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Where have the midwives gone? Everyday histories of Voetvroue in Johannesburg

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Where Have the Midwives Gone? Everyday histories of Voetvroue in Johannesburg

Tamia Botes

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**Everyday Histories of Voetvroue in
Johannesburg**

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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 on the margins of power. They are essential to networks of care in Eldorado Park, a historically classified Coloured township in the South of Johannesburg. The *Voetvrou* escapes the discourses of medical anthropology and indigenous knowledge systems. My research attempts to re-insert her into these discourses.

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 sank into the fine, red sand as I leaned forward, ready to be received by Aunty Zee's¹ garden of indigenous medicinal herbs. I closed my eyes and inhaled, breathing a plethora of aromas — some stronger than others. The *Wille-Als*² sang a sweet and creamy, yet sharp and sour song; each smell equally forceful and lulling. Its roots wrapped around my feet, pulling me into the womb 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 when 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. Whooops! 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. (6 July 2020)⁴

Aunty Zee's garden is in Eldorado Park, a community of people historically classified as 'Coloured.' At the heart of a complex network of medical and mythical knowledge sits the *Voetvrou* — an autonomous midwife who looks

1 Aunty Zee is one of four women 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* is *Artemisia Afra* (common name: African Wormwood), a tall, grey-green-coloured plant indigenous to South Africa. I first encountered it in Aunty 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.' The etymology of the word comes from the dutch word Voedvrouw. In Afrikaans, it is Voedvrou or Vroedvrou. The spelling of the word in this research report as Voetvrou is very intentional. I have chosen to spell it this way because my participants spell and pronounce it this way. There is also significance placed on the Voet (foot) in Voetvrou. As one of my participants explains, one is only a Voetvrou when one is called upon by others as such. Being a Voetvrou requires travelling near and far to assist, often on one's feet.

4 This Afrikaans anecdote comes from Nan, one of my study's informants. Tr: '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.' [All translations are my own.]

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, according to my prior research. A thick pall of fog lies over 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 relations between medical men and black autonomous midwives.⁵ The relationship between these men and women was underpinned by the 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 on 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 remains 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 refer to them specifically as ‘black autonomous midwives’ because commonly used words such as ‘untrained’, ‘traditional’, and ‘lay’ hold connotations of hierarchised knowledge that carries hidden Western epistemic underpinnings. I also specifically note that they are black midwives, to emphasise that the history of midwifery in South Africa is a racialised one.

1 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 on 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 twentieth 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 Deirdre 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 the commons are 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’, one that is not 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 (Harney & Moten, 2013, p. 8).

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, there 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 traces in chapters five, six, and seven, where I illustrate various forms of 'the commons' that emerge from *Voetvrouery* as a practice.

Creolisation

Under apartheid, with 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 those racially classified as 'Coloured' people. In grappling with such debates, unearthing notions of '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 categorisation. 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 glossing over the textures and experiences specific to those historically classified as '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.

However, it is essential that one 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 and politics and do not fall into the trap of ‘cultivating purity’, but that 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’ 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 1700s, 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 resulted from people’s movements and interactions. Erasmus notes:

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, the concept of creolisation 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 categorisation, creolisation serves as a conceptual tool to open 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 summary, 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 *Voetvrouw* — medicinal herb gardens as ‘a commons’, a knowledge commons of *Voetvrouery*, and a ‘commons of care’ in the form of *huis-hospitaal* or home-hospitals; third, processes of creolisation in the healing practices and rituals of the *Voetvrouw*; and fourth, the primary research — archival and in the field — on which this report is based.

2

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 their 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 among slave communities. In a time when 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 had been 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 inaugurated 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 United States

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, pp. 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 welfare. 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). Licence and regulation campaigns conspired with local law to enforce new training and registration requirements for previously autonomous midwives, a policy 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 southern United States. 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 [...] 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 on the margins of power operated from then on.

Midwifery during the twentieth century in the United States 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 in the Cape frontier of nineteenth-century South Africa reveals parallels with nineteenth- and twentieth-century America.

Midwifery in 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 was 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 is marked by a broad shift in power relations between medical men and black autonomous midwives at legal and institutionalised levels (Deacon, 1998, p. 272). Just as in the United States, 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 among 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 that 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 in midwifery, Deacon notes that by 1865 black women had '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 study, she observed 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 South Africa, it is vital that one analyse 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 may be valid but is too simplistic. If these women disappeared from

the public archive, what does it mean to 'appear' within the public archive? And 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, p. 19)

Archival research is then defined as an interrogation of said documents, in understanding its language, construction, and content. Mbembe also notes that an 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, p. 20). 'The archive, therefore, is fundamentally a matter of discrimination and of selection' (Mbembe, 2002, p. 21). The use of archival materials is never innocent or transparent; rather, the condition of their production often involves contradictory or partial evidence, laden with inherent political residues and overtones. The archive is thus never 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 significance: 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 a very few exceptions. My analysis is spurred by Catherine Burns' (1995) work on midwifery, nursing, and the interactions between black women and the apartheid health care system. I tracked a reference to untrained slave midwives in one of her footnotes (Burns 1995, p.

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.

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 Centuries

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 has sought to trace the development of nursing and midwifery in South Africa. Her genealogy of midwifery is one of the oldest, and it is the 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 white and Dutch. However, Searle 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. (Searle, 1965, p. 28)⁷

The juxtaposition of the Vrouw de Jager record and Van Riebeeck's journal entry 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

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

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 and 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 elevates 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 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 later 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). Searle also writes at length about the named, official midwives who did not come from the Netherlands, but rather were longer-settled, elderly white women who were certified and paid as midwives by the Company. Among these women she names Wilhelmina van Zijl (active c. 1751), Agetha Bloom (active c. 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 newborn 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. She 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 — 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 practised 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 a 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 licensing 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 and was deemed qualified by Dr Wehr; the total number of women to be instructed would be limited to six, four of whom were to be white Christians and two of whom were to 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 permitted to train alongside white midwives, once certified they were permitted to treat only non-white people (Searle, 1965, p. 97).

Before certification, midwives had to take an oath of office governed by Dr Wehr's code of ethics. This sought to mould a respectable and dependable doctor's assistant that would not stray too far out of line or beyond her 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 at the time she wrote as they were in the early 1800s (Searle, 1965, p. 97).

Despite Wehr's regulations for the Cape, untrained midwives continued to practise 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 practice 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, deprived, and dirty' (Searle, 1965, p. 99). Like medical officials of the time, Searle on the one hand demonises black autonomous midwifery, and on the other hand 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 in the register. Registered midwives would be struck off the register in the event that they violated the code of ethics. No black autonomous midwife was listed, 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 summary, 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 to be an 'appearance'? If it is the case 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, deprived, 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.

3

Towards a Living Archive: Midwifery in the Nineteenth- and Twentieth-Century Transvaal, Doulas in Twentieth-Century United States, 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 imprecise, 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 South Africa were simultaneously totalising and riddled with internal contradictions (Burns, 1995, pp. 20-21). From the early twentieth century, the state attempted to tighten its agenda on women's health. This period is saturated with internal debates which simultaneously consolidate and present deep cleavages among different levels of state and organisations 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 Central Archives Depot in Pretoria; the Intermediary Archive Depot with specific reference to the Public Health Department and West Rand Administration Board.

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 programme of midwifery training' which served as a blueprint for programmes 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 practise freely. The hospital served as a locus for 'civilising' both midwife and patient into productive, clean, ideal Christian motherhood (Burns, 1995, p. 2). Despite

this, both registered and unregistered midwives were recorded. Louisa Mvemve, a well-known black autonomous midwife, actively challenged the racialised boundaries of policy and legislation that shaped registration and the construct of midwifery by carving a space for herself amongst doctors and physicians which was almost unheard of at the time.

