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# Humanising Childbirth in South Africa

## The role of Indigenous midwives in countering obstetric violence

**by**

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**Opening ritual**

I begin this journey by honouring African women who came before me. I acknowledge their presence in my life, physically and spiritually. I celebrate the fact that I am alive today because my mother and her mother and all the women before her, including those who never set foot in a conventional classroom or hospital, survived colonialism, and its quest to colonise their wombs. I stand here as a midwife who has been initiated in a system that continues to look down upon the knowledges of my ancestors. My struggle is to harmonise my colonised and Indigenising splits into a whole.

**Declaration**

I, Matshilo Tumelo Ntswatswa Motsei, Student No 29569631, hereby declare that this is 'my' original work. I write 'my' in parentheses because Indigenous research methodology argues that knowledge does not belong to any one person. Instead, it exists within a set of relationships rooted in people, land, plants, animals, and the cosmos. This means I cannot REALLY claim that this is my original work in the true sense of the word. I further declare that the work has not been submitted to any institution for examination or degree purposes. I also declare that the material used to write this dissertation has, as far as I am aware, been adequately referenced.

Signed: _____  _____ Date: ___20/01/2024_____

**Dedication**

This is for my twin granddaughters, Letlotlo and Tlotlisang, who were born prematurely at the beginning of my research journey. When I visited them in the hospital for the first time, I found two tiny blobs of humans in incubators attached to tubes and machines. They came at that time to ensure that in my pursuit of reclaiming the knowledge of Indigenous midwives, I must not discount the fact that the biomedical model of birth has made a significant mark in saving lives of mothers and babies.

**Acknowledgements**

Embarking on this felt like climbing Mount Kilimanjaro. It does not matter how much you prepare yourself for such a journey. There comes a time when your entire being is turned inside out. I had many such moments during the data collection and write-up phases. To survive, I was supported by many people in the physical and spiritual realms.

To give thanks, I will start with my maternal ancestors. My great grandmother, Matau Maretela beetsi Setshedi. Mofokeng, kwena ya madiba. My grandmother, Mamoabi Setshedi beetsi Tladi. Mokgatla. A e namele setlhare e je borekhu. My maternal grandfather, Ramatlhodi Tladi, whom I have never met in the physical realm. E ne e le tlou, a mela dilo ganong, a fetoga kolobe. My paternal ancestors: my two great grandfathers, Ramogomotsi Moloisane. Motsopye wa bo kgomo mpoloke and Rantebo Motsei Mokgatla kgodisong, Mohurutshe tlholegong. My grandfather, Ramoloi Motsei, the gentlest man I know. My beloved father, Rantebo, gentle as his father, Ramoloi. He would have stayed up late with me during the harrowing phases of this journey. To my great-grandmother, Mankoko Matlala beetsi Moloisane. Mokone wa nchidikgolo. My grandmother, Mmatshilo Moloisane beetsi Motsei. My mother, Boitumelo Tladi beetsi Motsei, the She-Lion of the family, this is for you. The midwife who delivered babies in Mathibestad village and got around with a donkey cart or bicycle. Your contribution to the well-being of your people as a nurse, midwife, healer, and community leader is unmatched.

To the women who participated in this study. Ke a leboga. Ndza khensa. Ngiyabonga. Siya thokoza. Other than having had the opportunity to co-create knowledge with you, I was privileged to participate in sacred rituals and ceremonies. I am looking forward to the ongoing process of unlearning.

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To my children, my fellow soul travellers. My son, Katlego, for your big heart, for your willingness to help, and for driving me all the way up to the Northern Cape to conduct my interview. My daughter, Kgalalelo, for your wit, courage, and drive; for being my cheerleader. It means a lot for a mother to be a source of inspiration for her daughter. My son, Onkgopotse Rantebo, for your gentle nature, like your grandfather. Your birth story, as you know, is amazing. You have been nothing but an amazing miracle.

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To everyone in my life, my friends, colleagues, online 'family,' including those I haven't met in the flesh. Thank you for the love, for rooting for me, for urging me to move forward when I was stuck.

To my beloved ancestor, my aunt, Mme Kubele Motsei *beetsi* Motaung. You are the one who taught us that botlhale ga bo tswe kwa moseja, bo tswa kwa Lowe. It is from such a foundation that I know that the West is not the fountain of our knowledge.

Ke a leboga. Ka lerato.

**Abstract**

Obstetric violence has increasingly become visible following research, advocacy, and activism by researchers, feminists, birth advocates, and scholars worldwide. This visibility is a result of the courage of women who have begun to speak openly about their childbirth experiences. Much of what has been written is framed within biomedical, feminist, public health, and sociological perspectives. Indigenous midwives are rarely mentioned in the literature on obstetric violence.

This dissertation is an explorative and descriptive qualitative design using thematic analytical framework to explore lessons we can learn from Indigenous midwives to counter obstetric violence in South Africa. Adopting the Indigenous research methodology and Indigenous feminist theory, I undertook semi-structured in-depth individual interviews with 28 rural women sampled into three groups: 1) 10 women who gave birth in a healthcare facility assisted by biomedical healthcare practitioners, 2) 10 women who gave birth at home assisted by Indigenous midwives, and 3) eight Indigenous midwives who attend to women in their communities. I undertook the interviews using five languages i.e., Siswati, Xitsonga, Setswana, Sepedi and Sepulana. These are languages spoken across three provinces (Mpumalanga, Limpopo, and Northern Cape) in which the research was undertaken. Interviews were transcribed and translated into English.

The study revealed that women who gave birth in healthcare facilities experienced dehumanised care in the form of abandonment and neglect, unconsented medical procedures, suturing of the perineum without anaesthesia, abusive care and lack of cultural safety. Women who opted for home birth under the care and supervision of elders shared positive experiences of childbirth in the form of care and support during delivery, freedom to choose birthing position, holistic care that transcends the physical as well as participation in childbirth rituals and ceremonies. Interviews with Indigenous midwives deepened an understanding of the conception of birth beyond physiology to include social, cultural, and spiritual dimensions. In their view, birth is not just a physiological phenomenon, but it is also a spiritual rite of passage.

Research on obstetric violence often recommends solutions that seek to humanise medicalised birth without interrogating the impact of Western biomedicine which was exported to Africa during colonialism. This resulted in the suppression of knowledge and practice of Indigenous midwives. Countering obstetric violence without re-centering the knowledge and practices of Indigenous midwives constitutes a form of biomedical humanism (Gaines & Davis-Floyd, 2003) that upholds obstetric hegemony (Campo, 2014).

In this thesis, I argue that responses to obstetric violence must 1) de-centre biomedical birthing as a site of obstetric violence, 2) decolonise midwifery by re-centering Indigenous model of childbirth, and 3) integrate cultural safety in the definition of safe birthing practices. I conclude that a call to counter obstetric violence is incomplete if it continues to silence the voices of Indigenous midwives and exclude their knowledge and practices.

**Keywords:** Biomedical midwifery, medicalisation of childbirth, humanising childbirth, Indigenous model of childbirth, Indigenous midwifery, Indigenous research methodology, hierarchy of birthing knowledge, mistreatment, obstetric violence.

**Glossary, list of abbreviations and acronyms**

| | |
|---|---|
| ANC | Antenatal care |
| Badimo | Ancestors |
| Botsetse | Period of giving birth |
| C/S | Caesarean section |
| ICN | International Council of Nurses |
| IKS | Indigenous Knowledge System |
| ILO | International Labour Organisation |
| IMR | Infant Mortality Rate |
| Kgosi | Traditional Leader |
| Kgosana | Village Headman |
| Lekgotla | Traditional Council |
| Mmelegisi | Midwife |
| MMR | Maternal Mortality Rate |
| NDoH | National Department of Health |
| OV | Obstetric Violence |
| Postnatal | After Birth |
| Post-partum | After Birth |
| SANC | South African Nursing Council |
| SBA | Skilled Birth Attendant |
| TBA | Traditional Birth Attendant |
| THP | Traditional Health Practitioner |
| UN | United Nations |
| WHO | World Health Organisation |

# Table of Contents

## List of Figures

## CHAPTER 1: Introduction – Setting the scene

### 1.1 The beginning of the story

Wrapped in a blanket of darkness, a woman arrived at the hospital with a contorted torso. Her contractions sent shock waves from her hair follicles to the soles of her feet. Yet, she wobbled silently like a penguin towards the maternity ward. Her family drove with her in the back of a van. The matriarch of the clan who delivered all her babies at home, was also present. After waiting for what seemed like an eternity, the nurse called the woman to be examined by the doctor. The matriarch rose to her feet to follow. The nurse gave her a menacing look and walked away. Because she could read people, even though she could not read the alphabet, the matriarch sat on the bench, quietly. Later, she rose again when her daughter wobbled to the delivery room. She was reminded with a stare – this is not your place. The matriarch could hear her daughter's moans from where she was seated. To respond to the muffled sound of her daughter's labour pain, she began to tap on her lap like a drum. With her eyes closed, she invoked her ancestors for the safe landing of the baby and the good health of the mother. This space, where her descendants are ushered into the world, does not allow her to lead any rituals. Instead, her daughter's body is subjected to a multiplicity of foreign rituals. Dressed in an open gown that exposed her back and bottom, she struggled to climb on a high bed attached to tubes connected to machines. Finally, as she lay on her back with her legs raised in stirrups exposing the fullness of her genitalia, she was ready to push the baby out. To process the humiliation and shame that comes with such exposure, she left her body, even as her heart continued to beat furiously. From this position, she had no option but to hand over her body to the doctor who cut her perineum with scissors without even knowing her name, let alone asking for her consent. In no time, a whole human being was yanked out of its mother's body. There were no invocations. No chants. No ululation. No rituals to connect the departed, the living, and the unborn. Because she was not allowed to be part of the hospital rituals, the matriarch asked to take the placenta home. That, too, was denied.

## 1.2 Who is in the labour room?

Access to a room depicts one's power or powerlessness. Using examples of rooms such as newsroom, conference room, boardroom, the philosopher, Olufemi Táíwò, contends that access to these rooms is "often gained through some prior social advantage." (Táíwò, 2020, p. 1). Using what he refers to as standpoint epistemology, he argues that those affected by social injustice are often left out of the rooms or ignored by powerful people who occupy these rooms. As an attempt to give context to the story narrated above, I use his analogy to ask a few questions. Who has access to the labour room? What power and privilege do they have? Why is the matriarch not denied access to the room? What gives the midwife the power to deny her access? Who are the occupants of a labour room and how did this come about?

From time immemorial, birthing has always been in the hands of women. Mythological studies speak about goddesses and priestesses who were responsible for labour (Flemming, 2007a). Similarly, prehistoric drawings reveal pictures of women in a company of other women giving birth at home squatting or sitting on a birthing stool (Drife, 2002). Over time, as biomedicine became the property of male professionals who advanced a persuasive argument that the hospital is a safe place for babies to be born, childbirth was moved from home to hospital. This came with the introduction of instruments and machines which eroded the human element of birthing (Gamarnikow & Donnison, 1978). This increasing medicalisation of pregnancy and childbirth extended to the overall control of a woman's body.

The move from home to hospital brought forth suppression of midwifery which was accompanied by attack and denigration of women; a move which was supported by religion. The Great Goddess whose worship once served as a foundation for an egalitarian society was replaced by the male God who used a dominator model of power (Ehrenreich & English, 2010). Fuelled by the obsession with witchcraft and witch hunting of the Middle Ages, the Church, State and medical industry enforced patriarchal ideologies which suppressed women's sexual and healing powers (Drife, 2002; Gamarnikow & Donnison, 1978). When medicalisation of childbirth reached a peak in the 20$^{th}$ century, pregnancy and labour became a pathology that required medical intervention. Cahill (2001) argues that "the appropriation and medicalization of pregnancy by men is rooted in the patriarchal model that has been centuries in the making" (Cahill, 2001, p. 334). This medicalised model of childbirth was

exported to Africa during colonialism. By the time medical missionaries arrived in the Cape, they had already been through an era of the rise of medical dominance over birth which started in Europe in the early 19th century (Conrad, 1992).

In her critique of the medicalisation of birth, Dixon (2015) argues that because of the deference of power from the birthing woman to the institution and biomedical health practitioners who happen to be male, the hospital has become a site of obstetric violence (Dixon, 2015). In their critique of obstetric violence, Western[1] feminists advocated for a re-humanising of birthing which foregrounds the woman as an informed, empowered, and active participant who has the right to make informed decisions about her body and the birthing process (Conrad, 1992; Cahill, 2001; Beckett, 2005; Kitzinger, 2008). While these advocates of humanised birthing have been vocal against medicalised birth, many focused on a critique of medicine without interrogating unequal power between biomedical and Indigenous models of birthing. This lack of focus on the impact of colonialism on Indigenous midwifery is not limited to Western feminist practice. African feminists and midwives also advocate for respectful birth without interrogating the impact of colonialism on Indigenous midwifery.

In this study, I review Indigenous[2] midwifery with an eye of history to investigate ways in which the exportation of the biomedical model of birth during colonialism suppressed the knowledge and practices of Indigenous midwives. Specifically, the study was aimed at exploring the role of Indigenous midwives in countering obstetric violence. In my perusal of literature on Indigenous midwifery in South Africa, I could not find any study that included knowledge and practices of Indigenous midwives as a solution to the ever-increasing prevalence of obstetric violence in health-care settings.

Now to answer the questions: Who has access to the labour room? It is the obstetrician, Western trained biomedical midwives, and other professionals or technicians who intervene

[1] I use the term Western as a concept that depicts regions or countries that are in what is commonly referred to as the Global North. These include Europe and North America. Even though Australia and New Zealand are not located in the northern part of the globe, they are counted as part of the Global North not because of their cardinal position but because of global political and socio-economic reasons.

[2] Throughout the study, I capitalise Indigenous as a sign of respect for Indigenous peoples of the world.

on the body of a birthing woman, often without her consent. The next question is what/who gave the midwife the power to deny the matriarch access to the room?

South Africa adopted a Western biomedical model of medicine as its primary model of health care provision. Adoption of a biomedical model of medicine brought with it the medicalisation of childbirth. Included in this is how the history of midwifery in South Africa followed the footprints of a Western model of childbirth. Through its social construction within a medical framework of pathology and risk, the biomedical model of childbirth is accepted as the norm. In the process, other birthing knowledges, including knowledge and practices of Indigenous midwives, are devalued, or labelled as backward, if not dangerous. This ignores and overlooks the role of colonialism in suppressing the knowledges and practices of Indigenous midwives. According to a Western, interventionist, technocratic model of childbirth, the matriarch's presence in the labour room is an unnecessary interference and her knowledge is obsolete.

### 1.3 Who am I in the story?

Common convention dictates that people do research to understand others. Janesick (2007) argues that people undertake research to understand themselves better. This view on research speaks to me. At a personal level, my choice of this topic was an act of healing. I am a biomedically trained nurse and midwife, an African spiritual healer, a writer, and storyteller with a keen interest in integrating Indigenous teachings with modern innovations. I undertook my nursing and midwifery training at a rural hospital in the former Transvaal in the late 1970s. As a trained biomedical midwife, I have reflected on ways in which I was complicit (albeit unknowingly at the time) with the processes of dehumanising childbirth. As I read through the literature on obstetric violence, I was struck by the way in which biomedical midwifery training colluded with the disempowerment of birthing women. I look back at my life as a young woman who, at the tender age of 17, was initiated in the Western model of birthing. In my training, there was never any mention of Indigenous midwifery. Many decades later, I find myself undertaking research on the role of Indigenous midwives as a counter to obstetric violence in the same geographic area where I was trained to uphold the superiority of Western biomedicine. At a spiritual level, undertaking this study was an act of liberation. There were moments in the journey where I was caught in a traumatic in-between space between a colonised midwife, and a decolonising one, all in one person. I receive this study as an invitation to heal my birth trauma and the trauma of women who came before me.

## 1.4 Aims and objectives

The overall aim of the study was to explore the role of Indigenous midwives in countering obstetric violence in South Africa. This was premised on the following objectives:

1. Documenting rural women's childbirth experience in health facilities facilitated by biomedical health practitioners.
2. Exploring rural women's experience of home birth facilitated by Indigenous midwives.
3. Re-centering Indigenous midwives' knowledge and insights about pregnancy and childbirth.
4. Exploring ways in which Indigenous midwives can counter obstetric violence.

## 1.5 Research question

The main research question is: *What can we learn from Indigenous midwives to counter obstetric violence?*

### 1.5.1 Sub-questions

1. *How do rural women who gave birth with biomedical practitioners in healthcare facilities describe their experience?*
2. *How do rural women who gave birth with Indigenous midwives at home describe their experience?*
3. *What can we learn from these women's experience of birth about the role that Indigenous midwives can play in countering obstetric violence in the South African context?*

## 1.6. Definition of key concepts

### 1.6.1. Humanisation of childbirth

In the literal sense, humanisation refers to the act of making humans. What then does dehumanisation of health care mean? Hague & Waytz (2012) describe this as denial of humanity to humans (Haque & Waytz, 2012). This includes stripping of agency (capacity to choose) and experience (capacity to feel). From the outset, Hague & Waytz (2012) contend that dehumanisation in health care does not result from malicious intent. Instead, it is an

unconscious by-product of the inherent functionality of a medical environment. Such inherent dysfunctionality takes various forms, namely:

- Mechanisation: This originates from the conception of the body as a machine. Thinking of patients as entities made up of separate parts can be useful for diagnosis. Mechanisation occurs "because decomposing people and their symptoms into physiological systems and subsystems (from organ systems to organs to tissues to cells to molecules) is necessary for problem solving" (Haque & Waytz, 2012, p. 178). Combined with technology, diagnosis reduces the person into a set of observations, symptoms, and data which the clinician relies on for treatment. In other words, connecting pathology to symptoms occurs at the level of abstraction that disregards the patient's humanity.
- Empathy reduction: Failure to consider the patient as a full human being has the potential to reduce empathy. The reduction of empathy, Haque & Waytz (2012) argue, is necessary as a coping mechanism to regulate the emotional response to pain. Medical training also encourages this regulation of pain for purposes of effective diagnosis and treatment because humanising patients can "increase stress, and medical caregivers use dehumanisation spontaneously as a method to cope with stress" (Haque & Waytz, 2012, p. 179)
- Moral disengagement: To survive, biomedical practitioners need to "suspend themselves temporarily from their role in committing harm" (Haque & Waytz, 2012, p. 179). Thus, dehumanisation makes it easier to hurt others without personal distress. To survive, the biomedical practitioner must be emotionally detached from the patient.

The above inherent functionalities are enforced through various hospital procedures such as de-individuation and impaired agency. For example, being ill or incapacitated forces the patient to defer their decision-making powers to the healthcare practitioner. Similarly, a patient who is admitted to hospital is de-robed; she takes off her own clothes and anything that may be part of her identity. Meanwhile, caregivers are individuated through their uniform e.g., white coat and stethoscope and use of language that the patients do not understand.

The phrase "humanisation of childbirth" was first used by obstetricians who advocated for the use of forceps and other medical interventions in the early 20$^{th}$ century (Diniz, 2005). This reinforced a growing trend which conceptualised birth as a pathology which required medical

intervention by doctors who were largely male (Rattner, 2007). A highly medicalised birth came with a degree of dehumanisation.

Even though the term was first used by obstetricians in parts of Latin America, the concept was used by women to create a campaign that challenged the dominant medical birth narrative (Laako, 2017). The humanisation of childbirth campaign argued that the medical view of childbirth focused on access to medical services and not so much on safeguarding women's reproductive rights. This includes protection from obstetric violence. In the end, Laako (2017) cautions that while international activism continues to shift in favour of midwives, it remains stuck in the clinical approach (Laako, 2017). Davis-Floyd (2022) makes a distinction between superficial humanism which is comprised of compassionate treatment, creating comfortable birthing spaces, and allowing labour companions; and deep humanism which is about reconnection of the spirit and energies of the birthing mother and the baby (Davis-Floyd, 2022). What is different with superficial humanism is a woman may be treated kindly while she is subjected to multiple technological interventions some of which may be painful and unnecessary.

Wagner (2001) describes the humanisation of childbirth as an approach that understands that the woman is a human being and not a machine (Wagner, 2001). I argue that putting a woman in the centre of a birthing process calls for the de-medicalisation of childbirth. This relates to the physical birth space as well as the emotional and spiritual dimensions of childbirth. In this study, women who gave birth in healthcare facilities complained about beds being too high. According to labour room architecture, the customary practice is to put a high bed in the centre of the room. This is to make it easy for healthcare practitioners to carry out medical interventions. Further, a high bed in a healthcare facility does not allow for the use of any position other than supine or lithotomy. To humanise childbirth, the physical, cultural, and spiritual birthing space must change. The architecture of the birthing space is as important as institutional procedures that are carried out during birth.

### 1.6.2. Obstetric violence

Simply put, obstetric violence refers to violence that women are subjected to during childbirth. To try and define obstetric violence, researchers developed different typologies to describe various forms of violence. Bowser and Hill (2010) first identified seven categories of

disrespectful and abusive care during childbirth. These categories include physical abuse, non-consensual clinical care, non-confidential care, non-dignified care, discrimination, abandonment, and detention in healthcare facilities, mostly because of the inability to pay fees. In their report, these researchers use the words 'disrespectful birth' or 'abuse' and not 'violence' (Bowser and Hill, 2010). Later, Freeman and Kruk (2014) criticised the above review on the basis that these categories do not differentiate between forms of disrespect that stem from an individual's behaviour and those that result from systemic and structural health deficiencies (Freedman & Kruk, 2014). Expanding on seven categories, these researchers define disrespect and abuse during childbirth in relation to interactions of facility conditions deemed to be humiliating, undignified, or intended to be humiliating or undignified. In another study that reviewed systematic mistreatment of women during childbirth in 34 countries across all geographical and income levels, Bohren et al. (2015) further argued that the seven categories mentioned earlier lack operational definitions and can therefore not be standardised (Bohren et al., 2015). The original overarching categories were divided into several first and second-order subgroups to include physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and healthcare providers and healthcare system conditions such as lack of resources needed to provide women with privacy. Venezuela was the first country to use obstetric violence as a legal term in 2007 (Borges, 2018; D'Gregono, 2007; Pérez D'gregorio, 2010; Sadler et al., 2016; Williams et al., 2018).

### 1.6.3. Traditional birth attendant vs Indigenous midwife

The World Health Organisation (WHO) has defined two categories of birth attendants namely, skilled birth attendant (SBA) and traditional birth attendant (TBA). Skilled birth attendant is described as an accredited professional who is trained to manage childbirth. This includes physicians, midwives and nurses. Traditional birth attendant (TBA) is described as a person who acquired her skills by delivering babies herself or through apprenticeship with other TBAs (Wilson et al., 2012). The words "training" or "acquisition of skill" are mentioned in these two definitions. This implies that both practitioners have acquired some form of knowledge. One needs prior knowledge to practise a skill. Knowledge is information acquired through various inputs such as reading, writing, listening, and observation. Skills are acquired through practice. Practise pertains to continuing and consistent application of knowledge. According

to the WHO, a biomedical midwife possesses knowledge acquired through reading books, listening to lectures, observing tutor's skills, and attending to a woman during delivery whilst supervised by a skilled midwife. By virtue of having a skill, a traditional birth attendant also possesses knowledge acquired not by reading or writing the alphabet but by reading embodied knowledge of childbirth, listening to, and observing elders' birthing skills, and attending to a birthing woman whilst being supervised by a 'skilled' elder.

Given that skills are acquired in both definitions, does it mean that education only happens in a Western context? Further, one attendant is referred to as a skilled birth attendant while the other is described as a traditional attendant. Does being traditional preclude being skilled? The Setswana word for education is *thuto.* A learned person is not limited to someone who has gone through a Western education system because *thuto* comes in different forms. WHO's description of a traditional birth attendant acknowledges that skills have been acquired by delivering babies. According to the two definitions, the midwife and traditional birth attendant use an apprenticeship model of learning. However, the definition of traditional birth attendant does not regard learning from other women who are not 'professional' as education. The use of concepts such as 'formal' or 'professional' or 'education' is ascribed to the acquisition of Western knowledge. Traditional birth attendants are classified as 'uneducated' because they do not possess Western knowledge of birthing. This means that the veracity of their knowledge is questioned because they are not proficient in Western knowledge (Bruchac, 2020). Briggs and Sharp (2004) remind us that Western science is an Indigenous knowledge that is located within institutions of the West. This localised knowledge was transformed into universal knowledge through colonialism and neo-colonialism (Briggs & Sharp, 2004).

Before the use of English as a colonising and development language, the term 'traditional birth attendant' did not exist. What existed were Indigenous names such as *Mmelegisi* in Setswana. *Mmelegisi* comes from the verb *belega* (to deliver a baby). Like many other words in Indigenous languages, *belega* has multiple meanings. *Go belega* can mean giving birth, providing support, or carrying something, for example, carrying a baby on your back. Within the context of birth, the name *Mmelegisi* refers to a woman who delivers babies. As a Motswana researcher, it would be easy for me to use the term *mmelegisi* because of its clarity on the role of the Indigenous midwife. However, using the term throughout the text will affect the flow of the writing. This, I accept, is one of the academic contradictions that come with undertaking Indigenous research within an institution that uses a language foreign to my research area.

For purposes of this study, I use the term 'Indigenous midwife' for two reasons: my choice is a form of resistance to the term 'traditional,' which can be associated with colonial depictions of African knowledge as inferior and/or backward. I also choose not to use the term 'attendant' because it devalues Indigenous midwives' knowledge of childbirth.

### 1.6.4. Framing Indigenous knowledge

Diverse groups of people create Indigenous knowledges from across the world. Knowledges are used in the plural as an acknowledgement of a diversity of knowledge bases and different people who produce such knowledges. This is necessary to counter the common conception of Indigenous knowledge as homogenous. (Smith et al., 2016, p. 136) argues that Indigenous knowledges predate European imperialism and colonialism and that those who passed on left "legacies of amazing technological feats including complex city structures, plumbing systems, calendars, classification systems and intricate understanding of the worlds they created".

Even though such knowledge tends to be expressed in songs, folklore, proverbs, myths, and spiritual practices that are embedded in the language and culture of the people, Odora-Hoppers (2002) cautions that Indigenous knowledge is not limited to arts, culture, and spirituality. Rather, it includes knowledge employed within disciplines such as agriculture, obstetrics, health, nutrition, metallurgy, animal husbandry, astronomy, nature conservation, sustainable development, and many others (Odora-Hoppers, 2002). This refutes the

suggestion that Indigenous knowledge is largely intuitive with little rational thought and that Western science is purely rational (Liberda et al., 2021).

Within the development sector, the term 'Indigenous' surfaced in the 1980s when United Nations-funded programmes on sustainable development became concerned about the loss of biodiversity and ecosystems in developing countries (Nakata, 2002, 2007). The proponents of Indigenous knowledge argued that local knowledge was necessary to solve development problems. However, this came with a qualification that Indigenous knowledge had to be validated by the West before it could be recognised as knowledge (Rewi et al., 2022). In academia, Indigenous knowledge first emerged as a field of study within the domain of anthropology (Nakata, 2007; Stewart-Harawira, 2013). This was followed by a merger of anthropology and psychology in the 1960s, a move strengthened by the assumptions of Western social scientists who employed the hegemony of Western research methodologies to accord themselves the right to define Indigenous people's personality development (Stewart-Harawira, 2013). This resulted in the erasure of Indigenous knowledge and was accompanied by the loss of land, language and cultural heritage (Smith, 1999). In writing about cognitive imperialism in Canada, Pictou (2020) describes this as colonial violence against bodies, land, and nature (Pictou, 2020). This control over bodies and ancestral land, Pictou (2002) argues, normalised patriarchy by giving less rights to Indigenous women. Before then, land and women were revered as sources of life.

In the same way as in development, Indigenous knowledge in academia was framed from a pathology and deficit perspective. The perception was that Indigenous knowledge is an issue that needs to be corrected or improved by being incorporated into the Western curriculum (Rewi et al., 2022). Because of its monocultural approach, academia marginalised, devalued, misappropriated, and misinterpreted Indigenous knowledge by privileging Western knowing. In the end, Indigenous researchers are faced with the dilemma of advocating against colonial discourses while they navigate the requirements of degrees in institutions of learning known to be complicit with the colonial agenda (Rewi et al., 2022).

## 1.7. Research design and methodology

### 1.7.1. Research design

For this study, I employ exploratory and descriptive qualitative research designs. Robson (2002) identifies three forms of qualitative research designs: exploratory, descriptive, and explanatory (Robson, 2002). Distinction between the three depends on the study's objective. For instance, the aim of explanatory research is to explain why a phenomenon occurs, as well as predict possible future occurrences. The goal of descriptive research is to give an overall picture of people, circumstances, or events. It cannot explain why an event has occurred. Exploratory research is used to explore a topic that has not been well researched before or to explore an already existing topic with a view of producing new knowledge (Saunders et al., 2009; Swedberg, 2020). Obstetric violence is not a new concept. Exploring the role of Indigenous midwives in countering obstetric violence is a new framing of the problem.

## 1.8. Theoretical Framework

### 1.8.1. Indigenous research theory

A study on Indigenous midwifery seeks to challenge the view that the biomedical model of birth is superior. This challenges normative birthing practice and academic imperialism. 'Academic imperialism' is a phrase coined by Chilisa (2012) to refer to a practice where conceptual and theoretical frameworks and research methodologies that stem from the Global North continue to promote the superiority of Euro-Western thought (Chilisa, 2012). Chilisa (2017) concedes that African scholars trained in Western education in African universities continue to use methodologies embedded in Western cultures (Chilisa, 2017). In such a case, research can become a tool for ongoing colonisation.

In my search for a research design that fits this study, I considered a range of research methodologies which include transformative, postcolonial, decolonial and participatory action methods. The search (and the trauma response that comes with it) is described in detail in Chapter 4. My choice of Indigenous qualitative exploratory and descriptive research is based on a need to highlight and challenge the prevailing epistemological difference between Western and Indigenous research approaches. In the end, I incorporated principles of Indigenous research in the design which include relationality, respect, responsibility,

reciprocity and relevance (Chilisa, 2012; Hollingsworth, 2011). Employing an Indigenous research methodology is about immersing oneself in research methodologies that respect the beliefs, cultural protocols, and worldviews of communities. My interaction with women in their homes and healing huts, as well as participating in some of the rituals and ceremonies, gave me a glimpse of what total immersion would look like.

### 1.8.2. Indigenous feminism

Gearson (2021) describes Indigenous feminism as "an intersectional theory and practice of feminism that focuses on decolonization, Indigenous sovereignty, and human rights for Indigenous women and their families" (Gearon, 2021, p. 1). In her view, Indigenous feminism seeks to dismantle systems of capitalism, colonialism, patriarchy, and white supremacy. This means Indigenous feminism looks beyond patriarchy as the sole problem that women face (Msila, 2021). Instead, Wane (2011) argues, the pursuit of gender equality must be coupled with advocating for the sovereignty of Indigenous people (Wane, 2011). This includes the reclamation of lost cultural and spiritual knowledges. Land and nature remain key sources of such knowledges.

Within many Indigenous cultures, birth is a sacred ceremony that ushers an individual from the spiritual to the physical world (Giralt, 2017; Ohaja & Anyim, 2021; Wojtkowiak, 2020). In their role as midwives and leaders of birth rituals and ceremonies, older women serve families, clans, communities and land (Smith, 2017). The association of land with the placenta is worth a mention. The ritual of returning the placenta to the land is a way of centering a newborn child on land. In many Indigenous cultures, women and land were held in the highest regard as providers of life. In the Māori language, for example, land and placenta use the same name: *whenua* (Stewart-Harawira, 2007). Drawing from the Indigenous feminist literature, I argue that an Indigenous feminist approach to obstetric violence is necessary to acknowledge centuries of colonialism, which resulted in the systematic suppression of Indigenous birthing practices. By excluding Indigenous midwifery, Western feminist theory colludes with biomedicine to suppress Indigenous women's knowledge of birthing. An inclusive feminism, Stewart-Harawira argues, "is one that will not only recognise difference but seeks to disrupt the privileging impact of the unequal structures of power" (Stewart-Harawira, 2007, p.4). In this thesis, I argue that feminist advocacy against obstetric violence lacks inclusivity if it fails to integrate the knowledge and practices of Indigenous midwives.

## 1.9. Context of the Study Setting

I interviewed 28 women in three provinces in South Africa: Mpumalanga, Limpopo, and Northern Cape (Figure 1).[3]


*Figure 1: Provinces of South Africa*

In Mpumalanga, interviews were conducted in rural villages located in Bushbuckridge, Sabie, Graskop, and Skukuza. These are rural towns spread across three local municipalities: Bushbuckridge, Thaba Chweu, and Nkomazi. These are in the Lowveld, 410 km east of Pretoria (see Figure 2).[4]

[3] Map_of_South_Africa_with_English_labels.svg.png

[4] https://municipalities.co.za

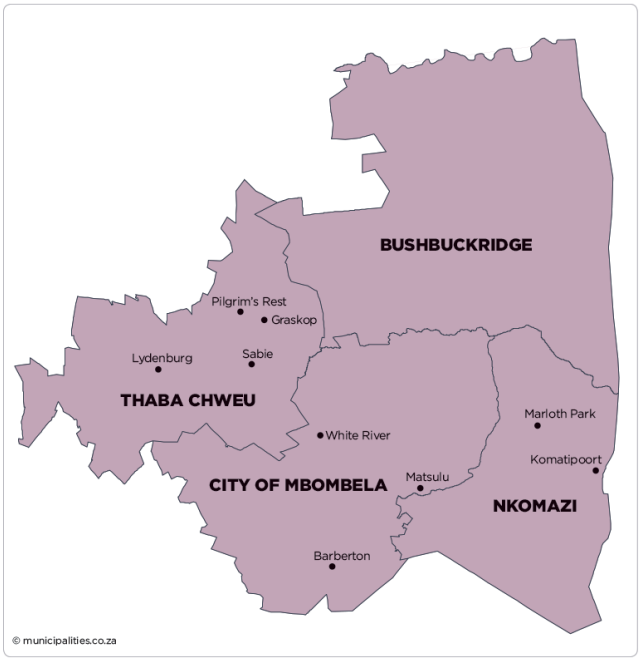


*Figure 2: Municipalities of research site in Mpumalanga*

In Limpopo, interviews were conducted in Klopper village located in Makhuduthamaga municipality, in Sekhukhune District. Makhuduthamaga municipality is situated 247 kms north-east of Pretoria (see Figure 3).[5]

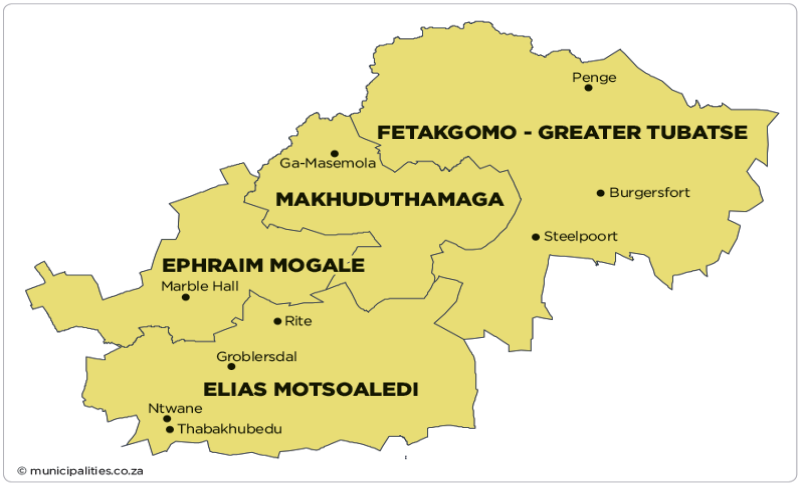


*Figure 3: Municipality of research site in Limpopo*

[5] https://municipalities.co.za

In the Northern Cape, one extended interview with an Indigenous midwife was conducted in Magojaneng village, 614 kms south-west of Pretoria, located in Ga-Segonyana municipality, between the towns of Vryburg and Kuruman (see Figure 4).[6]

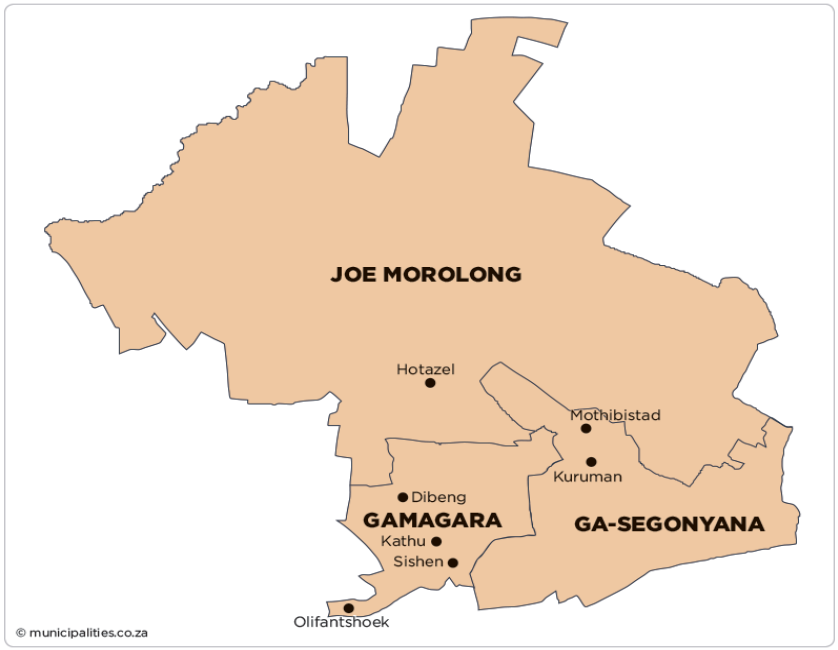


*Figure 4: Municipality of research site in Northern Cape*

All the research sites were rural and characterised by high levels of unemployment, poverty, and lack of basic services such as water. My first point of contact in Bushbuckridge was Ntate Malele, an elder serving as a member of the Traditional Council in one of the main villages in Bushbuckridge. In honouring the principle of respect for Indigenous governance, Ntate Malele accompanied me to meet with the Traditional Council, where he introduced me and helped me seek permission to interview women in local villages. After obtaining the Traditional Council's clearance to commence with the research, Ntate Malele introduced me to a local traditional healers' organisation called Hlakaniphani, led by Ntate Mashaba, who resides in Bushbuckridge. Ntate Mashaba introduced me to another elder, Gogo[7] Lindiwe, who resides in the neighbouring town of Sabie. Gogo Lindiwe served as my research community guide. Towards the end of my data collection process in Mpumalanga, a Facebook friend, Letlhogonolo Sechogela, referred me to an Indigenous midwife who lives in Northern Cape.

[6] https://municipalities.co.za

[7] *Gogo* is a Nguni word used for grandmother. In African spiritual healing terms, the term is also used for initiated healers. Sometimes the title is used for male healers who carry a female healer spirit.

At the end of my data collection process, I was informed by one of the healers in Limpopo about two elders in Klopper village in Limpopo. An elder I know from my previous work with rural women, Mme Tsiane, organised for me to interview the two participants. They were the last participants I interviewed. It took me over a year to complete the data collection process.

