s and 80s verdien because I have never been to a Coloured household who did not own a set*"¹⁵. Just by looking at them, I feel my spine contorting to find some element of comfort on that couch, much like I did on others as a child.

Two women sat behind the screen of a video call; entwined in the same history. Faeenza was clothed in a scarf. She was pressed against her Aunt, Rose, who was draped in a jersey because the only thing that kept her house warm was a small fan heater that catered to five other people that morning.

*Tamia: I guess... Aunty Faeenza se Ouma? Aunt Rose se Ma?*¹⁶

*Faeenza: Ja, waar het Ouma groot geraak? Kimberly?*¹⁷

Aunt Rose: Nee, die boere... ma was dan 'n slave Faeenza. My ma was... nege jaar [oud]. Hulle was baie kinders toe my Oupa ... dit was sy en haar twee klein susters... my Ma eintlik verkoop [het] aan die boere. Mrs De Borsch. Sy't gebly waar die zoo nou is... Parktown. Mummy het

¹⁴ Translates to: "Do you see the door with the Cross on it? That's my house"

¹⁵ Translates to: "Jinne, who made these couches? They made a lot of money off Colored families during the 70s and 80s because I have never been to a Colored household who did not even own a set"

¹⁶ Translates to: "I guess... Faeenza's grandmother? Aunty Rose's mother?"

¹⁷ Translates to: "Where did grandmother grow up? Kimberly?"

daar groot geword. Sy was... hou kan ek nou sê ... like a slave. En van daar het sy my Pa ontmoet...die madam het mos bietjie vir 'n tour nou gegaan'it. Toe die madam nou Swaziland toe gegaan dan moet my Pa vir my Ma. My ma het my Pa ontmoet en sy het getrou uit die huis uit en dan oppie... kla drie kinders gehad toe is dit die tyd wanne haar broer in die army gewees het en dan kom hy na Swaziland toegekom en sy het vir hom weer geontmoet'it. Toe vat sy haar na Kimberly toe, na haar susters toe. En so het sy gereunite weer met haar broers en susters. Maar die Voetvroue werk van haar het sy in 'n droom gekry. Haar Pa het babies gevang. Haar oorle Pa. Hy was 105. Jacobus. Ma sy het dit in 'n droom gekry. My ma het nie skool gegaan nie maar ... als vir haar in drome gekom'it. Dis wat sy vir ons gesê het en toe begin sy die midwife werk. Sy het terug Joburg toe gekom'it en dan practice sy. Maar sy was nie 'n registered midwife nie. Maar sy't mense gehelp. Emergencies. Tot op die... watter jaar was dit?... my een suster in die two in. Dis nog ons twee wat weer leef; sy het met my Ma gevat... my Ma het gaan... hoe roep hulle dit? Mondeling! Want sy kon nog nie skryf nie. Sy het mondeling gedoen vir die toets en sy was een van die tops boe uitgekom. So het sy 'n registered midwife gewees. Maar sy het vir ons gesê, sy het hande... als spiritual gekry. Maar sy het met Dr Yensen gewerk ook. Babas vang, bottles maak. Ons was klein toe die babatjies in die huis gebore. Ons het van haar afgesien. Laat ons ook ma hier gevang'it en daar gevang'it. Ja, maar ek sê jou my kind, ek kan 'n babatjie vang, dan wil jy 'n midwife issie.¹⁸ (1 September, 2020)

Aunty Rose's account of her mother's life history sets the scene for the chapter to come. It not only illuminates the very complex history Voetvroue are lodged in, such as its roots in slavery, regulation and training. It her account also brings to light themes such as the regulation of black autonomous midwives, the way in which their gift of knowledge is acquired and shared intergenerationally, infertility and birthing practices. Together with the pillars of this research, these themes are subsequently discussed.

¹⁸ Translates to: "No, the whites... Ma was then a slave, Faeenza. My mother was nine. They were many children when my Grandpa actually sold my Mom to the whites. Mrs De Borsch. She stayed in Parktown. Mummy grew up there. She was... like I can now say... like a slave. She met my Dad when the madam went for a holiday. My mother met my father and she married. They then had three children. Her brother was in the army. He was deployed to Swaziland and in Swaziland, they met again. Then he took her to Kimberly, to her sisters. She was reunited with her siblings. But the work of Voetvroue, she got in a dream. Her Dad delivered babies. He was 105 when he died. Jacobus. Mom, she got it in a dream. My mother did not go to school but... everything came to her in dreams. She came back to Joburg and then she practiced in Joburg. But she was not a registered midwife. Mom helps people. Emergencies. My siblings and I helped. It's only the two of us who are alive now. My sister and I went with my mom to... how do they call it? Oral examination! Because she could not write yet. She did oral examination for the test and she was one of the top achievers. The she became a registered midwife. Then she told us she's got spiritual hands. We were little when the babies were born in the house. We learned from her. Yes, but I'm telling you my child, I can catch a baby, but that doesn't make you a midwife.

‘It’s all in the hands’: Becoming a Voetvrou

Aunty Lola: *It’s a gift neh. This voetvrou story...my first baby [that I delivered], I was 19 years old. That morning, the father of this baby ... came and knock on the door. Early morning. Ek vra “wat, wat, wat?”. Hy sê “kom, kom, kom”. And the time when I get there...I asked “And now, what is really happening? She said, I’m waiting for the ambulance since 3 o clock this morning”. Ek sê “now you calling me?”. Ek sê vir haar “no, ek ken nie die werk nie, it’s not in my experience die”. But by the grace of God, really, he helped me through that morning. When I get on the bed, there was a voice that speaks to me. It just said “bend on your knees and help her. Ek sê “hoe kan ek nou help, I can’t help this lady. Ek weet nou nie wat gaan aan nie”. God only blessed me with this gift.*¹⁹ (4 September 2020)

Aunty Lola lives on the drier, less plush side of Klipspruit. Her house was one of two situated in a *hoekie*²⁰. It is on the left side of the main road as you travel from Lenasia to Eldorado Park. To get to her house, one had to walk a short sandy *draaitjie*²¹ that functioned as a driveway. Perched up on her couch, she described how she entered her very first delivery with no prior experience of birthing. For her, the only thing that led her through the delivery was the voice of God. Unlike other Voetvroue, Aunty Lola had not grown up around birth and deliveries. She claimed that her mother’s eldest sister was a *midwife*²², and that the gift perhaps came from that side of her family. All her knowledge of birthing and “*smeering*”²³ was ‘inherited’ from her mother’s side, stored almost in a spiritual collective unconscious that woke during times of need and was spoken through the voice of God. However, the gift of Voetvrouery is not only acquired through a sudden calling from God but also from practices of intergenerational knowledge sharing. Faeza’s maternal grandmother was a Voetvrou. Faeza had grown up in Kliptown, at a time when coal stoves, candles, paraffin lamps and long-drop toilets were the primary sources of functionality. She came from a family of four, being the second born. They lived with her mother and grandmother. Her childhood memories didn’t sound conventional.

¹⁹ Translates to: “It’s a gift neh. This voetvrou story...my first baby [that I delivered], I was 19 years old. That morning, the father of this baby that I went to go help came and knock on the door. Early morning. I asked “what, what, what?”. He says “come, come, come”. And the time when I get there, this woman was laying. I asked “And now, what is really happening?”. She said “I’m waiting for the ambulance since 3 o clock this morning”. I said “now you calling me?”. I said to her “no, I don’t know this work, it’s not in my experience this”. But by the grace of God, really, he helped me through that morning. When I get on the bed, there was a voice that speaks to me. It just said “bend on your knees and help her. I said “How can I now help; I can’t help this lady. I Don’t know what to do”. God only blessed me with this gift.”

²⁰ Translates to: “small corner”

²¹ Translates to: “a small turn”

²² It is unknown whether she held certification or was a black autonomous midwife

²³ “Smeering” loosely translated means rubbing or massaging

Every memory of *Kannetjie* and hop-scotch²⁴ was cut short by calls from her mother and grandmother to assist in washing the used bed sheets pregnant women delivered on. At an older age, these calls turned into requests for bottles of *Kruie*. She sat her bowl of Wheetbix onto her lap, held her head and with great frustration, said:

Aunty Faeenza: *I need to accept it. Because if I am not going to accept it, I am going to get sick. It's a gift... I got this gift and it just came out of nowhere. So, I have to accept. But I think it's all in the hands. The medicine you make, the rubbing you do, the children you see to because I can tell you, you can go make the same herbs but it might not work the same and it might not even do anything. So, I think it's all in the hands. It's a gift. It comes from mind, body and soul and the Lord will lead you. It's a gift from God.* (1 September 2020)

Unlike Aunty Lola, Faeenza knew she had a gift and especially knew that she could not reject it. It was possessed by the women before her. Faeenza described how her Swazi grandmother believed that her ancestors bestowed this gift upon her. Subsequently, her mother Aunty Rose came to acquire her knowledge by being sent out into the veld to look for particular herbs on the basis of pure smell. Each woman in her family was led not just by spirituality but by practice and observation—knowledge of which was cross-generationally shared from her grandmother, to her mother, down to herself. A culmination of such is acted out in her grandmother's home.

A Creolising Commons of Care

This site is more than its physical properties but encapsulates the belly of Faeenza's matriarchal line. It was not just a home, but also a rich source of intergenerational practices of care that lived and grew with time; that were watered and nourished by each generation that found themselves within this line. Key to this, however, is that knowledge, practice and *calling* is grounded and guided by their own respective perceptions of God. Against hegemonic literature on indigenous knowledge systems (IKS) and the transmission of knowledge, similarities can be seen. South Africa presents itself as an incredibly pluralist society, comprised of many systems of knowledge with their own unique spiritual cues. One of the more dominant tropes of such is the process of *Ukuthwasa*, a process of training someone who has *ubizo* from their ancestral lineage, generally communicated to them through their dreams. While there are similarities in the way in which a "calling" is bestowed and embodied, in the case of *Voetvroue*, this process does not follow the same steps. To animate the concept of creolisation at the centre

²⁴ Kannetjie and Hop-Scotch are common games that children play.

of this research report, it is important to situate the similarities and differences between dreams, callings, God and ancestors narrated by *Voetvroue* in relation to what are conventionally understood to be African rites of passage.