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 the 'sanitation syndrome' (Swanson, 1997, p. 387). A piecemeal public health system was built upon the 'sanitation syndrome' that 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, owing to the new configuration of the city. This shift manifested in a focus on hygiene, health, and motherhood. Race, gender, and urbanisation combined to push 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 Ordinance,⁸ 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 could continue practising, in theory, subject to licensing and registration (Lucas, 1979, p. 690). However, with the state in a flurry of concern over infant and maternal mortality and morbidity rates, at a more central and organisational level the Transvaal Medical Council opposed the promulgation of new measures to register and investigate midwifery practice (Burns, 1995, p. 102). It was opposed from the top on the grounds that it would take away medical control from physicians, and also by Medical Councils that currently had authority over licensing 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 the anxieties of physicians agitated by three facets of midwifery reforms. Burns records these facets. Physicians argued:

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,

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

they insisted that women found guilty of misdemeanours under new laws, should pay fines of the Medical Council. (Burns, 1995, p. 102)

None of these articles and publications called for the complete outlawing of unregistered and untrained midwives, but the general thrust of their argument was that even competent midwives were technically untrained and under-qualified to perform surgical assistance. Furthermore, physicians, especially those emerging from specialised fields such as obstetrics 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 physicians' letters published in the *South African Medical Record* (1909-1950) is that physicians imagined a city overrun and dominated by untrained midwives, whose patients would refuse physician care and leave 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 clutches of 'all forms of quacks' (Burns, 1995, p. 108). This idea persisted into the late 1920s and 1930s and underpins laws concerning midwifery, registration, and maternal health, as per Burns' work. While my reading of these professional journals paints a picture as to where regulation stemmed 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, on the other.

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 from that of physicians. Health visitors such as Morisse and Sistertson presented overwhelming evidence of a grave shortage of maternal beds and a 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 organisations among the urban poor, both black and white. During the late 1920s, the 1919 Public Health Act stipulated that female health visitors were to regularise birth and death notifications (Burns, 1995, p. 119). They were to track births 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 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 and untrained, registered and unregistered) existed on the ground. Burns provides a detailed analysis of investigations and summaries of health visitor reports for June of 1926 (Burns, 1995, p. 116).

Health visitors reported 410 births by trained midwives and 389 births by untrained midwives. Interestingly, the data were not broken down 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 was 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.⁹

Burns 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 and of who held registration and certification and from what district. However, the registered midwives' correspondence also provides intimate details of their interactions with, particularly, untrained midwives. Burns provides an extract from such correspondence:

⁹ These primary data were taken from the IAD/JPHD 48: 3233 'Health Visitors', Report, June 1926.

On visiting Mrs Evan, 40a Terrace Road, Fordsburg ... This morning, I found that her newborn 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, and memoranda, which are more qualitative in form and suggestive of the daily politics that the work of health visitors involved.¹⁰ Significantly, health visitor reports provide 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 to the cities, as well as a concern with how to subsequently formulate, implement, 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 concerned themselves with an apparent maternal health crisis. They agreed that maternal and child welfare was a medical problem, and hence the need for more medical specialists and the allocation of more resources (Burns, 1995, p. 126). What I find particularly interesting are the further investigations, on the part of the government in 1927, dedicated to tracking black midwives. While they list ten registered black midwives, only one of whom was qualified, they specify that the number of untrained and unregistered midwives is unknown. Despite their reservations about midwifery, McGibbons, a professor in obstetrics at the University of the Witwatersrand, addressed the Medical Council in a 1926 speech and asserted:

¹⁰ IAD/JPHD 48: 3233 'Health Visitors' August 1926 and IAD/JPHD 48: 3233 'Health Visitors' Report, June 1926.

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 licensing for untrained midwives. This was reflected in the 1928 amendment of the 1919 Dental and Pharmacy Act of 1919.¹¹ 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 that 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 accepted only white midwife and trainee nurses. This shaped the establishment of the Bridgman (Burns, 1995, p. 132).

The Establishment of the Bridgman

The Bridgman Memorial Hospital was opened in 1928 on the western edge of the city, adjacent both to white suburbs such as Melville, Westdene, and Brixton and to 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, such as 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 closure of the Bridgman around the same time (Burns, 1995, p. 195).¹²

The Bridgman’s founders dreamed of establishing a space that was ordered by Christian values. They sought to craft young women into good mothers

11 Government Gazette 2: 9801, June, 1919.

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

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 about contamination in the years before 1928, the establishment of the Bridgman sought to draw an iron curtain 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 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 in which 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, and it accepted young, black, unmarried women, who were drawn to the Bridgman because they were welcomed as *women* (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*¹³ 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 years old 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 nursing training because it intended to follow the British model of midwifery, which saw midwifery as a profession separate from 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:

13 *Umteteli wa Bantu* (Mouthpiece of the People), a newspaper established by the Chamber of Mines and the Native Recruiting Corporation (NRC) after a 1920 mineworkers’ strike. It published until 1956.

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 them, are not 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 in 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: from 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 which 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 being among the company of scientists and, while respecting Western science, saw herself as a doctor when '[d]ctors 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 wounds, 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 while 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 the 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?

Although an inquiry into the claimed ‘disappearance’ of black autonomous midwives from the public archives is necessary, it is important to note the connotations that this claim brings with it. Making such an assumption denotes a continuous 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, and ‘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 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 United States 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 provide the case of Gladys Milton, who, with the lobbying of the women leading this 'renaissance', became the first licensed *traditional* midwife in Florida and 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., in their attempt to de-romanticise so-called traditional midwifery, end up romanticising 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, those of Doulas in the United States, and traditional birth attendants (TBAs) in South African. Various case studies, in both contexts, provide some examples.

Doulas in the United States

Both Craven and Glatzel (2010) posit the idea that from the twentieth-century United States onwards, the black and indigenous autonomous midwife has 'disappeared'. However, heralded by Davis-Floyd et al., the figure of the Doula exemplifies histories similar to that of the twentieth 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) discuss the fact that Doulas were initially family members or friends in the community who volunteered their knowledge and experience, but have since been professionalised by DONA (Doulas of North America), an organisation founded in 1992 that sought to acknowledge unique child-birthing practices catering to the psychological and emotional needs of women, in attempts to 'humanize and demedicalize' birthing practices (Lantz, et al., 2005, p. 110). The institution thus provides a certification process to already experienced Doulas and allows them to work based on a fee-for-service to both public and private clients. Mitchell delves extensively into how Doulas are preferred particularly 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 wealthy. While providing 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 — are evidenced in the twentieth-century United States.

Ireland et al. (2019) posit that the modern discourse on Doulas places them within an ahistorical, acultural, and apolitical slot. In contrast, these authors locate Doulas within the broader struggles of 'indigenous' practices being subjected to commodification and neo-colonialism at the hands of the rich. They begin by showing 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) emphasise that these indigenous Doula practices seek to re-centre the spiritual reverence for childbirth while emphasising the sacred in addition to healthy and safe childbirth (Ireland, et al., 2019, p. 55). In addition, Doula 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, over which DONA holds the monopoly, is unrepresentative of poor, indigenous Doulas. They assert that training is still structured along Western biomedical lines concerning what 'alternative' childbirth entails. The training assumes a standard level of functional English, marginalising Doulas who are not English home language speakers; and while there are other programmes available, in order to practise 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 marginalises many indigenous Doulas from their practice. However, Ireland et al. do mention that within this space of marginalisation, poorer women can gain access to traditional training, and that traditional processes and practices can take place organically without intervention and standardisation. 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. 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 twentieth-century United States and the nineteenth-century Cape. Moreover, the Doula emerges, not as a wholly autonomous midwife, but a monolithic 'birthing attendant' that can serve only in a limited capacity. This heralds back to the gendered partitioning of medical labour in the twentieth-century United States and the nineteenth-century Cape. This is where the argument of Davis-Floyd et al. (2001) 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 health care 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) examined the role of traditional birth attendants 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 traditional birth attendants is that traditional birth attendants tend to end up being attached to a state-administered training scheme. In this Dududu study the

only definition provided for a traditional birth attendant 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 traditional birth attendants in the area. They reported mostly on procedures and recommendations that followed the traditional birth attendant training. These included the fact that traditional birth attendants were advised to consult the newly pregnant woman at her home, where health education is administered, and to avoid encouraging the use of *ishihlambezo* (a herbal infusion¹⁴) (Larsen, et al., 1983, p. 545). Attendants were required to capture the health history of the women for clinical documentation and then refer women to the nearest clinic for antenatal treatment. At clinics, traditional birth attendants were to assist only 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, three-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, traditional birth attendants were permitted 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 traditional birth attendant to visit the new mother and her infant for check-ups. During these visits, the traditional birth attendant 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 traditional birth attendant 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 health care, but it quickly morphed into a report on outcomes of the *Umphambinyoni* pilot scheme. Instead of addressing the racialisation of inequities in access to health care, traditional birth attendants were mobilised as an 'extension' of the state health care system. In essence, the state outsourced its responsibility for health care in rural black communities