## 1.10. Thesis outline

**Chapter 1: Setting the scene**

This chapter begins with a birth story that contextualises the research question by way of demonstrating a divergence of knowledge between biomedical and Indigenous birthing practices. Beyond defining the research question, the chapter provides an overview of the research design, methodology, and theoretical framework. The chapter ends by providing an outline of the thesis.

**Chapter 2: Biomedical model of childbirth**

The chapter gives an overview of the biomedical model of birth in the West, followed by an exposition of how obstetric violence is embedded in a medicalised, interventionist, facility-based model of birth which was exported to developing countries during colonialism.

**Chapter 3: Indigenous model of childbirth**

This chapter gives an overview of Indigenous midwifery in Africa. This is followed by an exploration of how the exportation of the biomedical model was used as a colonial tool. This factor resulted in the suppression of the knowledge and practice of Indigenous midwives. The chapter ends with an interrogation of the hierarchy of knowledge between biomedical and Indigenous models of childbirth.

**Chapter 4: Research design and methodology**

This chapter provides the theoretical framework that underpins the study. It begins by sharing the discomfort of being sandwiched between two opposing epistemologies. This is followed by an exposition of the Indigenous research paradigm and Indigenous feminist theory as a fitting theoretical framework for the study. Further, the chapter outlines methodology, methods, setting, participants, data collection, and the analytical framework.

**Chapter 5: Women's experience of childbirth**

This chapter presents the findings of interviews with two groups of women: women who gave birth in a healthcare facility (n=10) and women who gave birth at home (n=10).

**Chapter 6: Knowledge and practice of Indigenous midwives**

This chapter presents findings of interviews with eight Indigenous midwives who were asked questions about their knowledge and practice of Indigenous midwifery, followed by an exploration of how such knowledge can help to counter obstetric violence.

**Chapter 7: Struggling to be re-born – a reflexive review of my research journey**

This chapter is a reflexive chronicle of my research journey. It is my attempt to gain a deeper understanding of the cultural and spiritual context within which the relational co-creation of knowledge occurs. By centering an extended conversation with one of the custodians of Indigenous knowledge in Setswana, I challenge the Western construction of knowledge and knowledge-holders of childbirth.

**Chapter 8: Discussion, conclusion, and recommendations**

This chapter presents discussion of the findings, limitations, conclusion, and recommendations for future research.

## CHAPTER 2: Biomedical model of childbirth

### 2.1. Introduction

The purpose of this chapter is to review literature that helps to contextualise changes that took place in childbirth in Western societies and its implications for birthing practice in Africa. Literature search engines used for this purpose were Google search and CORE. The chapter begins with a historical overview of childbirth in the West from the Greco-Roman era. During this era, health was dominated by religion and spirituality (Kuoni, 2021; Marino, 2010). With the spread of Christianity and its focus on morality and sexuality, religious leaders sought to contain and control women's knowledge about conception, pregnancy and childbirth (Gamarnikow & Donnison, 1978). Emboldened by the discovery of forceps, this precipitated a transfer of birth from a home-based and women-centred environment to facility-based and male-led practice (Gamarnikow & Donnison, 1978; Newburn & MacFarlane, 2002). For this to thrive, the woman's body was defined as a machine and pregnancy as a pathology (Cahill, 2001; Westergren, 2021). This process of medicalisation of childbirth came with the suppression of midwifery which was at times accompanied by physical and spiritual attacks on women (Garratt, 2014).

In their response to the medicalisation of childbirth, feminists' critique varied from advocating against the take-over by male professionals and women's loss of control over birth (R. E. Davis-Floyd, 1994; Oakley, 1980; Rothman, 1982) to challenging the notion of women as passive subjects and the construction of technology as inherently patriarchal and bad (Annandale & Clark, 1996; Lorentzen, 2008; Pringle, 1998). While feminists differ regarding their critique of the medicalisation of childbirth, some argue that the depiction of birth as a medical condition predisposes women to obstetric violence (Bellón Sánchez, 2014; Chadwick, 2016; Pollock, 1999; Rothman, 1982; Shabot, 2020) while others argue that over-medicalised birth constitutes an act of obstetric violence (Chadwick, 2016; Koitsioe & Swemmer, 2022; Martín-Badia et al., 2021; Sadler et al., 2016). The critique of medicalisation was not limited to feminists. Midwives challenged and resisted the biomedical paradigm by continuing to provide holistic care as well as speaking out against the harm caused by what they regarded as unnecessary medical interventions (Allotey, 2011).

The chapter also gives an overview of obstetric violence globally and in South Africa. Building on the work of feminists cited above, I argue that obstetric violence is embedded in a colonial biomedical model of childbirth, which was exported to developing countries through colonialism. By introducing biomedical midwifery, colonial medicine positioned the biomedical model of birth as authoritative knowledge (Jordan, 1983). This contributed to the suppression of Indigenous birthing rituals and ceremonies (Davis-Floyd, 1994). A counter to obstetric violence is incomplete if it fails to decentre biomedicine and re-centre the role of Indigenous midwives in childbirth.

## 2.2. Historical overview of birthing during the Greco-Roman era

The main objective of this section is to illustrate the transfer of normal home births to medicalised births from ancient Western societies to the present. It is beyond my expertise and the scope of this thesis to write a comprehensive historical overview of childbirth during this era. What follows is a synthesis of some of the social factors that influenced and reinforced the shift of childbirth from women to men, from normal to pathology, as well as from home to hospital. The intention is to trace the impact of birthing in Western societies on birthing in Africa generally and in South Africa specifically.

Childbirth in ancient Greece was largely governed by patriarchal religious and spiritual beliefs (Flemming, 2007; Persson, 2016). One of the significant mythological stories that influenced the societal perception of women and womanhood during this time is the Pandora myth. A story is told about the first woman created by Zeus, the father of good and men, the establisher of law, order, and justice. This first woman was created as a punishment to Prometheus, who deceived Zeus by stealing the sacred fire and giving it to men. Zeus ordered the gods to make an evil woman dressed in fine garments and gave her the name Pandora. She would bring grief to all men since men could take pleasure in her, thereby becoming evil themselves. Pandora was sent to Epimetheus as a gift. Epimetheus, who was Prometheus' brother, had been forewarned by the latter not to accept the gift. Despite being forewarned, he accepted the gift only to regret it later. When Epimetheus accepted the gift, Pandora, carrying a jar filled with evil and hope, opened the lid, and evil flowed out. She then put on the lid and left hope inside. Humankind was now filled with evil and sickness (Persson, 2016).

While acknowledging the existence of many versions of the Pandora myth, Zeitlin (1996) argues that it is not different from the story of Eve in the Garden of Eden (Froma, Zeitlin, 1996). Eve is created from Adam's rib to ease his loneliness. At first, they were not embarrassed about their nakedness. A serpent convinced Eve to eat the forbidden fruit and she gave some to Adam. In Pandora's story, she is created in retaliation for Prometheus's theft of fire. Zeitlin (1996) opines that a woman's entry into the world is associated with evil and suffering (Froma, Zeitlin, 1996). Both Eve and Pandora are perceived as evil, and they are punished for their evil acts.

During this era, men's perception of women was shaped by mythological stories of evil women. Good woman roles were assigned to a perfect wife, while bad ones were given to lovers, concubines, rebels, and witches (Persson, 2016). To control and contain women, girls were married off from the age of 12 or younger. Once a girl reached puberty, she would be married off and no longer be a member of her family of origin. To gain the full status of a wife, a woman had to give birth to a son. It is worth noting that even though these beliefs were practised during ancient Greco-Roman societies, some of them are currently accepted as African culture.

Romans believed that a male child is conceived by the sperm from the right testicle which is higher than the left. In order to avoid having a girl, a man was advised to tie a cord around the left testicle during intercourse (Cook, n.d.). During that time, knowledge about conception and childbirth was the exclusive province of women. Midwives received knowledge from other women such as grandmothers, mothers or other women in the community (Dasen, 2011a; Drabkin, 1944). The midwife possessed birthing knowledge and knowledge of other branches of medicine, including knowledge of pharmaceutical preparations (Tsoucalas et al., 2014). In addition to facilitating births, midwives presided over birth rituals and ceremonies that marked the official entry into the family. These included visiting sanctuaries to thank the gods for safe delivery as well as presenting the child to the deity of childbirth by a mother who may be leading an animal for sacrifice (Dasen, 2011). Once again, note the similarity between African epistemology of birth (to be discussed in Chapter 3) and childbirth rituals during the Greco-Roman era.

In a handbook for midwives written at the beginning of the second century, Soranus (a Greek physician from Ephesus who trained in Alexandria) confirms that midwives possessed a high level of competence (Dasen, 2011b). He describes a midwife as a woman with expertise in general medical practice, obstetrics and other branches of medicine, including surgery and pharmacological preparations (Karamanou et al., 2013, p. 227). Even though midwives were knowledgeable, most midwifery manuals published in the 17th century were written by men. These manuals were first published in Latin and later translated and distributed across Europe (Epstein, 2021). While male physicians acknowledged midwives' technical proficiency and knowledge of medicine, they preferred a practitioner with a character that fits the ideal of a perfect Athenian woman (Persson, 2016). Greek male writers, including Socrates, spoke highly of midwives. However, their respect was expressed within a society that believed that a "woman is an afterthought, created as a secondary category following the emergence of a man" (Froma, Zeitlin, 1996).

Preceding the masculinist context described above, women were disallowed access to universities and medical schools which were governed by the church. Through the practice of oppressive Canon or Roman law, the Roman Catholic church assumed control over birthing. Aided by the church, male midwives took over the process of childbirth (Cahill, 2001; Drife, 2002; Gamarnikow & Donnison, 1978; Vernon, 2015). Subsequently, midwives were excluded for religious reasons. Those who continued to practise were considered illegal practitioners. The prohibition imposed heavy fines, prosecution, ex-communication and exile. Using opposing positions of Mary, the mother of Jesus, and Eve, the mother of the original sin, the clergy used religious teachings to cause conflict and confusion around sex and childbirth in the "minds of the fatalistic God-fearing mediaeval communities'' (Davies, 2017, p. 100). Drawing from the conception of a woman as a descendant of Eve, many clergy believed midwives were witches. From the 14th to 17th century, women were subjected to witch hunts and burning at the stake (Ehrenreich & English, 2010). Because of their knowledge of reproduction and access to foetuses, placentas, and practices associated with magic and healing, midwives were prime targets (Garratt, 2014). Witch hunts and burning suppressed the knowledge of women healers and midwives.

The period of witch-burning was followed by the emergence of biomedicine. During this era, the medical fraternity replaced the church as authority for licensing of midwives (Van Teijlingen, 2005). This means, midwifery was put under the control of biomedicine.

Westergren (2021) traces the origin of the biomedical view of health to the beginning of the Scientific Revolution in the late 16th and 17th century when Descartes introduced the theory of separation of the body and the mind (Westergren, 2021). Midwifery practice changed significantly after the introduction of forceps whose use was restricted to male midwives and physicians (Cahill, 2001; Drife, 2002). This era gave rise to the establishment of lying-in hospitals (Sheldon, 2012).

In the section above, I have demonstrated how mythological stories that depicted women as evil shaped men's perception of women in ancient Greece. Because they were fascinated with women's bodies, conception, and sexuality, men used various biological and religious arguments to justify the subordination of women. This inferior and negative depiction of women also affected childbirth (Flemming, 2007; Persson, 2016). Even though midwives possessed technical proficiency in birthing, their character was measured against the ideal of a perfect Athenian woman (Persson, 2016). Beyond ancient Greece, male midwives became fashionable in the rest of Europe (see Section 2.3 below). During that time, medicine operated as an exclusionary monopoly which exerted power over midwives by discrediting their knowledge, campaigning against their character, limiting their activities and controlling licensure (Cahill, 2001; Vernon, 2015).

### 2.3. Medicalisation of childbirth

In this section, I show how the subjugation of women described in the previous section continued to permeate and influence the increasing medicalisation of childbirth in the West. While I acknowledge that there are differences from one country to another, the purpose of this section is to contextualise the implications of the medicalisation of childbirth for birthing practices in Africa, given that Western birthing practices were imported to Africa through colonialism (Wagner, 2001).

Medicalisation is a process by which non-medical problems are defined as disorders that require intervention or treatment (Conrad, 1992, p. 209). Originally, the concept was associated with the dominance of biomedicine. This definition was expanded to include the dominance of pharmaceutical companies, biotechnology and politics (Conrad, 2005). Due to its name, biomedicine is primarily biological with no attention to the mind and spirit (Gaines & Davis-Floyd, 2003). By focusing on fixing a diseased body, biomedicine is characterised by

a hierarchical division of labour based on various factors, such as the category of medical personnel, the nature of medical interventions, and the target population. Intensive intervention is highly prized. As a result, surgeons have more prestige and are more highly compensated than family doctors (Gaines & Davis-Floyd, 2003). Similarly, the treatment of women, children, and elders carries less prestige. Equally so, nurses occupy a subordinate position when compared to physicians.

Over time, biomedicine turned into a technocracy, a factor that minimised contact between the patient and healthcare providers. In focusing on the body as a machine, the focus was on cure and not healing. Throughout the 19th and 20th centuries, medicine, which had become highly technological, was exported to the Global South as a result of colonialism (Cherniak & Fisher, 2008; Mc Leery, 2015; Pigg, 2008). The exportation of biomedicine continues to be driven by factors such as capitalism and industrialisation.

> "Biomedicine means the investment of huge sums of money in the construction of large hospitals (the factories of healthcare), the training of staff, and the incorporation of expensive medical technologies. Such modern medical facilities usually serve the colonisers and the middle and upper middle classes of colonised populations and are largely inaccessible to the majority of the population" (Gaines & Davis-Floyd, 2003, p. 11).

To maintain its monopoly, biomedicine co-opted and redefined knowledges. For instance, during the 1980s, biomedicine humanised its approach to childbirth by redecorating delivery rooms, allowing labour companions, and offering pain-free childbirth by offering epidural analgesia. In this way, biomedicine took the steam out of natural birth advocacy and incorporated its recommendations (Gaines & Davis-Floyd, 2003). At the same time, it increased technological interventions such as electronic foetal monitoring and caesarean sections. This means biomedicine reinforced its power over childbirth while it allowed women some degree of agency.

### 2.4. Medicalisation, women's bodies, and childbirth

The medicalisation of childbirth was a gradual takeover assisted by urbanisation, industrialisation and the building of hospitals (Gallagher, 1988). Founded on a metaphor of a body as a machine, the woman's body was perceived as lesser than that of a man.

> "The metaphor of the body-as-machine could have been inherently egalitarian, but the industrialising nations of the West were male-centred, patriarchal societies. Thus, the male body came to be medically viewed as the prototype of the properly functioning body-machine. The female body, as it deviated from the male standard, was regarded as inherently defective and dangerously under the influence of nature, which due to its unpredictability, was itself regarded as in need of constant manipulation by man" (Davis-Floyd, 2001, p. 6).

The view of a woman's body as a defective machine formed the philosophical foundations of obstetrics. Influenced by the industrial revolution, "the hospital became the factory, the mother's body became the machine, and the baby became the product of an industrial manufacturing process" (Davis-Floyd, 2001).

Prior to the medicalisation of childbirth, men participated in birthing only when they were called to respond to complications such as obstructed labour. Men performed embryotomies[8] using instruments such as perforators, crotchets, or craniotomy forceps. A craniotomy entailed crushing the head of the unborn baby (who could have been dead or alive) and delivering the remains by way of extraction (Blundell, 1827). In most cases, both the mother and baby would die (Newburn & MacFarlane, 2002).

From the use of embryotomy and craniotomy instruments, men invented a series of many others. The discovery of forceps is perceived to be one of the major influences in the medicalisation of childbirth (Gamarnikow & Donnison, 1978; Newburn & MacFarlane, 2002). The Chamberlen family, who lived in London during the 16th and 17th centuries, are credited with inventing the forceps used in obstructed labour. They kept these as a secret for many years by putting the pair in a huge container which was carried by two people. People were made to believe that they were carrying a big machine. This increased physician demand during childbirth (Masdottir, 2014). Later, forceps were made available to male midwives and physicians. This led to the emergence of male midwives who were doctors, tailors, carpenters, butchers or barbers (Garratt, 2014). Even though many had no prior knowledge of women's bodies and childbirth, they relied on using instruments to deliver babies. In the process, men

[8] Webster dictionary describes this as the mutilation of the foetus to facilitate removal from the uterus when natural delivery is not possible.

"cast themselves as the keepers of authoritative knowledge on women's bodies and their births, justified by their access to technology, organised training, literacy and medical manuals" (Masdottir, 2014, p. 8).

One of the best-known male midwives, William Smellie, is credited for establishing lying-in hospitals and midwifery training institutions (Masdottir, 2014). For the purposes of training male midwives, he created his own model of the female pelvis.

> "I endeavoured to reduce the art of midwifery to the principles of mechanisms, ascertained the make, shape, and situation of the pelvis, with form and dimension of the child's head, and explained the method of extracting, from the rules of moving bodies, in different directions" (Wilson, 1995, pp. 125–126).

Women were prohibited from using instruments. Male midwives charged high fees for their services. Despite this, many women continued to use midwifery services. To maintain power over female midwives, male midwives exaggerated the risk of pregnancy (Gamarnikow & Donnison, 1978). In addition, they used the power of the Church and the State to sideline what they referred to as untrained and unlicensed practitioners. To be licensed, practitioners had to be trained in a midwifery school or university. Women were excluded from studying at universities (Willis, 2006). This created a culture and practice that depicted nursing to be located in a position that is inferior to medicine (Conrad, 1992).

By the early 20th century, the male-dominated profession of gynaecology and obstetrics was flourishing. This was aided by technology that appeared to be employed for the benefit of women. One such example was a belief in the United States of America that births should be performed by means of a caesarean section to prevent stretching of the vagina, which was believed to be useful in preserving a happier marital state (Brown, 1930). Other delivery techniques were enabled by the discovery of scopolamine combined with morphine to create amnesia-induced twilight sleep.[9] Women with financial means continued to use medical and surgical deliveries in hospitals despite the potential danger of these interventions (Vernon, 2015). The availability of anaesthesia, analgesics, and antibiotics also offered women a pain-

[9] Twilight sleep is a form of childbirth in which the woman was given drugs that induced deep sleep prior to giving birth. When she wakes up, she would have no recollection of what happened. This was first used in Germany in the early 20th century (see the Embryo Project Encyclopaedia https://embryo.asu.edu).

free birthing experience and lowered puerperal sepsis[10] (Minkowski, 1992). Before then, puerperal fever was the main cause of death during childbirth (Drife, 2002). This consolidated the idea of a hospital as a safer place to give birth. With increasing medicalisation came increased technological interventions, a factor that influenced the change of birthing position.

### 2.5. From upright to supine birthing position

A 1961 survey of 76 global Indigenous cultures found that only 18% of the women assumed the supine position when giving birth (Naroll et al., 1961). The rest used one form of an upright position, such as squatting, kneeling, sitting up, standing, or lying on the side. In their study on women who gave birth upright, Di Franco and Curl (2014) reported that gravity helps expand the pelvis as the foetus moves down through the birth canal. Even though the use of an upright position for birth is associated with positive birthing outcomes, a supine position is normalised as standard medical practice during vaginal childbirth (Jiregna et al., 2020; Modrzejewska et al., 2019; Steen & Anker, 2008). This encourages extensive use of unnecessary medical interventions such as episiotomies (DiFranco & Curl, 2014b; Diorgu et al., 2016; Mselle & Eustace, 2020). Women who choose to give birth in a healthcare facility do so because healthcare providers instruct them to use the supine position as the best option (Mselle & Eustace, 2020). In South Africa, even though maternity guidelines endorse alternative birthing positions, midwives continue to enforce the use of lithotomy positions for their convenience (Musie et al., 2019).

> "I place the woman on lithotomy because I need to perform [an] episiotomy… it is much (more) comfortable for us; if she is in [a] squatting [position], how are you going to perform [an] episiotomy[?] We as midwives … are in control of the labour [and] we do what is comfortable for us" (Musie et al., 2019, p. 4).

The denial of the choice of birth position can be considered an unnecessary intervention for women who do not need any medical intervention (Henry, 1998). De Jonge et al. (2004) also argue that a bed can be considered an instrument. Continued use of the supine position and other medical interventions result in increased medical interventions during childbirth

[10] Puerperal sepsis is an infection of the uterus and surrounding tissues which occurs within 42 days after delivery or abortion.

(Oliveira & Penna, 2017). Because it interferes with normal birthing, the denial of birthing positions of choice constitutes a form of obstetric violence (Giacomozzi et al., 2021).

### 2.6. Feminist critique of the medical model of childbirth

Feminists hold different views and responses to medicalisation. For example, first wave feminists[11] defined pain relief during childbirth as a political issue Beckett, 2005; Riessman, 1983). Their legacy is one that won the right to pain relief but lost control over childbirth. In contrast to first wave feminists, second wave feminists[12] questioned the medical dominance of childbirth and called for a return to natural birth (Brubaker & Dillaway, 2009; Ann Oakley, 2016; Rothman, 1982). In their critique of second wave feminists, third wave feminists[13] focused on three areas. Firstly, third wave feminists argue against the idealisation of birth, which labels women who do not conform to it as bad mothers. In their view, natural birth may entrench traditional gender stereotypes, which feminism seeks to dismantle (Skowronski, 2015). Secondly, they argue against the construction of technology as inherently patriarchal and bad (Annandale & Clark, 1996). In their view, the valorisation of pain is moralistic, and it labels women who choose medicalised birth as bad mothers. Thirdly, they argue against the veneration of the home as an ideal location of childbirth. In their view, this reinforces a gender-stereotypical view of a woman belonging in the home. Overall, third wave feminists sought to reposition women's choice as a central issue by cautioning against oppositional constructions of birth (Beckett, 2005). In their view, medicalised birth is a choice some women make based on their circumstances. For example, women in the 19th century opted for the medicalisation of childbirth (Annandale & Clark, 1996; Beckett, 2005). For many working-class women, life was hard with no rest. Giving birth in a lying-in hospital offered relief from pain and a time and place to rest (Wertz, 1989). This does not eliminate medical dominance over childbirth (Riessman, 1983). Masdottir (2014) warns against opting for rigid

[11] First wave feminism arose in the context of industrial society in the late 19th and early 20th century in Europe and North America. It was concerned with equal access to opportunities.

[12] Second wave feminism arose from post war welfare societies in the 1960s and 1970s. It was linked to radical voices of oppressed groups such as Black people and Gay people.

[13] Third wave feminism arose from postcolonial, neoliberal, and global politics of the mid-1990s and beyond.

dichotomies because, by doing so, women may end up imposing new pressures on themselves (Masdottir, 2014).

Studies also revealed that some women accepted medical interventions out of choice. In a study of ten women who chose elective caesarean section in South Africa, Lappeman (2011) revealed that women chose to put their trust in the birthing knowledge and approach of their obstetricians (Lappeman, 2011). The study found that women's choice of elective caesarean section for non-health reasons is common. Women's birthing choices are not uniform but shaped by race and class (Manderson, 2016). In a study on the use of epidurals, Dillaway and Brubaker (2006) interviewed middle-class white women and African American teenagers (Dillaway & Brubaker, 2006). White middle-class adult women defined an epidural as a safe way to avoid the pain associated with childbirth; African American teenage mothers chose to forego epidural because of the risk associated with such an intervention.

Feminist critique of the medicalisation of childbirth has also been questioned because it presents women as passive consumers of obstetric interventions. Feminist theorisations about biomedical childbirth result in an "exaggeration of the power of medicine" (Lorentzen, 2008, p. 49). This potentially precludes the possibility of women's choice, agency, and resistance. Similarly, Annandale and Clark (1996) warn that in their quest to speak out against patriarchy, feminists "may enter into complicity with male hegemonic power by attributing to it the power it gives itself" (Annandale & Clark, 1996, p. 30). Using a relational model of power, Lorentzen (2008) perceives women as active participants in the medicalisation of childbirth. In her view, medical power is a "process of negotiation in which women experience both benefits and costs" (Lorentzen, 2008, p. 52). While some question the medicalisation of childbirth, others seek out medical interventions.

Ultimately, it is important to note that feminist views and women's lived experiences are not homogenous. Women are, therefore, not impacted by medical power in the same way. Elitism among white privileged middle-class women may silence differences among women (Annandale & Clark, 1996). For example, feminist calls for a natural birth experience with a midwife as resistance to the medicalisation of childbirth must consider that some women may not even have access to such an alternative. Western women whose culture is embedded in biomedicine may reproduce the medicalisation of childbirth more than those without access to basic health care (Davis-Floyd, 1994). In the end, feminist politics of childbirth is largely

framed by debates about medicalisation, agency, and choice premised on the experiences of women in the Global North (Chadwick, 2017).

The medicalisation of childbirth has continued to rise in high and middle-income countries (Lucinda, 2004; Newburn & MacFarlane, 2002; Shabot, 2021; Vinet & Zhedanov, 2011). Citing the use of a husband's stitch as an example, Kukura (2018) agrees that cultural attitudes towards women's bodies continue to shape the delivery of maternity services in the 21st century (Kukura, 2018). The husband's stitch is an extra stitch the physician adds when suturing the perineum following episiotomy or perineal tear. The husband's stitch tightens the vagina for the man's sexual pleasure (Simone G. Diniz & Chacham, 2004). The patriarchal medical discourse believes that the vagina would be too big after birth for male sexual pleasure. To ensure that the husband continues to enjoy sex, the vagina should then be reconstructed to its virginal state. Other than causing extreme pain and scarring, which may require further surgical intervention, the husband's stitch may cause deformities that result in painful sexual intercourse for the woman Simone G. Diniz & Chacham, 2004).

> "If they believe the vulva and vagina are passive, it is difficult for them to even understand that these tissues are able to distend for birth, and contract afterward. Thus, through episiotomy, physicians deconstruct and reconstruct the vagina, in accordance with cultural beliefs" (Diniz & Chacham, 2004).

The use of episiotomy is another example of medical intervention that reconstructs women's bodies even when there is no medical necessity. Episiotomy is a surgical incision made to widen the vaginal opening to make room for the baby's head. This intervention was introduced into clinical practice to expedite deliveries without significant scientific evidence of its benefits. In many instances, this surgical intervention is performed not so much for its health benefits but for the convenience of the institution and/or healthcare practitioner (Kukura, 2018).

### 2.7. Midwifery model of care as resistance to medicalisation of childbirth

It is important to note that midwives did not accept takeover of childbirth by biomedicine without any resistance. For instance, Agnodice, an Athenian midwife, fought for women's right to practise as midwives during the Greco-Roman era described in Section 2.2. She, together with other women, fought for access in a school of medicine established by

Hippocrates (Davies, 2017). Following the death of Hippocrates, authorities imposed the death penalty on any woman who was found to be practising midwifery or medicine. In order to continue practising as a midwife, Agnodice fought back by taking on a male identity (Phillips, 2007).

Beyond the Greco-Roman boundaries, other midwives challenged the take-over by male midwives. This includes four English midwives (Jane Sharp, Sarah Stone, Elizabeth Nihell and Margaret Stephen) who wrote treatises between 1671 and 1795 to condemn the male takeover as well as their indiscriminate use of instruments during childbirth (Allotey, 2011). Even though they had been in practice for more than 30 years, midwives lacked the professional network and educational support which men midwives enjoyed. Operating within a male-dominated society which was intolerant of women's status and knowledge made it difficult for them to operate.

Hundreds of years later, tension between physicians and midwives continues to rage in the 21st century. Currently, childbirth in most countries is still dominated by a medical model of care which puts the obstetrician as the lead professional. Expansion of the biomedical model has, however, not been effective in stamping out the midwifery model of care which defines pregnancy as a normal or natural phenomenon. Using the concept of "being with women'' as their philosophy, midwives strive to provide holistic care which incorporates core characteristics of midwifery outlined in the International Confederation of Midwives' Service Framework (Nove et al., 2018). These characteristics include optimising biological, psychological, and social processes of childbirth, timely prevention of complications and working in partnership with the birthing woman. In a global study that involved 15 trials with a population of 17, 674 mothers and babies, findings revealed that midwife-led care provides health benefits to mother and baby (Sandall et al., 2016). Specifically, the study revealed the following health benefits: greater chance of spontaneous vaginal birth, fewer episiotomies or instrumental births, low risk of mothers losing their babies and in some instances, the women were more likely to be cared for by women they know. This means midwives continue to resist medicalisation by providing women-centred care that show empathy to the women as well as allow them to participate actively in the birthing process (Moridi et al., 2020). Other than practising in birthing centres, midwives continue to play a central role in caring for women in hospital settings. However, their ability to provide women-centred care is often hampered by

poor working conditions, institutional standards and profit-driven hospital policies (Luegmair et al., 2022).

Reversing medicalisation of childbirth and de-centering the obstetric risk paradigm has been identified as key interventions necessary in creating an enabling environment for midwives to provide holistic care for birthing women in health care settings (Bogren et al., 2023). There are many compassionate midwives who continue to practise their profession with respect and care. However, as we will see in the next section, medicalised childbirth which is purported to provide quality care can easily become a site for violence during childbirth. In her critique of the medicalisation of birth, Dixon (2015) argues that because of the transfer of power from the birthing woman to the institution and biomedical healthcare practitioners, who are usually male, hospital births can make women feel unsupported, uncared for and violated (Dixon, 2015)). Further research has revealed that the depiction of childbirth as a medical condition predisposes women to obstetric violence (Loudon, 1992, Pollock, 1999, Davis Floyd, 2003, Oakley, 1980, Rothman, 1982, Chadwick, 2014). Others argue that over-medicalised birth constitutes an act of obstetric violence (Chadwick, 2016; Koitsioe & Swemmer, 2022; Martín-Badia et al., 2021; Sadler et al., 2016).

## 2.8. Obstetric violence

In this section, I write about obstetric violence globally and in South Africa. In defining the concept, I write about how the term 'obstetric violence' came about, including the debate between mistreatment and abuse, as well as resistance to using the term 'violence.' Linking obstetric racism to obstetric violence, I further argue that the dehumanisation of Black women's bodies and poor healthcare services for poor communities is a form of obstetric violence.

### 2.8.1. What is obstetric violence?

Currently, there is no universally accepted definition of obstetric violence. To try and define obstetric violence, researchers developed different typologies to describe various forms of violence. Bowser and Hill (2010) first identified seven categories of disrespectful and abusive care during childbirth. The study was based on a review of grey and published literature, in-depth interviews with nine key informants, as well as a structured focus group discussion. Stories documented in the report were taken from eighteen countries in Africa, Asia, Latin

America, and North America. The seven categories include physical abuse, non-consented clinical care, non-confidential care, non-dignified care, discrimination, abandonment, and detention in healthcare facilities, mostly because of the inability to pay fees. In their report, these researchers use the words 'disrespectful birth' or 'abuse' and not 'violence' (Bowser and Hill, 2010).

Freeman and Kruk (2014) criticise the above review on the basis that these categories do not differentiate between forms of disrespect that stem from an individual's behaviour and those that result from systemic and structural health deficiencies (Freedman & Kruk, 2014). Expanding on seven categories, these researchers define disrespect and abuse during childbirth in relation to interactions of facility conditions deemed to be humiliating, undignified, or intended to be humiliating or undignified. The study was based on women's self-reported childbirth experiences during a facility exit survey and a follow-up survey undertaken five to ten weeks postpartum. Common experiences reported include physical abuse, shouting, scolding and non-dignified care.

In a systematic review of the mistreatment of women during childbirth undertaken in 34 countries across all geographical and income levels, it was further argued that the seven categories mentioned earlier lack operational definitions and can therefore not be standardised (Bohren et al., 2015). The latter developed seven overarching categories with several first and second-order subgroups within the main categories. These include physical abuse, such as hitting with a hand or instrument, sexual abuse, verbal abuse, such as rude language, stigma and discrimination based on age, ethnicity, and socio-economic status, failure to meet professional standards of care, poor rapport between women and healthcare providers and healthcare system conditions, such as lack of resources needed to provide women with privacy. In addition, the review recommends using the term 'mistreatment,' which they viewed as more inclusive than disrespect and abuse.

Venezuela was the first country to use obstetric violence as a legal term in 2007 (Borges, 2018; D'Gregono, 2007; Pérez D'gregorio, 2010; Sadler et al., 2016; Williams et al., 2018). According to the Organic Law on the Right of Women to a Life Free of Violence adopted in Venezuela in 2007, obstetric violence is defined as:

> "The appropriation of women's bodies and reproductive processes as dehumanised treatment and/or abusive medicalisation and pathologisation of natural processes,

resulting in loss of autonomy and the capacity to decide freely about their own bodies and sexuality, negatively impacting women's quality of life" (Williams et al., 2018, p. 1209).

The adoption of a legal term framed obstetric violence as a crime; the penalty for the crime amounted to a fine and signed acknowledgement of wrongdoing. This came about because of tireless women's advocacy for humanised birth in Latin America. For instance, in 1993, the Network for the Humanization of Labour and Birth (Rehuna) adopted a charter recognising violence during childbirth (Diniz, 2005; Sadler et al., 2016). Five years later, in 1998, the Latin American Center for the Rights of Women published a report documenting abuse of women's human rights during institutionalised birth (Diniz, 2005).

Responding to the adoption of obstetric violence as a legal term, researchers began to document abuse systematically. This inspired the adoption of the Charter for Respectful Maternity Care drafted by the White Ribbon Alliance in 2011. The charter emphasises dignity, respect, non-coercion, and non-discrimination in healthcare delivery.[14] Two years later, in 2013, the United Nations Special Rapporteur on Torture reported torture and ill-treatment in healthcare settings, including the mistreatment of women seeking reproductive health.[15] In 2015, the WHO released a statement that declared that many women experienced disrespectful and abusive treatment during childbirth.[16] The statement reported that disrespectful birth violates the right of women to quality care, as well as threatens their right to life, health, bodily integrity, and freedom.

Initial attempts to define obstetric violence downplayed the term violence. In order to avoid hostility with healthcare providers, terms such as 'humanising childbirth,' 'respectful birth,' and 'mistreatment' were used (Diniz et al., 2015). Sadler et al. (2016) argue against the reluctance to use the term violence. In their view, the use of the term has the potential of addressing the structural dimension of violence and highlighting its intersection with gender-

[14] White Ribbon Alliance. Respectful Maternity Care: The Universal Rights of Childbearing Women. Washington D.C.: White Ribbon Alliance, 2011.

[15] Torture in Healthcare Settings: Reflections of the Special Rapporteur on Torture. 2013 Thematic Report (Washington D.C.: Center for Human Rights and Humanitarian Law, 2014).

[16] World Health Organization. The prevention and elimination of disrespect and abuse during facility-based childbirth, 2015.

based violence. Using the term, they further argue, will reveal the healthcare system's inherent power over women, bringing focus to interpersonal violence and power structures that may put birthing women at risk (Sadler et al., 2016). This will ensure accountability from within the healthcare system (Savage & Castro, 2017).

Many years after the adoption of the term 'obstetric violence,' some researchers still question its use. In their latest journal article on obstetric violence, two South African researchers ask the question: "Does the use of the term 'violence' inadvertently disempower the women that it is meant to empower?" (Lappeman & Swartz, 2021, p. 1). Drawing from their research about birthing women in a healthcare facility in Khayelitsha, a poor area in Cape Town, the two authors argue that the term can be harmful to efforts aimed at improving the prevalence and extent of violence experienced by women during childbirth. In their view, unintended consequences of asserting that hospitals are places of violence may affect opportunities to improve care. In response to this question, Chadwick (2021) argues that such debates can be harmful because they risk minimising women's experience of violence during childbirth. Not using the term will contribute to the problem of not seeing and therefore not accepting violence beyond physical harm (Chadwick, 2023).

One of the key findings in the Lappeman and Swartz' (2021) study was a culture of silence in the ward. It is my view that the silence of women in a labour ward in Khayelitsha is a response to various forms of violence that emanate from the legacy of apartheid with its unequal access to healthcare, poor institutional management and governance, and economic conditions that prevent ordinary Black women from attaining an education that will improve their health and life choices. Apartheid was a legalised and intentional form of violence which impacted people physically, economically, psychologically, culturally, and spiritually. Given the violent nature of inequality and poverty in post-apartheid South Africa, I argue that public hospitals and healthcare practitioners can easily become perpetrators of institutional and interpersonal violence.

### 2.8.2. Obstetric violence: A global overview

Even though obstetric violence is a relatively new concept, reports of violence against women giving birth appear in various publications using various names. As early as the 1950s, the topic of mistreatment of women during childbirth broke out into the public space in the

United States of America when a women's magazine called *Ladies Home Journal* published an article titled 'Cruelty in maternity wards' (Goer, 2010). The article reported that women were drugged with sleep-inducing medication such as morphine and scopolamine, a process that sometimes resulted in hallucinations or loss of consciousness. In order to prevent them from falling from their beds, women were handcuffed and their feet were shackled (Simone Grilo Diniz et al., 2015; Goer, 2010). The outrage caused a flood of letters to the editor. This influenced changes in maternity care, resulting in the formation of the American Society of Psycho-analysis in Obstetrics (Goer, 2010).

Before this article was published, morphine and scopolamine were used in Brazil by Fernando Magalhaes, who was dubbed the father of Brazilian obstetrics (Diniz, 2005). He perceived the use of drugs as a form of humanised birth which saved women from the torture of childbirth (Nucci et al., 2018). An injection of morphine was used at the beginning of labour, followed by Scopolamine which caused intense agitation. In addition to these drugs, the cervix was dilated with instruments and babies were extracted with forceps from the bodies of their unconscious mothers. Drugs prevented women from feeling pain. They also did not have any conscious recollection of what happened during labour. Many sustained physical injuries (Diniz, 2005; Diniz et al., 2015; Goer, 2010). Mistreatment that resulted from the medicalisation of childbirth was not limited to the United States of America and Brazil. Around the time of the article cited above, maternity hospitals in the United Kingdom were reported as spaces where women experienced a lack of care, support, rest, privacy, and healthy food, as well as a lack of consideration for the birthing of women's bodily integrity (Beech & Willington, 2007). This prompted the formation of women's advocacy organisations such as the Society for the Prevention of Cruelty to Pregnant Women, which later became the Association for Improvements in the Maternity Services (AIMS). This was started by Sally Willington in 1960 with the sole purpose of campaigning for better maternity care.[17] More than three decades later, obstetric violence continues to gain public attention in the United Kingdom and other parts of Europe (Reuther, 2021).

Various research reports reveal the occurrence of obstetric violence in all social classes and geographical locations. In a study that explored the link between obstetric violence and the

[17] aims.org.uk

medicalisation of childbirth in the United States of America, birthing women felt objectified, disrespected, and violated (Vinet & Zhedanov, 2011). Research in Sweden focused on the physical and psychological impact of obstetric violence (Annborn & Finnbogadóttir, 2022), while one study in Germany concluded that adverse consequences of obstetric violence affect the mother and the child (Reuther, 2021). The concept of obstetric violence includes structural violence that results from inequitable risk within the neoliberal system in New Zealand (Neely et al., 2020). In their view, societal inequality and poverty predispose women to poor maternal health. These authors ascribe poor maternal health to the failure of the state. In countries such as India, some research findings associated obstetric violence with demographic factors, with poor women experiencing greater levels of mistreatment (Chattopadhyay et al., 2018; Shrivastava & Sivakami, 2020).