However, knowledge transmission does not just exist within the home and within the maternal timeline. It transcends the basic kinship network in the home and is reproduced within communal and social groups. Aunty Zee explains:

Aunty Katie was a very fit women and she used to work. She did teach us of perde pis, dassie pis, wil als. All this. She did teach me. What I know today is through Aunty Katie. How to mix Dutch medicine with condensed milk so that when you on your period, it cleans you out. It even helps you to conceive. It helps you to hit away the cancer cells. All that things, Aunty Katie did teach me. We only knew Haarlemensis²⁵ we didn't know other things like how to mix with. She taught me all that. She just took me one day when she's rubbing someone and she said "Zee, staan, watch". It's all about concentration to see what she's doing and she tells us how to rub. "voel hier, voel hier"²⁶ and that's how we came to do these things. (30 August 2020)

It was only later in her life that Aunty Zee met Aunty Katie. She consulted her due to her long-standing issues with infertility. While Aunty Katie was unable to completely treat Aunty Zee's infertility, what she did provide Aunty Zee with apprenticeship. From a young age, Aunty Zee was considered gifted by her herbalist father. This was recognised by Aunty Katie, hence why she began training Aunty Zee. Their training together was neither formal nor bureaucratic. Aunty Zee spoke of Aunty Katie as a mother, a friend and role model. Conversations about Aunty Katie ranged between Aunty Zee contagiously laughing at their days together:

You know the first day with aunty Katie. We were sitting under the tree and she said, "Zee, weet jy waar ek kan perde pis kry?" So, I thought it piss from the horse so I told her, alright. Ek sê "Justin, bring die kar. Ons gaan plaas toe". Sy sê "Wat!". Ek sê "We must go, catch a horse, put a bucket and let it piss. That's mos perde pis?"²⁷. (30 August 2020)

The conversation grew heavier the closer we got to talking about Aunty Katie's passing.

²⁵ Haarlemensis is a variant of the Lennon's brand of medicine

²⁶ Translates to: "Feel here, feel here"

²⁷ Translates to: "You know the first day with aunty Katie. We were sitting under the tree and she said, "Zee, Do you know where I can get perde pis?" So, I thought it piss from the horse so I told her, alright. I said "Justin, bring die car. We are going to the farm". She says "Wat!". I said "We must go, catch a horse, put a bucket and let it piss. That's mos perde pis?"

Much like Aunty Zee, Ouma Yvette was trained later on in life. Belonging to the Zionist church, Ouma Yvette mentioned how she already possessed a spiritual calling in her own capacity as a prophetess. This made her a suitable candidate to be trained by her sister-in-law. Ouma Yvette expressed a particular repulsion in “catching babies”, purely for reasons related to the dislike of blood, and while she accompanied her sister-in-law to deliveries, she mainly observed how to “smeer” pregnant women and cook *Kruie* to treat infertility. What I found particularly interesting is that learning *Voetvrouery* was not limited to “lay” spheres but was shared by women across professions. Ouma Koekie has no family history of *Voetvrouery*. She learned to “catch babies” and “smeer” from her sister-in-law who was a qualified nurse.

Ouma Koekie: *My sister-in-law was a midwife. En dan somtyds sê sy “kom saam”. Dan ken ek nie die werk. My skoonsuster was experienced (she was a qualified nurse). Ek het niks geleer nie, maar ek het net gekyk met my oë en. Die Here het my duur gedra. Ek het kinders wat getrou is, wat op skool is afgelewer. I said thank you to Jesus.*²⁸ (2 September 2020)

The exchange of knowledge between *Voetvroue* and their apprentices is a mangle of various forms. Knowledge is passed on from one generation of women to another. However, this process is not limited to kinship networks but extends beyond the home into inter-community networks. As illustrated by the stories of Aunty Zee, Ouma Yvette and Ouma Koekie, their ‘training’ did not come from a mother, but rather a mother-like figure, and even with this being said, it may not apply to all cases. What is clear is that the process of learning *Voetvrouery* transcends the blood line and occurs between different women, at different times in their lives, from different professions and spheres. Furthermore, this knowledge circulates primarily in and around the lives of women in this community. The gendered nature of care includes who becomes a *Voetvrou* and who the *Voetvrou* cares for. This points to a *commons of knowledge* in Eldorado Park. This is a *commons of knowledge* about care held exclusively by women and headed by *Voetvroue*. This gendered authority over care in these marginal communities challenges western, male pedagogies about midwifery since its professionalization in the nineteenth century. It also reveals a site of agency on the part of black autonomous midwives despite the growing regulation of midwifery.

Significantly, respondents use formal words like ‘training’ or ‘apprenticeship’ to talk about the processes of learning in this knowledge commons. However, learning to become a *Voetvrou*

²⁸ Translates to: “My sister-in-law was a midwife. And then sometimes she says “come along”. But I didn’t know the work. My sister-in-law was experienced (she was a qualified nurse). I did not learn anything, but I just looked with my eyes. The Lord brought me through it. I have children who are married, who I delivered.”

very different from accounts of learning and apprenticeship in what are conventionally and officially considered ‘indigenous knowledge systems’ in South Africa. According to these accounts, learning in IKS closely resemble conventional meanings of ‘training’ and ‘apprenticeship’. For example, Thornton (2009) discusses how undergoing the process of *Ukuthwasa* means to enter into a particular school, known as *Mpande*, *Lefehlo* or *Iphephlo*, where one is taught about the gift they possess, the ancestors it was inherited from, and practices of care (Thornton, 2009, p. 29). This is transmitted through a formal system of education involving “*emagobela*” (teachers) and “*bathwasana*” (students) (Thornton, 2009, p. 17). Training time ranges from two to twelve months and is often very expensive (Thornton, 2009, p. 29).

The way in which a woman becomes a *Voetvrou* is very different. ‘Training’ and ‘apprenticeship’ are not organised by a bonified, monetised institution. Instead, knowledge is shared in unpredictable ways between various actors at different times and in different ways. *Voetvrouery* or autonomous midwifery among the black women of this study is not rooted in a set traditional symbolic form or order. There is no clear rite of passage nor are there a set of steps, rules or protocols for becoming *Voetvrou*. This is not to say that *Voetvrouery* is any less formal. Instead, *Voetvrouery* is an amalgamation of skills learned and spiritual cues elements of which are shared with what is conventionally understood as African indigenous knowledge systems, on the one hand and on the other, which escape representations of these systems. The trope of ‘rites of passage’ is present in the stories of *Voetvroue* but so are methods of learning that might not formally be considered such a rite. During this research, learning to be a *Voetvrou* emerges as an unpredictable, creolised, layered, process: a bricolage, a *mengelmoes*.

‘Making Bottles’ and ‘Catching Babies’

Aunty Lorrel: *You are the only one with the womb and when a baby is being conceived, you are the one that is protecting it. The man is only the sperm donor. Men never used to admit that they had a problem. All they wanted was a baby and they counted that maybe in three months’ time or four months’ time. Not even in the olden days but even now. If you have a boyfriend and he wants a baby and he says to you, within four months’ time, you need a baby and you know you are not ready but you love him, number one, and because the way he’s persisting about it and his family also... you know how they say... anders floek. “cement pants”, “kannie kind kry”. Nou voel jy inferior. So now out of your own, you’ll duck and dive for a child. Because during that time there by the clinics, daar*

*was nie van pille gee om baby te kry en al daai goete. Daar was net die voetvrouens so you needed to help and assist yourself.*²⁹ (30 August 2020)

Diedre Owens (2017) situates midwifery during antebellum slavery within a historical genealogy of sexual violence and exploitation, at the hands of the white medical world emerging in the nineteenth century. Antebellum-era slavery presented a specific moment for medicine because the value of a black enslaved female rested on her ability to reproduce and maintain the slave labour force, hence the close relationship between gynaecology and slavery (Owens 2017, 45-47). In a time where enslaved black women were defined and exploited by how well they reproduced, Owens holds that their reproductive power also becomes a site of sophisticated agency, in which the black midwife plays an important role. Enslaved women resisted the efforts of their slave masters laying claim to their "souls" by sharing long-held traditional beliefs and practices that were embedded within their indigenous African homelands (Owens 2017, 50). Albeit at a later time in history, Indigenous Doula [particularly work done by Doulas who did not register with DONA] work is positioned and based within a plethora of different cultural practices (Ireland, et al. 2019, 54-55). Within the realm of the autonomous Doula, poorer women can gain access to traditional treatment outside of intervention and standardization. This includes the treatment of infertility, of the aftermath of miscarriage, and performing abortions. Autonomous midwives of the antebellum slave era and indigenous doulas of ...century are cohorts of black women on the limns of racially regulated society who find refuge in their agency. Stories of infertility treatment in Eldorado Park bring this discussion to life in a contemporary setting.

Ma and Aunty Lorrel live on the outskirts of Eldorado Park, closer to what we know as Nancefield. They were wedged between Eldorado Park and Klipriversoog. They initially resided in Alexandra but were forcibly removed from Kliptown in the 1950s. By the dawn of democracy, they found themselves in Eldorado Park. Ma was just as old as the springs.