¹⁴ *Ishihlambezo* is a herbal infusion commonly used by Zulu women in South Africa as a labour-inducing tonic.

to traditional birth attendants, and researchers were complicit in facilitating this process. Furthermore, the training offered to traditional birth attendants was limited to a Western understanding of obstetrics that made Western tools and medicines the norm, over cultural and indigenous herbs. In part, the growing dominance of Western obstetrics was expressed in the discourse that appealed to traditional birth attendants to avoid the use of “herbal infusions”. Similarly, clinics were held as totalising health care facilities, whereby traditional birth attendant were required to continually refer pregnant mothers to clinics for treatment rather than administer 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 traditional birth attendant providing pre- and post-partum education, which prioritised encouragement of contraception and family planning, reproduced the 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 traditional birth attendant, forcing them to adhere to a Western mode of obstetrics, and then marketing or representing this as a process by which the state and the communities it oppressed worked together to ensure their access to health care. This echoed colonial schemes of indirect rule. What is concerning is that even in post-apartheid South Africa, parallels from the colonial era can still 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. The 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 ‘[s]afe 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 site of regulation, surveillance, and organisation by states that take on ‘humanitarian’ reproductive initiatives. What this amounts to

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 operated under the concern of a high maternal mortality rate and a high HIV/AIDS prevalence. They asserted that traditional birth attendants are poorly trained to deal with the complications that arise 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 was deployed to evaluate a pilot training programme for traditional birth attendants on safe deliveries, within a noted paradigm of emergency obstetrics. They used fifty TBAs from two unspecified 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 traditional birth attendant, traditional medicine and rituals, and monitoring follow-ups (Peltzer & Henda, 2006, p. 142). Their results state that after the training, more traditional birth attendants conducted prenatal check-ups and referred mothers to clinics for the administration of nevirapine (used in the prevention and treatment of HIV/AIDS). During labour, women with risk signs were referred to nearby health care facilities (Peltzer & Henda, 2006, p. 145).

What is concerning is that the study begins with an immediate assumption that traditional birth attendants 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 offered nothing more than a 'how to' guide on referrals. In this vein, there was no discussion regarding traditional medicine and rituals, although the study was purportedly focused on these; the silence around this tells a larger story of the marginalisation of traditional practices as against normative Western ones. What this study also seeks to do is outsource responsibility to available TBAs, rather than address macro structures of inequality leading to a high maternal mortality rate and poor access to health care. Yet again, the traditional birth attendant becomes an extension of the state's health care system, but in such a way that assimilates them into this said system rather than offering them a fair collaboration. As an extension of this idea, the traditional birth attendant is reduced to a monolithic, acultural appendage of the state. Furthermore, traditional birth attendants are assumed to exist only within rural areas — most studies, both pre- and post-apartheid, look at traditional birth attendants only in relation to rurality — further entrenching the harsh, stereotypical binary between biomedical and urban versus traditional birth attendants/traditional and rural. The reduction of the traditional birth attendant to an

acultural expendable tool of the health care system by the researchers is also telling of their preconceived ideas of what a traditional birth attendant is. The mere use of the term itself is problematic in its homogenisation.

An interesting juxtaposition to this narrative arises out of study, conducted 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 utilisation of and barriers to maternal health services experienced by women, both HIV positive and negative, in Paarl, Rietvlei, and Umlazi. What is interesting is that their results illustrated mainly socio-economic barriers to maternal health care 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 noted 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 shortfalls of the health care system: when clinics did not have medicine, or women had simply lost faith in the health care system, they turned to traditional healers for care and treatment (Tlebere, et al., 2007, p. 349).

Similarly, a study conducted by Abrahams et al. (2001) reported on how the experiences of Coloured and Xhosa women in the Western Cape impacted their decision to seek care. They noted that both groups felt their needs were not met by the 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 noted that most women expected to be treated badly by nurses upon arrival for their bookings; they expected negligence, scolding, and even beating. This was all based on prior experience or the 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 health care. Rather, their results reflect the true nature of barriers to health care: socio-economic inequality coupled with other social factors. This finding actively challenges narratives around supposedly ill-trained TBAs as the cause of maternal mortality. Furthermore, it avoids any discussion of the need 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 TBAs?

This chapter has provided a brief history of midwifery in the United States 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 regulation of the Self and the Other. This history 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 totalising 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 with '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 calls 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 raises a question as to what then characterises '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 characterise 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 the VOC settlement of the Cape, 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, and in correspondence between physicians. While it is debatable 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.

4 In the Field

Leaning against the traffic light, 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 related to the matter.

In the refreshing light of early day, the streets had hues of artistic dreamtime: a mixture of soft pastel paints, lively greenery, and dusty red sand. Without romanticising it, Eldos had a beauty to it. It 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 towards the sky. We passed Eldomaine Primary and then turned towards what used to be Shoprite. While 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 relaxer¹⁵, and burnt hair flooded back into my mind when peering at 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 institutional determinant of life and death in this community: the police station — the institution that 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

¹⁵ Hair relaxer is a cream-like treatment that is used to chemically straighten curly or coiled hair.

of the flats, colourful laundry waved. I could not help but 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 this was 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 space. All around were mixtures of moments of kind gestures, fleeting smiles, suspicious looks, and sharp stares. Such moments reminded me of both my inclusion in and exclusion from the space. At the head of the street, right across an unkempt park, nestled Ouma Yvette's house. There was no movement 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 Extension; 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 Tamati-evlei. The area leaks into current Pimville, Dlamini, Moroka, and Eldorado Park (Roux, 2009). In the middle of the area today lies Freedom Square, now known as Walter Sisulu Square. Kliptown is located 25 km from the centre

of Johannesburg and today forms a part of Soweto. The area is best known as being a place where the liberation movement's seminal document, 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 formed a prelude to 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 part of a larger project of nation building in the new democratic era (Roux, 2009, p. 34). Texts about Kliptown outside of this etching are 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, which engendered a state of fear in the minds of the commissioners (Roux, 2009, p. 13). Their primary concern was not that the area was unsuitable for human beings 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 re-housing the occupants and razing 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 earliest inhabitants transported in 1904. The township was particularly interesting because it was outside 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, it was not marked on municipal records but was instead known as 'spaces' between Klipspruit, Klipriviersoog farms, and the south-eastern edge of Soweto (Figure 1).

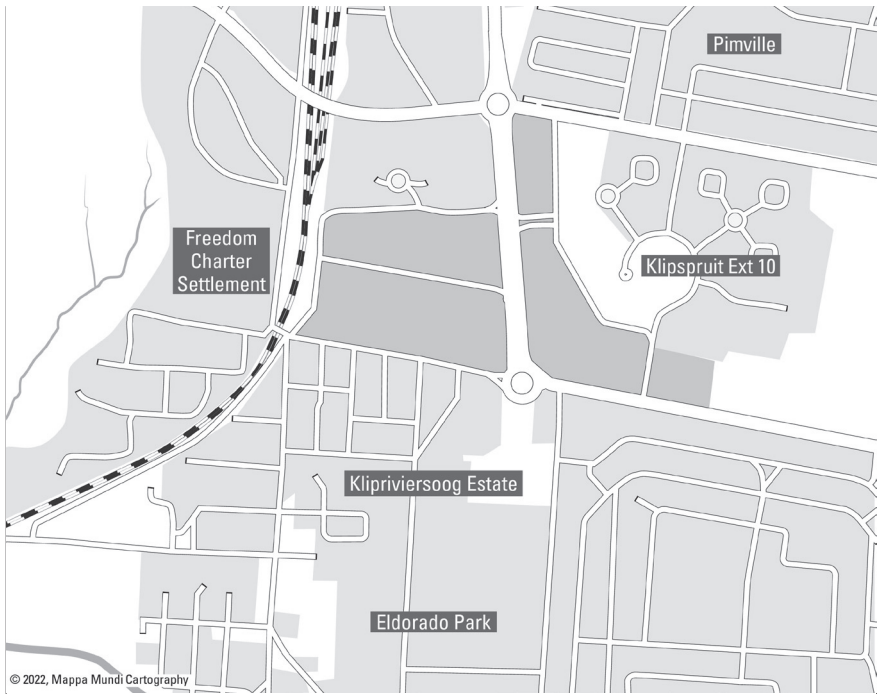


Figure 1
Map of the space that characterised Kliptown. Kliptown was not marked on municipal records but was rather made up of spaces between Klipspruit, Klipriviersoog Estate, Soweto, and Eldorado Park.
Source: Roux, et al., 2014, pp. 319-320