However, as found in research in Europe and the United States of America, obstetric violence is a global phenomenon that is common in all countries, irrespective of women's socio-economic status. Even though the countries cited above are different, the occurrence of obstetric violence in all of them is linked to the medicalisation of childbirth. In her article on obstetric violence, Borges (2018) reframes the term 'obstetric violence' by including routine medical examinations such as vaginal examinations, episiotomies, and caesarean sections that women are forced to undergo as forms of violence (Borges, 2018). Similarly, Perrotte et al. (2020) argue that because obstetric violence happens in a clinical setting, the healthcare facility where it takes place becomes an institution of violence (Perrotte et al., 2020). In their view, institutionalised medical practice legitimised power imbalance between healthcare practitioners and birthers. This makes obstetric violence to be intrinsic to institutional violence.

### 2.8.3. Obstetric violence in South Africa

In South Africa, Jewkes et al. (1998) first reported the mistreatment of women during childbirth following qualitative research based on 103 partially structured in-depth interviews and four focus group discussions with staff and patients at a public hospital (Jewkes et al., 1998). Birthing women reported neglect and verbal and physical abuse from nursing staff. The deployment of violence to create social distance and maintain power in a clinical setting was seen as an attempt by the nurses to assert their professional and middle-class identity and power over patients.

To grasp the notion of social distance between nurses and patients, one must draw from the history of nursing in South Africa. In *Divided Sisterhood,* Shula Marks traces the history of nursing from pre-colonial times, through the missionary era, up to the era of domination of Afrikaner nurses who were part of the Apartheid State (Marks, 1994). Firstly, trained nurses in South Africa were English "lady nurses" from 19th-century Britain whose identity and philosophy were influenced by the Nightingale model drawn from the Anglican sisterhood. Initially, lady nurses came from upper- and middle-class British families. Later, at the turn of the century, lower-class English women came out in substantial numbers in response to increasing demands for white nurses following the Anglo Boer War. Exported racial and class attitudes have since become part of the colonial hospital practice in South Africa (Marks, 1994).

Power relations between healthcare professionals and women in maternity settings represent a "hegemonic dominance" that parallels the social dominance of men (Jewkes & Penn-Kekana, 2015, p. 1). In an environment that devalues women and girls and in which both the practice and expectations of abuse of power are allowed, it is possible for staff to feel entitled to use violence to control or punish women for disobedience (Jewkes et al., 1998).

Like research undertaken globally, research on obstetric violence in South Africa focused on using the public health approach. Farrell and Pattison (2004) write about harmful practices observed by medical students at the University of Pretoria medical school during community obstetric orientation (Farrell & Pattinson, 2004). As part of their examinations, medical students were supposed to keep log books where they wrote what they had observed, witnessed, or learned in maternity wards. The following were some of the recurring threads in five thousand log books reviewed by the authors:

- Augmentation of labour using vaginal prostaglandin tablets indicated for cervix ripening before labour induction, possibly resulting in uterine rupture when used on a woman already having uterine contractions.
- Delay in doctor attendance in the case of emergency
- Performance of an episiotomy without local anaesthesia
- Lack of pain relief during labour
- Fundal pressure during the second stage of labour
- Verbal and physical abuse of birthing women.

A common feature in the reports was the physical and verbal abuse of women by midwives. This was referred to by the midwives as "verbal Pitocin"[18] to ensure that the birthing woman conforms to their instructions (Farrell & Pattinson, 2004).

In 2010, another study by Kruger and Schoombie (2010) interviewed nurses and women in a low-income semi-rural hospital (Kruger & Schoombee, 2010). The main aim of the study was to explore the psychological experience of motherhood in a low-income semi-rural community. The study used the social constructionist grounded theory and Foucauldian discourse analysis. There were ninety-three women interviewed three times by the same interviewer – a few days after giving birth and three and six months thereafter. The study found that in both sets (nurses and women's experience of childbirth) of interviews, witnessing the abuse of birthing women was a dominant theme.

The study also highlighted that nurses were disempowered in the hierarchy of the medical system and birthing women were docile and disempowered in the context of a medical ward and the dominating construction of the nurse-patient relationship. The study revealed that both nurses and patients felt frustrated and enraged in a system in which they could not care for or be cared for. Women reported neglect and abandonment, verbal abuse, and repeated painful vaginal examinations.

> "The sister takes her fingers and pushes them up in you, then she feels, she is practically digging… Then it is so painful. If I keep my legs closed and then it is, "Open your legs. You knew it would be painful" (Kruger & Schoombee, 2010, p. 95).

Kruger and Schoombie argue that neglect was used as punishment for non-compliance within the obstetric system. Many other researchers identify neglect as punishment for non-conforming behaviour (Chadwick, 2017; Chadwick, 2014; Dutton & Knight, 2020; Hastings-Tolsma et al., 2021; Jewkes et al., 1998; Lappeman & Swartz, 2021). Being vocal, assertive, and asking for help seems to be a punishable offence. To protect themselves, many women choose silence. In a study that employed participant observation and interviewed doctors, nurses, and cleaners at Khayelitsha Hospital in the Western Cape, Lappeman and Swartz (2019) identify that women were willing to "submit themselves to the supposed experts" and in so doing, allowed the experts to perform their tasks without question (Lappeman & Swartz,

[18] Pitocin is a synthetic drug which is used to cause contractions of the uterus to start labour.

2019, p. 10). In this regard, silence is protective for the woman and an expression of power for the nurse. Chadwick (2017) frames this phenomenon as a "performance of docility" (Chadwick, 2017).

In another empirical study undertaken by Human Rights Watch in 2011, women reported neglect, nurses' refusal to admit women who needed medical intervention, inappropriate discharge without pain medication or antibiotics, and risky healthcare facility practices such as forcing women who have recently given birth to make their own beds or clean up blood from the floor or carrying babies even when they are weak after a caesarean section (Odhiambo & Mthathi, 2011).

> "I was bleeding so much after delivery. My mom kept calling the nurse to help me and to change my bedding, but she ignored her. Later, another nurse came and removed the bedding. I was dizzy and the nurse forced me to stand up so she could change the bed. I fell under the bed, and she did not help me. My mum came to help me" (Odhiambo & Mthathi, 2011, p. 29).

To those women who did not have a birthing companion, they had to bear the pain of childbirth and the abuse from the nurses.

> "I had to feed the baby every two hours, so I kept walking day and night. I was bleeding. The nurse shouted at me as if I had done it deliberately and told me to get a mop and clean the blood… They did not let me use the mop to clean the blood. I had to bend so I could use tissue to wipe it, and then use the mop" (Odhiambo & Mthathi, 2011, p. 23).

Gross insensitivity on the part of healthcare professionals was also reported.

> "A lady and her baby died in our ward. I did not think I would survive. Later, another woman suffering from high blood pressure also died. I thought I was next. I was so sick. I had blurred vision. When the second lady died, the nurse asked me, "Oh, you are still alive?" and the doctor said, "That lady is dead? Who is next?" (Odhiambo & Mthathi, 2011, p. 23).

Studies on childbirth narratives in South Africa reveal the links between the birthing experience and factors such as the site of birth, class, age, marital status, and ethnicity. In a study that explored "good birth" narratives across diverse types of women in Cape Town,

Chadwick (2019) found that more than half of the women who gave birth in public hospitals narrated negative birthing experiences. In contrast, middle-class women, mainly white, who gave birth at home with private midwives, were the most satisfied (Chadwick, 2019).

### 2.8.4. Obstetric violence as a form of gender-based violence

At the outset, I admit that the literature I have referenced in the next few paragraphs is limited because it refers to gender violence exclusively using the term 'women.' Historically, narratives on birthing were framed from an understanding of an exclusive maternal womb. This is changing due to the increasing number of transgender pregnancies (Hoffkling et al., 2017). The discriminatory framing of sexual and reproductive health for women or men affects how other gender identities engage with healthcare services. It also influences how the healthcare system responds to their health needs (Moseson et al., 2020). Based on my limited expertise as a cisgender woman, it is beyond my scope of knowledge and lived experience to give this topic the attention it deserves. The most appropriate thing to do is to acknowledge the discriminatory gender language and framing as a limitation of the study.

Anderson (2009) defines gender-based violence as violence fuelled by a combination of gender identities, interactions, and structures. This definition highlights that even though women are disproportionately affected, gender-based violence also affects men, queer, trans, and gender non-conforming persons. Using the framework of gender as identity, interaction, and structure, Anderson (2009) shows how the drivers of specific forms of gender-based violence are gendered at the micro and macro levels (Anderson, 2009). At the micro level, people are socialised to identify themselves and others into single categories. Cultural beliefs play a role in normalising and justifying violence, for example, the cultural constructions of masculinity are defined as one of control and domination (Anderson, 2009; Buiten & Naidoo, 2020; Kim & Motsei, 2002). At a macro level, broader political and economic inequalities compound the problem. This explains how politics or the State's institutionalised gender inequality, breeds gender-based violence (Anderson, 2009; Bennett, 2000; M. Motsei, 2007).

Obstetric violence is both a form of gender-based violence and institutional violence that reflects gender inequalities within the healthcare system and in society broadly (Savage & Castro, 2017).

> "Structural gender inequality, i.e., women [have a] subordinate position in society […] compared to men. This systematically devalues the lives of women and girls… It also disempowers women and enables the use of violence against them" (Jewkes & Penn-Kekana, 2015, p. 1).

Shabot (Cohen Shabot, 2016) argues that obstetric violence differs from other forms of medical violence because it is "directed at women because they are women" (Cohen Shabot, 2016, p. 231) In her view, violence on what is otherwise a healthy but vulnerable woman's body punishes birthing women who may refuse to conform to the patriarchal prescription of submission as an expression of femininity. Other than that, they are subjected to violence because of their gender. Birthing women also receive care and support in a healthcare system which is characterised by an unequal hierarchical relationship between the birthing woman and the healthcare provider (Chadwick, 2016; Jewkes & Penn-Kekana, 2015; Lappeman & Swartz, 2019; Lévesque & Ferron-Parayre, 2021). Therefore, the woman is abused by both the individual and the institution in which she gives birth. In a system where a caregiver holds a superior position and knowledge, many women may have little choice but to defer power and authority to healthcare professionals in a setting that fails to be accountable for practitioners' acts of commission or omission (Chadwick, 2016; Jewkes & Penn-Kekana, 2015).

In addition to the effect of the hierarchical power dynamic described above, Kukura (2018) writes about the shame and guilt accompanying being subjected to obstetric violence. Society's expectation of maternal sacrifice expects mothers to subordinate their own needs and bodies in service to others (Kukura, 2018). African proverbs such as *mmangwana o tshwara thipa ka fa bogaleng* (a mother holds the knife at the sharp end) celebrate a mother's duty to protect. This duty puts women under pressure to withstand hardship and abuse as a demonstration of real womanhood. This includes sacrificing their bodies and lives for their children and families (Motsei & Kim, 2002). Women subjected to obstetric violence can therefore view obstetric violence as a normal consequence of honouring the socially gendered role of being a real woman and a good mother.

In a study conducted in Mexico, interviewed women expressed feelings of failure and humiliation after being subjected to obstetric violence (De Lopez, 2018). Even though some of them suffered from feelings of powerlessness and postpartum depression, they were afraid to speak out about obstetric violence (Castro & Frías, 2020; De Lopez, 2018; Kukura, 2018).

As mentioned earlier, women who are subjected to violence in the birthing room may employ coping mechanisms such as avoidance or silence in the same way that they deal with discrimination, oppression, and violence in the broader society (De Lopez, 2018). Tolton and Signorelli (2018) associate obstetric violence with a struggle between two levels in a hierarchy of knowledge in the birthing room, where medical knowledge is considered superior and authoritative (Tolton & Signorelli, 2018). The healthcare practitioners' knowledge ranks high in this hierarchy, while the birthing woman's knowledge is often dismissed. If she insists on applying her knowledge or refuses to follow instructions, she may be subjected to threats or actual incidents of violence.

To counter obstetric violence, birth advocates and feminists have called for a humanised model of childbirth that foregrounds the birthing mother as an informed, empowered, and active participant who has the right to make informed decisions about her body and the birthing process (Conrad, 1992; Cahill, 2001; Beckett, 2005; Kitzinger, 2008). The term 'humanisation' was first used by male obstetricians who advocated forceps and anaesthesia in the early 20$^{th}$ century (Diniz, 2005). From the mid-1940s, there was a growing trend of hospital births which conceptualised birthing as a pathology that required intervention by largely male doctors (Rattner, 2007). A highly medicalised birth practice came with a degree of dehumanisation (Wagner, 2001).

### 2.8.5. Linking obstetric racism to obstetric violence

Medicalisation is not only a story of the scientific and technological takeover of birthing by men. It is also a story of "racist, capitalist, and gender oppression" (Bobbitt, 2019, p. 10). Obstetric racism lies at the intersection of obstetric violence and medical racism (Davis, 2019). Obstetric violence must consider how racism affects Black women during medical encounters (Davis, 2019).

In the United States of America, J. Marion Sims is known as the father of gynaecology and is reported to have used enslaved women's bodies for experimentation (Owens, 2017). As legal property, Black women were subjected to medical violence entangled with biological racism (Campbell, 2021). Following the abolition of slavery, landowners and physicians worked together to ensure that Black women continued to give birth to children who would, in turn,

be owned by the landowner. An increasing number of white medical doctors took over midwifery services while kicking out Black midwives.

Medical racism against Black women's bodies in the United States of America did not end with slavery.

> "Physicians today still construe Black bodies through the prism of biological race and, as a result, as perpetually high-risk bodies. Biological race thus operates as both a cause of and a perverse justification for Black women's over-medicalisation and increased exposure to invasive risk management techniques" (Campbell, 2021, p. 50).

This dehumanisation of Black women's bodies, Campbell (2021) argues, is founded on the control of Black women's sexuality and reproduction. This, she further argues, is fuelled by the racist "Jezebel archetype that depicts Black women as hypersexual beings who want and deserve sexual attention" (Campbell, 2021). This justified landowner's violent and unconsented-to sexual access and exploitation of Black women. This makes sexual violence against Black women a racial and gendered phenomenon.

The use of enslaved women's bodies repeated itself in the Cape Colony. In her PhD dissertation on obstetric violence and colonial conditioning, Jessica Rucell (2017) writes about the continuation of the slavery project in the Cape and its impact on maternal health generally, and obstetric violence specifically. Using the racial and racist construction of Black women as hypersexualised, Rucell (2017) shows how the notion of Black women as subhuman justified different forms of gendered violence subjected to their bodies (Rucell, 2017).

From the colonial times of Sarah Baartman, whose body was dismembered and put on display when she died in 1815 (Abrahams, 1997), to the era of farmworkers who worked in white farms during apartheid being subjected to regular doses of the contraceptive Depo-Provera without consent (van der Waal et al., 2021), up to post-apartheid structural violence imposed on Black birthing bodies in public hospitals (Rucell, 2017), it is clear that Black women in South Africa are subjects of racist obstetric violence. Such violence is reproduced through the training of doctors and midwives initiated in colonial, misogynist, heteronormative, and racialised healthcare (van der Waal et al., 2021).

Most of the research on obstetric violence in South Africa is undertaken in public institutions that cater for poor Black women (Chadwick et al., 2014; Honikman et al., 2015; Jewkes et al.,

1998; Kruger & Schoombee, 2010; Lappeman & Swartz, 2019; Malatji & Madiba, 2020). While this focus is crucial to show the impact of health inequity on the quality of maternity services, it potentially reinforces the notion that violence is a problem of poor, unemployed, illiterate people who live on the margins of society. This hides violence in private healthcare facilities which cater for the rich, who are mainly white. The lack of research on private-sector obstetric violence feeds into the assumption that abuse only happens in public-sector healthcare facilities (Chadwick, 2016).

Many research studies on obstetric violence recommend training healthcare workers and enforcing healthcare protocols. This is, in my view, not enough. Obstetric violence is embedded in biomedicine. Changing the dominant narrative of childbirth also calls for a dissection of the coloniality of biomedicine. My focus in this thesis is violence embedded in the coloniality of the biomedical birthing model. Countering obstetric violence without re-centring the knowledge and practices of Indigenous midwives constitutes a form of biomedical humanism (Gaines & Davis-Floyd, 2003) that upholds the obstetric hegemony (Campo, 2014). Campo (2010) describes hegemony as a "description of the relations of power that rely on consent rather than force and that operates via ideological leadership" (Campo, 2010, p. 2). Reproductive health in South Africa cannot be divorced from the legacy of colonialism and apartheid, which was characterised by separate and unequal health care for white and Black women.

> "Colonialism and neo-colonialism widely destroyed Indigenous people's epistemes, made them invisible, or adapted them to the needs and interests of the former colonial power" (Dubgen, 2016, p. 4).

Based on the above, I argue that remedies for obstetric violence should dissect the role of colonialism in childbirth practices. This includes creating spaces to debate the need to dismantle the coloniality of the biomedical model of birthing in government maternity policies and guidelines. As I will show in the next chapter, this includes challenging international development cooperation founded on the belief that solutions to development problems in the Global South originate in the Global North.

## 2.9. Conclusion

In this chapter, I have demonstrated how biomedicine was centred on childbirth from ancient Greek societies to modern-day Europe. In ancient societies, men's perception of women as influenced by mythology and religion was instrumental in enabling the process of men's takeover of birthing from women, as well as a shift of birth location from home to hospitals (Kuoni, 2021b; Marino, 2010). This was influenced by factors such as urbanisation, industrialisation and the building of hospitals (Gallagher, 1988). Obstetrics was founded on the metaphor of the body as a machine, and it flourished and ushered in medical and technological interventions during labour (Davis-Floyd, 1994). With medicalisation, the birthing position was changed from upright to supine (Diorgu et al., 2016), and other interventions, such as episiotomy, became the norm (Diniz et al., 2015). By the 1930s, the male-dominated profession of obstetrics was flourishing. This was aided by the availability of anaesthesia and analgesics, which offered women pain-free birthing experiences, as well as antibiotics which lowered the prevalence of infection (Minkowski, 1992).

In writing about the global and South African account of obstetric violence, I attempted to show that this is a complex phenomenon at the intersection of biological, cultural, political, structural, and economic, as well as many other factors within which both the victim and perpetrator exist. The perpetrator is not limited to an individual. It includes institutions, systems, or paradigms. By introducing biomedical midwifery, colonial medicine positioned itself as "authoritative knowledge" (Jordan, 1983). With that came the suppression of Indigenous midwifery. While many feminists advocated against the medicalisation of childbirth (Annandale & Clark, 1996; Bellón Sánchez, 2014; Cohen Shabot & Korem, 2018; Koitsioe & Swemmer, 2022; Oakley, 1980; Pollock, 1999; Rothman, 1982), there has been little attention to colonialism and its impact on obstetric violence. Recent work of Van Der Waal et al (2023) concurs by advocating for an abolitionist approach to obstetric violence which focuses on a future that ceases to ignore the impact of obstetric racism on black women as well as undermine Indigenous midwifery practices (van der Waal et al., 2023)

In the next chapter, I write about ways in which the biomedical birthing model was used as a colonial tool to erase the knowledge and practices of Indigenous midwives. By questioning the hierarchy of knowledges between biomedical and Indigenous birthing practices, I argue that responses to obstetric violence must: 1) decentre biomedical birthing, 2) decolonise midwifery, and 3) integrate cultural safety in the definition of safe birthing by respecting cultural and spiritual needs of birthing women.

## CHAPTER 3: Indigenous model of childbirth

### 3.1. Introduction

In the previous chapter, I outlined an overview of a biomedical birthing model which was exported to Africa through colonialism. The chapter gave us a glimpse of how a home-based, woman-centred, and social phenomenon was replaced by an individualised, medicalised, interventionist facility-based event that predisposes women to obstetric violence. In this chapter, I retrace the steps to remember what a non-medicalised birth looked like.

I begin with a contextualisation of the naming of Indigenous midwifery and Indigenous midwives within a Western development discourse. This explains my choice of using the term 'Indigenous midwife' and not 'traditional birth attendant.' With that in place, I trace historical childbirth practices in ancient Africa using Egypt as an example. The objective of this is two-fold: 1) to foreground the role that women played in childbirth in ancient Africa, and 2) to review the conception of birth beyond biology to one that includes social, cultural, and spiritual dimensions. I also examine the concept of the medicalisation of childbirth as a colonial tool in South Africa. This is aimed at painting a picture of the role that colonial medicine, nursing, and midwifery played in suppressing and decentring knowledge and practices of Indigenous midwives.

Lastly, I argue that the practice of Indigenous midwifery is a form of anti-colonial resistance that helps to re-assert the validity of Indigenous birthing practice as knowledge that we can learn from to counter obstetric violence in South Africa.

### 3.2. Indigenous midwife vs traditional birth attendant

The term 'Indigenous' emerged from the struggles of people in the Americas (Stewart, 2018). Even though this was initially used as an umbrella term for Aboriginal Australians, Indigenous Americans, and the people of the Pacific Islands, the United Nations Declaration on the Rights of Indigenous People pronounced that Indigenous people live on all the continents, from the Arctic to the Pacific, across Asia, Africa, and the Americas.[19] According to the Declaration,

[19] United Nations Indigenous Peoples and the United Nations Human Rights System. Fact Sheet No 9/Rev 2; New York and Geneva, 2013.

there is no universal definition of Indigenous people.[20] In the absence of a universal definition, the following are used to define Indigenous people's distinct characteristics.[21]

- Historical continuity with pre-invasion and/or pre-colonial societies
- Determination to preserve, develop, and transmit knowledge to future generations
- Strong link to nature and natural resources
- Distinct social, economic, and political systems
- Distinct language, culture, and beliefs.

Use of the term 'Indigenous' in Africa poses challenges because it tends to be associated with nomadic pastoral or hunter/gatherer communities such as Tuareg, Khwe, San, Fulani, Maasai, Batwa, and many other nomadic or semi-nomadic groups scattered across the continent.[22] Chilisa (2012) asserts that use of the term in Africa should encompass all colonised people's struggles against invasion, political domination, and oppression (Chilisa, 2012). Many Indigenous people were colonised; some were conscripted into the advancement of the colonial agenda. Others were segregated from the colonial master, while some intermarried. This makes the notion of Indigenous identity complex and heterogenous (De la Cadena & Starn, 2007).

In the context of international development, the term 'Indigenous' is often associated with the term 'traditional.' This may be associated with backwardness, which development practitioners can use to diminish the value of Indigenous knowledges (Osman, 2009). It is within this context that Langwick (2011) argues that the term 'traditional birth attendant' is a global product that international development organisations coined in the second half of the 20th century (Langwick, 2011). In her analysis of the term within a colonial biomedical discourse, Langwick draws from Mohanty (1984), who argues that the creation of a profile of a typical Third World woman elevates the West as knowing and enlightened and the Third World as uninformed and underprivileged (Mohanty, 2003). Because they are situated in what is referred to as the third world, traditional birth attendants are described as untrained and unskilled. The assumption is that they require knowledge from what is referred to as the

[20] Ibid.

[21] Ibid.

[22] Ibid.

first world to get legitimacy to practise what they have been practising long before colonisation.

The WHO defines a midwife as "an accredited health professional, such as a midwife, doctor, or nurse – who has been *educated and trained to proficiency in the skills* to manage normal (uncomplicated) pregnancies, childbirth, and the immediate postnatal period, as well as in the identification, management and referral of complications in women and newborns"[23] (my emphasis). In contrast, a traditional birth attendant is defined as "a person, (usually a woman) who *assists a pregnant woman at childbirth, and who initially acquired her skills* delivering babies by herself or working with other traditional birth attendants"[24] (my emphasis). The word skill is mentioned in these two definitions. This implies that both practitioners have acquired some form of knowledge. You need prior knowledge to acquire and practise a skill. Knowledge is information acquired through various inputs such as reading, writing, listening, and observation. Skills are acquired through practise. Practice pertains to continuing and consistent application of knowledge. Based on the definition cited above, a biomedical midwife possesses knowledge acquired through reading books, listening to lectures, observing tutor's skills, and attending to a woman during delivery whilst supervised by a skilled midwife. Traditional birth attendants also have a skill; they possess knowledge acquired not by reading or writing the alphabet but by reading embodied knowledge of childbirth, listening to, and observing elders' birthing skills, and attending to a birthing woman whilst supervised by an experienced elder.

Reading is an art of making sense of symbols, but *is reading limited to making sense of the Western alphabet? Can reading include other forms, such as reading energies, emotions, signs, and nature?* To answer these questions, I will share a story I once heard at an Indigenous literature festival in Limpopo Province. For this exercise, I will give the main character the name Kitso, which means knowledge:

> Kitso was born and raised in a small village in Limpopo Province. Like most boys in his village, he spent time in nature taking care of goats. Even though he could not read

[23] WHO, 'Midwifery education and care' https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/maternal-health/midwifery

[24] De Lourdes Verdese, M. & Turnbull, L.M. 1975. The traditional birth attendant in maternal and child health planning: A guide to her training and utilization. Geneva, World Health Organization, p.7

> the alphabet or count numbers, he could immediately tell when one of the goats went missing. He could also read the energy of the goats. For instance, if one of them got sick, he could read the signs of the illness and use his knowledge of trees and plants to feed the goat so that it can recover. In other words, Kitso could read animals and nature. When he turned seven, he was sent to school. On the first day, the teacher asked him to count to ten in English. He could not. Other kids who had already been through a Western preschool education laughed at his inability to execute what was to them, a basic and simple exercise. Because of his inability to read the Western alphabet and numbers, Kitso was sent to a class of slow learners. The teacher in the new class continued to pressure him to learn in a language that was foreign to him. He hated the teacher and the school. Later, he dropped out (Original story quoted in Motsei, 2020, p. 80).

Drawing from Kitso's experience, I reflected on WHO's definitions of midwife and traditional birth attendant. What is different is how the two acquired their knowledge. In the first definition, the words educated and training are mentioned. *Does this mean education only happens in a Western context?* The Setswana word for education is *thuto.* A learned person is not limited to someone who has gone through a Western education system because *thuto* comes in various forms. According to the definitions, the midwife and traditional birth attendant use an apprenticeship model of learning. However, the definition of traditional birth attendant does not regard learning from other women who are not professional as education. The use of concepts such as formal, professional, or education are ascribed to the acquisition of Western knowledge. Traditional birth attendants are classified as uneducated because they lack Western birthing knowledge. This means the veracity of their knowledge is questioned because they are not proficient in Western knowledge (Bruchac, 2020). Briggs and Sharp (2004) remind us that Western science is Indigenous knowledge located in Western institutions. This localised knowledge was transformed into universal knowledge through colonialism and neo-colonialism.

> "Just as in the colonial period, an assumption dominates that either Western science and rationality are more advanced or refined than other positions, or, more simply, that they are the norm – 'knowledge' – in the singular form – from which others deviate in the fallibility" (Briggs & Sharp, 2004, p. 2).

Before the use of English as a colonising and development language, the term 'traditional birth attendant' did not exist. What existed were Indigenous names such as Mmelegisi in Setswana. Mmelegisi comes from the verb *belega*, which means to deliver a baby. Like many other words in Indigenous languages, *belega* has multiple meanings. *Go belega* can mean giving birth, providing support, or carrying something, for example, carrying a baby on your back. Within the context of birth, the name Mmelegisi refers to a woman who delivers babies. Mabotsetse comes from the name *botsetse* (perinatal and postnatal period). The phrase *go baya botsetse* includes taking care of a birthing woman during labour and caring for the mother and infant during the postpartum period.

Like Kitso, it would be easy for me as a Motswana researcher to use the term Mmelegisi because of its clarity on the role of the Indigenous midwife, not as an assistant of the biomedical practitioner. However, using the term throughout the text will affect the flow of the writing. This, I accept, is one of the academic contradictions that come with undertaking Indigenous research within an institution that uses a language foreign to my research area.

For purposes of this study, I will use the term 'Indigenous midwife' for two reasons: my choice is a form of resistance to the term 'traditional,' which can be associated with colonial depictions of African knowledge as inferior or backward. I also choose not to use the term 'attendant' because it represents a devaluation of the role of Indigenous midwives and their knowledge about birthing. I am aware of the controversies surrounding the term 'Indigenous,' which often connotes traditional, superstition, belief, and therefore unscientific. I am also aware that within the international development context, Indigenous and traditional are used interchangeably (Osman, 2009). For lack of a better-suited word in a language that has the capacity to devalue the African way of being and knowing, I choose to use the term 'Indigenous midwife.'

### 3.3. Historical overview of childbirth in Africa: Using ancient Egypt as a case study

Like in the previous chapter, I start by reviewing childbirth in Africa through the eye of history. In her book, *Being Born: Birth and Philosophy*, Alison Stone argues that birth happens within a "set of relationships, and situation in society, culture, and history" (Stone, 2019, p. 1). This means that even though the physiology of birth is universal, the experience of giving birth is shaped by various sociocultural factors into which a baby is born. Thus, the purpose of a

historical review of childbirth is to trace various factors that contributed to a shift of birth from the home to institutions and from women to men.

Like birth in the Greco-Roman era, birth in ancient Egypt was embedded in religion, mythology, and spirituality (see Section 2.2). Many reports about childbirth were about what happens before and after birth. This lack of information on the actual labour in medical texts could indicate that childbirth was not considered a disease for which a physician was required (Töpfer, 2014). In the absence of medical records of childbirth, other supporting information is taken from mythology, astrology, and art (Athanasekou, 2018). The following is an example of birth cited in one of the mythologies:

> "One of these days, it happened that Reddedet took sick, and it was with difficulty that she gave birth. The Majesty of Ra (= the sun-god) […] said to Isis, Nephthys, Meskhenet, Heket and Khnum: May you proceed that you may deliver Reddedet of the three children who are in her womb […]. These goddesses proceeded, and they transformed themselves into musicians, with Khnum accompanying them carrying the pack. When they reached the house…they found him standing with his apron untied […], he said to them: my ladies, see, there is a woman in labour, and her bearing is difficult. They said to him: Let [us] see her, for they are knowledgeable about childbirth […]. They locked the room on her and on themselves. Isis placed herself in front of her, Nephthys, behind her, and Heket hastened the childbirth. Isis then said: Do not be strong in her womb in this [,] your name of Wosref. This child slipped forth upon her hands as a child one cubit long […]. They washed him after his umbilical cord [had] been cut and he was placed upon a cushion on bricks" (Töpfer, 2014).[25]

While the above is a depiction of divine and not human birth, actual childbirth accounts depicted in ancient Egypt paint a picture of a woman giving birth kneeling on the floor, supported by two women on either side and another kneeling in front of her to receive the baby, while another is standing in the room holding ankhs on her hands making invocations to the gods and goddesses for safe delivery of the baby (Flemming, 2007; Fouly, Howieda; McCool William F.; Koucoi, 2012; Marino, 2010). Other sources of birth describe women

[25] In Simpson, William Kelly (ed.). 2003. *The literature of ancient Egypt: An anthology of stories, instructions, stelae, autobiographies, and poetry.* New Haven, Yale University Press p 21-22.

delivering babies in a squatting position with legs supported by birth bricks or sitting on a birthing chair. The birth brick was later developed into a low birth stool. The earliest representation of a birth stool was in a birth chamber in Luxor where Pharaoh Ammenophis III was born in 1450 BC (Thompson, 1922). The birthing space, including the chair or bricks the woman used for support, was fortified before use.

> "Like each activity before, during and after delivery, this act needs magical protection, because the physical separation of mother and child by cutting the umbilical cord is an important step and perhaps dangerous in the Egyptian comprehension" (Quoted in Töpfer, 2014, p. 330).

The birth of the placenta was given the same attention as the birth of the baby. After the placenta was born, the midwife made an invocation to thank the goddesses of childbirth for safe delivery. In the case of retained placenta, the women waited patiently with little interference, while one of them made an appeal to the goddess for safe delivery of the afterbirth. Invocations were done four times over a dwarf of clay on the brow of the woman. Amulets were also used as part of the rituals to open the womb.

More than one caregiver could fill the role of the midwife. Although many of these caregivers were midwives whom other women trained, there were references to women physicians. One of the first woman physicians mentioned in ancient Egypt is Peseshet, who lived around 2500 BC (Sullivan, 1997). The first record of formal midwifery training was established in 700 BC (Charmberlain, 2004). This was three hundred years before Hippocrates established a medical school in Greece, around 400 BC (Yapijakis et al., 2013). Initially, Hippocrates' school did not allow access to training of women physicians and midwives. As outlined in the previous chapter, some midwives, such as Agnodice, fought for the right of women to have access to the school (Davies, 2017).

Women in ancient Egypt delivered babies in upright or semi-upright positions in the company of other women. Midwives learned the trade by attending the births of other women first as observers and then being taught to practise midwifery by other experienced midwives. This means that knowledge was transferred from one generation to another. We also learn that birth was not just regarded as physical or biological. Cultural and spiritual dimensions of childbirth were honoured through various rituals and ceremonies. In the next section, I present the historical evolution of the Indigenous model of birth.

### 3.4. Indigenous model of childbirth in Africa: An overview

It is beyond the scope of this chapter to give a comprehensive historical overview of Indigenous birthing in Africa. In addition, I acknowledge the existence of extensive records of Indigenous birthing in other parts of the world, such as Asia, Australia, New Zealand, and the Americas. In my review, I limit my input to a summary of the African Indigenous birthing model, bearing in mind that Indigenous midwifery practices differ from one region and culture to another.

Within an Indigenous belief system, pregnancy is a normal event that does not require medical care. This means pregnancy is not perceived as a pathology, and a woman's body is not viewed as a machine that needs to be fixed. In Africa, women are perceived as life givers and birth is a sacred rite of passage for the mother (Beinempaka et al., 2015; Doenmez et al., 2022; Ngomane & Mulaudzi, 2012). Similarly, children are valued as spirits whose role is to continue the genealogical lineage of the clan (Naidu, 2013a). Birth happens in the home, mostly in a specially prepared birthing hut (Maimbolwa et al., 2003; Motsei, 2022; Naidu, 2013). Location of birth is influenced by many factors, such as marital status, whether the woman is giving birth for the first time, and social organisation of the group. For instance, in the case of Botswana and South Africa, social organisation is patrilineal. However, pregnant women often return to their mothers for the last few weeks of pregnancy, for birth, and the postpartum period (Anderson & Staugard, 1986). This is common when the woman is giving birth for the first time. The mother-in-law may attend the birth if she lives nearby. If she does, her role is to invoke the spirits through incantations or perform the first spiritual cleansing bath for the newborn baby (Anderson & Staugard, 1986).

There are usually between two and four women attending to the labouring woman. One or two helps to provide back support and relief by massage. Another is positioned in front of the woman, ready to catch the baby when it is born. The woman is free to choose the position in which she feels comfortable. This ranges from squatting and holding on to a source of support, which could be a pole or kneeling with both hands firmly on the floor (Naidu, 2013). While characteristics of Indigenous midwives differ across the continent, the following are some of the features that are common to many (Ngomane & Mulaudzi, 2012):

- They are already connected to the communities they serve
- They have a trusting relationship with birthing women

- They understand and respect cultural practices that are associated with pregnancy and birthing.

Practices of Indigenous midwives differ. A study done in Zambia identified the following practices (Maimbolwa et al., 2003):

- Some midwives use herbs to accelerate labour
- Many do not do vaginal examinations except in the case of complications
- In the case of delayed expulsion of the placenta, some women massage the abdomen, others encourage the mother to cough while kneeling, and some ask the woman to blow into a bottle, and if all this fails, some reported that they would deliver the placenta manually.

In Tanzania, Indigenous midwives assess progress by inserting a finger in the birth canal. If the finger goes in completely, it means the head is not engaged. (Anderson & Staugard, 1986). Many Indigenous midwives discourage pushing until the baby's head is visible. After delivery, the baby is put next to the mother on the delivery mat until the expulsion of the placenta. In the absence of complications, the umbilical cord is cut only after the birth of the placenta. To cut the cord, women used sugar cane peels, scissors, or razor blades. Thereafter, the mother and baby are bathed, the mother's abdomen and back are massaged, and the mother and the baby are both kept warm and comfortable. The new mother is kept in isolation and is not allowed to do any household chores. This will be discussed in detail in the next section.

## 3.5. Childbirth rituals

### 3.5.1. Defining the concept

Ritual is derived from the Latin word *ritus* (rites). This refers to actions carried out as part of religious or spiritual ceremonies (Etim, 2019). All religions practise rituals (Ogunleye, 2014). Aside from religion, rituals can be associated with Indigenous cultural practices, such as burying the placenta, or it can be aesthetic, like in performing arts, or political, like the opening of parliament.

A ritual is constituted by four elements (Ranger, 1972):

- Symbolic – a ritual is made of a totality of symbols that deepen the understanding of human behaviour

- Values – a ritual expresses an authoritative message about values that are sacrosanct for a specific group of people
- Telic – rituals are designed to have a specific emotional and spiritual effect on people, mainly focused on impacting the behaviour of future generations
- Role – rituals are relational, not a product of individualism; rituals transcend individual interests to embrace the idea of common good.

Based on the above, rituals are categorised into those that address calamity or affliction such as sickness, barrenness, or natural disaster; those that initiate an individual going through a life crisis into a cult, position, or rituals that are associated with rites of passage such as puberty, pregnancy, birth, or death (Ranger, 1972). Through rituals, the older generation passes on knowledge and values to the younger generation. Young people learn about their identity, cultural beliefs, and spiritual practices by participating in rituals.

Rituals are esoteric by nature. This means they are associated with symbolism and belief. This is irrespective of whether they are practised by white, Black, rich, poor, Africans, Asians, or Europeans. I compare the Christian ritual of pouring water on a baby's forehead in a church to make it holy with an African spiritual herbal-infused fire ritual performed on the tenth day after birth to ensure the baby is protected from evil. *How can I identify the connection between the act and the effect?* Belief plays a key role in understanding rituals.

It is common knowledge that African rituals are often criticised as primitive, irrational, and superstitious (Etim, 2019; Laidler, 1931; Ogunleye, 2014; Selepe & Thomas, 2000). Etim (2019) argues that African rituals cannot be judged on principles of Western scientific rationality. Such criticism, he further argues, is based on "an ontology which is alien to African conceptual schemes" (Etim, 2019, p. 12).

### 3.5.2. Rituals related to pregnancy and delivery

From the African point of view, childbirth is regarded as a natural biological phenomenon and a spiritual rite of passage that creates space for a new soul to enter the earthly realm. Because of its spiritual dimension, childbirth is filled with various rituals to protect the mother and the child (Beinempaka et al., 2015; Ogunleye, 2014; Ohaja & Anyim, 2021; Selepe & Thomas, 2000).

> "Ritual in the birth of a child starts from conception of pregnancy, and the expectant parents will perform the necessary rituals that will assure the safety of both the mother and child. At birth, the condition of the child will determine the type of ritual needed for its well-being" (Ogunleye, 2014, p. 215).