Aunty Lorrel explained that Ma became a *Voetvrou* at the age of thirty-six. She was taught how to 'make bottles' and 'catch babies' by her cousin, Aunt Ba, and she specialised in the treatment of infertility, an important subject for almost all *Voetvroue*. She described Ma as being "in the business of making life". This sentiment is expressed by all respondents in this study and might

²⁹ Translates to: "... you know how they say... others swear. "cement pants", "can't get a child". Now you feel inferior. So now out of your own, you'll duck and dive for a child. Because during that time there by the clinics, there was no pills to get babies. There were only voetvrouens so you needed to help and assist yourself."

explain why all respondents vehemently opposed performing abortions. Because their gift is premised on giving life and not taking it away³⁰.

For almost thirty years, Aunty Ivy, lives on the opposite end of Ma and Aunty Lorrel's flat. Her anecdotes brought her experiences to life:

Aunty Ivy: *Daar was nou 'n man wat met kruie van die berge afgekom 'it en ek het dit gemaak. ... my broer's se kind... weet ek maak kruie. Ek los 'it in die yskas in 'n kooldrank bottle ne. Hulle drink die kruie, hulle dink dis coldrink toe's hulle weer pregnant. ...Ek het gesê dis nie coldrink nie. Dis bottles vir babas! ... Kom kyk, hulles al drie pregnant van steel.*³¹(11 August 2020)

Aunty Ivy's stories also revolve around the treatment of infertility. Before coming to Johannesburg and settling in Eldorado Park, Aunty Ivy lived in Wentworth where she was born. She detailed how she learnt how to 'make bottles' and 'smeer' from a very young age. In the same way her mother assisted her in bearing children, she assisted her daughter. She explained that before her daughter [Jody] gave birth to her grandchildren, Jody visited her for infertility treatment. First, Aunty Ivy rubbed Jody's lower abdomen to feel if her 'tubes' were suitable for reproduction. She then prayed over her lower abdomen. Afterwards, she boiled and bottled a mixture of herbs and Lennon's for Jody to drink. This standard procedure of 'cleansing the body' was key in treating infertility:

Aunty Ivy: *...ek sal laat jy in kom, dan smeer ek, en dan sal ek voel waar en die tubes. Dan sal ek jou meer smeer en kruie gee. Dan moet jy twee of drie keer terug kom. Ek sal die kruie koop of pluk en ek sal dit gee sodat jy 'n baba kan kry. En in al wat ek doen, moet ek bid en bid en bid.*³² (11 August 2020)

³⁰ The topic of abortion was touched on in each interview. The topic aroused strong feelings in each of my participants. For the purpose of rapport, I did not dive into it further. Common sentiment was expressed that while they are not opposed to abortion, they refuse to perform it. They all held that their gift was given to nurture new life. They felt that it was wrong to step out of this scope and take life. There were many ethnographic stories about their encounters with abortions, however, there is very little room to discuss it within the scope of this paper.

³¹ There was now a man who came down from the mountains with herbs and I made it. The others are naughty. Now look, my brother's child. They know I make herbs. I leave it in the fridge in a soft drink bottle. They drink the herbs, they think it's a cold drink and then they got pregnant again. You have to ask what is this. Now they thought it was fanta grape or something. I said it's not cold drink. These are bottles for babies! Then they drank. Come see, they all three pregnant because they wanted to steal. You have to ask "Mama what is this".

³² Translates to: "All I do is I will let you in, then I rub feel for the tubes. Then I will give you more rubs and herbs. Then you have to come back two or three times. I will buy or pick the herbs and I will give them so you can have a baby. And that's all that I do, I must pray and pray and pray"

A Commons of Care

Practices involved in becoming a *Voetvrou* animate H&N notion of ‘the commons’. First, *Voetvrouery* is done on the margins of patriarchal power within the community and on the margins of official medical practice. Through these social practices of care *Voetvrouery* establishes modes of sociality specifically among women in these communities. Refuge for the women receiving care.

When asked if both partners were treated for infertility, Aunty Ivy responded by saying that she allowed it entirely but often, it would just be women who sought help. Aunty Ivy mentioned how she was often asked by her patients, to keep visits confidential from so that her husband or his family did not find out that she sought treatment for her inability to conceive. Aunty Lorrel also detailed how visits for infertility treatment were kept in confidence. In her dialogue above, she explained how women sought help out of fear of judgement and stigmatisation. This is the point that really ties Aunty Ivy, Aunty Lorrel and Ma together. Women visited these *Voetvroue* in hopes to somehow subvert shame and stigmatisation attached to infertility.

These treatment processes are gendered. Men can accompany their wives for joint treatment. But *Voetvroue* treat women only. These women secretly consult a *Voetvrou* because their known infertility is stigmatised. Labelled “concrete pants”, these women are shamed by their husbands and his family. This narrative resonates with Ross and Pentecost’s argument that shame is used to discipline and punish the hyper-responsible and hyper-moralised maternal body. In this context, black women were meant to understand their bodies as for the reproduction of a cheap labour force. The maternal, reproductive, and lactating body thus becomes a site for the mundane transactions of politics and power (Ross & Pentecost, 2019, p. 2). This is evident in Eldorado Park. Patriarchal normativity in this community brings women whose bodies are considered infertile to the *Voetvrou* for assistance.

However, much like the relationship between the midwife and the slave, and the indigenous Doula and the community, the *Voetvrou*’s ‘consultation room’ is a site of confidentiality and refuge from stigmatization and shame. There is a larger debate to be had here about the mechanisms of shame and discipline and whether the help of *Voetvroue* indirectly perpetuates a patriarchal status quo. Women are afforded a space to enact their agency, but to what limits and to whose benefit? These women remain trapped within a patriarchal, bio-political matrix. Does secretly seeking infertility treatment subvert or legitimate this matrix? Are *Voetvroue* indirectly complicit in reproducing relationships of dominance? There is also something to be

said in the way infertility treatment administered by *Voetvroue*, feed into broader bio-political projects. The state directly benefits from their work without contributing to either their ‘training’, ‘equipment’, or labour. These are important questions. However, it is equally important to remember that *Voetvroue* do not claim that their work topples structures of power. Respondents are acutely aware that they provide little carved out nooks in a society where marginalised women can give and receive care. Drawing on Hardt and Negri’s (2009) idea of ‘the commons’, I conceptualise this practice as a ‘*commons of care*’.

‘In the business of delivering life’:

Huis-Hospitale, Emergency Home-Deliveries, and Placental Rituals

Faeenza recalls her childhood Varraflei. She remembers her reluctant response to her Ouma’s call for assistance to collect the dirty sheets, put them in the *wasbak*³³ outside, and tramp on them with clean feet, until the sheets turned white again.

Much of Faeenza’s childhood was characterised by feelings of annoyance and dispiritedness, especially on that particular day. she had to gently tip-toe between different women and collect their sheets. She was quite irate at how her days revolved around women who would spend months on end there, without so much as a bag of potatoes provided. There was barely any space to walk and that is probably why they sent a child to collect sheets.

Die Huis-Hospitaal

She describes their home in Kliptown as barely big enough for her own family to live, let alone to function as a *huis-hospitaal*. This was her every-day. Constantly encountering pregnant women, who would stay for weeks on end until their babies were born. They occupied most of the space in the house, leaving Faeenza and Aunty Rose subject to the pantry as a place to lay their heads.

Catching babies was a norm in the lives of Faeenza and Aunty Rose; so much so that they took it on once Ouma deemed them fit enough. For them, birth and delivery happened in the *huis-hospitaal*; a centre of care that women from the community would be ‘booked’ into until they gave birth. No general timeline was known so they operated on the premise that birth would occur at any given moment. Because the space was so populated, women were forced to give birth in the very spot they spent weeks in. If it was the case that they received the bed, they delivered there. However, if it was the case that all they could receive was a mattress on the floor, they delivered there instead. It worked on a first-come-first-serve basis but they were best catered for.

³³ This is a bucket used for laundry.

During delivery, Faeenza and Aunty Rose note how they did not administer any pain medication in fear of the side effects it may have, especially considering that most of the time, they did not know the history of her patient and the condition of the foetus. What was instead administered was strong, black coffee. This was not only used for pain management but also to induce labour in certain instances. Birthing was not done in any particular position for any particular reason. Rather, it depended on the space available. True to Davis-Floyd et al (2001), it is inaccurate to view ‘lay’ midwifery as biomedicine’s ‘evil twin’ and simultaneously inaccurate and demeaning to romanticise it as a realm where no wrong occurs. The process of delivery was dangerous and volatile:

Aunty Rose: *Nee, dit was hard my kind. First of all, we only knew how to deliver babies because my mother was mos qualified. Jy moet die kop hou, draai die kind om, maak laat die skouer uitkom, dan ruk jy. And unfortunately, not all babies survived. Een minute huil die kind en die next is die kind lui. Dit was nie easy nie en die huis was altyd vol van swanger ma’ens. Kyk, daar was een aand, mama ‘n baby gaan vang by Mr Hajee, daar agter onse straat gewees en dit was net ek en my groot broer by die huis. Toe’s daar ‘n vrou ook by die huis wat ‘n baba kry. Aunt Mama was haar naam. Ons try om die baby te kry. Ons weet mos wat om te doen, maar ons kan nou nie hier kom om die slym uit die mond uit tehaal nie. Ons haardloop. Toe my ma kom het sy net so gemaak, toe haal sy die slym uit. We saw all kinds of things man. Hou noem jy dit? We called it a jelly baby. Dan moet jy die kind dokter toe vat om die skin te prick sodat die water kan uitkom. Ander tyds kry jy vrouens wat druk en druk maar niks kom uit. Jy sê mos ‘n phantom pregnancy. Ons het als by die huis gesien man.*³⁴ (1 September 2020)