Bremner asserts that Kliptown has always been conceived by the state as a community of 'surplus people living in leftover space' (Bremnar, 2004, p. 522). Removing people from the 'Coolie' location and into Kliptown 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, Kliptown has officially and physically been distant from the city's

administration. As a consequence, it served as a freehold area similar to that of Sophiatown and Alexandra, pre-Group Areas Act. Kliptown'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, Kliptown became an attractive place for people from all over the country. It grew into a thriving cosmopolitan location, with a bustling informal and formal commercial centre, home to a diverse group of people (Roux, 2009, p. 15). Roux notes how, since at least the 1920s, Kliptown has been a centre of commercial activity. This has contributed to its atmosphere of a small, self-sufficient town, rather than being a domiciliary suburb of the city. It was a thriving commercial centre in its own right, as 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 otherwise have hindered them from living 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 initially mandated that the area be classified as a white zone, but soon afterwards as a Coloured zone, leading many residents to sell their land and move, though many also remained illegally 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 distribution of people; so, as a place where people could somewhat bypass apartheid's imposed boundaries, Kliptown was characterised as a space where apartheid's ideology of racial segregation could, to some degree, be subverted and challenged (Roux, 2009, p. 37). It was its very unfettered nature that grounded the Congress of the People and the signing of the Freedom Charter.

Despite its history of resistance and independence, Kliptown was unable to entirely 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 occurred at the same time that certain areas in Kliptown were razed owing to their being designated as 'slum areas' — hence the move of people from Kliptown to Eldorado Park (Roux, et al., 2014, p. 325).

An even more pronounced dearth of writing is found for the history of Eldorado Park. What there is on the formation of Eldorado Park is written

from the economically dogmatic viewpoint of Malcolm Lupton. He credits the development of Eldorado Park to the Environment Planning Act of 1967. Lupton notes that a significant aspect of this legislation was devoted to 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, however, did create new employment opportunities for people classified as 'Coloured' in the Johannesburg region. Unhindered by influx control measures and pass laws, Coloured labourers flocked to the city in search of new opportunities. 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 ha 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 proclaimed by the state to be a Coloured zone and were purchased (Lupton, 1993, pp. 37-39). By 1965, the first 200 'sub-economic' houses were built. The lowest possible sums were spent on housing people. The suburb was not necessarily planned as a whole but rather extended when necessary, to alleviate the mounting housing crisis — hence, the progressive development of Eldorado Park Extensions 1-10 and Klipspruit 1 and 2 (Lupton, 1993, p. 38). As mentioned earlier, when Kliptown came under the management of the Community Development Board, the Board's tenure was known for periodic shack and slum clearances, leaving residents with no option but to move to Eldorado Park. This process was fraught with suffering for many, a suffering very scarcely documented (Roux, et al., 2014, p. 325). As Roux et al. 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 that 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.

Fieldwork during a Pandemic

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 someone’s face when they are recalling a childhood memory? Doing ethnographic research via a WhatsApp call cannot replace immersing one’s self into their field site. 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 kinds of questions and provide different kinds of data. Questions are required to be intimate but not brash or inappropriate, so that one can squeeze out as much ethnographic detail as possible. Such a pivot to the virtual involves a loss and a feeling of 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 participants of the comfort of their own spaces 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 emitted from a screen 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 such questions as, ‘How am I going to

do this project?’ — rather, questions about what a collection of data looks and feels like, what the absence of such data creates, and how one goes about harnessing and interpreting the texture of online data. How do we write about an environment by watching it on a flat screen from a world away? To overcome the loss and grief experienced in pivoting to WhatsApp audio and video calls, a combination of semi-structured telephone interviews, observation, and ‘walkabouts’ were employed. My non-directive or semi-structured telephone interviews were conducted using a prearranged initial set of open-ended questions.

Faeeza was one of the very first *Voetvroue* I was introduced to. At first, upon answering the phone, she played down who she was. She stated that she was instead Faeeza’s sister. Once I revealed my reason for calling, only then did she introduce herself. Several video calls took place a few days after that. We grew quite close.

Faeeza 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 me outside. The bottle was still warm. She left a note to say that it was freshly boiled *kruie*, good for overall health and well-being. While she did not specify the ingredients, this was a powerful gesture that required effective rapport-building before we got to this point. It required addressing her in Afrikaans, addressing her as ‘Aunty Faeeza’, many phone calls prior to formal interviews, and opening myself up to answer personal questions so that she could ensure I was not there with ill-intent.

Despite my reservations, I drank a sip of the liquid. It was bitter. It did not taste like overall well-being but sure tasted like health. I took my time to peer into Faeeza’s yard and explore her street, trying to imagine the routes she would walk, the friends she would visit, and the taxis she would catch.

Including Faeeza, I had interviewed eleven *Voetvroue* — Aunty Rose, Mimi, Aunty Zee, Aunty Lorrel, Ma, Ouma Koekie, Ouma Yvette, Aunty Lola, Aunty Ivy, and Mrs Basson — most of whom either lived in or grew up in and around Eldorado Park. They all were between the ages of forty-five and 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, having been recommended to them by those who call them *Voetvroue*. My previous research had allowed me to enter into a network of healers and seekers, and it was 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 telephone and WhatsApp video call interviews. I was able to contact younger relatives of those *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 interviews, each interview began with my reading out the two forms. After clarifying what everything meant and gaining verbal consent from the *Voetvroue*, I began the interview. Each interview's prearranged set of questions 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 the participants' narratives and providing extra information, apart from the information that the set questions sought to collect. From these interviews, I learned about the histories of these *Voetvroue* and their encounters with healing — about how healing is done, who healing is learned from, their own personal encounters with healing and care, the recipes they brew, the *kruie* they use, and their overall experience of *Voetvrouery*. Each interview lasted for thirty minutes to an hour. A follow-up interview was conducted in most cases. The general length of the interview was kept short owing to fatigue created by being in front of a screen. In total, I conducted two to three formal interviews with each participant. This was 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 the *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 contextualising their settings. In each case, verbal consent was given; however, for purposes of anonymity street names and numbers were changed from the outset of note-taking. In the case of Aunty Faeeza, 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 data collected from interviews and walkabouts 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 I produced. Online interviews and walkabouts have

provided surface-level texture, but they do not begin to capture the intimate spheres *Voetvroue* have existed in. There is a lack of the ‘unspoken’ element in the field work; the awkward silences, the moments of joy and laughter, and how these emotions revealed themselves in different parts of the body could not be captured. 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 note-taking were done, themes from these field notes were drawn. These themes include *Voetvrouery*; the ‘when,’ ‘who,’ and ‘why’ of care; *kruie*; and the ‘how’ of care. My research report centres around these themes.

5

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 standalone 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 Auntie 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.*'¹⁶ Behind the front door adorned with the Christian symbol of the cross is the home of Auntie Rose. She sits 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.*'¹⁷ 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 sit behind the screen of a video call, entwined in the same history. Faeenza is clothed in a scarf. She is pressed against her Auntie Rose, who is draped in a jersey because the only thing that keeps her house warm is a small fan heater that is catering to five other people that morning.

Tamia: I guess ... Auntie Faeenza se Ouma? Auntie Rose se Ma?¹⁸

Faeenza: Ja, waar het Ouma groot geraak? Kimberly?¹⁹

Auntie 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

16 Tr. 'Do you see the door with the cross on it? That's my house.'

17 Tr. 'Jinne, who made these couches? They made a lot of money off Coloured families during the 70s and 80s, because I have never been to a Coloured household that did not own a set.'

18 Tr. 'I guess ... Faeenza's grandmother? Auntie Rose's mother?'

19 Tr. 'Where did grandmother grow up? Kimberly?'

Borsch. Sy't gebly waar die zoo nou is ... Parktown. Mummy het daar groot geword. Sy was ... hou kan ek nou sê ... like a slave. En van daar het sy my Pa gemoet ...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 toegekome 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 af gesien. 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.²⁰ (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; her account also brings to light themes such as the regulation of black autonomous

20 Tr. 'No, the whites ... Ma was then a slave, Faeza. 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 practised 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. Then 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.'

midwives, the way in which their gift of knowledge is acquired and shared inter-generationally, infertility, and birthing practices. Together with the pillars of this research, these themes are subsequently discussed.