In many cultures, pregnant women observe certain taboos aimed at protecting the mother and the baby from evil attacks (see Section 3.5.3). Fear of evil attacks is not unique to Indigenous communities in Africa. For example, Nordic Viking communities who practised animistic religion also engaged in protective practices such as wearing protective amulets, recitation of spells, soaking the mother in salty water and bathing the child with water mixed with earth particles (Kvideland & Sehmsdorf, 1991). The practice of bathing the baby with earth particles among Nordic Viking communities is similar to the one practised by Batswana, which involves bathing the baby with soil taken from *makopanelo a ditsela* (crossroads). This ritual protects the baby after a period of isolation in the birthing hut (Motsei, 2022).

Maternal activity is encouraged throughout pregnancy. A woman continues to work until later in the pregnancy because it is believed that pregnancy is not a disease (Beinempaka et al., 2015). Drinking herbal medicine during pregnancy to strengthen the baby and prepare the mother for labour is common in many communities across Africa (Honkavuo, 2021; Mogawane et al., 2015; Ngomane & Mulaudzi, 2012; Ohaja & Anyim, 2021). Another way of keeping pregnant women healthy is to participate in Indigenous games led by elders. The aim is to increase physical activity for pregnant women as one way of ensuring optimum health (Motsei, 2022). The most important thing is to keep the woman physically, psychologically, and spiritually healthy and safe.

### 3.5.3. Rituals related to postpartum care

Many Africans believe that the infant has come from the spiritual world with an important mission and message to the world. In performing birthing rituals, elders are responsible for uncovering the child's mission through observation and divination. Thereafter, they craft a birth chart which outlines the circumstances surrounding the child's conception and birth (Kanu, 2000).

Cutting the umbilical cord is perceived as one of the first crucial rituals of separating the baby from the land of ancestors and initiating them into the family, community, and clan. After

cutting of the cord, the mother and the baby go through their initial cleansing ceremony. Important placental rituals follow. In African societies, the placenta is believed to hold immense power and should therefore be handled with care. For instance, the placenta is believed to have a special bearing on a woman's fertility. It ensures that the woman will have other children in the future (Maimbolwa et al., 2003). Because of its power, it is believed that the placenta can be used to bewitch a woman who may subsequently end up with miscarriages or stillbirths (Naidu, 2013).

After delivery, the placenta is buried at a designated place (Maimbolwa et al., 2003; Motsei, 2022). Burial sites vary; this can be next to the birthing hut, under a tree, behind an anthill, in the centre of the family hut, on the side of the birthing hut or at a special place in nature. The Tonga of Zambia bury the placenta under the *mupundu* tree (fertility tree) (Ohaja & Anyim, 2021). Burying the placenta in nature under a fertility tree evokes the spirit to "continue blessing the womb of the woman so that she can be as fruitful as the *mupundu* tree" (Siwila, 2015, p. 65). Amongst the Igbos, the tree under which the placenta is buried belongs to the child. It connects the child to the land (Siwila, 2015). In Mali, the placenta is washed, dried, and put in a bowl that is buried by the man in the house (Ohaja & Anyim, 2021). The Luo of Kenya distinguish between the left side of the placenta believed to be related to vulnerability and impermanence, and the right side associated with authority and permanence. The placenta of the female child is buried on the left side of her mother's house, while that of the male child is buried on the right side (Ohaja & Anyim, 2021). Some of the rituals, as we will also see in the next paragraphs, are founded on beliefs and practices that discriminate against girls and women.

In many cultures, the postpartum period is a period where a woman is perceived as unclean or vulnerable. The perception of the woman's body as dirty or evil has roots in religious societies that perceive menstruation, pregnancy, and childbirth as diseases (Gottlieb, 1989). It is common for postnatal mothers to be kept in isolation for an extended period. Isolation, rest, nutrition, and massages help the woman to recover from the physical and psychological stress of childbirth. While some cultures isolate the woman because of the patriarchal belief that perceives a woman's body as dirty, others may do so as part of postpartum care that promotes rest and recovery. Irrespective of whether the motive of the isolation is rest and recuperation or isolation because of the belief that the woman's body is contaminated, a

period of rest is necessary for the woman to recover from the gruelling experience of childbirth.

> "If the woman is unclean, she is considered to be a threat to her surroundings, whereas vulnerability implies that surroundings are dangerous to the woman" (Gottlieb, 1989, p. 460).

Other postnatal rituals include the singing of birth songs. Through song, women celebrate the new member of the family (Ohaja & Anyim, 2021). The lyrics of the songs signify that the baby belongs to a collective hence the age-old adage that "it takes a village to raise a child." The lyrics also announce the sex of the baby. In a society that discriminates against girl children, which makes up many in Africa, the birth of a boy is valued more. A woman who only gives birth to girls is regarded as childless, and her position in her marriage remains uncertain.

> "The patriarchal society rejoices when the new infant is male. A new messiah destined by the gods to take the place of the father and continue with the family name is born… Likewise, there is also happiness for the mother because begetting a son has automatically deep-rooted her in her husband's heart… Basically, the birth of a male child gives her the title of wife, prior to this time she is regarded as a wife only in anticipation" (Chukwu & Ume, 2020, p. 202).

The depiction of pregnancy as a time of joy is not universal. In her novel, *The Joys of Motherhood,* Buchi Emecheta explodes the societal construction of motherhood as a joyful experience (Emecheta, 1989). Navigating rural and urban Nigerian culture during the time of colonisation, Emecheta uses the life of her character, Nnu Ego, to reveal the burden of motherhood under the yoke of colonialism, patriarchy, and capitalism. Women may be forced to carry the pregnancy to term because of cultural pressures (Hanlon et al., 2010). In some instances, mothers may not be happy with the pregnancy. This is irrespective of whether the baby is a girl or boy. In the case where pregnancy may be an additional burden, such as in the case of extreme poverty or violence in the marriage, the woman will still be expected to carry the pregnancy to term because abortion in Africa is caught in the interface between culture, morality, and religion (Fr Turyomumazima, 2002)

While I appreciate the support that some of the rituals offer to women, it would be remiss of me to ignore negative ways in which they can harm or discriminate against women. Marriage is tied closely to reproduction. Motherhood is celebrated if it ensures the continuation of the

male lineage (Ellece, 2012, p. 81). A baby is celebrated as a channel for the return of ancestors. A woman who gives birth to a son is celebrated more than the one who gives birth to a girl. The one who cannot conceive is called derogatory names such as *moopa*[26] by in-laws or members of the community (Motsei & Kim, 2002). Infertility is a source of scorn for the bride and a source of harassment of women who struggle to conceive is common. The same treatment is not meted out to men. Male infertility is shrouded in silence and secrecy. If a woman cannot conceive, African proverbs such as "one who ate the baby's placenta" or the "one whose basket leaks" are used to mock her. This represents various ways in which patriarchy deploys hurtful and oppressive notions of motherhood (Siwila, 2015).

The association of *bogadi*[27] with female fertility is worth a mention. In a study examining the cultural marriage ritual performed by women during *patlo* [28] in Botswana, motherhood is delivered as a service to the people who have contributed *bogadi* (Ellece, 2012). This is illustrated in proverbs such as *Mosadi ke thari ya setshaba* meaning a woman is a placenta of the nation. By employing chants, songs, and rituals, women who perform the ritual make it clear to the prospective bride that motherhood is compulsory and necessary for the "continuation of the husband's progeny" (Ellece, 2012, p. 89).

In a study that examined pregnant women's delayed attendance of antenatal care in rural South Africa, Ngomane and Mulaudzi (2012) share similar findings.

> "The in-laws feel fulfilled when their daughter-in-law falls pregnant, because they feel that their son is fertile and is increasing the number of family members. Furthermore, the family feel that their *lobola* (price for the bride) has reaped rewards" (Ngomane & Mulaudzi, 2012, p. 33).

The application of culture through proverbs, wedding songs, and rites of passage can reinforce the depiction of women as vessels of reproduction who remain under the authority of men. The idea that the woman has a say in how rituals are applied or that she may not want to have children is unthinkable. In the end, not all rituals are beneficial to women. Some

[26] Derogatory Setswana name for a woman who cannot conceive.

[27] Dowry

[28] First phase of marriage where the prospective husband's delegation visits the women's homestead for the first time.

are oppressive, if not harmful. The absence of postpartum support increases the likelihood of postnatal depression (Cox, 1988). While there is agreement that postnatal support can decrease the likelihood of depression, Lee et al. (2004) point out that this is dependent on the nature of the care and character of the caretaker. It is possible for caregivers to be the cause of postnatal depression. For example, many women may not have good relationships with their mother's in-law. Others may find some of the rituals disempowering.

I argue that it is imperative to question culture because it is "the most authoritative canon to the African worldview" (Siwila, 2015, p. 69). This applies to all cultures and not just African Indigenous culture. The same principle applies to all religions. Combined with religion, culture can become an effective tool in legitimising male domination at the expense of women's physical, psychological, and spiritual well-being. The gendered nature of reproductive rituals needs further research.

### 3.5.4. Childbirth taboos

To protect the mother and the baby from bad spirits and witchcraft, the use of rituals and avoidance of taboos are perceived to be essential for positive pregnancy outcomes. In the context of African spirituality, taboos are not just restrictions. They are "manifestations of the sacred (that is, that which counters the profane) aimed at providing protection from any threat to the cosmic order, as well as at 'repairing' any disturbance of this order" (Naidu, 2013).

The following are some of the taboos known to different Indigenous communities:

Public knowledge about pregnancy in the first few months is discouraged because it is believed that this increases the mother's vulnerability to bad spirits and witchcraft (Hlatywayo, 2017; Maimbolwa et al., 2003; Motsei, 2022; Naidu, 2013). The woman is supposed to tell her mother first. In the absence of her mother, she can tell her mother-in-law, who will announce it to her family.

Amongst the Ndau in Zimbabwe, the announcement of pregnancy follows an elaborate process (Hlatywayo, 2017). Rituals for the announcement of pregnancy are usually done for the first pregnancy. The pregnant woman reports to her sister-in-law or aunt. The latter could be the one who accompanied her to her marital home after the wedding. The aunt informs the older sister-in-law, who will tell the mother-in-law. This is followed by formal notification

of the husband. Thereafter, the family will plan for a thanksgiving ceremony. Charcoal mixed with the foam of Indigenous beer is used to make marks on the pregnant belly as part of the celebration of the expansion of family lineage. Later as the foetus continues to grow, elders teach the young pregnant mother about what to expect during labour (Hlatywayo, 2017). In some communities, new brides are invited to observe other women giving birth (Selepe & Thomas, 2000). This is to ensure that they know what to expect when their time comes. One can argue that this is the beginning of antenatal classes, long before conception.

Pregnant women are encouraged to eat homegrown food such as green leafy vegetables with pounded groundnuts (Motsei, 2022). Some of the taboos related to nutrition include not eating eggs because it is believed that they will delay the rupture of membranes (Anderson & Staugard, 1986). In Zambia, some hold the belief that the baby will be born without hair (Maimbolwa et al., 2003). Similarly, pregnant women in Botswana were prohibited from eating the internal organs of an animal, for example, cow intestines. It was believed this may result in intense labour pain or the baby will have diarrhoea. Pregnant women were also not allowed to eat the meat of a cow that died when giving birth or one that had trouble in delivering a calf. It was believed that the mother may have difficult labour (Anderson & Staugard, 1986). Even though they are encouraged to be active throughout the entire pregnancy, in Sudan, women are prohibited from heavy chores such as planting potatoes because it was believed that frequent bending may result in the umbilical cord wrapping itself around the baby's neck (Beinempaka et al., 2015). In terms of clothing, women were encouraged to wear loose clothing without any knots. It was believed that tying knots (*mahuto* in Setswana or *amqhina* in isiXhosa) could cause delays during delivery (Naidu, 2013). Regarding sex, pregnant women are advised not to have sex from the time they are eight months pregnant. In Zambia, sex outside of marriage during pregnancy is discouraged because of the belief that it can cause problems during delivery (Maimbolwa et al., 2003).

In terms of behaviour, a pregnant woman is not supposed to walk into the kraal. It is believed that she may cause the cows to abort (Motsei, 2022). Similarly, she is not supposed to walk across the fields during ploughing because it is believed that the crops will fail (Anderson & Staugard, 1986; Motsei, 2022). Before delivery, the birthing mother and her midwives must untie knots on all their clothing because it is believed that this may cause prolonged or obstructed labour (Naidu, 2013). Birthing women are discouraged from screaming during labour and delivery (Anderson & Staugard, 1986; Maimbolwa et al., 2003). When that

happens, elder women would either beat the drums or sing to muffle the sound (Motsei, 2022).

It is common for men and other family members to be excluded during labour. However, groups such as the Pygmies regard birthing as a family affair (Anderson & Staugard, 1986), while the Brong of Ghana may call on men to provide support to the birthing woman (Peterson, 1982). In some parts of Sudan, the husband may be called to support the wife in labour (Beinempaka et al., 2015).

### 3.5.5. Unassisted births

Even though the use of Indigenous midwives is a common feature in many communities, there is a record of those who shun using midwives for reasons that may include fear of witchcraft. In a study on the cultural beliefs of AmaMpondo women in the Eastern Cape, Naidu and Nqila (2013) found that midwives can also be viewed as potential witches who may hurt the mother and child intentionally or unintentionally. Some women prefer to give birth independently to protect themselves from harm.

A pregnant woman must collect enough firewood to prepare for an unassisted birth. Fire is believed to be a source of comfort and safety. The mother must make the fire herself. If the fire could not be made before the onset of labour, it should only be lit after the baby has been delivered. Thereafter, any other person can make the fire. To prepare the birthing hut, the woman smears cattle cow dung on the floor and puts enough firewood in the hut. Once the birthing hut is ready, no one is allowed to enter the hut until the baby has been delivered.

During delivery, the pregnant woman uses a kneeling position, facing the direction of the fire, supporting herself with both hands on the floor. The kneeling position is believed to give the woman strength to push the baby out. *Impepho* (herb used to chase evil spirits or to communicate with ancestors) can also be burned during delivery. In the case of complications, a midwife pre-selected by the birthing mother is called in to assist with the delivery (Naidu, 2013). After delivery, the woman performs postnatal cleansing rituals. The first phase is to perform placental rituals followed by burying the placenta at a spot identified by the mother. In some instances, women are discouraged from using sharp instruments such as a knife to cut the cord because it is believed that this may predispose the child to anti-social behaviour at a later stage in life (Naidu, 2013).

In the table below, Anderson and Staugard (1986) provide a difference between biomedical and indigenous model of birthing (Anderson & Staugard, 1986):

| **Characteristic** | **Biomedical** | **Indigenous** |
|---|---|---|
| Definition of birth | Biological event; viewed as a medical condition/pathology<br>Belongs to experts/health workers | Sociocultural event<br>Belongs to women, family or kin or elders |
| Birth surroundings | Health facility which is foreign territory for the birthing woman.<br>Isolation from family<br>Supine position, lack of mobility<br>Clean and sterile environment | Home-based, familiar environment<br>Holistic (physiological, cultural, and spiritual), happens in the company of family<br>Midwife is familiar with family, their language, and beliefs.<br>Minimal clean/sterile environment and equipment which may predispose the mother and baby to infection. |
| Support/Management | Trained on physical aspects of birth.<br>Dominant/subordinate relationship.<br>Lack of cultural sensitivity.<br>Depersonalised care. | Trained to view birth as a physical and sociocultural event.<br>Shared decision making amongst the midwives and the birthing woman.<br>Older, experienced in birth.<br>Verbal/nonverbal encouragement using familiar language.<br>Local cultural sensitivity, offering spiritual support and care. |
| Type of care | Routine care<br>Emphasis on physiological outcome.<br>Birthing position accommodates health worker interventions.<br>Sometimes, mother and baby are separated. | Emphasis on process and outcome.<br>Mother and baby are not separated.<br>Choice of position not limited to lying on a bed. |
| Technology of birth | Medical/technical intervention.<br>Pharmaceutical comfort, medication given for pain.<br>Able to handle complications.<br>Available resources such as intravenous infusion in the case of heavy bleeding. | Minimal intervention.<br>Personal comfort e.g., massage.<br>Not always able to handle complications.<br>Minimal resources.<br>Depends on the natural process. |

### 3.6. Medicalisation of childbirth as a colonial tool

In this section, I write about ways in which colonialism exported biomedical birthing practices to Africa. Birthing in the colonies replaced Indigenous rituals and ceremonies with hospital rituals by introducing and upholding biomedical midwifery. I begin with the role of colonial doctors who also served as medical missionaries. This is followed by the role of colonial nursing and midwifery in suppressing Indigenous medicine and knowledge about birthing.

#### 3.6.1. Role of medical missionaries in the suppression of Indigenous knowledge

The origins of African Indigenous medicine stretch into millennia of the history of African people (Sadowsky, 1999). In pre-colonial Africa, responses to illness went beyond relief or the cure of symptoms to include the "totality of being" (Afolabi, 2011, p. 231). During colonialism, biomedicine was declared scientific and superior, and a Western theoretical framework about disease causation was incorporated into medical education and practice (Mc Leery, 2015). Colonialism came about because of the conquest of Africa by several European countries (Afolabi, 2011; Chirwa, 2016). This happened when the germ theory of disease and the use of pharmaceutical treatment, as well as vaccination campaigns, began to dominate health care in Europe (Lock & Nguyen, 2010). This model of health care was imported to South Africa when colonial doctors moved to the Cape. The number increased after the Anglo-Boer War when they came as medical officers attached to the army (van Heyningen, 1989). Because of their multiple roles as missionaries and medical administrators, colonial doctors played a crucial role in penetrating communities with the aim of imposing Western values. Health became a useful and powerful tool to fulfil the civilising mission and convert Africans to Christianity. Medical missionaries perceived the use of traditional medicine as a stumbling block to the conversion to Christianity (Marks, 1994). By defining biomedicine as a gift from God, they used their medicine to wean Indigenous people from their religion and culture.

> "Through the healing brought by the Gospel, the medical missionary would be the means through which the Faith or Kingdom of God could be brought to the ignorant or unbelievers… The mission doctor was thus part of the purpose of the mission which was to bring Light to the unbelievers" (Comaroff & Comaroff, 1991, p. 79).

Writing about the character of medical practice in the Cape, van Heyningen (1989) reveals that medical practice was largely served by middle-class British-born white men who were

educated in Scotland. Later, when universities were established in South Africa, they did not accept Africans. When they did, the curriculum excluded Indigenous knowledge and approaches to health and healing (Chirwa, 2016). Since most healthcare practitioners were men, white maleness became the face of medicine (van Heyningen, 1989). In this way, medicine created and reproduced racial and gendered inequalities (Marks, 1994).

> "The vast majority had British training, and the British influence on legislation and the professionalisation process came to the Cape not only through colonial authority, but also through doctor's exposure to British medical education" (Comaroff & Comaroff, 1991, p. 8).

British social organisation in the Cape was also exported through the implementation of segregated public health policies that had the main aim of imposing and consolidating the values of the British Empire (van Heyningen, 1989). For example, medical officials seized the opportunity during the plague outbreak in 1901 to establish locations[29] and moved Africans from cities such as Cape Town, East London, and Port Elizabeth. In Natal, they successfully excluded Black people from the vote (Swanson, 1977). During that time, medical services were also characterised by the extensive use of humans for experimentation, which was carried out in the absence of ethical standards for conducting research (Tilley, 2014). As late as 1955, Honor Smith, a British physician based at the University of Oxford, described Africa as an unlimited field of clinical research with unlimited access to abundant clinical material (Tilley, 2016, p. 746)). Knowledge acquired from Indigenous people in the pre-colonial era flourished in laboratories in Europe. This was exported back to the colonies as European expertise aimed at tackling certain tropical diseases (Mc Leery, 2015). In addition to experimentation, colonial medical authorities used civil and criminal laws to marginalise and suppress African Indigenous medicine. Colonial law was promulgated to criminalise traditional healing (Chirwa, 2016).

The association of conversion to biomedicine and Christianity was a key feature in the training of African doctors and some turned out to be staunch critics of Indigenous medicine. The first Black medical doctor in South Africa was William Anderson Soga, the son of Tiyo, who was

[29] Location or township is a term that was coined during apartheid to refer to segregated areas where Black people lived outside of, but close to the city or town.

ordained as the first Black minister in the United Presbyterian Church of Scotland on 10 December 1856 (Mayosi, 2015). Like his father, he was ordained as a minister in 1885, two years after qualifying as a medical practitioner in Glasgow. He returned to work as a medical missionary at the Miller Mission Hospital in Elliotdale. Tiyo is reported to have looked down upon African medicine and lambasted traditional healers (Chirwa, 2016). Many years later, another prominent Black doctor, Nthato Motlana, who later served as Nelson Mandela's family doctor after his release, was known for his scathing criticism of Indigenous medicine. In a speech at a medical graduation ceremony at the University of Witwatersrand, Motlana criticised Indigenous healers as people who practise mumbo jumbo (Urbasch, 2002). In a Nursing RSA editorial, Motlana confirmed his view of Indigenous healers as primitive and backward.

> "Here at home there are men and women who want to take us back to the dark ages by romanticising the half-naked drummer of the night (Motlana, 1991, p. 3).

From Frantz Fanon's essay on *Medicine and Colonialism*, Afolabi (2011) argues that an African doctor can become riddled with colonial trappings and become an integral agent of colonisation and domination. In his view, upholding the superiority of biomedicine is a way of sanctioning the colonial hegemony of Western medicine.

> "It is our assertion that the practice of medicine or health care is still largely colonial. What however differs from the scheme of things which were in the colonial days is that the perpetuators of this medico-colonial ideology are African professionals of Western medicine; that is physicians, pharmacists, nurses, laboratory scientists, as well as government (represented by her health policy makers)" (Afolabi, 2011, p. 240).

During the late 19$^{th}$ century, the training and certification of midwives in the Cape were facilitated by male doctors who were unwilling to work with "untrained" African Indigenous midwives (Deacon, 1998). The licensing of midwives began under the Dutch East Indian Company which sent midwives from the Netherlands (Botha, 1914). Even though Indigenous women already possessed the skill of birthing, they were perceived as bad women who gave birth alone in the veld (Deacon, 1998). Using Indigenous midwife services was a form of social degradation. Dutch women who had no assistance in childbirth were chastised for employing the services of "dirty savage mothers" (Deacon, 1998, p. 276).

Following colonialism, architects of apartheid healthcare built on the foundation of the British colonial government. From the inception of missionary medicine, African women's reproductive activities were a focal point of control for Christian medical authorities. Well-baby clinics were created not so much to improve the health of communities but to monitor African women (Amponsah, 2015). Health education emphasised obedience and cleanliness as qualities of a good Christian. Indigenous midwifery was classified as superstition, and Indigenous midwives and birthing practices were demonised (Hokkanen, 2013).

In writing about the cultural practices of Black people in 1931, a white Medical Officer of Health for East London in the Eastern Cape perceived the European way of birthing as a function of intelligent evolution which cannot be compared to 'Bantu' customs. His perception of Indigenous midwives was not only a result of the medicalisation of childbirth, but it was also a result of racism and apartheid.

> "The Native midwife is one of the chief sources of superstition and the establishment of a municipal location service of trained Native midwives would soon replace them" (Laidler, 1931, p. 422).

Like medical missionaries responsible for suppressing Indigenous medicine, the medicalisation of childbirth during colonialism and apartheid reinforced the suppression of Indigenous midwifery. This was reinforced by colonial nursing and midwifery (see Section 3.8.2).

## 3.7. Role of imperial nurses in the suppression of Indigenous health care and birthing

To fully capture the historical role of nursing in suppressing Indigenous health, one must cover three key phases: the pre-colonial era, missionary nursing dominated by religious sisterhoods, which increased after the Anglo-Boer War and the discovery of diamonds in Kimberley, nursing developments under apartheid as well as post-1994 nursing history. It is beyond the scope of this chapter to cover the extent and breadth of such history. My focus will therefore be limited to some of the key forces that help to contextualise the role of colonial nursing in suppressing the knowledge and practice of Indigenous midwives. Just like in the case of medicine, South Africa adopted a colonial hospital-oriented system of nursing practice and training. Outlining this brief inquiry into colonial nursing demonstrates its impact on Indigenous medicine and midwifery practices.

In Chapter 2, I wrote about the role of religion in the development of biomedicine during medieval Europe. In many of these societies, nursing was assigned to women (Ehrenreich & English, 2010). Skills were passed from one generation to the other. Women caregivers first formed themselves into organised groups during the early Christian era when Roman deaconesses who were matrons or widows were selected by bishops to visit and care for the sick at home (Egenes, 2009). Because the Catholic and Protestant churches controlled medical practice and training in Europe, the cause of disease was attributed to witchcraft, evil spirits, or God's punishment for sin (Kirchgessner, 2018).

Like medicine, nursing in the Middle Ages was based on religion. Nuns and monks started early hospitals. However, during the time of the Protestant Reformation, many monasteries and convents were closed – care for the sick became the responsibility of the working class, who were not able to find any other work. At that time, women from upper-class families were homebound, and they were expected to be married to wealthy men (Egenes, 2009).

During the late 18th century Industrial Revolution in England, people migrated to cities, with many living in overcrowded and unsanitary conditions. The role of the nurse gained prominence, and nursing training schools were established. During this time, Florence Nightingale established a training school for nurses (Klainberg, 2009). Dubbed the 'Lady of the Lamp,' Nightingale is well known for the impact she made at the British Army Hospital of Scutari during the Crimean War. She improved hygienic conditions, infection control, admission policies, as well as systems of supplying food and medicine that prevent theft of supplies. This is after she discovered high levels of corruption among army officials (Adu-Gyamfi & Brenya, 2016). She returned to England after the war, and Queen Victoria awarded her the Royal Red Cross. After the war, Florence Nightingale trained nurses and middle-class stay-at-home spouses to serve as agents of hygiene and sanitation. The affiliation of nursing with hygiene was tactical because it created a sphere of expertise which was not threatening to male doctors (Howell, 2013). In 1860, Florence Nightingale established a nurse training programme at St Thomas Hospital in London.

While Nightingale's impact in the United Kingdom was largely painted in glorious terms, her legacy relating to her treatment of Indigenous people in other parts of the world was different. Brookes and Nuku (2020) reveal Nightingale's racism in relation to the health of Indigenous people. In April 2020, members of the New Zealand Nurses Organisation refused

to celebrate Nightingale's 200th birthday. In their view, Nightingale supported the alienation of Māori land to create space for European settlements when she served the Governor of New Zealand, Sir George Grey (Brookes & Nuku, 2020). A statement written by the New Zealand Nurses Organisation reports that Florence Nightingale contributed to health inequity and discrimination against Māori people.

> "The continued veneration of Florence Nightingale in the Nursing Now campaign is therefore disrespectful and painful. It continues to highlight for our Indigenous nurses that their traditional knowledge and ways of being and doing are not respected. Raising her as a beacon for nursing globally causes trauma and re-ignites the history and pain of colonisation" (Brookes & Nuku, 2020, p. 34).

Many years after her passing, Florence Nightingale's legacy includes raising the status of nursing, establishing formal nursing training protocols, as well as her advocacy for and leadership in the process of professionalisation of nursing. With the philosophy behind it, Nightingale's model of nursing training and practice was imported by European nurses to Africa at the dawn of colonialism (Carey et al., 2020). Organised under the Colonial Nursing Association, which sent over 8400 nurses to the colonies, nurses' main mandate was to change customs and traditions that the British deemed harmful. With instructions to uphold European values by acting like ladies and wearing white uniforms day and night (dress, bonnet, cap, and a waist belt), colonial nurses viewed serving in the colonies as answering to the highest calling of the "civilising mission of imperialism" (Howell, 2013, p. 63).

> "The conceptual links between nursing and the empire run very deep. The profession of modern nursing was defined in the context of the Crimean war, as a tool to support soldiers and thereby Britain's national interests" (Howell, 2013, p. 63).

In addition, working abroad allowed European women to validate the need for women's work outside the home at a time when they were not allowed to work outside the home in their countries. As women, colonial nurses were caught between the yoke of patriarchy and the privilege of white supremacy. Colonial nurses were simultaneously oppressors and oppressed (Nestel, 1998).

> "European nurses in the colonial setting were deeply enmeshed in the nets of imperial power, most profoundly as regulars and inquisitors of native populations but also as those regulated by gendered medical hierarchies" (Nestel, 1998, p. 259).

In her book, *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession,* Shula Marks (1994) provides an elaborate account of how colonial, missionary, and apartheid health affected nursing in South Africa. Most of the probationers came from Britain. Henrietta Stockdale came to South Africa at the age of 27 with a mission to extend the work of Christ in Africa (Marks, 1994). She was first stationed at the Anglican sisterhood in Bloemfontein and later moved to Kimberley. The discovery of diamonds changed disease patterns in the area. Just like in Crimea, Stockdale found the area to be a horrific place not fit for healing. She introduced improvements to nursing in the area. Beyond nursing the sick, she was conscious of the broader civilising mission. Her achievements include advocating for nursing training based on the British model. She also succeeded in achieving nursing registration for nurses. After she had trained as a midwife under a local medical doctor, Stockdale began to train probationers.

> "Although concerned with the nursing of African bodies, Sister Henrietta was – like her fellow male missionaries – as concerned with capturing their soul" (Marks, 1994, p. 27).

At first, Stockdale was not interested in training Black women because she did not consider training Black people as nurses. When the training of African nurses did happen, probationers were handpicked from daughters of the Christian African elite. For example, Cecilia Makiwane's[30] father was a Presbyterian minister (Marks, 1994).

Dr James McCord, who was the first to train African nurses in Natal, believed that the work of medicine was twofold: to relieve suffering and open the way for the Gospel. From the foregoing, one can argue that the training of African nurses was aligned to the mission of suppressing Indigenous medicine. Similarly, Neil MacVicar, who pioneered nursing training for African nurses in the Eastern Cape, believed that the nurse's role is to fight against magic and superstition (Marks, 1994). A headline in the Johannesburg *Star* in 1943 was more revealing:

> "More native nurses needed to stop witchcraft."[31]

[30] Cecilia Makiwane was the first registered professional Black nurse in South Africa www.sahistory.org.za.

[31] *Star*, 13 April 1943. Quoted in Marks (1994) p. 82.

Years later, during apartheid, the disregard for African nurses continued. Charlotte Searle who was a prominent figure in South African nursing was trained at Kimberley Hospital in the 1930s. She served as Director of Hospital Services in the Transvaal. At the time, she was a key proponent of segregation in nursing.

> "The non-European nurse in South Africa is being drawn from a social milieu and has a psychological attitude which is completely different from the accepted concept in the Western world. Now, I can describe her as a good technician at most. I am not prepared to describe her as a real nurse." [32]

Overall, medicine was the perfect vehicle for the control and containment of Indigenous communities in Africa as justification for the imperial enterprise. Nurses were to become channels of modernity whose mission was to squash African beliefs and religion.

### 3.8. Knowledge is power: Whose knowledge counts?

In Chapter 2, I wrote about the ways in which biomedical knowledge about childbirth is framed within the conception of the body as a machine and labour as a pathological and risky phenomenon which requires medical intervention (Cahill, 2001; Davis-Floyd, 2001; Rattner, 2007). The medicalisation of childbirth transferred knowledge about birthing into the hands of a patriarchal medical establishment (Masdottir, 2014). This came with a displacement of the knowledge and practice of Indigenous midwives (Masdottir, 2014). In contrast to the biomedical model of childbirth, the Indigenous model frames birth as a relational and communal process. The biological body is inseparable from the cultural and spiritual environment in which birth takes place. Therefore, positive outcomes concerning pregnancy are not limited to a healthy, live baby. A healthy birth outcome is not just about the success or failure of the biological process. Instead, it is about the totality of, and quality of, human interaction, both in flesh and spirit.

To help us understand the suppression of Indigenous knowledge and displacement of Indigenous midwives by international development institutions, Langwick (2011) gives an elaborate historical account of the devaluation of Indigenous midwifery and the controversies that accompanied the process.

[32] Report of the Select Committee on Nursing, 153-157, Hansard, 15.6.87, page 1668.

- In 1955, the WHO became aware of women who deliver babies in rural areas at its 6th Session of the WHO Regional Committee for the Western Pacific Region. This sparked a discussion on "domiciliary midwifery." The discussion reached no consensus because of the potential tension between biomedical and "unqualified" midwives.
- In 1957, the topic of training "Indigenous midwives" appeared on the agenda at the 10th session of the WHO Regional Committee for Southeast Asia. Once again, the ambivalence of medical personnel and policymakers continued. This happened when nation states were unable to train enough biomedical midwives to provide maternity services for women in rural communities.
- In 1972, the focus was on training traditional birth attendants. This was followed by an international consultative meeting convened by WHO with UNICEF, UNFPA, the Population Council, International Planned Parenthood Federation, International Council of Nurses, International Confederation of Midwives, International Federation of Gynaecology and Obstetrics, consultants from London School of Hygiene and Tropical Medicine, and other researchers and scholars. Reports compiled from forty ministries of health and published works of scholars were used as references.
- By the end of the 1970s, the traditional birth attendant profile was defined as a good fit for WHO Health for All by the Year 2000. During the 1970s and 1980s, WHO promoted the training of traditional birth attendants as a strategy to reduce maternal mortality rates. The training happened in countries that inherited colonial healthcare services that relied on mission stations to provide healthcare for poor communities. Overall, traditional birth attendants were to be outreach workers who would reduce maternal mortality rates by referring and later accompanying women to a hospital. Their training reinforced their role as an assistant to the biomedical midwife. As Langwick (2011) puts it, "She was never conceptualised as a colleague in imagining the new nations' goal in relation to health, healing, and birth" (Langwick, 2011, p. 38).
- In 1987, the WHO, UNFPA, and the World Bank sponsored the first International Safe Motherhood Conference in Nairobi, Kenya. This gave rise to the Safe Motherhood Initiative. During the reign of the Safe Motherhood Initiative, the focus was on training traditional birth attendants.

- With guidelines designed in New York, Geneva, and London, the training focused on hygiene, nutrition, timing of birth, signs of danger, referral to hospital, sanitation, vaccination, and family planning. From the vantage point of the international development agenda, Indigenous knowledge about birthing knowledge was not included.
- The 1990s were marked by a series of international conferences organised under the banner of the United Nations. This included the 1994 International Conference on Population and Development in Cairo, Egypt; the 1995 International Women's Conference in Beijing, China; followed by the Social Summit in Copenhagen the same year.
- In 2005, WHO reported that the strategy of training traditional birth attendants was a failure with no demonstrable impact on lowering the maternal mortality rate.[33] The report advocated for the diversion of funds to improve obstetric facilities, including training biomedical midwives.
- Traditional harmful practices were highlighted and documented, while biomedical practices that are harmful to women, were not regarded as such.
- WHO redefined the role of traditional birth attendants to accompany women on their way to healthcare facilities. Some governments banned the practices of traditional birth attendants. This led to some of them practising in secret.
- Overall, the medicalisation of, and regulation of, Indigenous birthing practices through WHO and Nation States policies failed to suppress an ancient knowledge system.

Bendix (2016) argues that an international development agency, which also happens to be the donor, aims to ensure that deliveries are performed in a healthcare facility (Bendix, 2016). This entails supporting one system while suppressing another. Using the work of the German Development Cooperation in Tanzania as an example, Bendix outlines strategies used by colonial institutions to control obstetric care. These include increasing the number of colonial healthcare practitioners in the colony, training African midwives in biomedical interventions, building more hospitals and propagating Christianity as an effective tool in rooting out witchcraft and superstition. In his view, the work of international development institutions is to position the "southern Other as available to be changed, saved, or improved" (Bendix,

[33] The World Health Report. 2005. Make every mother and child count. World Health Organization, Geneva; Switzerland.

2016, p. 237). This corresponds with the idea of the West being the site for the solution of Africa's problems.

> "German professionals have thus always regarded themselves as having to guide East Africans towards German standards of birthing. This shows that the practice of trusteeship – imposing Western epistemology and modes of organisation – on the Global South is ever-present" (Bendix, 2016, p. 239).

In writing about obstetric care in Latin America, Laako (2017) argues that the hegemonic Western view of maternal health focuses on training more biomedical midwives, improving ambulance services, and building more high-tech maternity units. The priority is medicalisation and hospitalisation (Laako, 2017). Overall, it is believed that to improve maternal health in developing countries. These countries must be equipped with high-tech biomedical systems. This helps to uphold the perceived superiority of the biomedical model of birthing.

### 3.9. Politics of birthing knowledge production

The dominant narrative of international research on maternal health is that women die in childbirth because they do not utilise healthcare facilities (Graham & Davis-Floyd, 2021; Laako, 2017b; Langwick, 2011; Saravanan et al., 2011). In other words, to prevent women from dying, they must be directed to healthcare facilities (Berer, 2003; Gurara et al., 2020; Kruske & Barclay, 2004; Maimbolwa et al., 2003; Mbaruku et al., 2009; Ogbo et al., 2020; Sowunmi et al., 2020). In some instances, Indigenous midwives are either coerced or rewarded for referring women to a hospital. In countries like Guatemala, Indigenous midwives who fail to refer women to hospitals are threatened with a jail sentence (Giralt, 2017). The same sentence is not imposed on a clinic-based biomedical midwife who fails to refer a woman to a hospital.

In a study done in Nigeria, monetary incentives given to Indigenous midwives are reported to have increased referrals to healthcare facilities (Chukwuma et al., 2019). In another study in South Sudan, Indigenous midwives were given 12 South Sudanese Pounds (US$ 4) as referral incentives. This amount does not match their time and the cost of living (Wilunda et al., 2017). Indigenous midwives' roles are reduced to accompanying women to a healthcare facility, waiting long hours supporting a woman in labour, and providing postnatal care. This means

that Indigenous midwives are exploited. According to the International Labour Organization, women perform 76.2% of the total amount of unpaid care work. This is US$ 11 trillion (9%) of global GDP.[34] Household chores account for more time (81.8%), followed by direct personal care (13%) and volunteer work (5.2%).[35]

Given the characteristics of most Indigenous midwives (poor, with no Western qualifications and living in under-resourced areas), chances are they contribute to all three forms of unpaid care work. In addition to caring for their families, they also care for the birthing woman and her infant during the postpartum period. Not only do they carry the bulk of unpaid care work because they are women, but they are also required to contribute to care work in a system that does not recognise them as reputable care workers.

Closely related to the dominant narrative that blames high maternal mortality rates on the failure of Indigenous midwives to refer women to a hospital is the notion that women continue to give birth at home with Indigenous midwives because of inaccessible and/or unaffordable healthcare services (Bergstrom & Goodburn, 2001; Maimbolwa et al., 2003; Saravanan et al., 2011). In other words, the argument is that women do not have a choice because they do not have the money or transport to go to a hospital.

While lack of money is true for the majority of women in poor-resourced countries, some women choose Indigenous midwives for reasons that include: Indigenous midwives provide holistic care that includes support during delivery and after; the hospital setting is cold and clinical; birth is not a medical condition but a natural event; Indigenous midwives understand the importance of childbirth rituals; home birth allows the women the privacy that she needs; midwives understand the language and culture; hospital do not allow rituals and ceremonies (Cheelo et al., 2016; Maimbolwa et al., 2003; Mogawane et al., 2015; Ngunyulu et al., 2020; Peprah et al., 2018; Selepe & Thomas, 2000; Solomon et al., 2013).