Aunty Rose describes how they had a standard process of delivery because of her mother’s training as a midwife. They would ensure that the head of the baby was firmly held. They then turned the baby around and gently pried the shoulder out. The rest of the body would follow. Her experiences of delivering babies were filled with varying kinds of scenes; from still-borns to “jelly babies” to babies born with *hydrops fetalis*. She particularly details how delivery went

³⁴ The dialogue reads “No, it was hard my child. First of all, we only knew how to deliver babies because my mother was mos qualified. You must hold the head, turn the child over and make the shoulder comes out then you pull. And unfortunately, not all babies survived. One minute the baby is crying and the next it is still. It was not easy and the house was always filled with pregnant mothers. Look, there was one evening when my mother left to catch a baby by Mr Hajee’s daughter behind our street and it was just myself and my brother at home. There was also a woman, her name was Aunt Mama. We tried to catch the baby. We knew what we had to do but we could not get the slime out of the mouth. We ran to my mother and she came back to remove the slime. We saw all kinds of things. What do you call it? A jelly baby. Then you have to take the child to the doctor to prick the skin so that the water can come out. Other times, you get women who push and push but nothing comes out. You call that a phantom pregnancy. We saw everything at that house”

either way for both the mother and the child. Faeenza described it as having one foot on the earth and another in the grave and this was an everyday experience for Faeenza and Aunty Rose. The *huis-hospitaal* housed varying experiences of birth all of which I cannot fully articulate in the limited space of this research report. The stories narrated by respondents are raw, real and ghastly. Regardless, the *huis-hospitaal* served as a communal space, held in common by women in the Kliptown/Eldorado Park area.

Importantly, it was a non-monetary practice. Women who sought care could do so without costs incurred. In this regard, *Voetvroue* such as Aunty Rose and her mother, availed themselves *to* a community of women and solely *for* a community of women. The *huis-hospitaal* is a space of refuge for women in context of limited access to public maternity healthcare facilities and for *Voetvroue* who were actively side-lined by the biomedical sphere. Midwifery regulation and control have historically run along the explicit lines of race, gender and class morphing those deemed acceptable into a palatable class of subordinate birthing assistants, and rooting those deemed the very opposite, out. However, in the very midst of this history, black autonomous midwives have continuously carved out a place for themselves and for the women they serve. The *huis-hospitaal* is the physical space for *a commons of care*. However, not all births took place in a *huis-hospitaal*.

Emergency Home-Deliveries

For other *Voetvroue*, like Ma, Aunty Lorrel, Aunty Ivy, Ouma Yvette and Ouma Koekie, they did not have the privilege of waiting on babies in their own constructed *huis-hospitaal*. Rather, they were called out to the home of the mother on the day of delivery. As soon as their patients could define what they were going through as labour, the *Voetvrou* was called. Ouma Yvette described how during one instance, she was woken up at 3am in the morning to help deliver a baby at the home of one her patients across Eldorado Park. She recalled rushing to get dressed appropriately because on that particular morning, overnight temperatures dropped to as low as -2 degrees Celsius. All that she left the house with was her pre-made bottles of *kruie* and her coat and headed to a motorbike that would transport her to the home of the mother. Attached to it, her sister-in-law in the side car. Ouma Koekie also described how before she started delivering babies alone, both herself and her sister-in-law would travel to different parts of the city to deliver babies. She describes travelling to the “locations”, in the east, to help deliver babies. Aunty Ivy only served her block of flats. She said that it made it easier to act in an

emergency if her patient was a few doors down rather than a few extensions down. Like Faeza and Aunty Rose, on-call deliveries were just as dangerous and volatile. Aunty Ivy explained:

*Aunty Ivy: Kyk nou hier onder, Dit was nou twee maande terug. Dit was half past ten, eleven a clock in die aand, ek het die ambulance gebel 'it toe sê hulle nee, iemand moet haar help. Sy was bang om op te staan. Ek moet met haar hard praat sodat sy kan opstaan. Sodat ons kan net die kind uitkry, die cord afhaal en die after birth uithaal. Sy was so bang. Ek was bang jong! Nou nou sterf die baba. Ek het gesê dat sy moet asem haal en haar arms opmaak so ek kan alles regvoel en as sy te styf is, gaan die agterboorte terug toe en dan is it trouble vir haar. Ek sê "Jy moet jy hande op maak sodat alles kan uitkom". Die baba het luckily vuilig uitgekom en ek het dit toemaak en vir die ambulance gewag.*³⁵ (10 August 2020)

Aunty Ivy described her instances of birth as emergencies and not necessarily planned events. For many of my participants, they had to perform deliveries because the ambulance often did not arrive on time, or at all in some cases. As mentioned earlier in the chapter, Aunty Lola's first delivery was the result of an ambulance not arriving on time. Ouma Koekie stated that the reason she undertook the task of delivering babies was because "die ambulance in Kliptown was treurig"³⁶. Aunty Lorrel explained that one was lucky if they were called a day or two in advance for deliveries. For Aunty Lorrel and Ma too, they were called out in times of emergency. Her stories and overall tone resembled this.

Aunty Lorrel spoke with urgency. She sat on the very edge of her couch, animatedly explaining to me the process of birth. She flattened her hands out and motioned exactly how blankets and plastics sheets should be laid down before delivery took place. This was done so that blood did not leak on to the mattress, floor or couch and so that it kept the environment warm and insulated. She explained how during those times, latex gloves were not readily available so one did everything bare-handed. The only thing available to her and Ma was *Savlon*, warm water and salt. Birthing did not necessarily have a specific position to it. Ma and Aunty Lorrel allowed their patients to bend, squat, lay or sit in any position they felt comfortable in. Aunty Lorrel

³⁵ Translates to "Now look below, it was now two months back. It was half past ten, eleven a clock in the evening, I called the ambulance when they said no, someone has to help her. She was afraid to get up. I need to talk to her loud so she can get up. So, we can just get the baby out, take off the cord and take out the after birth. She was so scared. I was scared young! Now now the baby is dying. I said she needs to breathe and make up her arms so I can feel everything right and if she's too stiff the backbone goes back and then it's trouble for her. I say "You have to put your hands up so that everything can come out". The baby came out luckily dirty and I closed it and waited for the ambulance".

³⁶ Translates to "The ambulance in Kliptown was pathetic".

was also wary of administering pain medication and never did. Like Faeza and Aunty Rose, pain was managed with strong coffee. Its benefits were not known by Aunty Lorrel. She said she did it because Ma used to do it and that was affirmation enough.

Aunty Lorrel stated that the only way she knew the baby was close was based on the time between contractions and the length of the cervix. She said that once the cervix was as wide as one's left hand, delivery was near. In preparation for the baby, additional blankets would be laid out and she would sterilize everything needed post-delivery. She never made mention of how she felt while delivering the baby. She was quick, hasty and direct about everything that was done behind the scenes. Perhaps her lack of expressing joy towards delivering babies was clouded by the urgent and stressful conditions she worked under. She emphasised: "*Ons het 'ie tyd om te mors nie. Ons moet die baba net vuilig uithaal. We are in the business of delivering life here*"³⁷. Joy or pride was often expressed well after the event of delivery by my other participants. Ouma Koekie and Aunty Lola boasted about the babies they delivered who are all grown and romp around the community.

Gifts to 'keep one's path open'

Much like the *huis-hospitaal*, all of my participants who performed house deliveries described how they did not charge women for it. Aunty Ivy mentioned how *Voor as iemand vir my toe kom of ek daar toegaan dan wys die here dit vir my. Ek help mense, al wat... net vir even 'n R10, net om my pad oop te maak*³⁸ (10 August 2020). All of my participants worked on a gift exchange process for the purpose of "keeping their paths open". Aunty Lorrel described how it was wrong for a *Voetvrou* to charge for her services. Aunty Lorrel associated earning money from these practices of care with people like *sangomas* or people who performed abortions whom she claimed to be led by self-interest rather than a gift. Because a gift was bestowed unto a *Voetvrou* by god, reaping a profit off of it displayed ill-intent. She too operated on a gift exchange process for the purpose of "blessing her hand" and "furthering her gift", be it in the form of a pair of slippers or a recommendation. Some patients provided a sum of money but this was provided as a token of gratitude rather than a transaction. The concept of gifting to keep one's path open has both material and spiritual

³⁷ Translates to "We do not have time to waste. We just have to get the baby dirty. We are in the business of delivering life here".

³⁸ Translates to "Before when someone comes to me or I go there then the Lord shows it to me. I help people, all that... just for even R10, just to open my way".

dimensions. A gift given to a *Voetvrou* as a token of gratitude provides spiritual sustenance. It allows them to fulfil their gift and act upon it. A recommendation as a gift allows them to further their gift by enacting it upon others. In other ways, gifts provide material sustenance, be it in the form of money or articles of clothing. Whatever form the gift may take, there is a reciprocal exchange between a body of women that does not hinge upon monetary practise. Perhaps this gives more locale-specific substance to Marx's "from each according to his ability to each according to his need". Even though this is not housed under one room and therefore does not constitute a 'place', it, too, is 'a commons of care'. As argued by Dillon, the commons are not just an object or entity, but the material presence of ineradicably social practices which humans reproduce, inhabit, and use to survive together as they engender new acts of 'commoning', new engagements and new life modes in the face of disentanglement. The relationships between *Voetvroue* and their patients breathe life into this concept. Amidst dire circumstances these women create a common realm - a symbiotic space premised on the reciprocity of care - within bowels of power.

Postnatal Placental Rituals

Aunty Lorrel was as serious about the postnatal period as she was about birth. She described delivery as two-fold—both in safely delivering the baby and the after birth. Attached to the latter were important spiritual boxes that needed to be ticked. *Hulle sê die baarmoeder is your strength. It's a woman's strength* (30 August 2020). Although how the postnatal period was attended to differed from *Voetvrou* to *Voetvrou*, what was shared were spiritual aspects and importance to afterbirth.