‘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.²¹ (4 September 2020)

Aunty Lola lives on the drier, less plush side of Klipspruit. Her house was one of two situated in a *hoekie* (small corner). 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* (small turn) that functions 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 acquired not only through a sudden calling from God

21 Tr. ‘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.’

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

23 ‘*Smeering*,’ loosely translated, means rubbing or massaging.

but also from practices of inter-generational 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 assets of functionality. She came from a family of four, being the second born. They lived with her mother and grandmother. Her childhood memories did not sound conventional. Every memory of *Kannetjie* and hopscotch²⁴ 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 Weet-bix onto her lap, held her head up, and with great frustration said:

Aunty Faeza: 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)

Faeza knew she had a gift and especially knew that she could not reject it. It was possessed by the women before her. Faeza described how her Swazi grandmother believed that her ancestors bestowed this gift upon her. Subsequently, her mother came to acquire her knowledge by being sent out into the veld to look for particular herbs on the basis purely of 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 womb of Faeza's matriarchal line. It was not just a home but also a rich source of inter-generational 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* are

²⁴ *Kannetjie* and hopscotch are common children's games in South Africa.

grounded and guided by the individuals' own perceptions of God. Against hegemonic literature on indigenous knowledge systems and the transmission of knowledge, similarities can be seen. South Africa presents itself as an incredibly pluralist society, comprising many systems of knowledge, each with their own unique spiritual cues. One of the more dominant tropes of such systems is the process of *Ukuthwasa*, a process of training someone who has *ubizo*, a gift or calling 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 of this research report, it is important to situate the similarities and differences among 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 exist just 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 Haarlemensis;²⁵ 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 because of 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 was apprenticeship. From a young age, Aunty Zee was considered gifted by her herbalist father. This was recognised by Aunty Katie — hence the reason she began training Aunty Zee. Their training together was neither formal nor bureaucratic. Aunty Zee spoke of Aunty Katie as a mother, a

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

26 Tr. 'Feel here, feel here.'

friend, and a role model. Conversations about Aunty Katie were punctuated by Aunty Zee laughing contagiously over 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.

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 prophetic; this made her a suitable candidate to be trained by her sister-in-law. Ouma Yvette expressed a particular repulsion at 'catching babies', purely for reasons related to her dislike of blood; and while she accompanied her sister-in-law to deliveries, she mainly observed how to *smeer* pregnant women and brew *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. 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 potpourri of various forms. Knowledge is passed on from one generation of women to another. However, this process is not limited to kinship networks

27 Tr. '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?"'

28 Tr. '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. 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.'

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 from 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 blood lines and occurs between different women from different professions and spheres, at different times in their lives. 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 professionalisation 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 such as ‘training’ or ‘apprenticeship’ to talk about the processes of learning in this knowledge commons. However, learning to become a *Voetvrou* is 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 indigenous knowledge systems closely resembles conventional meanings of ‘training’ and ‘apprenticeship’. For example, Thornton (2009) discusses how undergoing the process of *Ukuthwasa* means entering into a particular school, known as *Mpande*, *Lefehlo*, or *Iphephlo*, where one is taught about the gift one possesses, 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 bona fide, 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 is there a set of steps, rules, or protocols for becoming a *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, on the one hand, are shared with what is

conventionally understood as African indigenous knowledge systems, and on the other hand, 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 be formally considered to be such rites. 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)

Deirdre 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, pp. 45-47). At a time when enslaved black women were defined and exploited by how well they reproduced, Owens holds that their reproductive power also became a site of sophisticated agency, in which the black midwife played an important role. Enslaved women resisted the efforts of their slave masters to lay claim to their ‘souls’, by sharing long-held traditional beliefs and practices that were embedded within their indigenous African homelands (Owens 2017, p. 50). Albeit at a later time in history, indigenous Doula work (particularly work done by Doulas who did not

29 Tr. ‘... 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.’

register with DONA) is positioned and based within a plethora of different cultural practices (Ireland et al., 2019, pp. 54-55). Within the realm of the autonomous Doula, poorer women can gain access to traditional treatment outside of intervention and standardisation. This includes the treatment of infertility and the aftermath of miscarriage, and the performance of abortions. Autonomous midwives of the Antebellum slave era and indigenous Doulas of the twenty and twenty-first-century are cohorts of black women on the margins 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 are wedged between Eldorado Park and Klipriviersoog. They initially resided in Alexandra but were forcibly removed from Kliptown in the 1950s. By the dawn of democracy in South Africa, they found themselves in Eldorado Park. Ma was as old as the springs that lay under the periphery of Eldorado Park.

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*. Aunty Lorrel described Ma as being 'in the business of making life'. This sentiment is expressed by all respondents in this study and might explain why all respondents vehemently opposed performing abortions — because their gift is premised on giving life and not taking it away.³⁰

For almost thirty years, Aunty Ivy has lived at 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'tit en ek het dit gemaak. ... my broer's se kind ... weet ek maak kruie. Ek los'tit in die yskas in 'n kooldrank bottle ne. Hulle drink die kruie, hulle dink dis cold drink toe's hulle weer pregnant. ... Ek het gesê dis nie coldrink nie. Dis

30 The topic of abortion was touched upon in every interview. This topic aroused strong feelings in each of my participants. For the purpose of maintaining a rapport, I did not delve into it further. The common sentiment expressed was 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, and they felt that it was wrong to go beyond this scope and take life. There were many ethnographic stories about their encounters with abortions; however, there is insufficient space to discuss this topic adequately within the scope of this study.

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 where she was born in Wentworth. She detailed how she learned how to 'make bottles' and to *smeer* from a very young age. In the same way that her mother assisted her in the bearing of 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)

A Commons of Care

Practices involved in becoming a *Voetvrou* illustrate Hardt and Negri's (2009) notion of 'the commons'. First, *Voetvrouery* is performed 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 and constitutes a refuge for the women receiving care.

When asked if both partners were treated for infertility, Aunty Ivy responded by saying that she fully allowed it, but often it would just be women who sought her help. She mentioned how she was often asked by her patients

31 Tr: '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.

32 Tr: 'All I do is I will let you in, then I 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.'

to keep visits confidential so that a woman's husband or his family would not find out that the woman had sought treatment for an inability to conceive. Aunty Lorrel also detailed how visits for infertility treatment were conducted 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 Aunty Ma together. Women visited these *Voetvroue* in the hope of somehow avoiding the shame and stigmatisation attached to infertility, as well as out of their own wishes to conceive.

These treatment processes are gendered. Men can accompany their wives for joint treatment that may be orally administered but *Voetvroue* only rubbed or "smeered" women. These women secretly consult a *Voetvroue* because their known infertility is stigmatised. Labelled 'concrete pants', infertile women are shamed by their husband 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 are 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 *Voetvroue* for assistance.

However, much like the relationship between the midwife and the slave, and between the indigenous Doula and the community, the *Voetvroue's* 'consultation room' is a site of confidentiality and refuge from stigmatisation 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 within 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 about the way infertility treatment, administered by *Voetvroue*, feeds into broader bio-political projects. The state directly benefits from the *Voetvroue* 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 undermines structures of power. Respondents are acutely aware that they provide a small, carved-out nook 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.'

6

‘In the business of delivering life’: *Huis-Hospitaal*, Emergency Home Deliveries, and Placental Rituals

Faeeza recalls her childhood in Varraflei, a part of Kliptown. 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 trample on them with clean feet until the sheets turned white again.

Much of Faeeza’s childhood was characterised by feelings of annoyance and dispiritedness, especially on those particular washing days. She had to gently tip-toe among different women and collect their sheets. She was quite irate at how her days revolved around women who would spend weeks on end there, without so much as a bag of potatoes provided for her in reward. There was hardly any space to walk, and that is probably why they sent a child to collect the sheets.

Die Huis-Hospitaal

She describes their home in Kliptown as hardly large enough for her own family to live in, let alone to function as a *huis-hospitaal*. But this was her everyday life: 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 Faeeza and Aunty Rose confined to the pantry as a place to lay their heads at night.

‘Catching babies’ was a norm in the lives of Faeeza 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 could 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 a bed when they arrived, they delivered there. However, if it

33 A bucket used for laundry.

was the case that all they could get was a mattress on the floor, they delivered there instead. Things worked on a first-come, first-served basis, though all women were catered for as well as possible.