Some researchers argue that Indigenous midwives do not add any value and their services should therefore be terminated.

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[34] Care Work and Care Jobs: For the Future of Decent Work. 2020. International Labour Organisation (ILO). Geneva, Switzerland.

[35] Ibid.

> "Where the resources for and access to a more skilled level of care are available, women seeking that care, and traditional birth attendants are slowly but surely being consigned to history – which is where they belong" (Berer, 2003, p. 37).

Mbaruku et al. (Mbaruku et al., 2009) consider Indigenous midwives as barriers to facility delivery aimed at reducing the maternal mortality rate. This is based on the study done on dissatisfaction with Indigenous midwives in rural Tanzania. In this study, some of the women who delivered at home reported that they have confidence in doctors and nurses. A study in Ethiopia recommends cessation of the practice even though women who were interviewed indicated that they prefer giving birth at home because of fear of unnecessary medical interventions such as episiotomy.

> "Traditional birthing assistants who are still engaged in assisting home births should be convinced to stop and if possible incentives should be given to them to accompany and refer mothers to give birth in healthcare facilities" (Gurara et al., 2020, p. e471).

Words such as uneducated, illiterate, or unqualified are used to describe Indigenous midwives. In their quest to uphold Western knowledge as superior knowledge, biomedical midwives in Africa fail to recognise that their lack of knowledge of Indigenous birthing practices is a form of illiteracy. In other words, biomedical midwives are uneducated regarding cultural birthing knowledge and practices. I argue that biomedical midwives look down upon Indigenous midwives from a place of cultural illiteracy.

In describing the negative attitudes of biomedical midwives reported in a study in rural South Africa, an Indigenous midwife reported that their work is suppressed because "the nurses regard us as non-religious, witches, and people who are illiterate" (Ngunyulu et al., 2020). Interestingly, this depiction of Indigenous midwives is similar to the colonial description of Indigenous medicine in the early 19$^{th}$ century.

> "The establishment of colonialism and colonial medicine required that traditional therapeutics be understood as unscientific and mistaken, and that traditions and witchcraft be replaced with 'new' strategies that materialised the body in a different set of institutions and effects, namely under medical scrutiny and regulation" (Prakash, 2000, p. 128).

In my view, decades after medicine was used as a colonial tool, biomedical midwives and other healthcare practitioners in postcolonial Africa became effective agents of advancing the colonising role long after the colonisers handed political rule to African political leaders. Modern and Western are still elevated, while African and traditional are looked down upon. The failure of a biomedical intervention is measured by people's resistance to abandoning their cultural beliefs in favour of what is perceived as a modern way of living.

It is true that biomedicine has answers that can save lives, but it does not have all the answers. Similarly, it is important not to romanticise Indigenous midwives and their practice as a panacea for decolonising midwifery. Not all Indigenous midwives are competent or caring. Every model has its dangers and limitations. For instance, Indigeneity is sometimes commodified and/or fetishised for economic gain. In her article, 'Commodifying indigeneity,' Rosallyn Adeline Vega examines how a return to humanised birthing in Mexico re-introduces racial hierarchy and exclusion of Indigenous midwives (Vega, 2022). A return to humanised birthing came about as a rejection of profit-driven interventionist birthing. However, this can easily be replaced by another form of enterprise which excludes Indigenous people and midwives. In the same way as medicalised childbirth, Indigenous midwifery in Mexico is turned into a form of tourism that excludes Indigenous people, as well as threatens sustainability. Not all Indigenous interventions are inclusive, humanised, and sustainable.

### 3.10. Dismantling the hierarchy of knowledge

In 2005, the WHO cancelled the strategy and programme of training traditional birth attendants because it failed to show a demonstrable impact on the reduction of maternal mortality rates. The report advocated for a diversion of funds to improve facility-based maternal health care. In the process, the WHO reduced the role of Indigenous midwives to one of accompanying women to clinics and hospitals. Graham and Davis-Floyd (2021) attribute the failure of the WHO's programme on training Indigenous midwives to a unilateral top-down approach which does not take people's cultural knowledge into consideration. In their view, the failure of the training programme lies in the "culturally inappropriate didactic, and biomedical orientation" that failed to include the knowledge and experiential modes of learning of Indigenous midwives (Graham & Davis-Floyd, 2021). The fundamental motive of the programme was not based on a need to preserve Indigenous birthing knowledge and

practice. Neither was it fuelled by the belief that Indigenous midwifery is essential. The intention was to increase the number of facility-based births.

> "Because of the current shortage of professional midwives and institutional facilities to provide prenatal care and clean, safe deliveries, as well as a variety of primary healthcare functions, WHO, UNICEF and UNFPA promote the training of traditional midwives in order to bridge the gap until there are acceptable, professional, modern healthcare services for all women and children."[36]

From the above, one can deduce that the international development institutions cited above support the framing of maternal health that views Indigenous midwifery as backward, unprofessional, and unacceptable. In their view, biomedical knowledge is the only acceptable and authoritative knowledge. In the absence of the opposite, the training of Indigenous midwives in the biomedical model of birthing was therefore designed as a stopgap measure until it was completely replaced by biomedicine. This stopgap attitude reveals that the overriding goal of these development agencies is to replace Indigenous midwives with biomedical practitioners. Considering that many of the former are older women, the institution will die once they stop practising and teaching the young. This will result in the death of knowledge. According to African cosmology, the death of an elder, especially the one who dies without passing on the knowledge, is likened to the burning of a library.

Studies on Indigenous midwifery in South Africa recommend collaborative working relationships with Indigenous midwives for the purpose of sharing knowledge and skill. Nolte (1998) recommends that Indigenous midwives must be trained, supervised and monitored by biomedical healthcare practitioners to improve their standard of care (Nolte, 1998). Selepe and Thomas (2000) recommend that Indigenous midwives must be educated in Western prenatal care so that they can incorporate this into their practice (Selepe & Thomas, 2000). Mchunu and Bhengu (2004) also recommend "continued training, monitoring and supervision by the Department of Health" (Mchunu & Bhengu, 2004, p. 49). Mogawane and Mothiba (2015) recommend training Indigenous midwives on harmful cultural practices and recommend creating opportunities for biomedical midwives to understand cultural childbirth practices (Mogawane et al., 2015). Ngunyulu Mulaudzi and Peu (2020) recommend that the

[36] Safe Motherhood Newsletter 1992. Quoted in Graham and Davis-Floyd p 2.

midwifery curriculum should include Indigenous birthing practices, values, and beliefs (Ngunyulu et al., 2020). Ngomane and Mulaudzi (2012) also recommend that student nurses should visit Indigenous midwives to give them an opportunity to observe use of other treatment modalities (Ngomane & Mulaudzi, 2012).

The research cited above advocates for collaboration between biomedical and Indigenous midwives with a view to reduce maternal mortality rate. Terms such as collaboration, integration, and cooperation are used to denote a need for a partnership between the biomedical and Indigenous models of birth. Given that Indigenous midwifery occupies an inferior position in the eyes of biomedical practitioners, *how possible would it be for biomedical midwives to learn from Indigenous midwives?* In other words, as Briggs and Sharp put it, *can the two knowledges sit equally together?* (Briggs & Sharp, 2004). *Is it possible for Indigenous knowledge holders to question Western science?* Briggs and Sharp (2004) argue that collaboration between the two systems is limited to sharing technical knowledge that will fit easily within the Western scientific paradigm.

> "Indigenous knowledge is allowed to offer contained technical solutions that fit within the current scientific/development world-view, but not to challenge the content, structure or value-system of this view" (Briggs & Sharp, 2004, p. 7).

Instead of decentring a biomedical model of birthing that is a vehicle of Western knowledge, Indigenous practitioners are invited to collaborate in a way that adds to or improves Western ways of knowing. This is a challenge that Indigenous midwives face. By sharing their knowledge, they expand the knowledge of biomedical practitioners without them being accepted as equal knowers. Current partnership models have been created by researchers from the West who engage Indigenous knowers in the expansion of their knowledge. Berenstain (2016) refers to this as epistemic exploitation.

> "Epistemic exploitation is a variety of epistemic oppression marked by unrecognised, uncompensated, emotionally taxing, coerced epistemic labour. It maintains structures of oppression by centering the needs and desires of the dominant group" (Berenstain, 2016, p. 570).

While I appreciate the work done by Western researchers who create bi-directional learning opportunities in their work with Indigenous women, I argue that by virtue of their positionality, Indigenous women may be engaged in uncompensated epistemic labour. While

this may not be coerced, it may also not be voluntary. The privileged feel entitled to the time of those less privileged, while the latter are expected to make themselves available for projects which may benefit them less than those who are privileged (Berenstain, 2016). For example, Hinojosa (2004) found that healthcare personnel value local Maya midwives for their role in furthering the goals of biomedicine (Hinojosa, 2004). To ensure bi-directional learning between biomedical and Indigenous midwives, Izugbara et al. (2009) recommend that the training must be "devised so that it does not give traditional birthing attendants the impression that their services are considered inferior or that while hospital-based providers have a lot to teach them, the traditional birthing attendants have nothing to teach hospital-based providers" (Izugbara et al., 2009, p. 44).

In my perusal of studies undertaken on Indigenous midwifery in South Africa, I could not find research focusing on Indigenous midwifery as a counter to obstetric violence. As outlined above, many focused on collaboration between biomedical and Indigenous midwives. As already indicated, most are aimed at improving access to biomedical midwifery. What is lacking is a focus on the impact of colonialism and apartheid on suppression of the knowledge and practice of Indigenous midwives.

### 3.11 Conclusion

In this chapter, I reviewed Indigenous midwifery with an eye of history to trace socio-political factors responsible for suppressing knowledge of and silencing the voices of Indigenous midwives in Africa. Included in this is the contextualisation of the naming of Indigenous midwifery within colonial development discourse. The key focus of the chapter was to start thinking about lessons to learn from Indigenous midwives to counter obstetric violence. Such an exploration is preceded by an understanding of the use of the biomedical birthing model as a colonial tool used in South Africa. The chapter also questioned the hierarchy of knowledges between biomedical and Indigenous birthing practices. I argue that response to obstetric violence must: 1) decentre biomedical birthing, 2) decolonise midwifery, and 3) integrate cultural safety in the definition of safe birthing by respecting the spiritual needs of birthing women.

The next chapter provides a theoretical framework that underpins the study. I begin by sharing the discomfort that arose from a feeling of being sandwiched between opposing

methodologies. To understand Indigenous research, I outline the framing of Indigenous knowledge, followed by an exposition of the Indigenous research paradigm and Indigenous feminist theory as a fitting theoretical framework for the study. The chapter outlines how I chose and accessed participants, my experiences during the data collection process, as well as a description of the data analysis framework. I end the chapter with the tensions of language and translation as erasure.

## CHAPTER 4: Indigenous research framework and methodology

### 4.1. Introduction

This was not an easy chapter to write. I begin by sharing the struggle of using a conceptual framework that privileges Eurocentric ways of knowing to search for knowledge founded on an Indigenous way of being and knowing. I spent time searching for words that would help me name the discomfort that arose from a feeling of being sandwiched between opposing epistemologies. I loathed the idea that those who have not been colonised will not face the same dilemma. In *Research is ceremony,* Shawn Wilson (2008) puts it this way*:*

> "Unfortunately, Indigenous researchers have often had to explain how their perspective is different from that of dominant system scholars; dominant scholars have seemingly needed no such justification in order to conduct their research" (Wilson, 2008, 2011, p. 55).

As I have been colonised, I was conditioned to first master Eurocentric ways of knowing at the expense of making sense of my own. This voyage into the colonised self can generate intense trauma not often spoken about in academia. My experience of this unnameable trauma caused me to slump into a state of depression. I gave myself permission to remain in a place of discomfort, even when I did not have a language to describe it.

In writing about the politics of discomfort, Chadwick (2021) asserts that staying with discomfort can disorient researchers in ways that can ultimately be useful for knowledge production and theory-making (Chadwick, 2021). While this made sense at an intellectual level, overcoming my disconnect with pursuing a doctoral degree at an institution founded on Western research paradigms felt like an insurmountable burden. Instead of being propelled to productive disorientation, I was immobilised by rage. The thought of dropping out crossed my mind. If I dropped out, it would mean I have failed. What does failure mean for a researcher expected to excel in a pedagogy constructed in ways that alienate her from her people's knowledge? Would dropping out constitute defiance or failure?

In order to find a way of crawling out of a state of "cultural disembodiment" (Perez et al., 2022, p. 415) triggered by what Wanda Pillow refers to as epistemic witnessing of theoretical oppression (Pillow, 2019, p. 121), I consulted a healer who understands the debilitating

impact of Eurocentric paradigms on Indigenous people's mental health. Only after I had undergone the initial consultation could I master the courage to step out and search for a language that would help me make sense of what I was going through. Zunguse (2019) contends that such trauma results from exposing people to experiences that deprive them of their knowledge (Zunguze, 2019). Ruiz (2020) describes this as hermeneutic violence used to erase or destroy Indigenous knowledge systems so that they can be replaced by colonial knowledge (Ruiz, 2020). Berenstain et al. (2022) also define this as colonial violence, which can result in epistemic trauma.

> "Settler systems of epistemic and conceptual resources and the relation among them are constructed to preclude certain forms of knowledge. This is not an accident; it is a central goal of colonial violence" (Berenstain et al., 2022, p. 284).

On the surface, this violence is not serious because it has been normalised. This emanates from the success of the idea that Eurocentric epistemologies are universal (Mignolo, 2009). Stinnett (2018) argues that those confronted with epistemic trauma respond by way of self-censoring and self-silencing, which leads to self-annihilation (Stinnett, 2018). Writing about my embodied experience is my way of countering the possibility of self-annihilation. As a Black woman who is also a product of Bantu Education and colonial nursing training in apartheid South Africa, I have been subjected to internal and external silencing. In theory, it is easy to engage in "epistemic disobedience" and unchain myself from the illusion of the superiority of Eurocentric knowledge (Mignolo, 2011, p. 45). Disobedience is hard work; it is also painful, and it takes time. The idea of dismantling Western science is overwhelming and debilitating. Instead of rejecting all Western theory, Linda Tuhiwai Smith recommends centring an Indigenous worldview and a "coming to know and understand theory from our own perspectives and for our own purposes" (Smith, 1999, p. 39). Wilson (2008) identifies different ways Indigenous researchers attempt to do research within Western dominant systems (Wilson, 2008). Some use Western research frameworks in their totality, others adapt a methodology that suits their own perspectives, while others include Indigenous cultures, protocols, and practices. Adaptation comes with the pressure of justifying the validity of a different research framework. In all these adaptations, Wilson (2008) argues, the researcher can never remove the tools from their underlying philosophical beliefs.

If you combine this internal wrestling with the challenging and hard work of writing a doctoral dissertation, the process feels unjust because it demands additional cognitive and affective labour. Studying for a doctoral degree is a limited endeavour in terms of time. Healing the effects of epistemic trauma requires life-long agency. I plan to traverse this journey more after writing this dissertation, both for my own healing and the healing of others. Drawing from Wanda Pillow (2019), I imagine such healing work giving birth to tools that will help us re-dream patterns of knowledge production that are not founded on "theoretical arrogance and co-optation" (Pillow, 2019, p.130). Such a space, Pillow asserts, is founded on love, rage, and responsibility. The idea of carrying droplets of rage and love in the same breath speaks to me. It is symbolic of the work I do as a healer. Rage is necessary and has a right to be expressed; there is also the responsibility to heal it with love. For now, my priority is to attempt to craft a coherent dissertation that will meet the requirements of a doctoral degree.

### 4.2. Chapter outline

The overall aim of the study is to explore the role of Indigenous midwives in countering obstetric violence in South Africa.

In Chapter 2, I have shown the link between the Western biomedical model of birthing and obstetric violence. This model was exported to Africa during colonialism. In Chapter 3, I wrote about how the Western birthing model was used as a colonising tool to erase the knowledge and practice of Indigenous midwives. This chapter gives an outline of the theoretical framework that underpins the study. This relates to how I frame what I am looking for with the help of theories. A way of knowing guides the choice of methodology and methods used in searching for answers to the research questions and shaping how the findings are interpreted and presented (Chilisa, 2012; Chilisa et al., 2017). Thus, this chapter explains my choice of an Indigenous research framework as an appropriate methodology for the study.

To understand Indigenous research methodology, I first engage in framing Indigenous knowledge. This is followed by an exposition of Indigenous research and Indigenous feminist theory as fitting theoretical frameworks for the study. I outline methods used to gather data, including challenges and shortcomings. I also write about how I accessed the participants and why Indigenous honouring Indigenous research principles of relationality, respect, relevance, reciprocity, and responsibility are important. I conclude the chapter with a description of the

data analysis framework and the challenges of applying Eurocentric research methodology to interpret and present participants' stories and experiences.

### 4.3. Framing Indigenous knowledge

Indigenous knowledges are created by diverse groups of people from across the world. Knowledges is used in the plural as an acknowledgement of a diversity of knowledge bases and different people who produce such knowledges. This is necessary to counter the common conception of Indigenous knowledges as homogenous. Indigenous knowledges predate European imperialism and colonialism and those who passed on left "legacies of amazing technological feats including complex city structures, plumbing systems, calendars, classification systems and intricate understanding of the worlds they created" Smith et al., 2016, p. 136). In his contextual expansion of the definition, Hammersmith (2007) defines Indigenous knowledge as "the totality of knowledge and practices used in the management of the socio-economic, spiritual and ecological facets of life" (Hammersmith, 2007, p. 34). Even though such knowledge tends to be expressed in songs, folklore, proverbs, myths, and spiritual practices embedded in language and culture, Odora-Hoppers (2002) argues that Indigenous knowledge is not limited to arts, culture, and spirituality. Rather, it includes knowledge employed within various disciplines, such as agriculture, obstetrics, health, nutrition, metallurgy, animal husbandry, astronomy, nature conservation, sustainable development and many others (Odora-Hoppers, 2002). This refutes the suggestion that Indigenous knowledge is largely intuitive with little rational thought and that Western science is purely rational (Liberda et al., 2021). Cajete (1994) argues that Indigenous knowledge also uses scientific principles of observation, hypothesis testing, documentation, and experimentation to help communities to gain new insights (Cajete, 1994).

Expanding the definition of Indigenous knowledge beyond intuition, Castellano (2000) identifies three broad aspects of Indigenous knowledge:

- Traditional knowledge is culture based and intergenerational. This is passed by elders from one generation to another. Even though orality is the primary mode of communication and transfer of knowledge, Dei (2002) points out that Indigenous knowledge can also be transferred through other forms that include visual representations such as rock paintings and Indigenous forms of writing (Dei, 2000).

- Empirical knowledge is based on careful observation of the environment followed by a series of experimentation and adaptations that results in the creation of new knowledge. Unlike in Western research, the acquisition of such knowledge is not based on inquiry in controlled settings but in interaction with people, land, and nature. For instance, a navigator needs to learn to read the sea and the stars to prepare for acquiring knowledge (Smith et al., 2016).
- Revealed knowledge is spiritually based and often comes through dreams, visions, and intuition from the ancestors or spiritual world. Such knowledge is sometimes called "blood memory" (Lavallée, 2009). In Setswana, it would mean *kitso e mo mading* (knowledge is in the blood). Blood is used here not as a physiological construct but as a metaphoric container of knowledge.

The above conceptions of Indigenous knowledge negate the perception that it is stuck in the past and is therefore not useful and/or relevant in modern society. In their essay, "Two-eyed seeing and developmental origins of health and disease,' Liberba et al. (2021) purport that the difference between Indigenous knowledge and Western science is more political than epistemic. In their view, both knowledges are dynamic and have the capacity to evolve over time. All knowledge systems possess both the rational/scientific and intuitive (Liberda et al., 2021).

Within the development sector, the term 'Indigenous' surfaced in the 1980s when United Nations-funded programmes on sustainable development became concerned about the loss of biodiversity and ecosystems in developing countries (Nakata, 2002, 2007). The proponents of Indigenous knowledge argued that local knowledge was necessary for finding solutions to development problems. However, this came with a qualification that Indigenous knowledge had to be validated by the West before it could be recognised as knowledge (Rewi et al., 2022). Nakata (2002) argues that such classification, verification and documentation by Western scientists was "similar to former colonial enterprises which co-opted land, resources, and labour in the interest of their own prosperity through trade and value-adding" (Nakata, 2002, p. 282). Rauna Kuokannen (2000) concurs. In her view, neo-colonial institutions were created to reinforce Western values by reframing Indigenous knowledge in a way that continues to interpret a world that upholds the superiority of Western knowledge (Kuokkanen, 2000). Disassociation from Indigenous culture continues to be reinforced by education systems. As a result, "subtle forms of colonialism have made many Indigenous

individuals devalue their own culture and anything that is connected to it" (Kuokkanen, 2000, p. 412).

In academia, Indigenous knowledge first emerged as a field of study within anthropology (Nakata, 2007; Stewart-Harawira, 2013). One of the first recorded was in 1952 at the University of Auckland, New Zealand (Stewart-Harawira, 2013). Using Māori culture as an example, Stewart- Harawira (2013) asserts that Indigenous studies were subsumed in research based on positivist approaches.

> "These social scientists redefined and reconstructed Māori Indigenous culture in ways that made sense to them within a worldview both foreign and in many ways opposed to Māori Indigenous culture, accruing considerable prestige and advancing their career at the same time as they developed, deformed, and distorted accounts of Māori social and cultural life" (Stewart-Harawira, 2013, p. 41).

The above was followed by a merger of anthropology and psychology in the 1960s. This was strengthened by the assumptions of Western social scientists who employed the hegemony of Western research methodologies to accord themselves the right to define Indigenous people's personality development (Stewart-Harawira, 2013). This resulted in the erasure of Indigenous knowledge accompanied by the loss of land, language, and cultural heritage (Smith, 1999). In writing about cognitive imperialism in Canada, Pictou (2020) describes this as colonial violence against bodies, land, and nature (Pictou, 2020). Included here is the destruction of Indigenous governance systems founded on relational accountability and responsibility to people, water, land, and all other forms of creation. This control over bodies and ancestral land normalised patriarchy by giving fewer rights to Indigenous women (Pictou, 2020). Before then, land and women were revered as sources of life. Indigenous struggles are therefore not limited to the question of identity. They include loss of cultural, political, economic, reproductive, and spiritual justice.

In outlining the conceptual distinction between decolonising research and an Indigenous research framework, Chalmers (2017) argues that the two are closely related in the sense that they are both aimed at transforming the academy (Chalmers, 2017). This is affirmed by Dei (2013) and Sium et al. (2012), who assert that the decolonisation of research is a multidimensional project with many pathways and goals (Dei, 2013; Sium et al., 2012). Dei (2000) cautions that decolonisation does not always mean indigenisation (Dei, 2000). Kovach

(2009) argues that decolonising methodologies originate in Western critical theory, while Indigenous methodologies are rooted in local epistemologies (Kovach, 2009).

In the same way as in development, Indigenous knowledge in academia was framed from a pathology and deficit perspective. The perception was that Indigenous knowledge is an issue that needs to be corrected or improved by being incorporated into the Western curriculum (Rewi et al., 2022). Because of its monocultural approach, academia marginalised, devalued, misappropriated, and misinterpreted Indigenous knowledge by privileging Western knowing. In the end, Indigenous researchers are faced with the dilemma of advocating against colonial discourses. At the same time, they navigate the requirements of degrees in institutions of learning known to be complicit with the colonial agenda (Rewi et al., 2022). Therefore, balancing the requirements of academia is juxtaposed with "balancing power differential inherent in research relationships, reconciling differences among Indigenous and mainstream research paradigms, not to mention conducting beneficial research with Indigenous communities" (Burnette & Billiot, 2015, p. 2). The pressing need to conduct research that is beneficial to communities emanates from communities that have historically been over-researched without beneficial returns (Burnette & Billiot, 2015; Smith, 1999)

In Chapter 3, I have shown how Indigenous midwifery had to be validated by Western biomedical midwifery before it could be considered knowledge. Even though researchers agree that Indigenous midwives are a valuable resource in maternal health care, the assumption is that Indigenous midwives need to be trained in Western birthing practices, as well as practise their craft under the supervision of biomedical midwives (Hodnett, 2012; Mchunu & Bhengu, 2004; Selepe & Thomas, 2000). Often, Indigenous midwives are valued for their role in furthering the goal of Western biomedicine (Gurara et al., 2020; Hinojosa, 2004). Overall, Indigenous knowledges are brought into the "mainstream" in a way that does not question Western conceptual frameworks. Similarly, research on obstetric violence cited in Chapter 2 upholds the superiority of biomedicine. This reinforces existing power structures between biomedical and Indigenous birthing knowledges. Given that biomedical research is bound with the history of colonisation, I argue that there is a need for decolonising methodologies that seek to decentre biomedical transformation as an exclusive solution to obstetric violence. My choice of a research framework that centres on the role and knowledge of Indigenous midwives is a crucial step in challenging the superiority of biomedical birthing in South Africa.

In the next section, I outline Indigenous research and Indigenous feminism as theories that underpin this study. Both relate to liberatory epistemologies (Perez et al., 2022). Indigenous research focuses on centring the voices of Indigenous people, while Indigenous feminist theories argue that Indigenous women are susceptible to oppression both as Indigenous people and women.

### 4.4. Indigenous research theory

The term 'theory' originates from the Greek word *theoria*, meaning to see (Nguyen et al., 2022). The function of theory is to provide a lens through which the researcher approaches questions or problems. Smith et al. (2016) describe a theoretical framework as the theory used to seek knowledge and make meaning in a given field of study (Smith et al., 2016). This links the way knowledge is defined, and the practices of inquiry used to gather such knowledge. In his book, *Research is ceremony*, Shawn Wilson (2008) argues that a theoretical framework reveals the beliefs that guide the actions of researchers. These beliefs include the way to view reality (ontology), how to think about or know this reality (epistemology), how to go about gaining more knowledge about reality (methodology), and a set of ethics and morals that make research meaningful and beneficial to the researcher and participants (axiology) (Wilson, 2008).

While it is agreed that the use of theory can inform methodology, some researchers argue that theory imposes meaning. For instance, Cresswell and Cresswell (2018) contend that if qualitative research may reveal multiple meanings of a construct, starting with a predetermined theory may impose meaning and limit understanding of phenomena (Cresswell & Cresswell, 2018). In the same vein, Willig (2017) argues that theories represent dominant groups of people (Willig, 2017). Thus, the application of theories in research may constrain the views of marginalised communities. Indigenous research lends itself to a political agenda that seeks to re-centre voices and knowledges that have been marginalised by the mainstream (Kuokkanen, 2000). This paves the way for the researcher to refrain from perceiving Indigenous knowledge holders as the other of the West (Kuokkanen, 2000). The overriding philosophy in an Indigenous research framework is relationality. Relatedness is not limited to people. It also includes animals, plants, environment, land, and the cosmos (Wilson, 2008).

> "Relatedness is therefore at the core and permeates all research activities. A relational ethical framework invites researchers to see 'self' as reflection of the researched 'Other,' to honour and respect the researched as one would wish for oneself, and to feel a belongingness to the researched community without feeling threatened or diminished" (Chilisa et al., 2017).

The following explains the relational characteristics of Indigenous research:

### 4.5. Relational ontology

Wilson (2001) defines relational ontology as "your way of being, what you believe is real in the world" (Wilson, 2001, p. 175). The nature of reality corresponds to a holistic and interdependent view of society. This stresses harmony and balance between people, nature, culture, and society (Dei, 2000). The underlying philosophy is that an individual is only meaningful in relation to the collective.

### 4.6. Relational epistemology

Relational epistemology refers to how you think about that reality (Wilson, 2001). The basic premise is that knowledge exists within a set of relationships rooted in people, land, and place (Chalmers, 2017). This acknowledges different ways of knowing, including the idea that knowledge emerges from experiencing the social world. Observation, practice, and experience form the basis of knowledge (Dei, 2000).

### 4.7. Relational methodology

Relational methodology refers to a set of assumptions about the nature of reality, which includes what constitutes knowledge and how knowledge is acquired (Chalmers, 2017). The main aim of Indigenous methodologies is to ensure that research is carried out in a respectful, reciprocal manner that is beneficial to the communities involved. Overall, methodology is based on relational accountability to the cosmos (Hart, 2010). Wilson (2001) defines relational accountability as a process by which a researcher is accountable to all her relations. In thinking through his accountability to a network of relationships, Wilson (2001) argues that the researcher must ask questions about relationality.

> "So your methodology has to ask different questions: rather than asking about validity or reliability, you are asking, *how am I fulfilling my role in this relationship? What are my obligations in this relationship?* The axiology or morals need to be an integral part of the methodology so that when I am gaining knowledge, I am not just gaining in some abstract pursuit; I am gaining knowledge in order to fulfil my end of the research relationships" (Wilson, 2001).

### 4.8. Relational axiology

Relational axiology speaks to cultural and spiritual beliefs which guide the research (Kovach, 2009). Chilisa (2017) describes relational axiology as an invitation for the researcher to see herself as part of the other (Chilisa, 2017). Based on the notion of interdependence between people, nature and society, relational axiology acknowledges multiple realities that integrate Indigenous knowledge with other knowledge systems. Emphasis is placed on responsibilities over rights, community over individual and mutual co-existence with nature over domination of nature (Dei, 2000).

### 4.9. Summary of Indigenous research theory

In Wilson's (2008) articulation of Indigenous research methodology, he depicts these four relational entities as a wheel or circle to demonstrate their interconnectedness (Wilson, 2008). This, he argues, is one of the distinguishing features that make Indigenous research different from Western research paradigms. Within Indigenous research, relationality is an aspect of methodology, whereas within Western constructs of knowledge, it may be viewed as bias and therefore be perceived to be outside of methodology (Stewart-Harawira, 2013) The other difference is the Western belief that knowledge belongs to an individual and it can be owned. Instead of viewing knowledge as an individual entity, Indigenous research discounts the belief that "the researcher is an individual in search of knowledge, knowledge is something that is gained, and therefore knowledge may be owned by an individual" (Wilson, 2001, p.176). Methods chosen should therefore be aligned with the idea of knowledge being shared with all of creation. From an African spiritual perspective, certain

people have access to sacred information.[37] This comes with an obligation on the part of the receiver of knowledge to respect how one uses and/or disseminates the information.

By choosing an Indigenous research framework, the researcher contributes to dismantling dominant systems that uphold and perpetuate the superiority of Euro-Western knowledge (Chilisa, 2012). Chilisa (2012) further argues that adopting an Indigenous research framework is a commitment to decolonise and indigenise. The indigenisation of research is "not assimilation nor is it acculturation where Indigenous cultures must change to something they are not. Rather, indigenisation is about uplifting cultural integrity and our ability to weave and strengthen knowledge systems to understand and appreciate others" (Virtanen & Seurujarvi-Kari, 2019, p. 118).

In this study, my theoretical stance is rooted in the belief that the knowledge of Indigenous midwives is worthy of being studied. The theoretical basis of my research, therefore, is grounded on Indigenous knowledge as knowledge. Because the objective of this study is to centre the knowledge and practice of Indigenous midwives, I found it fitting to use Indigenous feminist theory as a lens through which I seek to explain how and why the knowledge of Indigenous midwives is missing from the research on obstetric violence in South Africa.

### 4.10. Indigenous feminist theory

Like many other social science research theories, feminist research theories are varied. It is beyond the scope of this study to craft a comprehensive evolution of feminist research theories and epistemologies. What follows is a synthesis of theories that I regard to be relevant to this research. The aim is to show how and why I opted to use Indigenous feminist theory.

In outlining the historical origins of feminist theory, Manning (2021) writes about the evolution of feminist theory through the various waves of feminism, starting from the first wave that concerned itself with women's oppression and discrimination in society, the second wave that viewed gender as a social construct produced through dominant social institutions and epistemologies, and the third wave that began to map out the postcolonial feminist theory that calls for centering of lived experiences of women in the Global South (Manning,

[37] This is based on my experience of working with elders and healers in various communities.

2021). In her critique of the feminist wave model, Persard (2021) contends that the contribution of women of colour is lumped in third wave feminism "when they were, in fact, writing and organising alongside (and not to mention, prior to) those of the 'first' and 'second' waves" (Persard, 2021, p. 15). In her view, coloniality still forms an integral part of feminist theorising (Persard, 2021).

From the foregoing, it is clear that tearing down male oriented systems did not necessarily bring about a radical change in the perception of the West as the primary site of knowledge (Grey, 2004). Rather than being imposed externally, the universality of a Western way of knowing is maintained through coloniality. Coloniality refers to a pattern of power imbalances that emerged because of colonialism (Quijano, 2007). Such a pattern maintains itself through epistemic frames of the West. These frames, Quijano (2007) argues, are reinforced by the practice of dividing the world into continents and naming them as global south and north, first world and third world and developed and developing countries. Escobar (2007) argues that modernity and coloniality are mutually interdependent; there can be no modernity without coloniality (Escobar, 2007).

It is worth noting that theoretical concepts of decoloniality were developed by men who were not directly concerned with feminist theory. Quijano (2007) coined the term 'coloniality' and 'the coloniality of power'. Walter Mignolo engages in a critique of the dominance of Western epistemology and coined the concept of epistemic disobedience (Mignolo, 2009). The term 'coloniality of gender' was coined by Maria Lugones, a feminist scholar acknowledged for her contribution to what became decolonial feminist theory (Lugones, 2008). Through her assertion that gender is a colonial construct, Lugones challenges Quijano's coloniality of power, arguing that the colonial matrix of power affected gender structures and that the colonisers enacted racial and gender constructs (Lugones, 2008, 2010). Using the concept of the coloniality of gender, Lugones (2010) brings attention to the failure of white feminists to confront differential constructs of gender along racial lines. In her view, a focus on the coloniality of gender is an attempt to dislodge the persistent absence of race analysis in white feminist theory.

Lugones' decolonial feminist critique was preceded by other writings and movements, notably postcolonial feminism. As its name implies, postcolonial feminism fuses two critical theories: feminism and postcolonial theory (Struckmann, 2018). Post-colonial feminism

emerged as a reaction to postcolonial theory which was led by men who were preoccupied with rebuilding postcolonial nations. This means that postcolonial feminists challenge colonial power, patriarchy, and the hegemonic power of Indigenous men (Parashar, 2016). Included in their critique is the discussion on Western feminists who spoke on behalf of third world women. In her essay, 'Under Western eyes: Feminist scholarship and colonial discourses,' Chandra Mohanty (1991) highlights diverse ways in which Western feminist discourse positioned women. In the essay, she argues against the objectification of "third world women" as powerless victims of different systems.

> "Post-colonial feminism critiques Western feminism's assumption that the West is the primary subject of theory and praxis and that anything non-Western is therefore regarded as 'Other'" (Mohanty, 1991, p. 52).

Many other postcolonial feminist theories were developed in response to the varied needs of women in various countries, regions, and continents. These include African feminism, postcolonial sexualities, Muslim and Islamic feminism, decolonial feminism and the politics of intersectionality (Deckha, 2015).

In making a comparison between postcolonial and decolonial feminist theories, Espinosa Miñoso argues that postcolonial theorising remains colonised by hegemonic practices of Global South feminists who construct Indigenous women as the "Other" within the other (Miñoso, 2009). Writing about feminism in Latin America, Miñoso argues that after many decades, the question is still framed as a problem of poor, or rural, or Black women whose voices are included in the planning process, or gatherings or in some interventionist projects usually designed and managed by professional middle class and white supremacist feminists from throughout the continent (Miñoso, 2009). Persard (2021) contends that decolonial feminism fails to "prioritise the most epistemologically marginalised through colonialism, particularly Indigenous knowledges and histories" (Persard, 2021). In her view, the rhetoric of decolonial feminism continues to mute the voices of Indigenous women. Indigenous women's struggles need to transcend a struggle against patriarchy to include issues of dispossession of land, language, and the erasure of cultural and spiritual knowledges (Dorries & Harjo, 2020). In their essay 'Decolonising feminism,' Arvin et al. (2013) outline challenges that Indigenous women researchers or activists face in their work. These include:

- Refusing inclusion into the existing canon of feminisms that is complicit with the erasure of Indigenous knowledges; in their view, “Inclusion confers a preeminent hierarchy” (Arvin et al., 2013) which, they argue, seeks to absorb dissent and difference.
- Forming alliances with feminists who are critical of colonialism in a way that does not rely on Indigenous people to teach the latter on how to be effective allies.
- Recognising Indigenous ways of knowing, including their view of land as knowledge and not as extractable property
- Recognising that Indigenous concepts and epistemologies does not mean blind co-option, copying or performing on behalf of Indigenous people.
- Questioning academic participation in Indigenous silencing and dispossession, including dispossession of land, knowledges, and livelihoods.

In using an Indigenous feminist research framework to understand intimate partner violence, Luebke et al. (2021) argue that one has to examine the historical, socio-political and economic contexts that resulted in the breakdown of families and communities (Luebke et al., 2021). In their view, employing an Indigenous feminist framework as an approach to intimate partner violence in the lives of Indigenous women will contribute to a deeper understanding of the linkages between colonisation, historical oppression, and the ongoing structural violence that still exists in Indigenous communities. Gender-based violence experienced by Indigenous women is symptomatic of processes of colonial dispossession and the erasure of Indigenous values (Dorries & Harjo, 2020). In upholding the Western criminal justice system as an exclusive solution to gender-based violence in Indigenous communities, Dorries and Haro (2020) argue that women are forced to rely on the same system that promotes violence.

Drawing from the work cited above, I argue that an Indigenous feminist approach to obstetric violence acknowledges centuries of colonialism that resulted in the systematic suppression of Indigenous birthing practices. In Chapter 3, I outlined how Western biomedical birthing was used as a colonising tool to erase the knowledges and practices of Indigenous midwives. In their quest to uphold the superiority of Western biomedical practices, biomedical midwives in Africa fail to show a deeper understanding of the relationship between colonisation, apartheid, biomedicine, and obstetric violence. To understand the role of Indigenous midwives in countering obstetric violence, I chose to use an Indigenous feminist framework.

As with other feminist theories, there is no one Indigenous feminist theory. Gearon (2021) describes Indigenous feminism as “an intersectional theory and practice of feminism that focuses on decolonisation, Indigenous sovereignty, and human rights for Indigenous women and their families” (Gearon, 2021, p. 1). In her view, Indigenous feminism seeks to dismantle systems of capitalism, colonialism, patriarchy, and white supremacy. This means that Indigenous feminism looks beyond patriarchy as the sole problem that women face (Msila, 2021). Instead, Wane (2011) argues, the pursuit of gender equality must be coupled with advocating for the sovereignty of Indigenous people (Wane, 2011). Smith (2017) argues that Indigenous sovereignty is “not an add-on to the heteronormative and patriarchal nation state” (Smith, 2017, p. 2). Included in this is the reclamation of lost cultural and spiritual knowledges. Land and nature remain key sources of such knowledges.