In dominant IKS discourse on the postnatal period, it is commonly held that the placenta is a site of importance for the spiritual wellbeing of the mother and a site of manipulation or use for those with malicious intent. Hlatshwayo (2017) asserts that the placenta is a symbol of fertility in Ndaubelief. Extreme care is taken in its disposal in order to "preserve fertility" (Hlatshwayo, 2017, p. 171). The placenta is generally buried in a designated field near the home. However, the disposal of the placenta is dependent on family tradition (Hlatshwayo, 2017, p. 171). Hlatshwayo cites two ways in which the placenta is disposed: "burying the placenta in a fertile field that belongs to the mother or burying the placenta in a small grave in the family burial site" (Hlatshwayo, 2017, p. 171). The latter is done for the purpose of marking the final connection in death when the person connected to the placenta dies (Hlatshwayo,

2017, p. 171). The disposal of the placenta is common in other Southern African communities. Among the Mpondo, the new mother has to clean the birth-place herself to prevent those with ill-intent to use and manipulate the blood or placenta (Naidu, 2013, p. 131). This ritual is an essential in the postnatal birth process and begins with the disposal of the placenta. It is believed that the new mother is to bury the placenta herself. A clod of soil is placed on the placenta and the two are combined together until it becomes one homogenous mixture and the placenta cannot be recognised. Thereafter, a hole is dug and the mixture is buried in the night, away from the prying eyes of those who harbour ill-intent (Naidu, 2013, pp. 131-132). Dominant IKS detail postnatal placental rituals that include culturally determined behavioural sequences which operate as “anxiety-releasing mechanisms and serve as a means to maintain spiritual control or welfare” (Naidu, 2013, p. 133). Similar placental and after-birth rituals are displayed amongst *Voetvroue* in Eldorado Park.

Aunty Lorrel detailed how a big aspect to delivery was that it consisted of crude apparatus that was readily available on hand. All of my participants explain how the in the same position of birth, upon the same sheets and blankets, the mother was expected to deliver the after-birth in the same way the baby was, otherwise the mother would die. Most *Voetvroue* detailed the scene of how an old *Clover* milk bottle was used for the mother to blow into. Aunty Lorrel gestured the size of the *Clover* bottle with her hands and explained how mothers were to blow into it to help them push. Aunty Lola, albeit a signal from God, also expressed how her first instinct in aiding the expulsion of the after-birth was to give the mother an old *Clover* bottle to blow into. They noted that this was done because it was the only thing they had on hand and because the mother lacked strength to push after delivery so relying on the *clover* bottle assisted in delivering the after-birth. Once the after-birth was expelled, the mother was given a chance to rest and the placental ritual was dealt with.

Aunty Lorrel: Then you will take the afterbirth very carefully and then put it in the plastic, tie it up and leave it aside. The mother has to take it, dig a hole as deep as possible. Remember, the mother cannot go and dig because she is weak. The husband is there so he must. If there's no husband, maybe a boyfriend of a family member, they will dig and very deep holes, where the dogs and people who want it for muti, can't reach it and put it in. (30 August 2020)

It is not so much that a particular meaning is attached to the delivery and disposal of the placenta. The placenta does have spiritual meaning and significance, but its significance does not correlate with that of fertility or the preservation of fertility as it does in dominant IKS. Rather, its spiritual meaning and significance has a dialectical relationship with people who

sought it out for perceived malicious intent and that's what drives this ritual. It is only given spiritual significance because of its perceived spiritual value on an economy of malice. It therefore perhaps has extrinsic spiritual value and not intrinsic spiritual value. 'Disposal rituals' of the placenta are done primarily as a means of protection, so that those with perceived ill-intent do not get hold of it and threaten the spiritual wellbeing of the body it came from. Auntie Rose explains:

Auntie Rose: Sometimes you give it to the mother ne. It's the best to give to the mother or otherwise my mother used to bury it and my brothers had to dig deep holes but one time there was a other prophet that came to my mother and said please, cant she help him with the placenta of a young girl. Her first baby. From then my mother stopped the burying story. While the patient is in the room busy with my mother, then we will pack the gelly, like the fire. When my mother's done, she will sit by that fire till everything is burned out. Dan as iemand dit vat, dan raak jy of jou kind siek of iets. (1 September 2020)

However, some *Voetvroue* did not perform any process of disposal. Auntie Ivy, Ouma Yvonne and Ouma Koekie explained that the placenta was given to the mother to do with it as she wished. They incinerated it or buried it if that's what the mother had asked of them. They did agree that in the wrong hands, it could be used in harmful ways but they did not perform any particular ritual regarding the disposal of the placenta. They did however make specific mention of ritual regarding the amniotic sack of the baby.

'Die Helm'

Die 'helm' is described as the amniotic sac of the baby. It was rare that babies were born with their helm still around them but many *Voetvroue* noted instances where it occurred. As with the placenta in Ndau or Mpondo beliefs, die helm is believed to have intrinsic value because a baby born still enclosed in the amniotic sac happened so rarely. Auntie Zee described it as an additional layer of spiritual protection that should be handled properly so that the baby's 'gift' could stay with them throughout their life. Auntie Lorrel, Auntie Zee and Auntie Ivy described how a piece of die helm was cut and fed to the new-born. The ingestion of die helm linked the new born and its gift. Auntie Rose and Ouma Koekie described burning a piece of the helm and sprinkling the ashes of it on to the head of the new-born. Other *Voetvroue*, such as Auntie Lola and Ouma Yvette described folding up the *helm*, placing it into an old *Vaseline* container that belonged to the mother and giving it to her to keep. It was placed into a *Vaseline* container so

that it did not dry out and specifically into that of the mother's so that any misfortune brought unto the new-born, because of *die helm*, was not a result of the *Voetvrou*. It was only Ouma Koekie that mentioned that she either advised the mother to bury *die helm* or place it on the roof of the house, both to preserve it and keep it safe.

What is most interesting about placental and after-birth rituals is that they are loosely shared amongst *Voetvroue*—not mirrored or generalised amongst all, but loosely shared—however, this point of commonality has no symbolic order to it in the same way rituals practiced by the Ndaou or the Mpondo have symbolic orders to it.

It is not just noted in post-natal ritual but is a developing thread throughout: an unpacking of *Voetvrouery* by using the conceptual tool of creolisation, allows to unearth the deep historical interconnections and entanglements in a context of severance and disentanglement. It is especially significant to do this here because we are able to see *Voetvrouery* outside of just being a 'Coloured thing', exceptional to 'Coloured' communities, such as Eldorado Park. Rather, we are able to look inside the bounds of this category and see a multiplicity of elsewheres forged together that precipitates invention and the processes of remaking and reengineering life. In the Lacanian sense, creolisation is the process of reconstructing the broken or lost symbolic order. The Clover bottle as a means to expel the afterbirth paints a beautiful picture of this argument: what once was an already consumed product, seen by others as little more than waste, is given value in a particular moment and location that eventually trickled down time and found itself a vital member in complex postnatal processes shared by *Voetvroue*. It serves as a manifestation of invention and reengineering. The used Clover bottle was born out of leftover-ness and waste but was remade and repurposed as a "something else", much like how, the creolisation of the subject is "precipitated by living with contradiction, ambiguity and doubt and turning this into 'something else'." (Erasmus, 2017, p. 98).

To bring a thread of events to a short conclusion, *Voetvrouery* is made up of not just mundane methods of learning, birthing, ritual and practice but also of vague images found in dominant IKS discourse. It comes together to present an ambiguous, layered picture that serves as an alternate way of understanding the cultural processes of historically classified 'Coloured' *Voetvroue* in Eldorado Park—not as exceptional to 'Coloured' communities, but as part of a larger process of creolisation. Like Erasmus notes, it is a picture of drawn together "unknown elsewheres" to create a *Mengelmoes*.

Kruie: Mixtures, Methods, Purposes

Aunty Faeenza: *Dankie my kind. You know, it's so nice to talk about this things to someone and to see the young people so interested in Ouma se rate. Ek het nou nou 'n vars potjie kruie gemaak. I just did it for my own well-being as a woman. It helps cleanse the insides nicely. Ek gaan 'n bietjie in 'n bottle vir jou uitlos ne. Jy moet dit Donersdag kom haal. Sê vir my wanne jy naby is en dan sal ek dit buite die hek los*³⁹. (3 September 2020)

Faeenza lives a stone's throw away from the four blocks of flats in Eldorado Park. Her house is among the last on the street. After our second conversation, she graciously offered to leave me a parcel of boiled *kruie* at her gate. Despite my reservations, my appetite for rich ethnographic data led me to accept. A small patch of kept grass continues from the pavement at her driveway into her yard, past the short, prefabricated walls around her house. In the front corner, her herb garden creeps over the wall. The *Wilde Als*⁴⁰, a light green, aromatic small-leafed plant, and the *Wynruit*⁴¹, a darker, more robust plant tangle. Their aroma is familiar: a combination of sweet and soft smells that were also pungent and bitter. Lower down the yard, are her *aloe vera* among other herbs which I did not recognise, but could smell. Her garden is special. Faeenza told me that she grows her herbs in places anyone can reach so that people can pick what they need without asking. These herbs are not *hers*, she said. Instead, she sees her yard as a site for growing communal herbs which everyone can harvest.

I leaned against her wall and in my peripheral view, I noticed a brown paper bag at the foot of her gate. She had written my name on it and attached a sticky note. In it was a mason jar filled with what looked like tea. I drank it before it cooled. True to my grandmother's saying - what is good for the body is not always good on the tastebuds - the murky, brown water tasted as it smelt, bitter and dry. The note read: *"1 small bunch of wynruit, 1 small bunch of wilde-als, 2 cups*

³⁹ Translates to: "Thank you my child. You know, it's so nice to talk about this things to someone and to see the young people so interested in Grandma's remedies. I just made a fresh jar of herbs. I just did it for my own well-being as a woman. It helps cleanse the insides nicely. I'm going to leave you a little in a bottle. You have to pick it up on Thursday. Tell me when you're near and I'll leave it outside the gate."