Faeza and Aunty Rose noted how, during a delivery, they did not administer any pain medication, fearing the side effects it might have, especially considering that most of the time they did not know the history of her patient or the condition of the foetus. What was administered instead was strong black coffee. This was used not only to manage pain 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 the observation of 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:

Aunt 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 doktor 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)

Aunt 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

34 Tr. 'No, it was hard, my child. First of all, we only knew how to deliver babies because my mother was most 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,

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 various kinds of scenes, from stillborns to 'jelly babies' to babies born with *hydrops fetalis*. She particularly detailed how delivery went either way for both the mother and the child. Faeza described it as having one foot on the earth and another in the grave, and this was an everyday experience for Faeza and Aunty Rose. The *huis-hospitaal* housed various experiences of birth, all of which I cannot fully describe in the limited space of this research report. The stories narrated by respondents are raw, real, and sometimes ghastly. Regardless, the *huis-hospitaal* served as a communal space, held in common by women in the Kliptown / Eldorado Park area.

Importantly, this was a non-monetary practice. Women who sought care could do so without incurring costs. In this regard, *Voetvroue* such as Aunty Rose and her mother made themselves available *to* a community of women and solely *for* a community of women. The *huis-hospitaal* is a space of refuge for women in a context of limited access to public maternity health care facilities and for *Voetvroue* who were actively sidelined 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 out those deemed to be the opposite. 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*. Of course, not all births take place in a *huis-hospitaal*.

Emergency Home Deliveries

Other *Voetvroue*, such as Ma, Aunty Lorrel, Aunty Ivy, Ouma Yvette, and Ouma Koekie, 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 three in the morning to help deliver a baby at the home of one of her patients across Eldorado Park.

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.'

She recalled rushing to get dressed appropriately, because on that particular morning overnight temperatures had dropped to as low as -2° C. All that she left the house with were her pre-made bottles of *kruie* and her coat, and she headed to a motorbike that would transport her to the home of the mother. Attached to the bike was 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 described travelling to the ‘locations’, in the east, to help deliver babies. Aunty Ivy served only 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 veilig uitgekom en ek het dit toemaak en vir die ambulance gewag.³⁵ (10 August 2020)

Aunty Ivy described her instances of delivering newborns as emergencies and not necessarily planned events. For many of her clients, she 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. In the cases of

35 Tr. ‘Now look below; it was now two months back. It was half-past ten, eleven o’ 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 safely, and I closed it and waited for the ambulance.’

36 Tr. ‘The ambulance in Kliptown was pathetic.’

Aunty Lorrel and Ma also, they were called out in times of emergency. Aunty Lorrel's stories and overall tone resembled these accounts of emergency calls.

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 to indicate exactly how blankets and plastic sheets should be laid down before delivery took place. This was done so that blood did not leak onto 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* (an antiseptic), warm water, and salt. Birthing did not necessarily have a specific position to it. Aunty Ma and Aunty Lorrel allowed their patients to bend, squat, lie, or sit in any position they felt comfortable in. Aunty Lorrel was also wary of administering pain medication and never did so. Like Faeza and Aunty Rose, pain was managed with strong coffee. Its benefits were unknown to Aunty Lorrel; she said she did it because Aunty Ma used to do it and that was affirmation enough for its use.

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 sterilise everything required post-delivery. She never made mention of how she felt while delivering a 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 veilig uithaal. We are in the business of delivering life here.*'³⁷ Joy or pride were 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 up 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 their services. As Aunty Ivy mentioned: '*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 tien rand net*

37 Tr. 'We do not have time to waste. We just have to get the baby safely. We are in the business of delivering life here.'

*om my pad oop te maak*³⁸ (10 August 2020). All of my participants worked on the basis of 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 as being like *sangomas* or people who performed abortions, whom she claimed to be led by self-interest rather than by a process of gift exchange. Because a gift was bestowed on a *Voetvrou* by God, reaping a profit from it displayed ill-intent. She too operated on a gift exchange basis for the purpose of ‘blessing her hand’ and ‘furthering her gift’, be the gift in the form of a pair of slippers or a recommendation. Some patients offered a sum of money, but this was provided as a token of gratitude rather than as a transaction.

The concept of gifting to keep one’s path open has both material and spiritual dimensions. A gift given to a *Voetvrou* as a token of gratitude provides spiritual sustenance. It allows *Voetvroue* to fulfil their gift and act upon it. A recommendation as a gift allows them to further their gift by enacting it with 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, among a body of women there is a reciprocal exchange that does not hinge upon monetary practice. Perhaps this gives more locale-specific substance to Marx’s saying: ‘from each according to his ability to each according to his need’. Even though this process is not housed under a single room and therefore does not constitute a ‘place’, it too is *a commons of care*. As argued by Dillon, the commons is not just an object or entity, but the material presence of ineradicable social practices that 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 dislocation. 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 the bowels of power.

Postnatal Placental Rituals

Aunty Lorrel was as serious about the postnatal period as she was about the birth itself. She described delivery as two-fold: safely delivering the baby and the after-birth. Attached to the latter action were important spiritual boxes that needed to be ticked. ‘*Hulle sê die baarmoeder is your strength. It’s*

38 Tr. ‘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 ten rand, just to open my way.’

*a woman's strength*³⁹ (30 August 2020). Although how the postnatal period was attended to differed from *Voetvrou* to *Voetvrou*, what was shared were the spiritual aspects and importance attributed to the afterbirth.

In dominant indigenous knowledge systems' discourse on the postnatal period, it is commonly held that the placenta is a site of importance for the spiritual well-being 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 Nda⁴⁰ belief. 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 of: '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 location is 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 from using and manipulating the blood or placenta (Naidu, 2013, p. 131). This ritual is essential in the postnatal birth process and begins with the disposal of the placenta. It is believed that the new mother herself should bury it. 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 at night, away from the prying eyes of those who harbour ill-intent (Naidu, 2013, pp. 131-132). Dominant indigenous knowledge systems 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 evidenced amongst *Voetvroue* in Eldorado Park.

Aunty Lorrel detailed how a large aspect of delivery was that it consisted of a crude apparatus that was readily available to hand. All of my participants explained how, in the same position of birth and upon the same sheets and blankets, the mother was expected to deliver the after-birth in the same way the baby was delivered; otherwise, the mother would die. Most *Voetvroue*

39 Tr. 'They say that the womb is your strength. It's a woman's strength'

40 The Nda^u are an ethnic group which inhabits the areas in south-eastern Zimbabwe in the districts of Chipinge and Chimanimani.

detailed the scene of how an old *Clover* milk bottle was used for the mother to blow into. Aunty Lorrel gestured to illustrate 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 acting upon 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. The women noted that this was done because it was the only thing they had to 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 muti⁴¹ 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 in the way it does in dominant indigenous knowledge systems. Rather, its spiritual meaning and significance has a dialectical relationship with people who might seek it out for perceived malicious intent; that is what drives this ritual. It is given spiritual significance only because of its perceived spiritual value in an economy of malice. It therefore, perhaps, has extrinsic spiritual value and not intrinsic spiritual value. 'Disposal rituals' for the placenta are performed primarily as a means of protection so that those with perceived ill-intent do not get hold of it and threaten the spiritual well-being of the body it came from. Aunty Rose explained:

Aunty Rose: Sometimes you give it to the mother. 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, can't 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 jelly, light the fire. When my mother's done, she will sit by that fire till everything is burnt out.

41 'muti' refers to herbal medicine but in this context, is denoted as 'black magic'.

Dan as iemand dit vat, dan raak jy of jou kind siek of iets⁴². (1 September 2020)

However, some *Voetvroue* did not perform any ritual of disposal. Aunty Ivy, Ouma Yvonne, and Ouma Koekie explained that the placenta was given to the mother to do with as she wished. They incinerated it or buried it if that was what the mother 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 a placenta. However, they specifically mentioned a ritual regarding the amniotic sac of the baby.