Within many Indigenous cultures, birth is a sacred ceremony which ushers an individual from the spiritual to the physical world (Giralt, 2017; Ohaja & Anyim, 2021; Wojtkowiak, 2020). In their role as midwives and leaders of birth rituals and ceremonies, older women serve the clan, land, and communities (Smith, 2017). The association of land with the placenta is worth a mention. The ritual of returning the placenta to the land is a way of centering a newborn child on land. This ritual is the foundation of life (Gearon, 2021). In many Indigenous cultures, women and land were held in the highest regard as sustainers and providers of life. In the Māori language, for example, land and placenta use the same word, which is *whenua* (Stewart-Harawira, 2007).

In writing about the impact of colonialism on Indigenous women’s leadership, Anderson (2019) argues that the imposition of heteropaternalism, which involved teaching heteropatriarchal roles in schools and sending “missionaries out to reorder Indigenous women as docile housewives in heteropatriarchal nuclear homes”, was a deliberate colonial strategy of disrupting political, economic, social, and spiritual leadership which was largely managed by women through ethics of relationality, reciprocity, and responsibility ( Anderson, 2019, p. 123). Anderson (2019) further argues that colonial settlers had to break extended kin networks to break a community. I argue that the agency of birthing led by elder women who perceived birth as a social and spiritual practice was one of the ways in which a symbiotic relationship between people and nature was sustained.

Knowledge is power. The erasure and/or suppression of knowledge is a denial of power. Western feminist theory and biomedicine act in collusion to suppress Indigenous women's knowledge and birthing practices as a counter to obstetric violence. This is a key decolonisation point. An inclusive feminism, Stewart-Harawira argues, "is one that will not only recognise difference but seeks to disrupt privileging impact of the unequal structures of power" (Stewart-Harawira, 2007, p.4). I argue, therefore, that a call to counter obstetric violence is incomplete if it fails to integrate the knowledge and practices of Indigenous midwives.

### 4.11. Research design

'Research design' is a term used to describe the plan, methods, and procedures used to collect, analyse and report research findings (Creswell & Plano, 2007). There are two main research designs: qualitative and quantitative (Yilmaz, 2013). Unlike quantitative research methodology which is focused on collecting numerical data to control and predict phenomena, qualitative research aims to explore, observe, understand, and interpret a phenomenon (Smith et al., 2009). Various researchers describe qualitative research differently. Punch (2013) describes qualitative research as working with non-numerical data with the aim of understanding life through a study of targeted populations (Punch, 2013). Gentles et al. (2015) describe it as a snapshot of people's perceptions in a natural setting (Gentles et al., 2015), while Walia (2015) describes it as research that focuses on words to understand the meaning that people make from their day-to-day life experience (Walia, 2015). Because qualitative research is situated in the participants' natural setting, it seeks to understand the lived experience of the participants from the participants themselves (Creswell, John, 2013). Its main objective is to explore, describe, and make sense of human phenomena.

> "If the purpose is to learn from participants in a setting or a process the way *they* experience it, the meanings they put on it, and how they interpret what they experience, the researcher needs methods that will allow for discovery and do justice to their perceptions and the complexity of their interpretations" (Atieno, 2009, p. 16).

Choosing a qualitative research method is the resolution of one part of the problem. The other question is, *which qualitative approach fits the purpose of this study?* Robson (2002)

identified three forms of qualitative research designs: exploratory, descriptive, and explanatory (Robson, 2002). To make a distinction between the three, Robson argues that it depends on the objective of the study. For instance, the aim of explanatory research is to explain why a phenomenon occurs, as well as to predict possible future occurrences. In contrast, the goal of descriptive research is to give an overall picture of people, circumstances, or events. It cannot explain why an event has occurred. Exploratory research is used to explore a topic that has not been well researched before or to explore an already existing topic with a view of producing new knowledge (Saunders et al., 2009; Swedberg, 2020).

Exploratory research does not aim to provide conclusive answers. Instead, its goal is to explore the research topic in depth. In my literature search, I came across numerous research studies on obstetric violence in South Africa (Chadwick, 2017, 2021; Chadwick et al., 2014; Chadwick, 2016; Dutton & Knight, 2020; Hastings-Tolsma et al., 2021; Jewkes et al., 1998; Kruger & Schoombee, 2010; Lappeman & Swartz, 2019; Odhiambo & Mthathi, 2011; Rucell, 2017). However, I have not come across a study that focused on the role of Indigenous midwives in countering obstetric violence. Obstetric violence is therefore not a new concept. The role of Indigenous midwives in countering obstetric violence is a new understanding of the problem. Because of its focus on people's lived experiences in their natural settings, I chose qualitative research as an appropriate design for making an inquiry about the role of Indigenous midwifery in countering obstetric violence. For this study, I employ both exploratory and descriptive designs. My aim is to explore an aspect of a phenomenon that has not been researched. In addition to that, I give descriptive accounts of how women who gave birth in healthcare facilities and those who gave birth at home describe their experiences.

My choices are made with an awareness of the limitations of qualitative research. What makes qualitative research good research is "the ability on the part of the researcher to systematically demonstrate transparency and accountability throughout the whole research process" (Kalu & Bwalya, 2017, p. 44). This can be achieved through a consistent process of reflexivity. Indigenous research and Western research do not often coalesce on what constitutes bias (Mataira et al., 2019). Within Indigenous research, reflexivity is not limited to how the researcher takes ownership of own bias and situatedness in relation to the topic under investigation. By asking the question, whose side am I on, an Indigenous researcher owns her bias which emanates from challenging dominance of Western way of knowing. Bias

is therefore not limited to interactions between researcher and the researched. Instead, it includes declaration of the researcher's vulnerabilities (Mataira et al., 2019), questions how the community benefits from the research (Smith 1999) as well as questioning dominant Western ways of doing research (Ahenakew, 2016).

### 4.12. Linking qualitative research with an Indigenous research framework

In my search for a research design that fits this study, I was guided by the following questions:

- What kind of design would allow me to include historical socio-political factors that framed the obstetric violence narrative over centuries?
- How can I undertake research in a way that benefits the community of Indigenous midwives?
- How can I avoid maintaining the dominant academic discourse and use this research to disrupt it?
- How will I present the voices of Indigenous midwives whose knowledge and practice have been historically suppressed?

As a way of finding answers to above questions, I considered a number of methodological approaches that range from transformative, critical, postcolonial and decolonial. In writing about critical, transformative and postcolonial paradigms which all emerged as reaction to traditional positivist approaches, Omodan (2022) argues that the aim of these research approaches is to empower those who have been historically excluded by dominant systems of knowledge production (Omodan, 2022). For this to happen, research is viewed as a co-learning experience and knowledge as socially constructed. Other than finding answers to the research question, transformative research can be used by the researcher to advocate for equality and social justice. According to Omodan, this is about "listening to the people affected by the problem under investigation and involving them in finding the solution to the problem. This approach is based on the belief that those closest to the problem are often best equipped to find a lasting solution." (Omodan, 2022, p.278)

Postcolonial research paradigms also follow the same approaches as transformative research paradigms by challenging dominant Western research methodologies and therefore giving voice to those who have been historically marginalised. Other than perceiving knowledge as socially constructed, postcolonial paradigms posit that there is no single universal truth.

Instead, knowledge is perceived as relational and contextual (Chilisa and Kawulic, 2022). In writing about decolonial research, Smith (1999) uses the term decolonising as a way of conducting research with Indigenous communities in a way that places their voices and epistemologies in the centre of the research process (Smith., 1999). Does this mean that postcolonial or decolonial research is inherently inclusive of the voices of Indigenous people? In other words, do postcolonial and decolonial research approaches value Indigenous methods on an equal footing? Datta (2018) argues that decolonising research can still suppress the voices of Indigenous people (Datta, 2018). This, he argues, is a result of invisible power over Indigenous people that seem to be fixed within the Western mindset. In writing about decolonising methodologies such as critical race theory which seek to question power imbalance based on race, and feminist theory which challenges inequalities based on gender, Braun et al (2013) contends that while critical and participatory approaches are transformative in nature, their foundation is still Eurocentric (Braun et al, 2013).

One of the most challenging decisions I had to make as any researcher was to select an appropriate research design, theoretical framework and methodology that is aligned to the research question. From an Indigenous researcher's point of view, the challenge is compounded by the fact that research has historically been founded on methodologies that originate from Eurocentric ways of knowing. A study on Indigenous midwifery seeks to challenge the Western view that the biomedical model of birth is superior and authoritative. This challenges normative birthing practice and academic imperialism. Academic imperialism is a phrase coined by Chilisa (2012) to refer to a practice where conceptual and theoretical frameworks and research methodologies that stem from the Global North continue to promote the superiority of Euro-Western thought (Chilisa, 2012). Chilisa (2017) concedes that African scholars trained in Western education in African universities continue to use methodologies embedded in Western cultures (Chilisa, 2017). In such a case, Chilisa (2017) argues, research can become a tool of ongoing colonisation.

My way out of the research methodology search was to borrow from Peltier (2018) who employed the concept of "two-eyed seeing" to synthesise Western participatory research with Indigenous research methodology (Peltier, 2018). Two-eyed-seeing, a concept which was popularised by a Mi'kmaq Nation Elder, Albert Marshall, speaks to an ability to see from the strength of each eye (i.e. Western and Indigenous) for the benefit of all (Peltier 2018, Liberda et al 2020). At its core, two-eyed seeing includes principles of ownership, control, access, and

participatory research (Liberda et al 2020). This reinforces the critical role that Indigenous people play in knowledge production. Guided by this model, I incorporated the following principles of Indigenous research in the design:

- Relationality: This is based on the notion of knowledge as relational. Relationality transcends people to include ideas, land, other creations, and the cosmos. Inherent in this principle is the idea of multiple ways of seeing and knowing (Chilisa, 2012; Wilson, 2008.
- Respect: Practising respectful research with Indigenous communities includes an openness to learn from Indigenous perspectives rather than appropriating or judging their knowledge. This creates an opportunity for the researcher to co-create knowledge with the researched. This also includes respect for cultural ways of knowing which is informed by the overriding principle of relationality expressed through various tools such as language, rituals, and ceremonies (Hart, 2010; Wilson, 2008). As custodians of knowledge, elders have a vital role to play in guiding research.
- Responsibility: The researcher's responsibility is to collect, interpret and disseminate data in a responsible manner with an attitude that is informed by an understanding that "the most important responsibility for researchers is a willingness to learn from rather than about Indigenous people" (Carjuzaa, Jioanna, Fenimore-Smith, 2010, p. 7). This includes refraining from the exploitation of Indigenous knowledge as a commodity. This connects to the principle of respect for participants, the project, and the entire research process. This also evokes the principle of governance and decision making, which demonstrates respect for Indigenous sovereignty (Wilson, 2008. In the end, the community has an ethical responsibility to safeguard their own knowledge.
- Reciprocity: Research is founded on power determined by those whose knowledge is valued (Wilson, 2008). Dismantling differential power dynamics between knowledges is often coated in terms such as participatory research. As Ball and Janyst (2008) point out, much research involving Indigenous people tends to reinforce the superiority and authority of Eurocentric paradigms (Ball & Janyst, 2008). When this is done in a way that diffuses the ordering of knowledges as superior or inferior, this may establish a false sense of equality. Reciprocity also includes undertaking research that is of value to participants. This raises the question: who benefits from the research? Other than benefiting the community, this speaks to the Indigenous protocol of gifting

participants who share the knowledge with the researcher (Hart, 2010; Wilson, 2008; Kovach, 2009). Relevance: This seeks to answer the question, how relevant and beneficial is the research to Indigenous people and their communities? Is it transformative or oppressive? Is it regenerative, empowering, or is it extractive and disempowering? (Wilson, 2008; Kovach, 2009; Smith, 1999). This includes using one's skills to assist communities with issues that extend beyond the focus of the research. Learning from Indigenous people and using one's skills to assist communities with issues that extend beyond the focus of research is an acknowledgement of the value of their knowledge as well as, which has historically been defined as inferior, primitive, tribal, or local.

Employing an Indigenous research methodology is not only about acknowledging and writing about past injustices. It is also about immersing oneself in research methodologies that respect the beliefs, cultural protocols, and worldviews of communities. In the sections below, I share how I succeeded or failed in incorporating the principles of Indigenous research during the preparation, data collection, and analysis stages of the study.

### 4.13. Research setting

Initially, I had planned to undertake research in Tafelkop, Sekhukhune district, Limpopo Province. I chose this community because of my historical connection with Pulo Ya Meropa Cultural Trust. The trust originated from an annual healers' festival started by local healer Ngaka Mpubane Rakgetse in 1978. Over the years, the festival transformed into a village-based development forum whose aim is to create Indigenous arts-based economic activities for members of the community. I participated in the festivals in my role as a storyteller, writer, and healer.

The 2020 Covid-19 lockdown hampered the initial recruitment of participants. This was exacerbated by the passing of one of the elders who was to be my key guide in the area. My efforts to organise briefing encounters with women in Tafelkop failed. Because time was running out, I had to make an alternative plan. A telephonic conversation with an 80-year-old headman with whom I had a previous working relationship in Maviljan village in Bushbuckridge was the answer to my dilemma. My initial setting changed from Tafelkop in Limpopo to Bushbuckridge in Mpumalanga. Bushbuckridge is a place where I trained as a biomedical midwife as a young woman fresh out of school. I am familiar with the villages and

languages spoken in the area, which are Xitsonga, Sepulana, and Siswati. A rich cultural heritage meant a greater chance of accessing more women who practise as Indigenous midwives, as well as those who gave birth at home.

Overall, interviews were conducted in three provinces: Mpumalanga, Limpopo, and Northern Cape (see Figure 5).[38]


*Figure 5: South Africa map*

In Mpumalanga, interviews were conducted in rural villages located in Bushbuckridge, Sabie, Graskop, and Skukuza. These are rural towns spread across three local municipalities: Bushbuckridge, Thaba Chweu, and Nkomazi. These are in the Lowveld, 410 km east of Pretoria (see Figure 6).[39]

[38] Map_of_South_Africa_with_English_labels.svg.png

[39] https://municipalities.co.za.

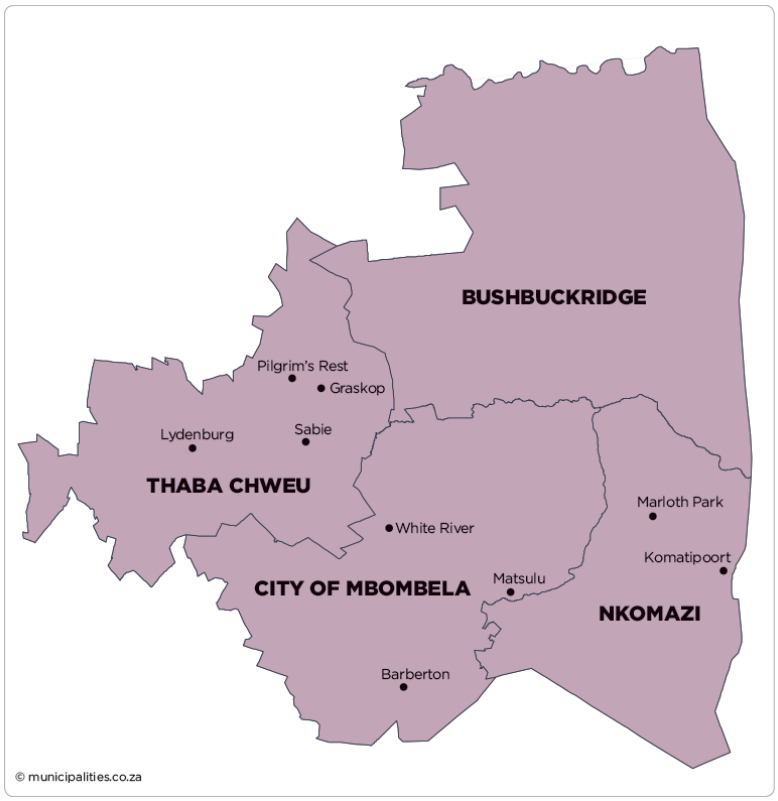


*Figure 6: Mpumalanga map*

In Limpopo, interviews were conducted in Klopper village located in Makhuduthamaga municipality, in Sekhukhune District. Makhuduthamaga municipality is situated 247 kms northeast of Pretoria (see Figure 7).[40]

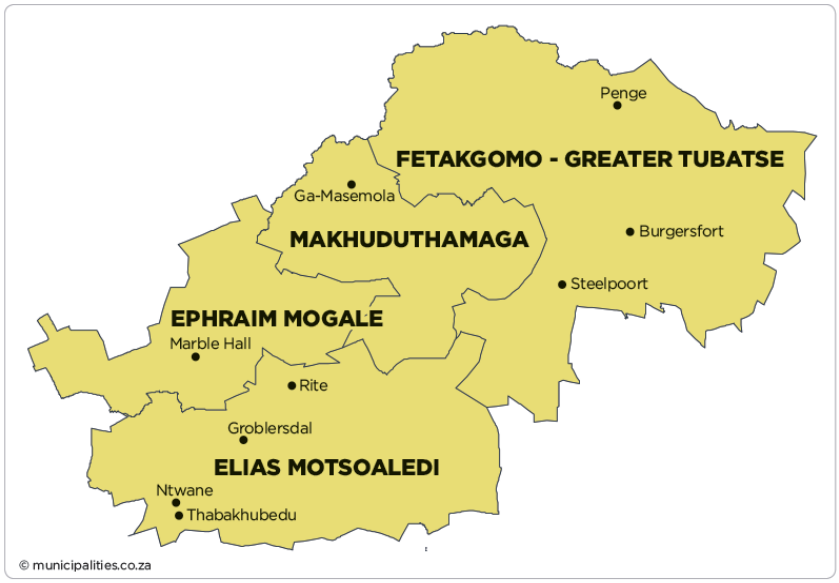


*Figure 7: Limpopo map*

[40] https://municipalities.co.za.

In the Northern Cape, one extended interview with an Indigenous midwife was conducted in Magojaneng village, 614 km south-west of Pretoria, located in Ga-Segonyana municipality, between the towns of Vryburg and Kuruman (see Figure 8).[41]


*Figure 8: Northern Cape map*

All the research sites were rural and characterised by high levels of unemployment, poverty, and lack of basic services such as water.

### 4.14. Negotiating access

My first point of contact in Bushbuckridge was Ntate Malele, an elder serving as a member of the Traditional Council Ga-Malele which is one of the main villages in Bushbuckridge. I first met him when I was living in isolation in a dilapidated Lutheran mission house in Maviljan in Bushbuckridge after I had published *The Kanga and the Kangaroo Court: Reflections on the Rape Trial of Jacob Zuma*[42]*.* Because I was homeless at the time after having lost my home in Pretoria, Ntate Malele used to take me around, showing me land upon which I could establish a home. Ultimately, I went back to Pretoria.

[41] https://municipalities.co.za.

[42] Motsei, M. 2007. The Kanga and the Kangaroo Court: Reflections on the Rape Trial of Jacob Zuma, Johannesburg, Jacana.

In honouring the principle of respect for Indigenous governance, Ntate Malele accompanied me to meet with the Traditional Council, where he introduced me and helped me seek permission to interview women in local villages. After obtaining the Traditional Council's clearance to commence with the research, Ntate Malele introduced me to a local traditional healers' organisation called Hlakaniphani led by Ntate Mashaba, who later introduced me to another elder, Gogo[43] Lindiwe Mdluli, who resides in the neighbouring town of Sabie. Gogo Lindiwe served as my community guide in honouring the principle of respect, relationality and co-creation of knowledge.

In Mpumalanga, I interviewed women in villages around Bushbuckridge, Sabie, Hazyview, and Graskop. Towards the end of my data collection process in Mpumalanga, I was referred by my Facebook friend Letlhogonolo Sechogela to an Indigenous midwife who lives in the Northern Cape. I write more about my encounter with Mme Kebelediwang Manyeke in Chapter 7. At the end of my data collection process, I was informed by one of the healers in Limpopo about two elders in Klopper village in Limpopo. An elder I know from my previous work with rural women, Mme Tsiane, organised for me to interview the two participants. They were the last participants that I interviewed.

### 4.15. Study participants and sampling

Robinson (2014) identifies the following key steps to follow in sampling participants: defining a sample universe, deciding on a sample size, selecting a sampling strategy, and sample sourcing (Robinson, 2014).

#### 4.15.1. Defining sample universe

Defining the sample universe refers to specifying the inclusion and exclusion criteria of the research study. Starting with Indigenous midwives, I used the following exclusion criteria to ensure that they are purposefully selected:

- Live in the community
- Over the age of 60

[43] Gogo is a Nguni word used for grandmother. In African spiritual healing terms, it is also used for initiated healers. Sometimes the title is used for male healers who carry a female healer spirit.

- More than five years of working as an Indigenous midwife.

The rationale for choosing women over the age of 60 was made on the assumption that they would have gathered considerable embodied knowledge and experience of having practised as Indigenous midwives.

I also sampled a group of women who gave birth in a hospital in the past five years and a group of women who gave birth at home in the past five to ten years. There was no age limit for these two groups.

### 4.15.2. Deciding upon sample size

My initial plan was to interview 30 women with the following characteristics:

- Ten women who gave birth in a healthcare facility under the supervision of a biomedical healthcare practitioner.
- Ten women who gave birth at home under the supervision of an Indigenous midwife.
- Ten elders who practised or are still practising as Indigenous midwives.

I interviewed 28 participants for this study. The first group were women who gave birth in a hospital (n=10). The second group were women who gave birth at home (n=10). The third group were Indigenous midwives (n=8).

### 4.15.3. Selecting sample strategy

Creswell (2013) contends that there is a need to plan as much as possible. However, he encourages researchers to be flexible because sampling can change during the study and/or researchers can use more than one sampling strategy in a single study (Creswell, 2013). Because of differences in the groups of women interviewed (women who gave birth in a hospital, women who gave birth at home, and women who facilitated birth at home), I used purposive snowball sampling. Snowball sampling is a purposeful, non-random sampling method used when "the focus of the study is on subtle issues, possibly concerning a relatively secretive matter, and thus requires the knowledge of insiders to locate people for the study" (Etikan, 2016, p. 2). Very often, the population of interest may be hard-to-reach participants who may either be geographically dispersed or those who require trust to participate in the research either because the topic is sensitive and/or secretive or in the case where participation in the study may be risky (Parker et al., 2020). In my case, the distance between

the villages was vast. I spent a greater part of the day driving on challenging roads. I also got lost many times during the data collection phase.

*Figure 9: Driving from one village to another, Bushbuckridge, Mpumalanga*

Using snowball sampling, I used my social networks to access a few initial contacts (seeds) who fit the research criteria. The participants were then asked to recommend others who fit the research criteria and are also willing to be interviewed. The first group of women who gave birth in a healthcare facility with biomedical midwives were easy to find. The second group of women who gave birth at home with Indigenous midwives was also easy to find, but some were reluctant to be interviewed. Having Gogo Lindiwe as my community guide helped to allay any suspicions. Her role was first to identify potential participants and connect with them telephonically. Once they gave permission for me to visit, she introduced me to the participant. The third group of Indigenous midwives were not easy to find. In their case, I combined snowballing with opportunistic sampling. Creswell (2013) refers to this as instances where unexpected referrals happen (Cresswell, 2013). I therefore had to accommodate the unexpected changes to my interview plan.

My experience of opportunistic sampling happened when I was in one village in Bushbuckridge interviewing a woman who had given birth at home. Before I arrived, the participant had sent out a message to two young women who lived in a neighbouring village to come for the interviews. They walked a long distance in the scorching sun because they thought I was conducting job interviews. When they arrived, I explained what the purpose of

the research was. None of them had any children but they knew an older woman in another village who used to help women deliver at home. Even though they were disappointed, they were kind enough to drive with Gogo Lindiwe and me to introduce me to the elder they were speaking about. I had arranged to interview another woman in a different village, but I had to be flexible enough to accommodate an unexpected participant.

One key criticism against snowball sampling is selection bias because not every participant in the population has an equal chance of being selected. As a non-random sampling strategy, snowball sampling is used where generalisation, representativeness and external validity are not sought after (Parker et al., 2020). Despite its limitations, snowball sampling is not uncontrolled because the researcher is actively involved in developing and managing the origination and progress of the sample and seeks to ensure that the chain of referrals remain within the limitations that are relevant to the study (Etikan, 2016). When viewed critically, Noy (2008) argues that this method can generate unique knowledge generated from people that a researcher would not normally be able to reach (Noy, 2008). To avoid the possibility of ending with a sample skewed in one direction, the researcher must ensure that the original set of respondents is varied. In my case, I had the advantage of interviewing women dispersed across rural towns and provinces. Not only did they speak different languages, but they were also connected to different socio-cultural networks.

### 4.16. Data collection process

The purpose of this study was to explore lessons learned from Indigenous midwives as a way of countering obstetric violence in healthcare facilities. As I used a bi-cultural approach of both biomedical and Indigenous midwifery in my exploration, I needed to understand women's experience of birthing both in a healthcare facility and at home. I also interviewed Indigenous midwives who have experience facilitating births at home.

In the middle of the research, I realised I should have included a sample of biomedical midwives. I then enquired about ways of obtaining permission to interview midwives working in healthcare facilities in the research area. I was told by an acquaintance who worked in a nursing association in the province that getting permission to interview biomedical midwives is a laborious process that involves writing a letter to the Department of Health. Following this route would also require that I revise my initial research proposal for ethical review by

the University of Pretoria Research Ethics Committee. These delays would have extended the implementation of my research study beyond the time allocated to complete my degree. This is therefore one of the limitations of this study.

### 4.17. Interviews

To gather data, I used a semi-structured interview protocol with questions focused on women's experience of childbirth with a specific focus on labour and the postpartum period. The same questions were posed to women who gave birth at home and in a hospital. To gain a deeper understanding of Indigenous birthing practices, I also interviewed Indigenous midwives who shared their experience of helping other women to give birth in their homes. At the beginning of each interview, I introduced myself and the purpose of my visit. According to African Indigenous protocol, introductions are not limited to names or where we are from and what we do for a living. By sharing the meaning of my name and the historical significance of my surname, my totem, and a brief background of my lineage, I opened an opportunity for the participant to welcome me to her space in a way that speaks to her cultural practice. I left it to the participant to welcome our collective ancestors and me to her space in a way aligned with her spiritual beliefs. In a few instances, interviews were preceded by a spiritual ceremony in the form of reciting heroic poetry and/or *go phahla* (spiritual incantations to give thanks to the ancestors) that brought us together.

Initial introductions were followed by explaining the purpose of the research and an invitation for participants to ask any questions if there were any. Then I explained informed consent and told each participant they had the right to refuse to participate or discontinue participation even after commencing the interview. After signing consent forms that included permission to record the conversation, interviews commenced. Interviews lasted from 45 minutes to two hours. The longest were the ones undertaken with Indigenous midwives.

Open-ended questions were posed to elicit participants' accounts of their experience with pregnancy and childbirth at home and in the hospital. Indigenous midwives were asked specific questions about their birthing knowledge. Even though a set of questions were used to guide the interviews, interviews with elders went in many different directions, such as teenage pregnancy, poverty in rural communities, and the generation gap between elders and young people. Many of the elders spoke about the loss of cultural identity.

### 4.18. Duration

It took me over a year to complete the data collection process. I first went to Bushbuckridge in Mpumalanga from 12 to 16 September 2021. I booked accommodation in a mountain cabin between Bushbuckridge and Graskop. Later in the week, I had to move because of a lack of telephone signal and internet connection which was required to arrange daily trips to neighbouring villages. I then moved to a bed and breakfast in Hazyview until the end of the week. My plan was to return the following month (October 2021) to continue with interviews. I could not continue because of Covid-19 inter-provincial travel restrictions.

My next round of interviews was planned for November 2021. I acquired accommodation in Hazyview to be closer to a group of women in Sabie and Khokho, a village not far from the Kruger National Park. On the second day, I experienced mechanical problems with my car, and it had to be taken in for inspection in White River. The car had a mechanical problem and fixing it came with considerable cost. The only way I could return home was for the technician to jump-start the car and I drove back to Pretoria without stopping on the way. In the process, I forfeited payment for four nights of accommodation I had secured in Hazyview.

The next round was in February 2022. Once again, I secured accommodation in Hazyview. During this time, I interviewed women in villages around Bushbuckridge, Sabie, Hazyview, and Graskop. The next round of interviews took place in June 2022. Because of a lack of financial resources, I sought accommodation from a friend, Helen Mmethi, who lives and works in Skukuza in the Kruger National Park. This was located far from the villages in which I was doing research. As a result, I spent a considerable amount of time driving to research sites. During that week, I interviewed women in villages around Bushbuckridge, Skukuza, and Graskop.

A month later, in July 2022, my son, Katlego, drove me to Dithakong village in Northern Cape to interview a 78-year-old woman who had been practising as an Indigenous midwife for over 30 years. We acquired overnight accommodation at Kathu, outside of Kuruman in the Northern Cape. I spent one and a half days with her. We had been speaking over the phone for several months. The final round of interviews was in August and September 2022 in Klopper, Limpopo. Because it was not easy to find Indigenous midwives in one place, I followed all the leads I received about women working as Indigenous midwives in various provinces.

### 4.19. Challenges, limitations, and shortcomings

I covered thousands of kilometres in three provinces – Mpumalanga, Limpopo, and Northern Cape. In the process, I incurred significant costs for travel amidst a major increase in petrol price. Paying for accommodation was another major cost. The pressure of lack of funding and the enormity of the task made me question why I undertook to do the research in the first place. To try and ease my financial burdens, I packed up all my house belongings into storage, so that I should not have to worry about rent for the duration of the data collection and the writing up of this study. It was painful but easy to make this decision because I had been homeless before after my house was repossessed following the release of my book, *The Kanga and the Kangaroo Court: Reflections on the Rape Trial of Jacob Zuma* in 2007. Even though life was hard then, I managed to crawl out of a dark hole. Because I had done it before, it was not difficult to get back on the saddle and continue with the research.

All the interviews happened in the homes of the participants. In many of these interviews, family members invited themselves. This means what was planned as an individual interview could easily turn into a dialogue between two or three people. These could be relatives or neighbours. In one case, the participant was accompanied by a neighbour who came to visit as soon as she noticed the car at the gate. In another situation, the interview had to be stopped because the entire family came to join us on the *stoep*. This included the participant's daughter and her friends, including their children. The interview turned into an animated dialogue with everyone responding to the questions. This proved to be difficult for me to continue with the interview.

In almost all the interviews, children walked in and out the interview space with ease. There were times when participants had to stop the interview to attend to the needs of their children. In one case, the interview happened at a home of a healer who initiates other healers. One of the initiates went into a trance and she had to be attended to by drumming and chanting. I was invited to participate in the ceremony. Afterwards, when I left, the participant offered me gifts of herbs to treat a severe bout of indigestion which I had been suffering from because of the food I had eaten. Some participants would not allow me to leave without offering me gifts such as vegetables and fruits from their gardens. In another incident, the participant cooked a dinner of porridge and nkaka (Indigenous vegetable). When

I completed the interview, it was already late at night. Instead of eating dinner at her home, she dished the food for me to take with me.

From the above, it is clear that the conventional individual interview did not work as planned. In her critique of the individual interview method as an instrument of data collection within an Indigenous research framework, Chilisa (2012) argues that standardised interviews lean towards Western methodological frameworks, which are based on the belief of the individual knower. In contrast, relational ways of knowing are based on the collective construction of knowledge and its implementation in practice (Chilisa, 2012). In the case where one or two additional people invited themselves to the interview, I focused on the responses of the main participant while noting inputs from others.

Upon my return from fieldwork during the first round of interviews, I sent an email to my supervisor. In the email, I explained that I had uncovered information that could not be captured through individual interviews. I also asked for advice regarding the possibility of using sharing circles. She responded that while the possibility of group interviews is an innovative idea, the challenge is that I did not get clearance to use any instruments other than individual interviews. She advised me to reflect on the matter, and if I would like to include additional instruments, I must re-apply for ethics clearance. In my perusal of literature, I came across sharing circles as an instrument, which can be used in Indigenous research. Sharing circles constitute a form of narrative research method used to capture people's lived experiences. Whilst these are like focus groups, what sets them apart is that they can be used for ceremonies, healing, as well as the creation and sharing of knowledge (Lavelle, 2009). In Indigenous research terms, this method leans towards collective knowledge production. In addition, the use of sharing circles lends itself to the concept of research as a ceremony (Wilson, 2008).

My view was that an inclusion of sharing circles would create some form of alignment and coherence between my proposed theoretical framework and a methodology based on relational principles of knowing. One of the key principles of Indigenous research is that knowledge is relational and is therefore co-created with others. Using methods aligned with this principle would have been a better fit for the study. Because of the limited time and resources available to complete the research, I was advised to continue with individual

interviews but focus on documenting responses from the main participants. This constitutes another limitation of the study.

### 4.20. Ethical considerations: An Indigenous perspective

Techniques of collecting data in once-colonised communities are not always ethical because such research happens within a historical context of colonisation, which gave rise to suppression and/or misinterpretation of Indigenous knowledges (Chilisa, 2012). University ethics protocols are concerned with the well-being and rights of research participants. While this is important, there is a lack of equal concern about the domination of Western cultures. Overall, ethics committees are concerned with "empirical generalisability and under-concerned with generalisability of domination" (Carjuzaa, Jioanna, Fenimore-Smith, 2010, p. 6). Therefore, it is possible for a researcher to disrespectfully undertake ethically approved university research. Researchers can be implicated in reinforcing the colonial agenda when they participate in othering other people and their knowledge (Chilisa, 2012). It is important, she further argues, to note that "theories on colonised people were produced and legitimised through processes of measurements defined as objective in the contexts of scientific colonialism" (Chilisa, 2007, p. 25).

I am conscious of the potential risk of essentialising Indigenous cultural practices and therefore overlooking its errors and dysfunctionalities. Like any other culture, Indigenous culture cannot be frozen in pre-colonial and pre-industrial times with no capacity to evolve in alignment with contemporary challenges. I believe that Indigenous practitioners and scholars must also engage in a process of constant self-critique. Such self-reflection is part of the political agenda aimed at interrogating Africa's past traditions in order to heal and revitalise people's search for cultures that are fundamentally human (Dei, 2000).

In making comparisons between university and community ethics clearances, the following Indigenous ethical challenges came up:

- *Balancing university and community ethical requirements:* After acquiring ethical clearance from the University of Pretoria,[44] I went on to seek permission to undertake the study with the community. I was first introduced to the Malele Traditional Council which

[44] Faculty Application Number HUM029/0121.

introduced me to Hlakanipani, a local organisation of healers and Indigenous knowledge holders. This means I received more than one clearance to proceed with the research. This is in accordance with the principle of respect.

- *Upholding Indigenous principles of respect and responsibility:* An elder was assigned to me not only to introduce me to potential participants but also to guide me on Indigenous protocols. This was necessary to ensure that research was conducted in a manner that respects participants' cultural beliefs and practices.
- *Upholding the principle of reciprocity:* One of the major ethical principles of Indigenous research is that it must yield benefits to communities. Gogo Lindiwe informed me that one of their greatest needs is to organise an intergenerational dialogue on Indigenous birthing. Elders were concerned that they would soon die without having passed on the knowledge. I managed to organise an Indigenous midwifery summit at the end of the data collection phase. This was done in partnership with my organisation, Afrika Ikalafe Pluriversity, and Black Women's Blueprint, a women's organisation based in New York, United States of America. This helped to create an intergenerational platform for elders to share their knowledge with young women. Depending on the availability of funding, women mentioned an interest in ongoing intergenerational meetings. This has the potential to open avenues of community activism. This may include future dialogues with biomedical midwives on holistic birthing practices that can be adopted to counter obstetric violence.

Where I failed as an Indigenous researcher is not being able to honour the principle of reciprocity as it relates to sharing gifts with elders. In our tradition, we have a practice called *go rufa* or *go khanyisa*, which is a way of honouring elders and their ancestors for life-enhancing knowledge. Suffice to say, this research was not funded. This means I had to cover my own research costs (travel, accommodation, meals, and other related costs). Buying small gifts for elders as tokens of appreciation for their generosity was therefore not affordable. As mentioned in the paragraph above, helping them to organise their gathering was my limited way of giving back.

### 4.21. Data analysis

Given that this study is founded on an Indigenous research framework, the biggest challenge I faced was the dearth of information on Indigenous qualitative data analysis. In writing about

Western and Indigenous storied approaches to research, Susana Caxaj identifies the following differences (Caxaj, 2015):

- Within the Western academy, narrative is bounded by the expression of self that belongs to the narrator alone. This contrasts with Indigenous views of the collective construction of knowledge.
- Western narratives often neglect the material realities of Indigenous people. In this way, the outcomes of research tend to reflect the values of privileged populations.

In my search for an appropriate analytical framework, I opted to use reflexive thematic analysis developed by (Braun & Clarke, 2006). Thematic analysis is a tool for identifying, analysing, and interpreting patterns of meaning within qualitative data. My choice of this analytical tool was influenced by the fact that it can be applied across a range of theoretical frameworks and research paradigms (Braun & Clarke, 2019). Not only does it seek to identify patterns within and across data sets in relation to participants' lived experience, views and perspectives and behaviour, it helps the researcher to understand what participants feel, think or do (Braun & Clarke, 2023). In this study, I interviewed rural women about their birthing experience in health care settings and at home. I also interviewed Indigenous midwives about what they think about their knowledge and practice and its possible role in countering obstetric violence. Thematic analysis was useful to help me identify and understand what the participants felt about their birthing experiences, how they described such experiences, their views and perceptions about women's childbirth experience in general and about obstetric violence in particular.

Qualitative data analysis can be deductive or inductive. Inductive analysis means that the patterns, categories and themes of analysis "emerge out of the data rather than being imposed on them prior to data collection and analysis" (Srivastava & Hopwood, 2009, p. 306). Deductive tends to be analyst driven as predicated on prior theoretical framework or conceptual framework while inductive tends to be data driven so as to produce codes that are free from any preconceived theory. It is however not possible for data to fall neatly into one approach. Often, data reflects a combination of the two (Byrne, 2022)

> "It is arguably not possible to conduct an exclusively deductive analysis, as an appreciation for the relationship between different items of information in the data is necessary in order to identify recurring commonalities with regard to a pre-specified

> theory or conceptual framework. Equally, it is arguably not possible to conduct an exclusively inductive analysis, as the researcher would require some of criteria to identify whether or not a piece of information may be conducive to addressing the research question(s) (Byrne, 2022, p.1397)

By following the steps of thematic analysis formulated by Braun and Clarke as outlined below, I was able to make meaning of the data (Braun & Clarke, 2023). While these phases or stages are organised in logical order, researchers need to be aware that analysis is iterative. This means, in analysing the data, the researcher moves back and forth through the phases to interpret and reinterpret data (Byrne, 2022).