⁴⁰ "Wilde Als", "Wormwood" or "Artemisia" is a tall, grey-green coloured plant that is indigenous to South Africa (Swart 2009)

⁴¹ "Wynruit", or "Rue" is a tall green-blue coloured plant that bears an usually musky smell (Swart 2009)

*of water... Gekook en uitgespan... Gebruik vir gesondheid. Dankie dat jy na my stories geluister het, my kind*⁴²

Home-made herbal tea is one of many everyday examples of “*Kruie*” seen in the community of Eldorado Park. The Afrikaans term “*Kruie*” directly translates to “herbs” but in this report, it is a broad term that describes medicine-making. In this chapter I explain how, why and for whom *Kruie* is made. I illustrate the ways in which *this* praxis of *Voetvrouery* brings to life two ideas that are central to this report: creolisation as a process, and ‘the commons’.

***Kruie*: the how, why, what, and for whom of medicine-making**

Medicine-making occupies many of my childhood memories. Before we knew the taste of banana-flavoured anti-biotics, the children in my family knew the taste of *Kruie* mixtures from our family *Voetvrou*, Aunty Christine. That these working cures were not safeguarded behind a pharmacy counter, always interested me. They grew in our gardens, flowed from bottles stored in our fridges, and brewed in pots on the stove. *Kruie* include herbs, Lennon’s medicines, and everyday ingredients. It was comforting to see that in Eldorado Park today, medicine-making remains part of everyday life for the *Voetvrou*. Each has her unique and eclectic practices of care, and all *Voetvroue* draw from gardens, pantries, and medicine cabinets. These sustain all cycles of life. Apart from infertility treatment and ‘catching babies’, *Voetvroue* are called on to assist in treating everyday illnesses that range from mundane flu, to more severe illnesses like diabetes, and to spiritual and mental illness called “*Kopstype*”.

In this vein, Faeza explained that she treated several people daily each presenting with a different illness. Her stove was always filled with pots of *Kruie*, ready to be bottled and served to those who needed it. On the morning of our interview, she reported brewing a fresh pot of *Kruie* from her garden with portions of *Lewensessens*⁴³ and *Stuipdruppels*⁴⁴ to loosen up a cloggy chest. She said that she kept this mixture on tap to help subside the symptoms of Covid. This *Kruie* mixture also helped to clear babies’ chests during winter. Similarly, Ouma Yvette described that she boiled *wilde dagga* into a tea, allowed it to steep, blessed it with prayer, and administered it to the sick in age-specific dosages. She also described boiling *wille-als*, *groen*

⁴² Translates to: “... Cooked and strained... use for health. Thank you for listening to my stories”

⁴³ A product of the Lennon’s range (SAEPI, 1997)

⁴⁴ A product of the Lennon’s range (SAEPI, 1997)

*amara*⁴⁵ and *wynruit* to treat children and adults with high blood sugar levels and possibly diabetes. She reported sending those she treated home with a few bottles of her medicine. Her advised dosage was half a cup, three times a day. She ‘cooked’ *Khatazo* and garlic into a tea which she blessed with prayer before administering it to colic babies.

In addition to boiling *kruie*, Aunty Zee described her use of *olieblaar*⁴⁶ as a topical remedy of leaves for pain management—migraines, breast sensitivity or general muscle pain. She reported that she placed the leaf on the painful area to “draw out the pain” and described that she knew the pain was ‘drawn out’ once the leaf turned a dark colour. Her *kruie* consist of *Haarlemensis*⁴⁷, *Versterkdruppels*⁴⁸ and *Rooileventel*⁴⁹, steeped *Wilde-Als* and *Wynruit* for general strength and cleansing. She used this mixture to treat endometriosis and fibrosis and to cleanse the body after a miscarriage or abortion. Significantly, most of my participants noted that medicine-making incurred no cost to their patients. The tables below present some of the *Kruie* mixtures, how they are made, and their intended purpose as a treatment.

As described by Aunty Ivy:

Kruie Mixture	Method	Intended Purpose
“ <i>Balbruiters</i> ” (described as long, grass-like herbs)	It is soaked in water and ingested by the patient.	Intended to induce labour.
“ <i>Wildeknoeffel en Kamfer</i> ”	It is boiled into a tea and ingested by the patient.	To induce labour or “ <i>om die vrou los te maak vir boorte</i> ”.
“ <i>Kalmmous</i> ”	“ <i>Laat die vrou laat drink oor die rasper dan blaas jy dit in die vrou se gesig.</i> ”	To ensure a safe delivery.
Vaseline provided from the patient	Used to massage the abdomen.	Used for “smeering” to exam the health of the “tubes” and to promote fertility. It is also used to “smeer” the baby into place.
A combination of <i>Haarlemensis</i> and <i>Entressdruppels</i> .	Mixed together and administered orally.	Administered to treat Meningitis.

⁴⁵ A product of the Lennon’s range (SAEPI, 1997)

⁴⁶ A leaf taken from what is commonly known as 'Thorn apple' or 'Olieboom'

⁴⁷ A product of the Lennon’s range (SAEPI, 1997)

⁴⁸ A product of the Lennon’s range (SAEPI, 1997)

⁴⁹ A product of the Lennon’s range (SAEPI, 1997)

Duivelsdrek and red flannel	<i>“Jy smeer die duivelsdrek op die rug dan sit jy die rooi flannel aan en rub”.</i>	Used to treat asthma and bronchitis.
A combination of <i>“Dassie-pis”</i> , <i>“mooi meisie”</i> (described as a white flower), <i>klipdagga</i> , <i>wonderkroon</i> and <i>kalmous</i> .	<i>“Jy moet dit drie keer in water gooi dan ook moet jy bid voor die person die kruie kry en drink.”</i>	Used to treat both infertility and to cleanse the body after a miscarriage.
Nutmeg and egg white	It is whipped together to form a mixture and ingested.	Used to treat <i>“magspoel”</i> or diarrhoea

As described by Aunty Zee:

Kruie Mixture	Method	Intended Purpose
<i>“Daggabossie”</i> and <i>“Skulpad”</i>	Boiled in water into a tea and administered orally	Used to treat a cough.
<i>Wille-als</i> , <i>Wynhoes</i> , and <i>Bokdrolle</i> . (Described as herbs grown in gardens)	Boiled in water into a tea and then added to bath or washing water.	Used to treat Psoriasis.
<i>Olieblaar</i> (Described as a thick leaf)	Placed on the particular part of the body that needs to be treated.	Used to treat pain, such as headaches, tender breasts, bone pain.
<i>Roosmarain</i>	Mixed with hair oil.	Used to promote hair growth.
Sunlight soap	Rubbed down with water into a paste, placed into a syringe and administered orally.	Used to treat constipation in babies.
<i>Haarlemensis</i> , <i>Versterkdruppels</i> and <i>Rooileventel</i> .	Mixed with a little bit of warm water and administered orally.	Used to treat fibrosis and endometriosis: “however you bleed, its gonna push out all that clots and lumps”
<i>Turlington</i> , <i>Haarlemensis</i> , <i>Balsam Kopiva</i> , <i>Versterk Krampde</i> , ½ tin of milk and 1 can of condensed milk.	Mixed together and administered orally.	Used to treat a variety of sicknesses, such as period cramps and cancer: “If you have bad period cramps then you just drink this. But it can be used for so many other things also.”

<i>Doepa, Duivelsdrek, Kampfer</i> and other <i>Nyamstokkies</i> .	Burnt until it releases smoke. The sick baby is held on top of the smoke, upside down so that the smoke can enter into their nasal passage.	Used to treat Meningitis.
Crab water	A crab would be boiled and the water left over is drank.	Used to treat a cough.
Salt	Rubbed into wounds.	Used to treat and clean a wound.
<i>Wildedagga</i> (described as red flowers from a dagga plant)	Boiled into a tea and administered orally	Used to treat bronchitis and pneumonia

As described by Ouma Yvette:

Kruie Mixture	Method	Intended Purpose
<i>“Dagga leaves, the als, and the absence salt with a little bit of rough salt”</i>	<i>“you put it and you cook it up and then you strain it and you pray over it and give it to them”</i>	Used to “make bottles” to treat infertility.
Holy oil and holy ash	It is prayed over and rubbed on children.	Used to treat Meningitis.
<i>Khatazo</i> and garlic	Boiled as a tea then orally administered. <i>“if the baby is one month, you give half a teaspoon. If the baby is getting older, then give one spoon until the medicine is finished”</i>	Used for <i>“cleaning the baby from inside the stomach. Even if the baby doesn’t go properly out, it makes the stomach loose to let the... and I just put a little piece of garlic in it and then I pray over it”</i> .
<i>Dagga pods</i>	Boiled into a tea and administered orally.	Used to “open the chest”.
<i>“Wynruit and the wille-als and the groen Amara”</i>	Boiled into a tea. <i>“A half a cup they drink in the morning and then in the afternoon and at night”</i>	Used to treat diabetes in children and adults

Apart from “conventional biological” understandings, explanations and treatments of illnesses, it is important to mention that illness is not only understood in relation to the body but also the broader social and spiritual world. As cited by Naidu (2013, p. 1), Van Wyk (2004) notes that beliefs about health, wellness and illness bear its influences in the “religio-cultural matrix”. A spiritual and social understanding of the body is especially true for *Kruie*.