‘Die Helm’

The *‘helm’* (helmet) is the term used for 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 had occurred. As with the placenta in Ndaou or Mpondo beliefs, the *helm* is believed to have intrinsic value because a baby born still enclosed in the amniotic sac occurs so rarely. Aunty Zee described it as an additional layer of spiritual protection, which should be handled properly so that the baby’s ‘gift’ could stay with them throughout their life. Aunty Lorrel, Aunty Zee, and Aunty Ivy described how a piece of the *helm* was cut and fed to the newborn. The ingestion of the *helm* linked the newborn and its gift. Aunty Rose and Ouma Koekie described burning a piece of the *helm* and sprinkling its ashes on the head of the newborn. Other *Voetvroue*, such as Aunty Lola and Ouma Yvette, described folding up the *helm*, placing it into an old *Vaseline* container 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 a container owned by the mother so that any misfortune brought unto the newborn, because of the *helm*, was not a result of the *Voetvroue*. It was only Ouma Koekie who mentioned that she advised the mother to either bury the *helm* or place it on the roof of the house, both to preserve it and to 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, unlike the rituals practised by the Ndaou or the Mpondo, which do have symbolic orders to them.

42 Tr. ‘... Then if someone takes it from you, you or your child might get sick’

This lack of symbolic order is not just of note in postnatal ritual but is a developing theme throughout: an unpacking of *Voetvrouery* by using the conceptual tool of creolisation allows us to unearth the deep historical interconnections and entanglements in a context of severance and dislocation. It is especially significant to do this here because we are able to see *Voetvrouery* beyond its just being a ‘Coloured thing’, exceptional to ‘Coloured’ communities such as that in Eldorado Park. Rather, we are able to look inside the boundaries of this category and see a multiplicity of ‘elsewheres’ forged together that precipitate 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 household waste, is given value in a particular moment and location, a product that eventually trickled down time and found itself to be a vital member in complex postnatal processes shared by *Voetvroue*. This 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 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 the thread of this account to a short conclusion: *Voetvrouery* is made up not just of mundane methods of learning, birthing, ritual, and practice, but also of vague images found in dominant indigenous knowledge systems’ discourse. It comes together to present an ambiguous, layered picture that serves as an alternative 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. As Erasmus notes, it is a picture of ‘unknown elsewheres’ drawn together to create a *mengelmoes*.

7

Kruie: Mixtures, Methods, Purposes

Aunty Faeeza: 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.⁴³ (3 September 2020)

Faeeza lives a stone's throw 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 low, prefabricated walls around her house. In the front corner, her herb garden creeps over the wall. The *Wilde Als*, a light-green, small-leaved, aromatic plant, and the *Wynruit*,⁴⁴ a darker, more robust plant tangle together. Their aroma is familiar: a combination of sweet and soft smells that are also pungent and bitter. Lower down the yard is her *Aloe vera*, among other herbs that I did not recognise but could smell. Her garden is special. Faeeza 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 that everyone can harvest.

I leaned against her wall, and in my peripheral vision 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 bottle 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 taste buds — the murky, brown water tasted as it smelt: bitter and dry. The note read: *1 small bunch of Wynruit, 1 small bunch*

43 Tr. '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.'

44 '*Wynruit*' (Rue) is a tall, green-blue-coloured plant that bears a usually musky smell (Swart 2009).

*of Wilde Als, 2 cups of water... Gekook en uitgespan ... Gebruik vir gesondheid. Dankie dat jy na my stories geluister het, my kind.*⁴⁵

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 used as 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 antibiotics, the children in my family knew the taste of *kruie* mixtures from our family *Voetvrou*, Auntie 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 were brewed in pots on the stove. *Kruie* includes 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 upon to assist in treating everyday illnesses, ranging from mundane flu to more severe illnesses such as diabetes, and to spiritual and mental illnesses called '*kopstyp*'.

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*⁴⁶ and *Stuipdruppels*⁴⁷ to loosen up a clogged chest. She said that she kept this mixture on tap to help alleviate the symptoms of COVID. This *kruie* mixture also helped to clear babies' chests during winter. Similarly, Ouma Yvette related that she boiled *Wilde Dagg*a 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*

45 Tr. '... Cooked and strained ... use for health. Thank you for listening to my stories.'

46 A product of the Lennon's range.

47 A product of the Lennon's range

Amara,⁴⁸ 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 that she blessed with prayer before administering it to babies suffering with colic.

In addition to boiling *kruie*, Aunty Zee described her use of *Olieblaar*⁴⁹ 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 how she knew the pain was ‘drawn out’ once the leaf turned a dark colour. Her *kruie* consists of *Haarlemensis*,⁵⁰ *Versterkdruppels*,⁵¹ *Rooilaventel*,⁵² 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 costs for their patients. The tables below present some of the *kruie* mixtures, how they are made, and their intended purpose as a treatment.

48 A product of the Lennon’s range

49 A leaf taken from what is commonly known as ‘Thorn apple’ or ‘*Olieboom*.’

50 A product of the Lennon’s range

51 A product of the Lennon’s range

52 A product of the Lennon’s range

As described by Aunty Ivy:

| Kruie mixture | Method | Intended purpose |
|---|---|--|
| <i>Balbruiters</i> (described as long, grass-like herbs) | Soaked in water and ingested by the patient | To induce labour |
| <i>Wildeknoeffel</i> and <i>Kamfer</i> | Boiled into a tea and ingested by the patient | To induce labour or ‘ <i>om die vrou los te maak vir boorte</i> . ⁵⁶ |
| <i>Kalmmous</i> | <i>‘Jy moet dit rasper dan blaas jy dit in die vrou se gesig’</i> ⁵³ | To ensure a safe delivery |
| Vaseline provided by the patient | Used to massage the abdomen | Used for <i>smeering</i> , to exam the health of the ‘tubes’, and to promote fertility. It is also used to smear the baby into place |
| A combination of <i>Haarlemensis</i> and <i>Entressdruppels</i> | Mixed together and administered orally | To treat meningitis |
| <i>duivelsdrek</i> and red flannel | <i>‘Jy smeer die duivelsdrek op die rug dan sit jy die rooi flannel aan die rug en rub.’</i> ⁵⁴ | 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>kalmmous</i> | <i>‘Jy moet dit drie keer in water gooi dan ook moet jy bid voor die person, die kruie kry en dan drink.’</i> ⁵⁵ | To treat infertility and to cleanse the body after a miscarriage |
| Nutmegg and egg-white | Whipped together to form a mixture and ingested | To treat ‘ <i>magspoel</i> ’(diarrhoea) |

53 Tr. ‘You rub the *duivelsdrek* on the back and then you put the red flannel on the back and rub’

54 Tr. ‘You must wash it in water three times and then you should also pray over the person, the herbs and then drink’

55 Tr. ‘To induce labour or ‘make the woman loose for labour’

56 Tr. ‘To induce labour or ‘make the woman loose for labour’

As described by Aunty Zee:

| | | |
|---|--|--|
| 'Daggabossie' and 'Skulpad' | Boiled in water into a tea and administered orally. | 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. | 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. | To promote hair growth. |
| Sunlight soap | Mixed with water into a paste, placed in a syringe, and administered orally. | To treat constipation in babies. |
| <i>Haarlemensis</i> , <i>Versterkdruppels</i> , and <i>Rooilaventel</i> | Mixed with a little warm water and administered orally. | To treat fibrosis and endometriosis: 'However you bleed, it's 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. | 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</i> , <i>Duivelsdrek</i> , <i>Kampfer</i> , and other <i>Nyamstokkies</i> (incense sticks) | Burnt until it releases smoke. The sick baby is held upside down over the smoke so that it can enter into their nasal passage. | To treat meningitis. |
| Crab water | A crab is boiled and the leftover water is drunk. | To treat a cough. |
| Salt | Rubbed into wounds. | To treat and clean a wound. |
| <i>Wilde Dagga</i> (described as red flowers from a <i>Dagga</i> plant) | Boiled into a tea and administered orally. | To treat bronchitis and pneumonia. |

As described by Ouma Yvette:

| Kruie mixture | Method | Intended purpose |
|---|--|--|
| 'Dagga leaves, the <i>Wille-Als</i> , and the Epsom salt with a little bit of rough salt' | 'You put it and you cook it up and then you strain it and you pray over it and give it to them.' | To 'make bottles' to treat infertility. |
| Holy oil and holy ash | Prayed over and rubbed on children. | To treat meningitis. |
| <i>Khatazo</i> and garlic | Boiled as a tea, then orally administered. '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.' | Used for 'cleaning the baby from inside the stomach. Even if the baby doesn't go properly out, it makes the stomach loose to let thend I just put a little piece of garlic in it and then I pray over it.' |
| <i>Dagga</i> pods | Boiled into a tea and administered orally. | To 'open the chest'. |
| ' <i>Wynruit</i> and the <i>Wille-Als</i> and the <i>Groen Amara</i> ' | Boiled into a tea. 'A half a cup they drink in the morning and then in the afternoon and at night.' | 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 understood in relation not only to the body but also to 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 their 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'it 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 [points 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 sister 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.⁵⁷ (10 August 2020)

Like Auntie Ivy, Auntie Lorrel believes that *kopstyp* (meningitis) does not lie within the body, but rather is contracted through social means:

Auntie 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.⁵⁸ (31 August 2020)

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 breastfeeding put themselves and their child at risk of contracting *kopstyp*. Auntie Lorrel emphasises that certain body parts carry both spiritual power and spiritual vulnerability to 'wandering eyes'. Exposure of these body parts permits 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 as pathogens to newly born babies. This is why Auntie Lorrel and Auntie Zee emphasise the importance of ensuring the spiritual protection of a child,

57 Tr. '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 [points to the centre 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. The bottle that I made for him helped."