- *Step 1: Familiarisation with the data.* I familiarised myself with the data by listening to the recordings. This started after the first group of interviews and continued through the data collection phase. At the end of this phase, I began with the process of transcribing the recordings. This involved active listening which helped in recalling different settings, encounters, gestures, emotions and rituals. After transcription, I read the transcripts whilst highlighting interesting passages as well as noting my thoughts and feelings.
- *Step 2: Generating initial codes.* Codes are the building blocks of what later become themes. I generated initial codes by going through each segment of a transcript and identifying anything that seemed to be relevant to the research question. I did not have any pre-set codes. Rather, I developed them as I worked through the data. Rather than using qualitative data analysis software, I opted to engage data by working through hard copies using different colours to mark what seemed to represent similar codes.
- *Step 3: Generating themes.* My next step was to arrange codes into colour themes. Some codes fell neatly into similar themes. In a case where codes did not fit into a theme, I wrote them down on paper and stuck them to the wall. The themes were descriptive, describing patterns in the data relevant to the research question. As I moved from one code to another across the data set, I began the process of discard codes that did not fit with the research question.
- *Step 4: Reviewing potential themes.* Like in the step above, I did not use qualitative data analysis software. Instead, I opted to use a cut-and-paste method, clustering themes with the same colours together. Even though the cut-and-paste method was laborious and time consuming, it helped to deepen my familiarity with the data. In trying to make sense of the themes, I asked myself these questions, *how are they related to the research*

*question? How often do they occur? Are there any sub-themes? How are the sub-themes related to the main theme?*

- *Step 5: Defining and naming the themes.* In identifying the essence of the themes, I continued to use the questions described in the previous step. Naming the themes may look trivial but it is one of the most important tasks because it is the first indication to the reader of what has been captured from the data. Researchers are advised to use catchy names that may capture the attention of the reader whilst also communicating an important aspect of the theme. Once I was done with this phase, I began the process of translation. Following translation, I assigned pseudonyms to each participant to ensure anonymity and confidentiality.
- *Step 6: Producing the report.* In this phase, I began to pay attention to the order in which the themes could be reported. In certain instances, I opted for a departure from traditional reporting. For instance, in Chapters 5 and 6, I present biographical data of the participants differently. For the first group of women who gave birth in a healthcare facility, I used names commonly used in respective research sites. In the second group of women who gave birth at home, I continued with the same practice of pseudonyms but added the prefix 'Mme' to the names. This group was older than the first. The prefix shows respect. In the last group of Indigenous midwives, I replaced pseudonyms with totems. A totem is a natural or mythical animal, plant, bird, insect, or other creation which serves as a symbol of a clan (Makgopa, 2019)

My approach to analysis was to centre the voices and lived experiences of birthing women and Indigenous midwives. The first step in the process was to transcribe all the interviews verbatim. I first transcribed all the interviews with women who gave birth in a healthcare facility, followed by those who gave birth at home. The last group was Indigenous midwives. The other step was to translate all the interviews into English. My proficiency in all the languages spoken helped in this regard. After completing the transcription and translation processes, I sent the findings to a writer/language reviewer who resides in the research area. He checked transcribed versions of the data for accuracy.

In addressing the tension between Indigenous languages and knowledge translation theory, Smylie et al. (2003) views Indigenous knowledge as relational and communal, while Western science is linear and singular (Smylie et al., 2004). It is within these diametrically opposing paradigms that translation can force Indigenous ontologies to fit Western practice. In

expanding on this view, Ronaldo Vazquez (2011) argues that translation is responsible for epistemicide:

> "The practices of translation have been instrumental for the epistemicide; translation is a particular mechanism of the other side of modernity: coloniality" (Vázquez, 2011, p. 30).

It is through translation, Vazquez (2011) argues, that colonial epistemic territory is demarcated and reinforced while everything else that does not fit within the parameters of modernity is rendered invisible. Other than exploring the potential of Indigenous midwifery in countering obstetric violence, this research seeks to re-centre the voices and visibility of Indigenous midwives. In my view, translating their voices is one of the ways of making them invisible. This study presents excerpts of women's narratives in Sepedi, Sepulana, Setswana, Xitsonga, and Siswati. To harmonise the internal revolt which emanates from my "colonial wound" (Mignolo, 2009) with the requirements of a doctoral degree, I chose to present some of the excerpts in African languages in the body of the research as opposed to the common practice of relegating them to appendices.

The next question to consider was validity and transparency. Most qualitative research has its origins in traditions that argue that the information we obtain or produce is mediated by, or constrained by our beliefs, culture, and view of the world. This makes the scientific requirement of obtaining objective knowledge unachievable (Yardley, 2017). The question that arises is: how then can we demonstrate that a qualitative study has been carried out to a high standard? Yardley (2017) classifies procedures for evaluating validity of qualitative research under the following dimensions:

- Sensitivity to context: Striving to apply the principles of Indigenous research methodology throughout this study was, in my view, an effective way of ensuring sensitivity to the context and participants as co-creators of knowledge. As a researcher who is trained in biomedical midwifery and initiated in African spirituality, it was easy to adopt and practise cultural humility. Initiates are trained by elders who may not have set in a conventional classroom. This does not make their knowledge inferior. I addressed the notion of hierarchy of knowledge adequately in Section 3.9.2.
- Commitment and rigour: This speaks to in-depth engagement with participants, the topic and other related elements of the research through data collection, including undertaking

in-depth analysis. My journey through this research created opportunities to immerse myself not only in the interviews but also in some of the rituals and ceremonies. I write about this in detail in Chapter 7.

- Transparency and coherence: In a transparent study, a reader is able to see how the interpretation of data was derived from data. In my presentation of findings in Chapter 5 and 6 and in my discussion and recommendations in Chapter 8, I weave the findings of the study with relevant literature to deepen the discussion.

In summary, I chose thematic analysis to arrange what the women were saying into themes and subthemes. All themes were reviewed to ensure that I understand what they represent. The first steps focused on what the women were saying. The latter step focused on interpreting what was said in relation to the research question. At the completion of the analysis process, hard copies were stored in a locked cupboard, while soft copies were stored in my laptop and external hard drive. As per the University of Pretoria policy, transcripts of the interviews will be stored in an anonymised format at the Department of Sociology for a maximum of 15 years.

### 4.22. Conclusion

In this chapter, I started by sharing my embodied discomfort and dilemma of undertaking research using an Indigenous methodology in an institution that does not privilege an Indigenous way of knowing. To understand Indigenous research methodology, I first framed Indigenous knowledge. This was followed by an exposition of Indigenous research and Indigenous feminist theory as fitting theoretical frameworks for the study. I expand on methods used to gather data, including some of the challenges and shortcomings. I also outlined how I accessed the participants and why it was important to honour Indigenous research principles of relationality, respect, relevance, reciprocity, and responsibility. I concluded the chapter with a description of the data analysis framework, as well as the challenges of applying Eurocentric research methodology to the interpretation and presentation of participants' stories and experiences. This includes tensions between language and translation as erasure.

In the next chapter, I outline women's experiences of childbirth in a healthcare facility and at home. By immersing myself in women's accounts of their birth, I first identify different forms

of violence that women were subjected to, as well as explore lessons to learn from Indigenous midwives to counter obstetric violence. In Chapter 6, I extend this exploration by sharing the findings of my interviews with Indigenous midwives. In Chapter 7, I present a critical reflexive reflection on how I immersed myself in the research and navigated challenges and opportunities between my positionality and Indigenous research epistemology.

## CHAPTER 5: Women's experience of childbirth

### 5.1. Introduction

In the previous chapter, I shared moments of disquiet which emanated from a feeling of being sandwiched between two epistemologies. I also outlined the research design, data collection, and analytical framework I used in this study. In this chapter, I present findings of my interviews with two groups of women i.e., women who gave birth in healthcare facilities (n=10) and women who gave birth at home (n=10). This chapter is divided into two parts. The first part focuses on women's experience of giving birth in a healthcare facility. The second part outlines findings from interviews with women who gave birth at home.

Women who gave birth in hospitals largely shared negative stories. This does not mean that there are no positive birth stories in a healthcare facility. My sample is too small, and the research location too narrow to make an assertion that hospital or clinic births are negative. The same can be said about stories of women who gave birth at home. Given the expansive definition of obstetric violence which I presented in Section 2.4, I cannot claim that women who give birth at home only have good birth stories to tell. The most important element of the findings is to explore a connection between women's descriptions of their birthing experience at home and in a healthcare facility with their experience of obstetric violence.

To honour the principle of respect as an integral part of the Indigenous research framework, I present most of the women's voices in their languages with English translations. Where African languages are not used, it is because the women responded to some of the questions in English. I also introduce each of the participants with a few biographical notes using pseudonyms taken from Sepulana and Xitsonga as predominant languages spoken in the research area.

### 5.2. Women who gave birth in hospital

#### 5.2.1. Naming the participants

- Kgaugelo is 29, a traditional healer from Bushbuckridge. She is a mother of a 12-year-old son who lives with his grandmother. Her second baby died in a hospital during birth. She is supported financially by her husband, who works in a timber factory in Sabie. She passed

Grade 12; her dream was to study biochemistry, but she could not go to university because her parents did not have money.

- Lesedi is 46, from Matibidi in Graskop. She studied up to Grade 11. She is unemployed and survives on piece jobs (part-time work) and social grants. She has three children.
- Nyakallo is 39, from Matibidi in Graskop. She passed Grade 12. She is unemployed and is supported financially by her sister. She has one child.
- Amukelani is 35, a traditional healer from Khokho in Hazyview. She has two children of her own. She is also raising two of her sister's children and the family has adopted a boy they found lost in the bush. She is supported by her husband who works at Kruger National Park in Skukuza.
- Khutjo is 45, from Majembeni in Bushbuckridge. She studied up to Grade 10. She has three children. She used to sell food in Tembisa township in Gauteng. She saved money to build rooms which she rents out to migrant workers in Bushbuckridge.
- Wisani is 42, from Khokho in Hazyview. She used to work as a domestic worker after passing Grade 12. She has four children, two were born in a hospital and two at home. She is unemployed, lives on ZAR 350 government grant, and sells vegetables. She tried looking for a job with no success. She keeps herself busy by working as a home-based care volunteer.
- Khensani is 40, a mother of three from Khokho in Hazyview. She studied up to Grade 11 and thereafter worked as a domestic worker. She lives on a ZAR 350 government grant. She also sells vegetables that she plants in her yard. She manages a local netball team to keep the girls in the village occupied. She also gives her time to the community as a home-based care volunteer.
- Nkateko is 32, a traditional healer from Khokho in Hazyview. She studied up to Grade 12. She has two children.
- Ntsako is 25, from Khokho in Hazyview. She studied up to Grade 10 and has one child. She is unemployed and she receives a child support grant.
- Mapula is 46, from Ratanang village in Bushbuckridge. She is a mother of four children, three born in hospital and one at home. She lives with her children and husband disabled due to injury at work. They survive on his disability grant and subsistence farming. She sells vegetables at the market. She has a primary school education.

The women's stories reveal high levels of economic hardship and unemployment. To survive, the women are involved in a range of economic activities that include selling vegetables at the market, working as domestic workers, surviving on seasonal jobs, or practising as traditional healers. Many depend on some form of a social grant, for example, a child support grant, disability grant, or ZAR 350 government grant.

What I found heartening is that even though some of them struggle with unemployment and lack of income, they volunteer their time in community-building activities such as home-based care or managing a local netball team to keep young women engaged. Even though their stories reveal major economic challenges, they are willing to help others where possible. For instance, Amukelani has the heart to raise her children, her sister's children, and a boy they found lost in the bush. During the interview, the children were all playing together in the yard. If you did not know the story, you would think that they are siblings. This is, according to me, the highest form of an expression of *botho. Botho* is a noun derived from *motho* (human). It is a way of being that expresses the principle of cosmic unity which reflects a connection between the creator, ancestors, people, animals, plants, and other animate and inanimate creations (Mbiti, 1990). The essence of *botho* is measured by respect for a shared life force.

## 5.3. Themes

Except for two women (Mapula and Wisani) who experienced birth at home and in a healthcare facility, all the others gave birth in a clinic or hospital. Six major themes emerged: Abandonment and neglect during labour, unconsented medical procedures, lack of care after birth, abusive care, lack of cultural safety, and hospital beds too high.

### 5.3.1. Abandonment and neglect during labour

More than half (n=7) reported being abandoned and neglected during and after labour. Some reported being abandoned for long periods before giving birth, others reported being left alone for hours on cold and soiled linen after giving birth. Giving birth is the most vulnerable and traumatic experience for women. Being left alone at that moment of heightened vulnerability just after you have expelled a human from your vagina, with blood and other body fluids dripping from you, is in my view, the most disrespectful form of care.

Twenty-two-year-old Nyakallo broke down when she shared her experience of neglect and abandonment in a hospital. Because it was her first pregnancy, she did not know what to expect.

> "Kore ba tla go boka nkare o ntji. Nkare ga se wene motho go tshwana le bona. Ende ka mo o kwa go baba. Ketekwa gore ngwana se o nyaka go tjwa. Ga ba tjheke, ba fo nlesa ke ntoshi. Ka mo drip ya baba, ka mo mpa le yona ya baba. Ba fore "dula moo." Ke gore o tla jika-jika, o nagana gore ge o feta feta mo ba duleng gona ba tla go bulabudisa. Bona ba busy ka difounu. Futi, a ba go rapeletje, a ba na taba le motho." Nyakallo.
>
> (They will make you invisible like a fly on the wall. As if you are not human like them. On top of that you are feeling extreme pain. They do not bother to check you; they just left me alone. The drip was painful, the contractions were painful. You will toss and turn alone on the hospital bed with no one to help you. I walked to where they were sitting hoping that they would give me attention. They were busy with their phones. They do not care.)

After pushing the baby out, Nyakallo felt that there was still something left inside. She had no idea what the placenta was even though she attended antenatal care.

> "Nna a ke tjibi selo mara ke a kwa gore go na le so se sheleng. Se ke bona nurse a tjhela letsogo ka mo, gore ba ntshiye ying, nna ga ke tjibe selo. Ke fo kwa selo se re "phuthu." Mo ke se bona ka ho sekotleleng nkare ke sebete" Nyakallo.
>
> (I did not know anything about childbirth. I felt that there was something left inside. The nurse put her hand inside of me. All I heard was the sound "phuthu." When I looked at this thing in a dish, it looked like liver.)

Sometimes, abandonment ends with grave outcomes such as loss of a baby. Twenty-nine-year-old Kgaugelo shared her story after having lost her baby during childbirth.

> "I was eight months pregnant when I went into labour. My husband took me to hospital. We arrived at 06h00 in the morning. The nurses examined me. I was bleeding. They called the doctor. He was drunk. He said he was going to stop labour. Thereafter, I was left with my husband for a long time. Later, the doctor returned and examined me. He said he could not hear the baby's heartbeat. They put me on a drip

> and transferred me to the labour room. My baby was born. She did not cry. I felt betrayed by the nurses at the clinic. They could have seen that this was a complication during my pregnancy and referred me to the hospital earlier. And the doctor – why did he say he is going to stop the labour? Something could have been done to save my baby" Kgaugelo.

In the above incident, Kgaugelo attended an antenatal clinic early in her pregnancy. In terms of the District Health Policy, nurses at the clinic in her village are supposed to have referred her to the hospital when they diagnosed the possibility of a complication. In Kgaugelo's view, nurses were supposed to have identified the complication early in her pregnancy. Kgaugelo was affected by the loss of her baby and the midwives' lack of care about the loss.

> "They put me in a room with an empty incubator. This was a constant reminder that I lost a baby. I cried myself to sleep, I woke up with a swollen face. I did not get any counselling. I also had an episiotomy. It was another reminder. I had to stay in hospital because I had lost a lot of blood" Kgaugelo.

Towards the end of the interview, Kgaugelo started crying. She mentioned that our interaction felt like therapy because it was the first time she shared the story with someone other than her mother.

> "There is no one who asked me how I am doing. Sometimes I felt it was my fault, that I should have known that there was something wrong with my baby. This interview feels like counselling which I did not get when I lost my baby. Everybody expects that the baby did not make it. You are not the first person to lose a baby, so move on. We had to move out of my husband's family home. I did not want to be reminded of my loss" Kgaugelo.

Lack of care or abandonment was not only physical. There was also no empathy and psychological support. After her baby died, Kgaugelo was kept in a hospital for observation. Midwives focused on monitoring signs of possible complications that may arise from excessive bleeding. While this was critical and necessary, they failed to provide any psychological or spiritual care. A study of women's experiences of bereavement following childbirth in Kenya and Uganda revealed that a woman who has lost a baby receives physical, psychological, and spiritual support (Ayebare et al., 2021). She is cared for physically (cooked for, massaged, and given herbal preparations to strengthen the body) and is also comforted

by women who may have experienced the same loss. Participating in death rituals in the company of elders also helps the grieving woman to come to terms with her loss.

Of the ten women interviewed, Nkateko underwent a caesarean section. She was admitted to a hospital for three weeks before surgery because she had high blood pressure. After some time, she was told she would be given pills to make the baby come out. This could mean that she was induced without informed consent.

> "After a few hours, I experienced intense pain. I was given more pills. The doctor came and told me to sign a form. Afterwards I changed into another gown, and I was taken to the theatre for an operation. It took me a long time to wake up after the operation. When I finally woke up, they shouted at me saying I wanted to get them into trouble. They had been trying to wake me up for a long time" Nkateko.

A few years later, Nkateko became pregnant again. Because of having had a caesarean section before, she was booked for another caesarean section.

> "When I got to the theatre, there was someone else in the operating room. I had a strong urge to push. I told the nurse who was next to me. She was busy on her phone. She checked me. They gave me an injection on my back. Doctor took scissors to cut my vagina. He used something that looks like a pump to pull out the baby. Afterwards they stitched me. They took me to the ward. I could not get on the bed; it was too high. I was helped by one of the mothers, '' Nkateko.

Nkateko's experience of being cared for by other women in the ward was a common feature in this study. Without professional care and support, mothers nursed one another. While this is commendable, it frees midwives from their duty and responsibility of caring for women during childbirth. In South Africa, abandonment is a violation of regulations that govern midwifery. According to the South African Nursing Council regulations, a midwife must not leave a woman alone in the imminent second stage of labour.[45] By abandoning the women, midwives failed to adhere to their scope of practice.

[45] South African Nursing Council regulations relating to the scope of practice of persons who are registered or enrolled under the Nursing Act of 1978.

Interviews also revealed that it was common for women to give birth on their own in a hospital. Khensani shared a story of how she almost gave birth in the bathroom after repeatedly going to the nurses' desk to ask for help.

> "Labour pain started at night. In the morning, I prepared myself, took a taxi, and went to hospital. The nurses examined me and allocated a bed for me. They left me alone for a long time. I felt that the baby was near, so I went to the nurses' desk to ask for help. They told me that everyone is feeling pain and that my pain is not special. I went to the toilet; I was ready to push the baby out. The sister heard that someone was pushing in the toilet and came rushing. She dragged me to my bed. I struggled to get on the bed because hospital beds are too high. They gave me a chair while they shouted at me and pinched me. You end up dealing with different types of pain – pain of giving birth, and pain from being pinched by the nurses. I still have scars on my thighs" Khensani.

In the story above, Khensani was subjected to various forms of violence. First, she was abandoned and neglected. When she felt that the baby was near, she went to seek help from the midwives who subjected her to verbal abuse. She then went to the toilet to give birth on her own. She was subjected to more verbal abuse and physical violence.

Amukelani also shared the story of her birthing experience in a hospital after she had been left alone for a long time. She screamed for help when she felt the baby's head with her fingers.

> "Se ndzi ticheka ndzi kuma kuri nhloko se yi la. Loko u nga huweleli uta bebula uri weshe. Ngozi ya kona hi ku mbhedo u le henhla. N'wana u ta fayeka. Vele vanhu va kutala va lo ti bhebhulisa a xibedlele" Amukelani.
>
> (I checked myself with my fingers and felt the baby's head. I screamed for help. If you don't scream, you will give birth on your own. The problem is the beds are too high. If you give birth on your own and the baby falls, it can be crushed to death. There are many women who deliver babies alone in hospitals.)

Wisani also went to the midwives' desk to ask for help. When they did not respond, she went to her room and gave birth on her own.

> “A ndzi nga swikoti na ku famba kahle. Se ndzi kasa, ndzi koka sheet, ndzi khisama, ndzitibhebhurisa n’wana. Loko sister a ta, n’wana ase a ri kona” Wisani.
>
> (Because I could not walk properly, I crawled back to the room, pulled the sheet from the bed, squatted, and delivered the baby. When the midwife came, the baby was already out.)

All the women who gave birth in a healthcare facility confirmed that it was common for women to give birth on their own. This means choosing to give birth in a facility that is commonly regarded as a safer place to give birth does not guarantee that you will receive care and support. Abandonment during childbirth does not only happen in poor under-resourced facilities. Chadwick (2018) argues that women who give birth in private hospitals may not give birth alone. Yet, they too may be subjected to neglect and disregard which leaves them “feeling abandoned, unworthy and unsafe” (Chadwick, 2018). Once again, this raises a question*, is a hospital a safer place to give birth in comparison to a home birth?* Chattopadhyaya et al. (2018) argues that advocating for safe delivery in a hospital hides the reality of the poor quality of health care that women receive (Chattopadhyay et al., 2018). Such poor quality of care also includes violence.

### 5.3.2. Unconsented medical procedures

This theme is divided into three sub-themes: induction, episiotomy, and insensitive vaginal examinations.

#### 5.3.2.1. Induction

Two women reported that they were induced without any explanation or consent. Nkateko is the only woman who underwent a caesarean section and had an experience of being induced without any information or explanation.

> “I experienced a lot of pain. After three hours, they gave me more pills. They did not tell me anything. Then the doctor came and told me to change and prepare for theatre. I was asked to sign a form. Even then, I had no idea what the problem was. I called my family, and they asked if I agreed. I told them I am in pain so I will do whatever the doctor tells me to do” Nkateko.

Nyakallo also had an experience of being induced without any explanation or consent.

> "Mo ba fetsa go tjhela drip, leshoko le ba strong ka matla. A ba ntjheke. Ke moka ke ya kwa byalo gore di ya baba. Ba sena taba le nna. Mo ke kwa gore ngwana wa tjwa, ke mo ke bitsa nurse. O fore "tjhetjhisa o nsale morago. Ke sokola go phologa mpeteng, ga a nthushe. Mo ke fihla ka kua ke sokola go kalama mpeteng, ga a thuse go kalama. Mpeto wa gona o godimo. Ke moka ke palama ba re phusha. Ke fo bona a tseya skero ba nsega, ngwana a tjwa" Nyakallo.
>
> (After they put up the drip, I realised that the pain was getting stronger. They did not check on me. When I felt that the baby was near, I called the nurse. She walked into the room and instructed me to get off the bed and follow her to the labour room. She said I must hurry because the baby is close. I struggled to get off the bed. When I got to the labour room, I struggled to get on the bed. She did not help me. When I managed to get on the bed, she said I must push. She cut me with scissors and the baby came out.)

Nyakallo did not have any information about what was in the drip. In other words, she did not consent to the labour induction. The latter is a process of stimulating labour artificially by administering oxytocin or prostaglandins or by manually rupturing the membranes.[46] This is done to achieve vaginal birth for a woman not in active labour. Like other medical interventions, induction has its uses and risks. These include foetal hypoxia,[47] which can lead to death, cord prolapse, uterine rupture, and postpartum bleeding (Rydahl et al., 2019). World Health Organisation (WHO) guidelines on induction of labour advocates against the use of the procedure for the convenience of the healthcare worker where there is an absence of foetal or maternal complications.[48] The guidelines also recommend that the woman and her family must have a clear understanding of the indications, potential risks, and benefits of the procedure. The women who were induced were not given any information about the procedure.

[46] Managing complications in pregnancy and childbirth, World Health Organization, 2003.

[47] Hypoxia is a lack of oxygen. Foetal hypoxia is an inadequate amount of oxygen during delivery or immediately after birth.

[48] WHO recommendations: Induction of labor at or beyond term. World Health Organization, 2018.

#### 5.3.2.3. Episiotomy and suturing without anaesthesia

All the women, except for the woman who underwent a caesarean section, were cut without any explanation or consent. Some were sutured without anaesthesia.

> "Mo ba go sega ga ba go bulabudise. Mo ba go roka ga ba hlabe selo. O kwa nalete ge e hlaba nameng le mo ba goga hlale ya gona. Kore o fo loma meno gore ba fetse" Nyakallo.
>
> (When they cut you, they do not say anything. When they stitch you, they do not give you an injection for pain. You feel the needle and the thread through your skin. All you do is clench your teeth until they are done.)

After suturing of the perineum, women were not told how to take care of the wound. Neither was there any support for the women who had difficulty moving about in the ward.

> "After they stitched me, it was difficult to get on and off the bed. It was too high. I asked other women to help me. When I was discharged, they did not tell me what to do to care for the wound" Lesedi.

Some of the women reported that they were cut even after they have delivered babies. Those who had episiotomies mentioned that the wound takes a long time to heal.

> "Le lehono ga ke fole, ke sa na le pain. Mo ke lebelela ngwana ke kwa go baba gore ba fo nripa a se a le gona" Lesedi.
>
> (Even up to today, I still have pain. The wound does not heal. When I look at my child, my heart breaks because they cut me after he was already there.)

Even though routine episiotomies are discouraged, a study done with medical practitioners and midwives in KwaZulu-Natal found that the practitioners were reluctant to limit the number of episiotomies (Maphanga & Naidoo, 2021). Many of these are imposed as routine care without any prior information or consent. In this study, women were cut without any explanation or consent. Zaami et al. (2019) argue that episiotomy without consent constitutes a form of obstetric violence (Zaami et al., 2019).

#### 5.2.3.4. Insensitive vaginal examinations

All the women reported that midwives were insensitive during vaginal examinations. One was reported to have done a vaginal examination while talking and laughing with someone over the phone. Just like in other procedures, midwives did not explain and ask for consent before doing a vaginal examination. Women complained about the disrespectful attitude and cryptic communication that midwives use when they do a vaginal examination.

> "Buya, gibela, pfula milenge…kube mhunu wa kona ubusy hi phone. Se va ko holobela leswako mirhandza ku bhebhula. Se a ku holobela unga endlanga nchumu. Loko u ku "sister wa ndzi babisa," utaholoberiwa ngopfu. Se hi lo miyela. Uku cheka a khome phone" Khensani.
>
> (Come, get on the bed, open your legs… she speaks to you while she is busy on the phone. Then she shouts at you saying it is because you people like to give birth to many children. Then she shouts at you for nothing. When you complain that she is hurting you, she will shout at you even more. So, we just keep quiet.)

The development of the modern biomedical system where birth happens in a hospital has resulted in a situation where birthers are expected to consent to whatever test or examination the healthcare worker may regard as necessary. The result is an assumption that all birthing people will submit to the power of healthcare providers and consent to all procedures. In the quotes above, women were not asked to consent to vaginal examinations. In cases where the examination was painful, and the woman objected, she was scolded. Asking questions or refusing to comply often becomes a punishable offence. To protect themselves, women choose silence.

Kgaugelo also spoke about the way in which the woman is rendered invisible by healthcare workers. They focus on the birthing body, which they separate from the woman.

> "Bula maoto," a tjhele matsogo. Mo go kena doctor, se ke tjiba gore ke bule maoto. Mo a fetsiye se o ngwalangwala mo khateng a sa o bulabudise" Kgaugelo.
>
> ("Open your legs." Then they insert their fingers. When a doctor comes in your room, you already prepare yourself to open your legs. Afterwards, he writes in the hospital card without greeting you or looking at you.)

Unconsented procedures during childbirth are reported as a worldwide phenomenon. Where consent was obtained, like in the case of Nkateko, who underwent a caesarean section, it was nothing more than a signature on a form. All the above raises questions about *how possible is it to apply the requirements of the law in a country characterised by inequality, low literacy levels, and hospitals that do not allow women to practise their cultural beliefs?* In this study, women and healthcare practitioners speak the same languages. However, as outlined earlier, women reported that nurses do not treat them as human beings who deserve respect.

#### 5.3.2.5. Lack of care and support after birth

All the women interviewed complained about the lack of care and support after giving birth. After giving birth, Khensani was told to move from the labour room to the ward even though she was feeling dizzy.

> "I lost a lot of blood. The midwife asked me to stand, but I could not. I was weak. Another midwife brought me a wheelchair. Sometimes when you move around in the ward and you bleed on the floor, they shout at you and instruct you to clean the floor. Sometimes you cannot even walk. If your bladder is full and there is no one to help you, you crawl to the toilet" Khensani.

Nyakallo also shared her story of how she was treated after giving birth.

> "Mo ba fetsa o kwa ba re, "tseya selo seo" (ba era ngwana) o ye wardeng. Ke ngwana wa mathomo, aketjibi le gore ngwana o tshwariwa byang. A ke kgone go sepela, ke ya thothomela. Ngwana wa lla, aketjibi le go mo yangwisa. Ke butsisa gore ke yangwise naa, se ba ya nlakatsa. Mo o sa butsise le gona go fo tshwana" Nyakallo.
>
> (After delivering the baby the nurse said bring *that thing* with you (referring to the baby) and go to the ward. This was my first baby; I didn't even know how to hold a baby. I could not walk. I was shivering. The baby was crying, I didn't even know how to breastfeed. When I ask questions, they shout at me. When I do not ask questions, they still shout at me.)

Nkateko also shared her difficulty of taking care of her baby after surgery. In the absence of help and support from the nurses, women in the ward provided support for one another.

> "It was difficult to take care of the baby because of the pain of the operation. You are expected to get out of bed, carry the baby from the cot, and breastfeed. If they find that you have put the baby next to you in bed, they shout at you. Midwives just come to give you pills and take temperature. You get help from other women. They help you to get in and out of bed. The beds are too high, they are no good" Nkateko.

After her discharge from a hospital, Nkateko received quality postnatal care at home.

> "My mother in-law took care of me. She prepared a bath for me every day. She bathed the baby, cooked meals for me, and helped me with the baby when I was sleeping. I had a chance to rest. The hospital is a busy place. You cannot rest. There you are expected to bathe yourself and the baby. Sometimes they do not even bathe the baby after delivery. You are expected to do everything yourself. If you do not have energy to bathe your baby, you will come home with a baby who is not bathed" Nkateko.

Wisani confirms that the care of the mother and baby is different at home in comparison to the hospital. In her view, babies are more likely to survive when they are born at home.

> "I gave birth to four children, two at home and two in hospital. There is a difference between giving birth at home and in hospital. There is more care and support at home. In hospital you will be in pain alone" Wisani.

Guidelines for maternity care in South Africa spell out the functions of the midwife in providing the necessary care and support after delivery.[49] Recommended support focuses on monitoring the physical and physiological state of the woman and child. There is little or no focus on psychological, emotional, and spiritual care during and after delivery. Training of healthcare practitioners emphasises detachment from and objectification of the birthing body (van der Waal et al., 2021). The practitioners learn to fragment the body into various parts. In doing so, they fail to care for the woman in all her dimensions. As a result, van der Waal et al. (2021) argue healthcare practitioners become "professionals in the medicalisation of childbirth, instead of caring for people in childbirth physically and emotionally" (van der Waal et al., 2021, p. 37).

[49] Guidelines for Maternity Care in South Africa: A Manual for Clinics, Community Health Centres and District Hospitals. Fourth Edition. National Department of Health, Republic of South Africa, 2015.

#### 5.3.2.6. Abusive care

Even though the women shared stories of being neglected and mistreated during labour, none of them defined this as violence. The only time they used the word violence is when there was physical violence. Four of the women reported that they have witnessed violence against women during childbirth.

> "I have heard that nurses beat up women who are giving birth. There was this woman lying flat on the floor in the bathroom. I reported to the nurse, she did not care" Kgaugelo.

> "There was another woman who was left alone for a long time. She then went to the toilet; she squatted and delivered the baby. She was beaten up by the nurses for delivering in the toilet" Ntsako.

> "I once heard a woman crying after being beaten up by the nurses. They left her alone for a long time, they said they were not there when she was enjoying sex" Amukelani.

> "When you feel an urge to push you go to them. They tell you to go back to your room because you know nothing about childbirth. When the baby comes out in their absence, they assault you. They say you want to get them into trouble" Mapula.

In responding to the question, *what can we do to stop abuse of women during childbirth,* women had varying views.

> "Women don't want to report the abuse because nurses are protected by the law" Wisani.

> "Allow family members to be present when you are giving birth. This will stop nurses from beating up women. But sometimes they abuse you in the presence of your relatives" Kgaugelo.

> "Even though we can report them, nothing is going to happen. They have no respect for us" Nyakallo.

> "The best way of avoiding violence is to do everything that the nurses tell you to do so that you can deliver and go home as quickly as possible" Khensani.

> “What can we do? They will tell us that we are not educated. Nurses do not regard us as human beings. If you report and nothing happens, you must just come back when you are stronger and beat them up. The law will not help us with anything” Mapula.

In sharing her story further, Mapula narrated how she mobilised her sisters to beat up the nurses who mistreated her when she was giving birth at a local clinic.

> “When I gave birth to my other child, I went to the clinic. The nurse examined me, and she said I was in labour. Then she asked me where the baby’s clothes were. I told her they were at home and that I will call my husband to bring them. She forced me to get off the bed and instructed me to go home and get the baby’s clothes. I called my husband, he said I must not leave, he will come. I overheard one of the nurses saying, “Do you know this woman, call her back otherwise you are going to be in trouble.” They called me back, but I refused. I waited outside. My family came and confronted them. I went in to give birth. They left me alone the whole time. I gave birth on my own. The following day my sisters went back to the clinic to beat up the nurses. Luckily, those nurses were not there. We wanted to teach them a lesson called " Mapula".

Some of the women were discriminated against on the basis of their age or class. Lesedi, who was ridiculed for her poverty, was admitted for over a month at a local hospital for observation. She delivered her baby after ten months.

> “Ke dule kgwedi kamoka go fihlela ke belega. Mola o yetsele, ba re o yetsele, o nagana gore ke hotela mo. O tlele go tlo ja bushwa mo khwi. Wene o yetsele mola basadi ba belega ba sepela” Lesedi.
>
> (I was in a hospital for a month before I delivered. When they find me sleeping, they say “you are sleeping, you think this is a hotel. You are here for the food. You are here to sleep while other women come to give birth and go home”)

Forty-year-old Khensani was ridiculed by the young nurses for giving birth to what was described by the nurses as too many children. Similarly, forty-five-year-old Khutjo shared a story of being insulted by young nurses for being pregnant at what they perceived to be an advanced age.

> “Sa mathomo ba mputsisiye gore ke ngwana wa bokae? Ka re wa boraro. A re gaka, “ke kgopela o dire modiro wa ‘go mosadi, e tla re mo se o beyiye ngwana fase wa mpitsa.” Ka

mo fetola ka gore ba resa gore spetlele ke re buyiye fela. Batho ba tla mo spetlele ba tlo belega ba buya fela. Kare wa raloka. Mo se go baba ka matla, ka bitsa Sister ye mongwana a tle a nthushe" Khutjo.

(The first thing she asked me was how many times have I given birth? When I said this is the third time, she said, "You know the drill. You will call us when you have delivered the baby." I responded by saying, it is true that many women who come to hospital to deliver babies come home empty-handed. When the pain became intense, I called another nurse to help.)

Rude and disrespectful language was the norm. Ntsako shared a moment when the midwife told her to put that thing down (referring to the baby) when she wanted to take her temperature.

"Xibedlela kahle kahle kukhoma vanhu avaswikoti" Ntsako.

(Hospital staff do not know how to relate to people in a respectful manner.)

**5.3.2.7. Birthing position**

All the women interviewed gave birth lying on their backs. Unlike those who give birth at home, those who deliver in a healthcare facility are not given the option to choose a position they may prefer.

"Ge ba go beyiye mpeteng, o ka se gane. Ge o gana, ba go lakatsa." Khutjo

(Once they tell you to lie down on the bed, you cannot say no. If you do, they will scold you.)

Even though some were uncomfortable with the supine position, none asked if they could use an alternative position, such as kneeling or squatting. Those who had experience of giving birth at home mentioned that it is difficult to give birth when you are lying on your back. The biomedical model of childbirth has normalised giving birth in a supine position (Oliveira & Penna, 2017). Women who choose to give birth in healthcare settings adopt a supine position because healthcare providers instruct them to do so (Mselle & Eustace, 2020).

"In the hospital we do not have a choice. We do what they tell us to do" Mapula.

Henry (1998) argues that denial of choice of birthing position can be considered an unnecessary intervention for women who do not need to undergo medical procedures (Henry, 1998b). Giacomozzi et al. (2021) argue that denial of the birthing position of choice constitutes a form of obstetric violence (Giacomozzi et al., 2021).

#### 5.3.2.8. Hospital beds too high

The issue of beds being too high is a common feature in this study. Women who were in active labour shared stories about their struggles of getting on and off hospital beds when they were moved from the first stage to the labour room. Those who had just given birth complained about the same thing when they were asked to get off the bed and move to the lying in room. The same struggle of pain and discomfort of getting on and off the bed was also reported by women who had undergone medical interventions such as episiotomies or caesarean sections. None of the women was supported or helped by the midwives. Instead, women in the ward took care of one another. For instance, in the case where a woman who had undergone a caesarean section could not get out of bed to get her baby out of the cot to breastfeed, other women carried the baby for her. The same happened in the case of women who needed to get off the bed to walk to the bathroom. As indicated in Chapter 2, supine and lithotomy positions were normalised as a standard because of the medicalisation of childbirth. During the creation of lying-in hospitals, birth beds were ordinary hospital beds. From the mid-1800s, medical designers added leg harnesses and stirrups to obstetric tables. The main aim was to facilitate the interventionist nature of hospital delivery.

Lack of knowledge about Indigenous birthing rituals and practices

Even though some of the women did not have any information about childbirth rituals, they felt that there is value in learning about Indigenous practices used in the past to protect the mental, cultural, and spiritual well-being of the mother and the baby.

> “When you are pregnant, you carry your spirits and the baby’s spirits. Elders know rituals that they do at the beginning of the pregnancy and just before birth. Hospitals do not allow any cultural rituals. Families are forced to hide or suppress their cultural beliefs when they deliver in a hospital” Kgaugelo.

The women held varying views when asked about the benefits of a collaboration between biomedical and Indigenous midwives.

"It will not be possible. Nurses see themselves as better and more educated than elders. They do not see culture as a form of education. If we work with them, they are going to make us do all their dirty work" Mapula.

"Indigenous midwives have information that midwives do not know. If it is possible, they should work together" Amukelani.

"Mina loko vhaku kuna xibedlela xa xintu, antaya kona. Vhokokwana vha ku khoma kahle. Xintu xi famba amahlweni kundlula xibedlela xa vhalungu" Ntsako.

(If there were a hospital that caters for Black people's cultural beliefs, I would go there. When you deliver at home; elders will treat you well. Our medicine is better than white people's hospitals.)

Women who also had experiences of giving birth at home reinforced the need to learn more about Indigenous birthing practices.

"Older people are patient. Unlike giving birth in a hospital where nurses rush from one woman to another, Indigenous midwives have time for you. They are more human; they know what to do to calm you down. Patience helps to reduce fear and stress. Childbirth is not easy" Mapula.

"If I delivered at home, I would not have too many scars inside of me. Now, the stitch does not heal. And I can no longer carry heavy things. I am just a *skrep*[50]" Nkateko.