Aunty Ivy: By die hospitaal sê hulle dis meningitis want die hoof is sag. Hier rond sê hulle dit is klogana en kopstyp. Dit is iets vuil. As sy rond geloop het. Miskien het sy getrap in iets wat sy moes nie ingetrap't nie of jy kry dit baie as jou boyfriend of jou man rond loop of snaakse goete buite doen, dan bring hulle dit terug na die kind toe en daai kind moet gesmeer word. Hulle sê dis 'n twee kop slang'. Is 'n worm wat twee koppe het. Dan eet hy die kind bo. Dit maak 'n gat hie in (ushers to the centre of the skull) en in die kind se sterre. Ek saal miskien kruie water kook om die kind te gee. En dan sê hulle daars groot mense wat meningitis het. Hiers my suster se man. Hy was by die hospitaal. Hulle sê hulle kan nie vir hom help nie. Toe sê ek vir my suster, sien hie dit raak diep hier bo (points to the centre of the head, where the “soft spot” is known to be). Die man het meningitis. Die bottle wat ek het vir hom gemaak het gehelp.⁵⁰ (10 August 2020)

Like Aunty Ivy, Aunty Lorrel believes that *Kopstyp*, or meningitis, does not lie within the body but, rather, is contracted through social means:

Aunty Lorrel: Say now I march all over the road, by die plek, by daai plek. Ons sê jy loop en slaap met manne. You understand? Sê nou ek gaan slaap met daai man dan kom ek net so vuil na jou toe. Ek het nie gewas nie. Jou kind is 'n skoon kind. Daai kind kom van die moederbaar af. And because of the dirtiness I carry, the child contracts it and the child gets sick. So now because me and you are close together, we are sitting, you are my friend. You are taking out your breast and breastfeeding your child, that's also another way in which it happens.⁵¹ (31 August 2020)

⁵⁰ Translates to: “At the hospital they say it's meningitis because the head is soft. Around here they say it's klogana and kopstyp. This is something dirty. If she walked around. Maybe she stepped on something she should not have stepped on or you get it a lot when your boyfriend or your husband walks around or does funny things outside, then they bring it back to the child and that child needs to be smeared. They say it's a two head snake. Is a worm that has two heads. Then he eats the child upstairs. It makes a hole in it (ushers to the center of the skull) and in the child's buttocks. I will boil herbs boiling water to give the child. Here's my sister's husband. He was at the hospital. They said they could not help him. Then I said to my sister, see here it gets shallow here. This man has meningitis.

⁵¹ Translates to: “Say now I march all over the road, at this place, at that place. We say you walk while you sleep with men. You understand? Say now I'm going to sleep with that man then I'm just as dirty coming to you. I did not wash. Your child is a clean child. That child comes from the mother. And because of the dirtiness

She explains that newly born babies whose umbilical cord has not yet fallen off are especially susceptible to this. Women who sit with others while breast feeding put themselves and their child at risk of contracting *Kopstye*. Aunty Lorrel emphasises that certain body parts carry both spiritual power and spiritual vulnerability to ‘wandering eyes’. Exposure of these body parts permit the entry of spiritual pathogens carried by others. It is important to note that she does not claim that all people maliciously ‘infect’ babies and new mothers. Instead, she explains that certain social behaviours that are seen as ‘dirty’ or ‘impure’ attach themselves to the body and are transferred to newly born babies as a pathogen. This is why Aunty Lorrel and Aunty Zee emphasize the importance of ensuring the spiritual protection of a child, using *Kruie*, so that *kopstye* is not contracted. This includes rubbing the baby down with *Haarlemensis*, adorning them with protective articles, such as bangles, a black dot or a micro-*Manora* blade, and rubbing a mixture of specified Lennon’s on the soft spot. In some cases, babies are “burnt out” with *Doepa*⁵², *Duivelsdrek*⁵³, *Loban*⁵⁴ or *Nyamstokkies*⁵⁵ before they are brought into contact with anyone outside of the immediate family. The smoke from the incense, and a thick oily layer of *Haarlemensis* act as a barrier between the body of the baby and the outside world. In the event that *Kopstye* is contracted, babies are “burnt out”. They are kept airborne and held by their feet above burning frankincense. This allows for the smoke to easily travel into the nasal and chest passage of the child. These rituals show that *Kruie* as a praxis of *Voetvrouery* combines biological, spiritual, and social understandings of illness and the body.

What I find particularly interesting is that aside from the different paradigms of illness and healing, medicine-making derives from different sources. The use of *Lennon’s*, alongside herbs, has a complex history which I argue is about processes creolisation.

Lennon’s is currently marketed as an alternative medicine and is found in most South African pharmacies. Its commercialisation can be traced to 1858 when its Dutch founder - Grey Lennon - first made the product available in local pharmacies (Aspen Holdings, 2009). Its roots stretch beyond commercialisation and is officially known to ‘originate’ from folk medicine developed by *Afrikaner trekboere*. As the story goes, it emerged from the need for self-reliance. Elderly

I carry, the child contracts it and the child gets sick. So now because me and you are close together, we are sitting, you are my friend. You are taking out your breast and breastfeeding your child, that's also another way in which it happens”

⁵² A product of the Lennon’s range (SAEPI 1997)

⁵³ A product of the Lennon’s range (SAEPI 1997)

⁵⁴ “Loban”, otherwise known as “Frankincense”, is an aromatic resin

⁵⁵ A general term for frankincense

Afrikaner women mixed medicines and stored them in their “*Huis Apotheeke*” as “*medisyne trommeltjies*” (Genealogical Research Service, 2014). However, it is widely known that these medicinal mixtures were not pioneered by these women, but drew on cross-cultural sharing and knowledge. *Trekboere* used thousands of indigenous African plants to create these *medisyne trommeltjies*. A list of these remedies, most of which can be traced to *Lennon’s* and their corresponding equivalents, is given in the *South African Medical Journal* of June 1957 (Genealogical Research Service, 2014). It must especially be noted that against dominant discourse that *Lennon’s* belongs to *trekboere*, the rich Bantu and Khoisan lore that contributed significantly to the creation of folk medicine has long been ignored and denied and has only recently been acknowledged (Genealogical Research Service, 2014). A detailed history of how *Lennon’s* came to be is out of the scope of this report. Nevertheless, I wish to emphasise that these bottles of medicinal mixtures store historical weight, relationships of contestation, power, turbulence, and the sharing and eventual appropriation of knowledge.

These bottled and branded mixtures are an important part of the inventory of the medicine cabinets of *Voetvroue*. Medicine-making in Eldorado Park encompasses a literal pulling together of different items and practices: some mundane and out of necessity, some transplanted and grown, and some with deep historical narratives. All of which comes together to form not only heterogeneous mixtures of medicine, but heterogenous repositories of histories and cultures, freshly boiled, steeped, and bottled by *Voetvroue*.

***Kruie* Gardens as a Commons**

Aunty Zee’s garden is not unfamiliar to me. Nor is it unfamiliar to most residents on her street. The rest of her yard is barren: dry, red sand; the kind perfect for mud-pie making. But nestled between two walls and demarcated with a thin, wired fence is her garden of herbs. One does not need to stand close to catch its freshness. At its foot grew *Aloe Vera*, Thyme, Dania, Lemon Grass and Rosemary. Behind these plants stood tall, propped-up shoots of *Wilde-Als*, *Wynruit* and *Wilde Dagga*. She often told the story of how she believed a bird carried a seed from somewhere else and dropped it in her soil, and thus grew her herbs. These herbs knew not just the hands of Aunty Zee but the hands of almost everyone who passed by her house and happened to spot the herbs. She spoke of how often she would get called out of her home by people asking for a shoot or two of her herbs. Graciously, she always provided just enough for them to replant it in their gardens. Aunty Lorrel detailed how the *Kruie* that she grew would pass from wall to wall in her street: *Ons groei mos onse eie Kruie. Babatjie, die vrou wat langs*

*aan ons bly vra altyd vir 'n bondeltjie. Paar dae later sê Aunt Dolly vir my hoe mooi werk my Kruie. That time Aunt Dolly is my neighbour se neighbour se neighbour.*⁵⁶. (3 September 2021)

All my participants spoke of a garden which they tended currently, or which they remember tending to as they grew up. Before moving to Johannesburg, Aunty Ivy detailed how her mother's herb garden stretched across their back yard. What is left of it sits along the windowsill of her kitchen. As minute as Aunty Ivy's 'garden' is, it supplies women from her block of flats. All of my participants note that herbs are freely given without requiring compensation: *Daars nie tyd om geld te vra nie*⁵⁷ (date). All they ask is that an appropriate amount is harvested so that enough is left for other people and so that the plant can continue growing. Perhaps this alludes to a consciousness of the commons. The gardens of *Voetvroue* embody a material commons where locale-specific modes of knowledge is revalorised and everyone in the community has equal access to it.

Drawing on Sylvia Wynter, DeLoughrey (2011) describes the plantation as, on the one hand, "Euclidean grids of monoculture, defined as a European social hierarchy and as the commodity cultivation of non-sustainable crops", but on the other hand, and on the very periphery of the plantation, provision grounds of diverse intercropping of indigenous African cultivars, integral not only to the diet of slaves, but to their cultural creations and resistance (DeLoughrey, 2011, p. 59). DeLoughrey posits that the historical and metaphysical connections between people and soil are of vital significance to the recuperative power of the provision grounds—the excavation of the provision grounds reflects the historical plot of cultivating cultural sustainability amid the terrors of the plantocracy (DeLoughrey, 2011, p. 59). Wynter refers to the provision grounds as "the roots of culture" (DeLoughrey, 2011). DeLoughrey beautifully describes the provision grounds as a "cared plot of land where slaves... found *groundation*" (DeLoughrey, 2011, p. 63). Amidst systemic dislocation humans come together and enact new ways of 'commoning' which enable cultural re-creation and resistance. While the gardens that exist in Eldorado Park are in no way comparable to the plantation, the concept of the provision grounds can be applied to the function of the gardens.