58 Tr. '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 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.'

using *kruie*, so that *kopstyp*e 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*,⁵⁹ *Duivelsdrek*,⁶⁰ *Loban*,⁶¹ or *Nyamstokkies*⁶² before they are brought into contact with anyone outside of the immediate family. The smoke from the incense along with a thick oily layer of *Haarlemensis* acts as a barrier between the body of the baby and the outside world. In the event that *kopstyp*e is contracted, babies are 'burnt out.' They are kept airborne and held by their feet above burning frankincense. This allows 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. Its roots stretch beyond commercialisation and are officially known to 'originate' from folk medicine developed by *Afrikaner trekboere*, *pastoral farmers that moved to the interior of South Africa*. As the story goes, it emerged from the need for self-reliance. Elderly *Afrikaner* women mixed medicines and stored them in their '*huis apotheek*' as '*medisyne trommeltjies*' (medicine bottles) (Aspen Holdings, 2009). 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. 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. A detailed history of how Lennon's came to be is beyond

59 A product of the Lennon's range.

60 A product of the Lennon's range

61 'Loban', otherwise known as 'frankincense', is an aromatic resin.

62 A general term for frankincense.

the scope of this report; nevertheless, I wish to emphasise that these bottles of medicinal mixtures carry 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 roots and narratives — all of which come together to form not only heterogeneous mixtures of medicine, but heterogeneous 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 grows *Aloe vera*, Thyme, Dania, Lemon Grass, and Rosemary. Behind these plants stand 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 own gardens. Aunty Lorrel related 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 Aunty Dolly is my neighbour se neighbour se neighbour.⁶³
(3 September 2021)

⁶³ Tr. '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 neighbour's neighbour's neighbour.'

All my participants spoke of a garden that they tended currently, or which they remember tending to as they grew up. Aunty Ivy related how, before moving to Johannesburg, her mother's herb garden stretched across their backyard. 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*'⁶⁴ (3 September 2021). 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 are revalorised and everyone in the community has equal access to them.

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 for 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 cultivation of the provision grounds reflects the historical intention to cultivate cultural sustainability amid the terrors of the plantocracy (DeLoughrey, 2011, p. 60). Wynter refers to the provision grounds as 'the roots of culture' (DeLoughrey, 2011, p. 60). 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 recreation and resistance. While the gardens that exist in Eldorado Park are in no way comparable to the plantations, the concept of the provision grounds can be applied to the function of these gardens.

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 production. The gardens function, much like the provision grounds, as autonomous, non-commercial, non-

64 Tr. 'There is no time to ask for money.'

hierarchical spaces where everyone has access to their 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 organise themselves around a small body of herbs. Be it a small patch of demarcated land or a windowsill, their gardens provide a space beyond the confines of power and commodification — *for all, at no cost*.

However, it must be noted that this 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* (nook) among the ‘backrooms’ that Aunty Zee built to bring in an income after her husband died. Nonetheless, these gardens remain small nooks of autonomy for everyone to harvest from.

8

Outside of *Voetvrouery* Encounters with the Biomedical Sphere

Davis-Floyd notes ironically the emergence of a phenomenon he calls ‘post-modern midwifery’ (Davis-Floyd, 2001, p. 4), a term aimed at capturing aspects of so-called contemporary midwifery practice that fall outside the binaries of ‘traditional’ and ‘biomedical’ (Davis-Floyd, 2001, p. 5). This is part of a larger ‘lay midwifery renaissance’, first emerging in the 1970s. The term is meant to highlight qualities that emerge from the discourse and political engagement of ‘contemporary’ midwives, those 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. 5). They play with and between paradigms, shape-shifting to subvert the biomedical system while appearing to use it as a complementary system. The ‘contemporary’ midwife builds bridges, forging alliances and networks between themselves and the biomedical sphere (Davis-Floyd, 2001, p. 5). While I agree with Davis-Floyd’s definition of an apparent ‘New Age’ midwife, there is nothing new or particularly ‘contemporary’ about this kind of midwife. As Burns has noted, despite narrow and conservative legislative parameters, the Western biomedical sphere is not as totalising 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 grassroot levels, even under a purge of ‘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, when black autonomous midwives are perhaps not hunted by the state but co-opted and morphed into extensions of the state, we still see *Voetvroue* tacitly acknowledged by the state and thus allowed to occupy a recognised space of existence within the biomedical sphere.

Kliptown Connections

Mrs Basson, one of my oldest participants, 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 various parts of the city. However, as Mrs Basson mentioned, Ouma Cummings' story did not begin 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: *'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 noted that amidst virtually no maternity health care facilities for women of colour other than the Bridgman and Baragwanath hospitals later, *Voetvroue* such as 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 apply only to Newclare; Aunty Lorrel recalled Ouma Cummings working with the Kliptown-based doctor of Chinese medicine, Dr Yensen, whom she called upon for a second opinion. Dr Yensen's services were also frequently called upon by Aunty Rose's mother. Aunty 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 totalising institutions 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 are 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 beyond the grip of apartheid legislation. The connections made here thus made sense in this context.

A Tacit Acknowledgement

Aunty Ivy: Ons was eers baie bang gewees. Ouers het nie papiere nie. Hulle gaan registreer nie hulle kinders nie. 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 ...⁶⁵ (29 August 2020)

Despite their constant fear of prosecution because of a lack of qualification or ‘papers’, *Voetvroue* often encountered different characters within the local state. Above, Aunty Rose recalled that for one of her patients to register the birth of her child, she was required to accompany her to the registration offices to declare that she had 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 had delivered the babies at the births to which they were called. Similarly, as with 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 tacitly acknowledged and documented their existence. Such acknowledgement reveals a meta-politics in which the state ‘outsources’ 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 definite elements of neo-liberal patterns of outsourcing state responsibility.

⁶⁵ Tr. ‘We were first very scared. Our parents did not have papers. People did not register their children. Then the child is already six, seven years old and I have to go with the aunty to Pretoria. Then I have to swear that the child was birthed and I delivered them.’

9

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 lie beside the *Voetvrou*, what do we come to know? However valid Deacon's (1998) claim of an apparent 'disappearance' may be, it is too simplistic. Literature has demonstrated that 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, and in correspondence between physicians that predate and follow the key moment of 1865. While it is debatable whether they ever 'appeared' in the archive in the first place (in order to later 'disappear'), their existence is not well documented in any case.

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, ritual, and medicine-making — knowledge of which is shared not just inter-generationally but within and across familial lines. *Voetvroue* create and inhabit spaces of various 'commons': a commons of knowledge, a commons of care, and a commons of *kruie* gardens. 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 learned 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 ‘Coloured-ness’. 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 ‘Coloured-ness’. It actively pushed against that. Rather, it formed its own ambiguous, unstable picture of ‘something else’. When I stepped off the watchtower 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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IAD: Intermediary Archive Depot, Johannesburg, containing these collections:

JPHD: Johannesburg Department of Public Health 1904-1960

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UPSpace: Institutional Repository, containing these collections:

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This book is based on Tamia Botes's Master's thesis 'Where Have the Midwives Gone? Everyday Histories of Voetvroue in Johannesburg', winner of the African Studies Centre, Leiden's 2021 Africa Thesis Award. This annual award for Master's students encourages student research and writing on Africa and promotes the study of African cultures and societies. 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 become 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?



Tamia Botes is an PhD student in the Anthropology department of Wits University, Johannesburg. She is supervised by Professor Zimitri Erasmus. Her current research focuses on focuses on the social history of Eldorado Park as a discursive space for reimagining race and the 'human' in a South African context.