⁵⁶ Translates to: "We grow our own Herbs. Babatjie, the woman who lives next to us always asked for a bundle. A few days later Aunt Dolly says to me that my herbs work nice. That time Aunty Dolly is my neighbor's neighbor's neighbor"

⁵⁷ Translates to: "There is no time to ask for money"

In the face of growing medical commercialism, the gardens of *Voetvroue* are repositories of locale-specific knowledge and herbs that are kept alive for anyone to harvest at no cost. These are autonomous spaces that escape the grip and co-option of capitalist development and hierarchy, where each person has equal access to the means of its production. The gardens function, much like the provision grounds, as autonomous, non-commercial, non-hierarchical spaces, where everyone has access to its social wealth. While the gardens present themselves, at first, as a small ethnographic detail that could well be overlooked, their existence carries immense power for understanding the way *Voetvroue* and their social circles organize themselves around a small body of herbs. Be it a small patch of demarcated land or a windowsill, their gardens provide a space outside of power and commodification *for all, at no cost*.

However, it must be noted that it does not escape the broader world of power—these gardens grow smaller and smaller as time passes. Aunty Ivy noted that she will never be able to grow a herb garden outside of her flat because she does not possess the land to do so. What was once a garden that stretched over her entire backyard, is now squashed into a small *hoekie* among the ‘backrooms’ that Aunty Zee built to bring in an income after her husband died. Nonetheless, these gardens are small nooks of autonomy for everyone to harvest from.

Outside of *Voetvrouery*

Encounters with the Biomedical Sphere

Davis-Floyd ironically notes an emergence of a phenomenon they call “post-modern midwifery” (Davis-Floyd, 2001, p. 169), a term aimed at capturing aspects of so-called “contemporary” midwifery practice that falls outside of the binaries of “traditional” and “biomedical” (Davis-Floyd, 2001, p. 169). This is part of a larger “lay midwifery renaissance”, first emerging in the 70’s. The term is meant to highlight qualities that emerge from discourse and political engagement of a “contemporary” midwife”; one who are “scientifically informed: they know the limitations and strengths of the biomedical system and of their own, and they can move fluidly between them” (Davis-Floyd, 2001, p. 170). They play with and between paradigms, shape-shifting to subvert the biomedical system while appearing to use it as complimentary. The “contemporary” midwife builds bridges, forges alliances and networks between themselves and the biomedical sphere (Davis-Floyd, 2001, p. 170). While I agree with David-Floyd’s definition of an apparent ‘New Age’ midwife, there is nothing new or “contemporary” about this kind of midwife. As Burns has noted, despite narrow and conservative legislative parameters, the western biomedical sphere is not as totalizing as it appears to be. Figures emerging from the archive, such as Louisa Mvemve, are indicative of this and thus what Davis-Floyd calls a “contemporary” midwife, is not a new concept. At grass-root levels, even under a purge for “untrained” midwives, *Voetvroue* have always occupied the role of shape-shifters, networkers and bridge-builders with characters of the biomedical field from as far back as the famous Ouma Cummings in her Newclare days, roughly around the early 1950s. Even under post-1994 biopolitics, where black autonomous midwives are perhaps not hunted by the state but co-opted and morphed into extensions of the state, we still see *Voetvroue* latently acknowledged by the state and thus allowed to occupy a recognised space of existence within the biomedical sphere.

Kliptown Connections

Mrs Basson was one of my oldest participants who had lived in both Newclare and Eldorado Park. She grew up amongst *Voetvroue* but ended up acquiring certification at a later stage. Much like my other participants, she spoke highly of Ouma Cummings. From what I initially knew, Ouma Cummings served women who hailed from varying parts of the city. However, as Mrs Basson mentioned, Ouma Cumming's story did not start in Eldorado Park but much earlier, in Newclare where she was trained by an older *Voetvrou*, Ouma Davies. Mrs Basson mentioned that her family kept children away from birthing spaces so she did not have much to say about the intricate workings of birth, ritual and practice. However, what she did mention was that both Ouma Cummings and Ouma Davies both worked with medical doctors in the area.

Mrs Basson: They weren't ignorant about things. They had the doctor as the backstop for them, in case of any complications (30 August 2020)

Mrs Basson discussed that amidst virtually no maternity healthcare facilities for women of colour other than the Bridgman and Baragwanath Hospitals later, *Voetvroue* like Ouma Cummings and Ouma Davies worked side by side with doctors. If any complications occurred that *Voetvroue* could not solve alone, they called on the well-known doctors in the area to assist. This did not just apply to Newclare. Auntie Lorrel recalled Ouma Cummings working with the Kliptown based doctor of Chinese medicine, Dr Yensen who she called on for a second opinion. Dr Yensen's services were also frequently called on by Auntie Rose's mother. Auntie Lola was unsure of the name, but she also referred to a doctor in Kliptown whom she called Dr Hessen, that *Voetvroue* called upon for assistance in certain situations. Even in the face of narrow legislative conditions imposed both by the medical realm and the apartheid government, *Voetvroue* travelled through spaces and built alliances with Kliptown's biomedical sphere, undermining simple-minded assertions that the authority of science created totalizing institutions or dioramas out of the practice of black autonomous midwifery in the city. Rather, against the backdrop of local state initiatives to suppress autonomous midwifery, everyday connections between *Voetvroue* and medical doctors were created and sustained for a very long time. Like the life of Dr Louisa Mvemve, the muscle and authority that medical boards appeared to flex is weakened in the face of such dynamic, synchronous figures. It is also no coincidence that such relationships between doctors and *Voetvroue* existed in a place as

significant as Kliptown. In its true renegade fashion, it was a place that slipped out of the grip of apartheid legislation. The connections made here thus made sense in this context.

A Latent Acknowledgement

Aunty Ivy: Ons was eers baie bang gewees. Ouers het nie papiere nie. Hulle gaan registreer nie hulle kinders nie, dan moet ek so met die aunties sig. Dan is die kind al ses, sewe jaar oud, dan moet ek met die aunty Pretoria toe gaan. Dan moet ek gaan sweer daai kind is gebore en ek het dit gedoen... (29 August 2020)

Despite their constant fear of prosecution because of a lack of qualification or “papers”, *Voetvroue* often encountered different characters within local state. Aunty Rose, above, recalled that for one of her patients to register the birth of her child, Aunty Rose was required to accompany her to the registration offices to declare that she delivered the child. Aunty Lola mentioned that her encounters with state actors did not begin with registration officials but much earlier on when waiting on the ambulance. She had to declare to paramedics that she delivered the babies at the births to which they were called. Similarly, as did Aunty Ivy—she recalled rigorous questioning from paramedics about her process of delivery. While this may seem ethnographically insignificant, it is essential in understanding *Voetvrouery* vis-à-vis the external medical world. While *Voetvroue* never assumed positions or roles within state facilities, each of them faced instances where the state latently acknowledged and documented their existence. Such acknowledgement reveals a meta-politics in which the state ‘out-sources’ its responsibilities to unpaid carers in communities. This report does not have sufficient evidence to suggest that the state actively sees *Voetvroue* as an extension to its health services. However, one sees here elements of neo-liberal patterns of outsourcing state responsibility.

Conclusion

“It is a history of creolisation: processes by which ways of living and forms of community – for the most part (but not only) born of struggles against violent power – are forged in order to survive and to remake histories... This diasporic history gestures towards fragments of multiple, mostly unknown elsewheres: historic, geographic, religious, cultural and epistemic... possibly other unknown elsewheres”

Zimitri Erasmus

‘Race Otherwise’, 2017

After its roots wrap around us and we are finally sucked into the belly of history, where we lay beside the *Voetvrou*, what do we come to know? However valid Deacon’s (1998) claim of an apparent ‘disappearance’ may be, it is rendered too simplistic. Literature has shown, black autonomous midwives, since settlement, have never held weighable words in the archives. They have been painted as voiceless, nameless, contribution-less silhouettes along the periphery of care. However, they have not disappeared altogether. The archive, while epistemically violent, has left traces of their existence in statistical values, in legislation and regulation, in health visitor accounts, in correspondence between physicians, that predate and proceed the key moment of 1865. While it is debatable as to whether they ever “appeared” [in order to “disappear”] in the archive, their existence is not well documented.

Upon an exploration of the *living* archive, we come to know that the everyday experiences of *Voetvroue* revolve around the treatment of infertility, birthing, gifting and ritual, medicine-making; knowledge of which is shared, not just intergenerationally but within and across familial lines. *Voetvroue* create and inhabit spaces of various ‘commons’: a knowledge commons, a commons of care, and *Kruie* gardens as commons. These spaces are not just enclaves of refuge and autonomy, but importantly, they are spaces of creolisation. Drawn together and produced by violent processes of modernity and colonialism as expressed historically in medical practice, these spaces are a bricolage of “unknown elsewheres”, lines, knots and bundles of different histories. And this is perhaps the most valuable lesson I have learnt throughout this research report.

I conceptualised my report on the grounds that uncovering the history of *Voetvroue* would contribute to a larger argument about the ‘culturelessness’ of ‘Colouredness’. However, thinking this way makes the race category ‘Coloured’, and the politics attached to it, incredibly durable. The ethnographic data that emerged could not fit within a homogenous understanding of ‘Colouredness’. It actively pushed against that. Rather, it formed its own ambiguous, unstable picture of ‘something else’. When I stepped off the watch tower of race categories, I came to understand this ‘something else’ as a *mengelmoes* of the legacy and effects of classification and politics. This research report emphasises understanding life not *by* race categories but *because* of and *despite* race categories.

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