Overall, the stories shared reveal experiences of different forms of disrespectful behaviour legitimised by the superiority of the biomedical model of birthing. A study in South Africa reveals that such violence is normalised because of a lack of accountability from healthcare authorities and a lack of action taken against those who abuse women during childbirth (Jewkes et al., 1998). In this study, the power imbalance between healthcare providers and birthing women dominates the stories. Operating from a place of power, healthcare providers feel entitled to use violence to control, contain, and coerce women into compliance. Women who refuse to comply or raise an issue about abuse that comes in the form of various interventions, such as insensitive vaginal examinations, are punished for speaking out. In many ways, neglect is used as a form of punishment that serves to put birthing women in

[50] *Skrep* refers to her inability to do things for herself because of the long-term impact of biomedical birth.

their place (Chadwick, 2017; Chadwick, 2014; Kruger & Schoombee, 2010; Lappeman & Swartz, 2019). One key limitation of the study is that I did not interview healthcare providers to get a sense of their challenges, constraints, and limitations within which they provide care.

All the women I interviewed gave birth in public healthcare institutions that cater for poor Black women. Rucell (2017) draws attention to the dehumanisation of Black women's bodies in a biomedical system exported through colonialism and apartheid. Violence against women during childbirth in South Africa is therefore not just about healthcare providers exercising their power over birthers (Jewkes et al., 1998). It is violence that is traced back to colonialism and colonial conditioning (Rucell, 2017). By internalising racism, Black healthcare providers treat women who look like them as inferior and less human (Marks, 1994). Beyond the acts of omission or commission of healthcare practitioners, this is also structural and systemic violence legitimised by a State that upholds the superiority of the Western model of birthing at the expense of Indigenous models of birthing.

## 5.4. Women who gave birth at home

In this section, I present findings from interviews with ten women who gave birth at home under the guidance of Indigenous midwives. Eight reside in Mpumalanga and two in Limpopo. Except for one interview which was held in a *ndumba* (healing hut), all the interviews were held in the yard under a tree.

### 5.4.1. Naming the participants

Continuing with the practice of upholding respect as a key element of Indigenous research, once again, I introduce the participants with a few biographical lines. Because many of them are older compared to the group that gave birth in a hospital, I will use the prefix Mme with their names. Like many African words, Mme has multiple meanings. It is commonly used to refer to a woman or mother. In both instances, it is used as an expression of respect. Once again, I have used pseudonyms taken from Sepedi, Sepulana, and Xitsonga, which are common languages spoken in the part of Mpumalanga and Limpopo where I conducted the interviews.

Mme Ngoato is 43 and lives in Bushbuckridge, Mpumalanga. She works as a traditional healer and *gobela* (one who initiates other healers). She is the mother of four children, all born at home.

Mme Tebello is 60 and is from Morebeng in Graskop, Mpumalanga. She gave birth to nine children, one in hospital (first delivery), and the rest (including twins) were born at home.

Mme Mathapelo is 64 and is from Matibidi in Graskop, Mpumalanga. She gave birth to seven children, all born at home. Two died in adulthood.

Mme Ntiyiso is 68 and lives in Skukuza near Hazyview, Mpumalanga. She worked as a domestic worker all her life. She is the mother of three children, two born at home, and one in hospital. She lives with her grandchildren.

Mme Nhlamulo does not know her age and lives in Saselani in Bushbuckridge, Mpumalanga. She has never been to a conventional school. (I intentionally use the term 'conventional' for lack of a better English word to avoid using terms such as uneducated or formal schooling as if Indigenous institutions are informal.) She gave birth to 13 children, 11 at home and the last two in hospital.

Mme Mokgadi is 64 and is from Matibidi in Graskop, Mpumalanga. She is running her own catering/baking enterprise after having worked in the hotel industry all her life. She gave birth to two children all at home.

Mme Dipolelo is 64 and is from Matibidi in Graskop, Mpumalanga. She earns an income from selling arts and crafts at a local resort. She gave birth to three children, the first one in hospital and the other two at home.

Mme Makwena does not know her age and is from Klopper in Sekhukhune, Limpopo. She gave birth (including a breech birth) to eight children at home.

Mme Makgotso does not know her age and is from Klopper in Sekhukhune, Limpopo. She gave birth to one child at home. She lives with her children and grandchildren.

Mme Mabyala does not know her age, she lives in Matibidi in Graskop, Mpumalanga. She did not attend a conventional school. She gave birth to five children at home. She lives with her children and grandchildren.

### 5.4.2. Themes

Six themes emerged from this sample. These are: Presence during labour, Demedicalised care, Embodied knowledge of birthing, Go beya botsetse (postpartum care), Cultural safety and Humanised birth setting.

#### 5.4.2.1. Presence during labour

Women who gave birth at home shared stories of how elders present during labour. Such presence begins long before the onset of labour. Mme Ntiyiso mentioned that as soon as she passes seven months, her grandmother keeps an eye on her. After nine months, her grandmother shares a room with her at night.

> "Kokwana u etlela na mina. Nkari ungwanyana ndzitwa ndzi khoma yixirongwana le xikulu. Loko ndziku phapha, swi ta hi matimba. Se ndzi mo hlakahla ndziku sweswi se tiavuta. Se a pfuka a ndzihlola aku n'wana u le henhla kumbe tindlela a tipfulekanga kahle" Mme Ntiyiso.
>
> (When I was in labour my grandmother shared my bed. Sometimes I fall into a deep sleep, and when I wake up, I feel the intensity of the contractions. I would then wake her up and say I think it is time. She woke up and examined me and said either the baby is still high, or the path is not yet open.)

Being with a woman giving birth is also about giving the woman support, especially when she has no strength to push the baby out.

> "Ge o le swak, ba re o khuname. Kokwana a ka go pota ka morago a go tshwara ka magetla. O mongwe o go pota ka pele gore a tope ngwana. Sekere se gaufi, ba ripa lela le la, ke moka ba mo tata khubyana" Mme Makwena.
>
> (When you are weak, one of the elders will move to your back and support your shoulders while the other kneels in front of you, getting ready to receive the baby. Once it is born, they cut the cord and tie the stump.)

Mme Mokgadi shared the experience of witnessing her own daughter being neglected by the nurses even when it was clear that she was ready to give birth.

"Sepetlele ba go lesanya o le ntoshi. O fo phenduganya o le maponapona. A ba na taba. Gae bokokwane ba dula nago go fihlela o bofologa" Mme Mokgadi.

(At the hospital, they abandon you. You will keep rolling around in the bed, naked. They do not care. At home, our grandmothers will stay with you until you deliver the baby.)

All the women who gave birth at home mentioned that other women's presence helps to provide physical and emotional support. In a study that explored women's experience of what constitutes good birth in South Africa, presence was identified as a key element of good-birth narratives (Chadwick, 2019). The study makes a distinction between self-presence, which is a woman's presence and active participation in birth, as well as the presence of supportive others. All the women who gave birth with others mentioned that they were satisfied with how they were supported during labour.

#### 5.4.2.2. De-medicalised birth

The main thread in the stories of women who gave birth at home is that the body knows how to give birth. For that reason, there should be minimal intervention.

"Mmele wa moimana o tseba go belega" Mme Dipolelo.

(A woman's body knows how to give birth.)

"Ge o belegisa ke bokokwana, ba lesa ngwana a titjwele ka bo yena. Ga ba sware sware. Mola a wela fase, ba mo topa ba mo ncha lerere ka ganong. Kobo le yona ga ye senye nako. E fo te tjwela" Mme Mathapelo.

(When you deliver with our elders, they don't interfere with the birthing process. They allow the baby to come out naturally. The same with the placenta. They let it come out on its own.)

One of the women who had experience of giving birth at home and in hospital reported that giving birth at home was better than giving birth in hospital.

> "With my previous pregnancy, I first went to hospital; they said I was not in labour. They discharged me. There were many of us, we did not have money to go back home. I got a lift. After I got home, I went into labour. My mother-in-law asked if she should get a car. I said it is costly to hire a car to take you to hospital and when you get there,

they don't treat you well. My mother-in-law sent the kids to call my mother who did not stay far away. She arrived, made a fire, and prepared an herbal mixture for me. Two old women – my mother and my mother-in-law were my midwives. My mother in-law invoked the spirits of our ancestors while my mother supported me until I was ready to push the baby out. Once the baby was born, they started to ululate. They cleaned me up, prepared a bed for me, and I slept for hours. They took care of me and the baby" Wisani.

From the above, home birth differs from hospital delivery in various ways. Firstly, the birthing woman is taken care of by the same person/s. In Wisani's case, she was taken care of by her mother and mother-in-law. In a hospital, nurses change shifts. As a result, the woman is attended to by different women at different times. In addition, other personnel are involved in the delivery, for example, medical personnel, midwifery, medical students, and many other people and their machines. The focus of birth in a hospital is on extracting the baby out of the mother's body. There is little focus on the woman as a human being with fears, concerns, feelings, beliefs, and innate knowledge of giving birth. In contrast, as seen in Wisani's story, birth at home is like a rite of passage. This means the physiology, psychology, cultural, and spiritual dimensions of birth are incorporated in the midwife's care. For instance, hearing two women ululating after delivery made an indelible impact in Wisani's initiation into motherhood. It is part of spiritual maternity care. Postpartum care at home is also different from postpartum care in the hospital. Wisani was able to sleep for hours, knowing that her baby was in good hands.

#### 5.4.2.3. Free to choose birthing position

All the women interviewed preferred a squatting or kneeling position.

"Spetlele o belega mpeteng. Gae re a khuthama. Ngwana o tjwa gabutji" Mme Tebello.

(In a hospital you lie down, at home we squat with the back supported against the wall. It helps with pushing the baby out.)

"Le swi swa ku tlela swi hetana matimba" Mme Ntiyiso.

(Giving birth when you are lying down drains strength and power out of you.)

When they get tired, birthing women lie down to rest between the contractions. If they get weak, elders are there to support them. When contractions start, they either squat or sit up with back support.

Mme Ntiyiso shared her experience of witnessing a woman denied her preferred position during labour.

> "The woman wanted to squat. It was not her first birthing experience. Her body knows how to give birth. A squatting position is what her body knows. Nurses forced her to give birth lying on her back. Labour took a long time" Mme Ntiyiso.

Mme Mokgadi also shared the experience of witnessing a woman being denied the squatting position in a hospital.

> "One day, I accompanied a woman to a hospital. She wanted to squat when she was giving birth. It was not her first time giving birth. She knew what she was talking about. The nurses refused. She was forced to deliver a baby while she was lying on her back. Giving birth while lying on your back takes away your strength. It works against the body" Mme Mokgadi.

One of the reasons why women choose to give birth at home is the freedom to move around during labour instead of being strapped to a bed surrounded by machines. Women in this sample appreciated that they could choose their preferred birthing position instead of being forced to adopt the supine position by healthcare workers.

#### 5.4.2.4. Absence of unnecessary medical procedures

All the women reported that elders do not normally do a vaginal examination unless there is a complication. What they do is check the vulva to assess if the head or any presenting part is visible. They do not encourage pushing until the head has descended fully into the pelvis. Unlike in a hospital, waters are not broken artificially. They allow the process to happen naturally. Some of the babies are born in intact sacs.

According to Mme Ntiyiso, her grandmother only performed vaginal examinations if there were complications, for example, when the head takes longer to descend into the pelvis. Others mentioned that they did not undergo any vaginal examinations during delivery.

> "Aowa, rune ga re tjhele menwana ka mo sesading" Mme Tebello.

(We don't insert our fingers into the vagina.)

"Ga re tjhele menwana…Mmele o tseba go belega ngwana. Le metji a tithuba ka bo ona" Mme Mathapelo.

(We do not insert fingers… The body knows how to give birth. We don't break the waters as well; they break on their own.)

" Metji re ya emela gore a tithube. Mola a thubega, se re a tjiba gore namane e kgauswi" Mme Makwena.

(We wait for the waters to break on their own. Once that happens, we know that the baby is near.)

Unlike the group that gave birth in a hospital where water was broken artificially, elders allow the birthing process to unfold naturally. What elders do have is patience and time when compared to healthcare providers in a healthcare facility. The woman giving birth is the centre of their attention.

### 5.4.3. Embodied knowledge of birthing

The embodiment of birth speaks to the role that the body plays in giving birth. Medicalisation and the use of technology have taken over the role of the body in giving birth. The body in labour is defined in medical terms, with machines and professionals taking over the process of birthing.

Mme Dipolelo delivered her first baby in a hospital and two at home.

> "Wa mathomo ke mmelegele sepetlele. Babangwana ke te pelegisiye. Ke yadiye lesaka la thule, ka tseya lepayi le sheet ya kgale ka yala godimo. Ke moka ka kgothama. Ke fo theetsela mmele gore o nyaka gore ke dire ying, Ngwana a re phara! Be ke se ke beyiye dilo ka moka; legare, tlhale, metji. Kobo ya ngwana e tjwile go sena mathata. Ke moka ka ntsha ngwana lerere, ke ya mo tlema, ke ya se hlapisanya, ke ya se phuthaphuta" Mme Dipolelo.
>
> (I delivered the first one in a hospital. Others were born at home. To prepare myself, I made a floor bed by placing an old mielie bag, then a blanket, and an old sheet on top. I had already prepared scissors, cotton, and water. Then I squatted and listened

to what the body wanted me to do. Once the baby was born, I removed the mucus in the mouth and nose. The placenta popped out without any problem. I cut and tie the cord, then cleaned and covered it nicely.)

Mme Ngoato, who delivered four children at home, shared her interaction with midwives when she attended an antenatal clinic a day before her youngest daughter was born.

"MaNurse ba mpotsiye gore nko belegeng kgwedi e e tlang. Ke ba botsiye ka re se ke kgauswi. Ke moka ka ya gae. Boshigo se ke a kwa gore ngwana se o tseleng. Ke moka ke a itukisha. Ka belega ngwana. Ka m'tshwane se ke boyela kliniki ke re ga bona ngwana wa lena wa next month shu. Ba makele ka matla. Ke moka ke re ga bona, lune mo re tla kliniki le no fela le re lakatsa kganthe ga le di tjibe gore le rune re a di tjiba gore re make ying mo ngwana se a nyako segela" Mme Ngoato.

(Nurses told me that I will deliver the following month. I told them that I was near. They did not believe me. I went home. At night I could feel that the baby was coming. I prepared myself and delivered the baby. The next day I took the baby to the clinic. I said to them here is the baby who was supposed to be born next month. They were surprised. I said to them, the problem with you is when we come to the clinic you always shout at us. You don't know that we also have our knowledge. We know when the baby is near.)

Mme Makwena, who gave birth to nine children, reported that she has never set foot in a hospital.

"Nna go tlogeng ga ka, ke berekisa Sesotho. Ga e sa le ke belegwa, ashinki ke le gate kliniking" Mme Makwena.

(I believe in practising my own culture. Ever since I was born, I have never set foot in a clinic.)

Women who give birth at home also shared stories of dealing with complications. In one case, Mme Tebello gave birth to twins on her own.

"I delivered one baby and then the contractions did not stop. I did not know that I was carrying twins. I then squatted; the second baby came out. I cut their cords, cleaned the mucus out of their mouths, bathed them, and wrapped them up. I cleaned myself. We

then hired a car to take them to the clinic to be checked. They were healthy and well" Mme Tebello.

Similarly, Mme Makwena shared a story of a breech delivery at home.

"Ba ba seven ba tlile ga pila pila. O wa bo shupa ke ena o beng a ntlaba a tla ka maoto. Byanong shule ke mosadi o a ropota. Ke lethari o a ropota. A kere ka dikgoanyana tsa lena le re a ka se phele. O tlile ka maoto a re "sutlhu." Le byale o sa phela, ebile o bogadi" Mme Makwena.

(All the others were born without any complications. The seventh one is the one who came out feet first. She is alive. Isn't it that your Western beliefs say a baby born feet first at home will not make it? She is an adult now, she is married.)

Mme Ngoato is 40 and has delivered four babies at home. Her parents died when she was still young. Her grandmother taught her about childbirth.

"O mpotsiye gore ngwanaka wa di bona gore ga o na batswadi o chuwana, go nyaka gore o kgone go di emela ka se sengwana le se sengwana. O nchutisiye gore ke tsebe go tepelegisha ka gore motho o mongwana a ka fo tla a re wa thusa kganthe wa mpolaya. A re o tichutise go di makela" Mme Ngoato.

(My grandmother said, my child, you know you are an orphan. You must rely on yourself for everything. You need to learn to give birth on your own because other people may pretend that they are helping you when their real motive is to bring you harm.)

Mme Ngoato mentioned that she often works until the last day of her pregnancy.

"Mo se nako e segele, ke lokisha magare, dithapo, metji, ke yala kobo fase. Ke moka ke a kgothama ke a phusha. Ke moka mo se hlogo e tjwile, ke hlapa letsogo ke goga lerere gore ngwana a heme gabutji. Ke moka ke a mo phuthela. Ke moka ke tseya sekere ke a ripa, ke tseya thapo ya lesaka la thule ke a bofa. Ke moka ke dula godimo ga bakete ke ncha placenta. Morago ke hlapisa ngwana, le nna ke a tisolanya. Ke moka ke fatela placenta ka malobana" Mme Ngoato.

(When the moment comes, I prepare a floor bed. I get a razor, cotton, warm water in a basin, spirits, clothes, and blankets for the baby. When the baby comes, I squat and deliver the baby. Once the head is out, I pull the baby out gently. I wash my hand and remove the

mucus from the nose and mouth. Then I cut and tie the cord, wrap the baby and put it aside. To deliver the placenta I sit on a bucket and push it out. Thereafter, I bathe the baby and myself. In the evening, I perform a ritual to bury the placenta.)

Of the ten women interviewed, four opted to give birth on their own multiple times. Two of the women delivered their first babies in a hospital. Home birth in subsequent pregnancies is a choice they made shaped by negative birthing experiences in a hospital. Two women who gave birth to nine and four children respectively have never set foot in a hospital. They made a choice to deliver at home for reasons that include avoiding the possibility of abuse in a hospital, including unconsented vaginal examinations and episiotomies, as well as their belief in Indigenous birthing practices. For them, home birth is a safer option.

### 5.4.4. Go beya botsetse (postpartum care)

In Setswana, Sepedi, and Sepulana, the postnatal period is called go baya botsetse. Botsetse is a period of giving birth, including a few weeks or months after delivery, and is distinguished from *boimana* which refers to pregnancy. *Moimana* refers to a pregnant woman, while *motsetse* refers to a birthing woman. *Go baya botsetse* refers to postpartum care.

Care of the umbilical cord is regarded as a crucial task for a midwife. Bleeding is perceived to be a real danger. Women reported that the cord was cut with a razor and tied twice with a strong thread or cotton. In Mpumalanga, women mentioned using their fingers to determine the length of the cord cut and tied. In Limpopo, they mentioned measuring the cord length from the umbilicus to the baby's knee. Often, the cord is cut after the birth of the placenta, but if the latter is delayed, they cut the cord and clamp it to ensure that it does not go back into the mother's body.

The women emphasised the importance of ensuring the placenta is complete after birth. Mme Nhlamulo mentioned that it is also possible for the baby and the placenta to be born at the same time. Everyone was familiar with the danger of a retained placenta.

> "Ge o feditse go belega ngwana, sa bohlokwa ke go bona gore kobo ya ngwana e tjwile ka moka. Ba nyako se bona ka nnete gore se tjwile le gore se feletse. Ge e sa tjwe, ke kotsi e kgolo. Ba ka go fatela" Mme Mokgadi.

(Once the baby is out, elders must make sure that the whole placenta is out. They check it to make sure that nothing is left behind. If it is retained, it can cause a major problem. You can even die.)

One intervention that the women mentioned is that when the birth of the placenta is delayed, Indigenous midwives help the woman to squat or sit over a bucket and blow into a bottle.

The mother is encouraged to rest the body after the ordeal of childbirth. After bathing, she often sleeps as much as possible. Women reported that they were not expected to do household chores after childbirth.

"Ba go fagela metogo, wena ga o sware selo. O a khutja" Mme Mokgadi.

(They make sorghum porridge for you. You do not touch anything. All you do is rest.)

Food after delivery is also high in fibre. Because the body has gone through intense strain, some of the ensuing complications can include constipation. For women who had episiotomies, defecation can be painful.

"Ba yapeya motogo wa ngwahuba. Ngwahuba ke mohuta wa lebele. Ge ba setla ngwahuba ba tlhokola ka kika le motsho, ba fefera mmoko, ba hlaganisa mmoko le ting ba dira motogo. Lebele le thusa gore mosadi a ye ntle ga butji" Mme Ntiyiso.

(Elders cook porridge made of ngwahuba grain. When they grind the grain, they take the outer part and mix it with sorghum to make porridge. You eat the porridge with milk. This grain helps with regular bowel movement.)

New mothers are also supported by being taught how to hold, bath, and breastfeed the baby. They are also served nutritious food like *mabele* (sorghum) and *morogo* (wild spinach) which stimulates milk production. In some instances, women are given herbal mixtures to clear the womb and help with involution. In this study, women were reluctant to share the names of the herbs because of fear of biopiracy. 'Biopiracy' is a term used when multinational corporations appropriate medicinal herbs for profit (Ageh & Lall, 2019). Indigenous communities have been robbed of their knowledge of herbal medicine. My role as a researcher was to respect their views and feelings.

Other women shared that their families slaughtered a goat to welcome the arrival of the baby. The skin of the goat is treated to be used as a *thari* (cradle) to carry the baby. As far as the

isolation of the mother and the baby is concerned, the period differs from one cultural group to another.

> “Ke ntse ka mo ntlung go fihlela khubyana e wa. Ke moka re mo kota meriri. O tjea khubyana o hlakantsha le meriri le dihlare, re epa molete ka mo ntlwaneng ya go belega re a di epela. Ka Sesotho ba re ngwana o alafela ke mmane wa gagwe ka ngwakong” Mme Dipolelo.
>
> (I was isolated in a birthing room until the umbilical stump fell off. Afterwards, we cut the baby’s hair, mixed it with the stump and herbs. We dug a hole in the birthing hut and buried them. In Sesotho, they say a baby is fortified by its mother in the birthing hut.)

Other than allowing the mother to rest, this period protects the mother and the baby from infection.

### 5.4.5. Cultural safety

One of the most important reasons cited for home births is that mothers are free to practice their cultural rituals and practices. This includes the cultural belief that the first baby must be delivered in the birther’s childhood home in the presence of the pregnant woman’s mother.

> “Sesotho se re ngwana wa mathomo o mmelegela ga mmago” Mme Makwena.
>
> (According to our culture, the first child must be delivered at your childhood home)

This means a pregnant woman goes back to her ancestral home to deliver her first child under the care and supervision of her mother. Four of ten women returned to their ancestral home to deliver their first baby. Three were delivered by their mothers and one by her grandmother. Two of the women delivered their first child at their marital home under the care of the mother-in-law and sister-in-law respectively.

In this sample, two women helped their own daughters to give birth at home.

> “Bana ba ka ba belegishitje ke nna ka moka” Mme Makwena.
>
> (I helped all my children to deliver at home.)

> “Ke belegishitje ngwana wa ka. A belega monate, go sena mokgwa. Ka wa bofelo ne ke shitega ka lebaka la bolwetse, ka ba romela sepetlele. Ga a fihla sepetlele, a fihla a hlaka, ba be ba mo isha opreishene” Mme Makgotso.
>
> (I helped my daughter to deliver all her children. She delivered easily, with no complications. In her last pregnancy, I could not help her because I was sick. She had no option but to go to the hospital. When she got there, she suffered, they ended up sending her for an operation.)

Other key cultural rituals include care of the umbilical cord and placenta. The latter is viewed as a spiritually powerful organ which links the baby with the ancestors. It is buried in a secret place by the mother or grandmother. If the birthing woman does not have female guardians, she can bury the placenta herself. In the past, when births happened in mud huts, the placenta was buried in the same hut. A special ritual needs to be followed when burying the placenta. If the cord faces down, it is believed that this may affect the woman’s ability to give birth in the future.

> “O ka e ribega, mosadi a ka sa hlole a belega. O sa e kwale molomo. O e dudise gabutji ka mashago, molomo o lebelele godimo” Mme Tebello.
>
> (If you bury it the wrong way, the woman will no longer give birth. Make sure that you do not close its mouth. Make it sit on the ground properly.)

The timing of placenta burial is also important.

> “When you give birth at night, bury it before sunrise. When you give birth during the day, bury it in the evening” Mme Ntiyiso.

In other instances, the placenta may be used to heal the mother.

> “O ya ka leshakeng la dipudi goba la dikgomo. O tjea mmutele, o tjhela kobo ye ke moka o a ye gatela ka maoto ka mo ntlong. Ke moka mo o fetsiye, o a yepa gona ka mo ntlong o a yepela” Mme Mabyala.
>
> (Sometimes you can take goat or cow dung and fill up the placenta. Then you walk on it with your feet. Thereafter, you dig a hole in the birthing hut and bury it.)

Burying the placenta can also be done in such a way that the woman asks to conceive a baby of a different sex, for example, when you have girls only, you can bury it in a way that is a

request for ancestors to give you a boy or vice versa. Some women mentioned the danger of abusing the placenta for witchcraft. They also confirmed that they had heard of an underground trade of placentas between traditional healers and hospitals.

> "Di nyaka o belegisha ke motho ye o mo tshepang. Ba ka tseya ntlo ya ngwana o mathateng. Nna ke tjhutisiye bana ba ka go te pelegisa. Ge ba ka tseya kobo yela ba dira tsa go sa loka, o ka se tsoge" Mme Mathapelo.
>
> (It is important that when you give birth you are assisted by someone you trust. If they take the placenta to use in witchcraft, you are in trouble. I taught my own daughters what to do when they are faced with the possibility of giving birth on their own. If they took the placenta and used it to bewitch you, that's the end of you.)

The stories shared above indicate that the placenta is not just a blood-filled physiological sac that allows for the exchange of gases and metabolites between the mother and the foetus during pregnancy. All the women who chose to give birth at home spoke about the placenta as a sacred organ. Thus, the burial of the placenta and associated rituals are necessary to connect the baby with its ancestors, land, and heritage.

Overall, the stories shared by women revealed that cultural safety was important as a measure of safe birth. As a term, cultural safety was coined by a Māori nurse called Irihapiti Ramsden. In coining the phrase, her intention was to develop appropriate health services for Māori people (Jeffs, 2001). In understanding the concept of cultural safety, it is important to make a distinction between learning about other people's cultures i.e. learning about the other and exploring and reflecting on your own cultural make up as well as how such a makeup impacts on the service that you provide as a healthcare practitioner (Kruske et al., 2006). By understanding your culture, including your privilege, Ramsden (1993) argues, it is easy for health workers to understand rather than blame patients for historical origins of their deprivation, suffering and ill-health (Ramsden, 1993). Another important part of cultural safety is that once health workers understand their own personal culture, they have the intellectual and emotional means to review the impact of the dominant culture of their profession on women. Giving birth in a hospital can be a traumatic and frightening experience, it can put mothers and babies at risk (Wardaguga & Kildea, 2004)

### 5.4.6. Registration of births

Participants mentioned that women who give birth at home are required to go to the hospital or clinic after delivery, even when there are no complications. They also mentioned that nurses write in their register that the baby is delivered in a hospital and not at home. This means that other than visiting the clinic to be checked, mothers also go so that they can get the letter required for registration of babies at the Home Affairs Department. Given that many mothers depend on social grants, visiting the clinic for a letter may also be a matter of economic survival. If this is proven right, it would mean that a considerable number of babies are born at home but recorded as having been born in a hospital. This has implications for the accuracy of national birth statistics. There is a need for more research on this.

Other than the inaccuracy of statistics, one of the women lamented that current government registration protocols do not cater for Indigenous beliefs in relation to the care of the newborn, as well as in respecting rituals such as naming ceremonies.

> "I know many women who give birth at home, but afterwards, they take the baby to the clinic. You will not get a birth certificate if you do not have the letter from the clinic. In the past, you could even go when the child is a bit bigger because according to our culture a baby must stay indoors for two or three months. Now you must apply for a birth certificate within ten days. It is difficult to get a birth certificate when the baby is born at home. That is why there is a rule that if you deliver at home, you must go to the clinic or hospital. Nurses record that the baby was born in a hospital. The laws of this government are against our traditions. We are not allowed to observe rituals after giving birth because we must go to Home Affairs. We do not even have transport or money to go to the clinic. This government is the one that makes us break our cultural practices. So now a baby must go all over when the umbilical cord has not even dried up" Mme Mathapelo.

### 5.4.7. Medicalisation of childbirth as a site for obstetric violence

Of the ten women interviewed, three of them once gave birth in a hospital. Only one amongst those who once gave birth in a hospital reported a positive birthing experience. After delivering two babies at home, Mme Ntiyiso was forced to go to a hospital after prolonged labour.

> “I was in labour for a few days. I went to the clinic. They checked me and told me to go home. The next day the contractions were stronger. I went back to the clinic. My baby was born there. The nurse who delivered the baby was kind to me. She explained everything” Mme Ntiyiso.

Even though Mme Ntiyiso reported that she had a positive birthing experience in a healthcare facility, she also mentioned that she did not feel at home at the clinic.

> “It was my first time at the clinic after having given birth at home. It was not easy. It felt foreign to me. They did everything according to their culture, not mine. I could not ask to take the placenta home with me” Mme Ntiyiso.

Mme Dipolelo went to the hospital for her first delivery and she experienced mistreatment, which made her vow never to return to a hospital for delivery.

> “Wa mathomo ke mo swaretse sepetlele. Mmane a re ga ka:” Ke kgopela kuwa sepetlele sek’á ba le kgang wa fetolana le ma-nurse. Goba ba ya go tjipa, goba ba ya go lakatsa, goba ba ya go teya, o sa bulabula selo. Ge re belega nurse be e re tjipa. Taba ya go tjipa ke molao wa sepetlele. Yemongwana wa rune a yarabana le ma-nurse. O buyiye fela. Rune ka gore re be re tekgomolela, re buyiye le bana” Mme Dipolelo.
>
> (I delivered the first one in a hospital. My mother said “when you are at the hospital, don’t argue with the nurses. If they pinch you, or they shout at you, or they hit you, don’t say anything. When we delivered nurses used to pinch us. It is the law of the hospital. One of us answered back at the nurses. She went home empty-handed. Us who kept quiet returned with our babies; our babies didn’t die in hospital”)

Mme Dipolelo’s mother shared her experience of giving birth in 1957. This brings to light that obstetric violence is not a recent phenomenon. A woman who gave birth in 1957 told her daughter that she witnessed different forms of violence inflicted on birthing women. The daughter disagreed with her mother. She vowed that she would rather come home without a child rather than allow nurses to be violent towards her.

> “Ke mmotsiye ka re nna nka sa ba lese. Ke tlo tulana nabo. Nkampa ka buya fela” Mme Dipolelo.
>
> (I told her I am going to fight back. I would rather come home without a baby.)

Mme Tebello gave birth to her first child in a hospital and eight others (including twins) at home. She cites nurses' lack of care as her main reason for choosing to deliver at home after her only experience of hospital birth. She argues that if home birth is as risky as they say, then hospital birth is worse.

In contrast to the two stories shared above, Mme Nhlamulo delivered the first nine at home and the last two in a hospital. At the time of birthing her last child, soon after the death of her husband, she was suffering from high blood pressure.

> "I used to deliver babies at home. For my first pregnancy, my mother taught me, and helped me to deliver the baby. From the second baby onwards, I delivered the babies on my own. I did not like going to the hospital. I was afraid of being cut. Because when you get there, they tell you that you have complications even when there is nothing. And they cut you" Mme Nhlamulo.

Even though the women who gave birth at home did not experience violence during childbirth, they confirmed that the physical abuse of women in healthcare facilities during childbirth is common. Mme Mokgadi shared a story of how she witnessed her daughter being subjected to neglect while in hospital. Mme Ngoato said the reason she does not go to a hospital is because nurses are rude, and that some of them even assault the mothers. In her view, women react differently to labour. Some can take the pain in silence, and others cannot. Nurses must not expect women to behave the same.

> "Phela mashoko a batho a matshwane. O mongwane o tla kgohlelela, o mongwane o fo kreya a lla ka matla. Nurse e tshwanetse e tsebe gore batho ba fapaana, eseng go no fotsekisa motho. That is why batho ba nyako pepulela gae ka lebaka la ma nurse a go lakatsa. Ba babangwana ba ba teya. Ba go tlala ba belega ba le ntoshi ba kela ba le spetlele. Ngwana a ka no wela fase. Ba go tlala ba hwela sepetlele. That is why nna ke sa ye spetlele" Mme Ngoato.
>
> (Women react differently. Some take the pain in silence; others cannot take the pain. Nurses must understand that people differ. Some of the nurses shout at you. Others beat you up. Sometimes they will leave you alone for a long time. Many babies die in hospitals. That is why I do not go there.)

When asked the question, what can be learned from Indigenous midwives to counter obstetric violence, some said collaboration between nurses and Indigenous midwives will help to curb increasing levels of obstetric violence. Others felt that nurses will be against such a collaboration because their practice is not based on African cultural beliefs and practices. While they agreed that things might go wrong during a home birth, they insisted that there is value in learning from elders. This is necessary to cater for the physical, cultural, and spiritual needs of birthing women.

## 5.5. Conclusion

Women's experience of birth in a healthcare facility and at home reveals two different epistemologies of childbirth: biomedical and Indigenous. Women's experience of childbirth in healthcare facilities was characterised by feelings of abandonment, neglect, and unconsented medical interventions, such as episiotomy and induction of labour. Major themes were dehumanised care, unconsented medical procedures, abusive care, and lack of cultural safety. Women who opt to give birth in healthcare facilities do so because they need care and support. However, as seen in this study, many end up giving birth alone. This means that giving birth in a hospital is no guarantee that one will receive care and support. This explodes the common narrative that views healthcare facilities to be safer when compared to home birth. Unlike those who gave birth in a healthcare facility, women who opted for home birth under the care and supervision of elders shared positive experiences of childbirth. In the next chapter, I present findings from interviews with Indigenous midwives who were asked questions about their knowledge and practice of midwifery. The focus is to explore ways in which Indigenous midwives can counter obstetric violence.

## CHAPTER 6: Knowledge and practice of Indigenous midwives

### 6.1. Introduction

In this chapter, I present findings from interviews with eight Indigenous midwives. Two reside in Bushbuckridge, four in Sabie, one in Graskop, Mpumalanga. One lives in Magojaneng village in the Northern Cape between Vryburg and Kuruman. Elders were asked questions about their knowledge and practice of Indigenous midwifery, how and when they started to practise, the services they provide, the role and value of birthing rituals, as well as an exploration of how their knowledge can help to counter obstetric violence. All of them mentioned that they have been helping women to give birth for over ten years.

The following themes emerged: 1) training of Indigenous midwives, 2) care during pregnancy and labour, 3) postnatal care, and 4) violence during childbirth.

### 6.2. Naming the participants

Continuing with the principle of respect, I introduce the participants with a few biographical lines. Unlike the first two groups, I replace pseudonyms with totems. Totems are metaphoric expressions of identity represented by various animals, plants, and other natural creations. People with the same totem have an allegiance to their specific totem. To honour their totem, they learn about its characteristics and adopt some of its qualities as a guide in their lives. It is taboo to kill the animals assigned to you as your totem.

> "The choice of a totem (which may be an animal, bird, plant, or natural object) by a specific group or clan owes allegiance and loyalty to the physical environment. A specific totem is chosen by a group or clan for several reasons that are closely linked to the physical environment" (Makgopa, 2019).

Beyond clans, totems can also be chosen by a nation. For instance, the Shona people of Zimbabwe have a bird as their totem. The bird is used as an emblem in their national flag (Makgopa, 2019b). The adoption of totems is not limited to Africa. Many other Indigenous communities around the world have totems as their metaphoric allegiance and connection to the environment. I once worked with a Native American healer in Canada whose totem was a tortoise.

Because totems constitute a form of respect, there is therefore no need to put any prefix such as Mme or Gogo before the names of participants.

### 6.2.1. Mophuthing (*phuthi* is an antelope)

Mophuthing (*phuthi* is an antelope) is 60 and lives in Bushbuckridge, Mpumalanga. She is a mother of four children, three born at home and one in hospital. She was trained by her grandmother and mother, who have since passed on. The interview was done in her lounge.

### 6.2.2. Mokwena (*kwena* is a crocodile)

Mokwena (*kwena* is a crocodile) is 61 and is from Sabie, Mpumalanga. She has three children, all born at home. She stays with her youngest daughter and grandchildren. She was trained by her mother-in-law who also taught her about herbs. The interview was undertaken in the home of one of the local healers.

### 6.2.3. Monareng (*nare* is a buffalo)

Monareng (*nare* is a buffalo) is 60 and is from Sabie, Mpumalanga. She has five children, all born at home. She started to practise as a midwife by chance after she was called to assist a neighbour who was in labour. Before then, she had observed her mother and grandmother helping women to give birth. The interview was undertaken in the home of one of the local healers.

### 6.2.4. Motlhaping (*tlhapi* is fish)

Motlhaping (*tlhapi* is fish) is 70 and is from Sabie, Mpumalanga. She is practising as an herbalist. She mentioned that different healing herbs come to her in dreams. The interview was undertaken in her shack on the outskirts of town.

### 6.2.5. Mokone (clan name)

Mokone (clan name) is 77 and is from Matibidi village, Mpumalanga. She has five children, all born at home. Other than pension money, she earns her living by selling arts and crafts at a local resort. The interview was undertaken under a tree in the yard of the local community leader.

### 6.2.6. Motloung (*tlou* is elephant)

Motloung (*tlou* is elephant) is 59 and is a healer, herbalist, and midwife from Sabie, Mpumalanga. She started to practise as a midwife at an early age after being trained by her grandmother. She has five children, three were born in hospital and two at home. The interview was conducted in her *ndumba*.[51]

### 6.2.7. Motaung (*tau* is lion)

Motaung (*tau* is lion) is a healer and midwife from Bushbuckridge, Mpumalanga. She does not know her age. She gave birth to 12 children, nine were born at home and three in hospital. The interview was conducted in her yard under a mango tree.

### 6.2.8. Motshweneng (*tshwene* is baboon)

Motshweneng (*tshwene* is baboon) is 78, a healer and midwife in Magojaneng village, Northern Cape. She gave birth to nine children, including twins, all born at home with the assistance of her mother-in-law. She learned midwifery from her ancestors through visions and dreams. The interview was conducted in her *ndumba*.

## 6.3. Training as Indigenous midwives

Four of the elders were taught by their grandmothers, one by her mother, two by their mothers-in-law, and one learned the art of birthing through ancestral visions and dreams. Others started assisting births with the delivery of their own children's grandchildren. This was followed by assisting women in the community.

> "All my sisters, all five of them, were born at home. My mother was assisted by my grandmother. They invited me to be part of delivery so that when my time came, I already knew what to expect" Mophuthing.

Mophuthing's grandmother did not only prepare her for her own birthing experience. She was later trained to assist other women give birth.

[51] Healing hut

> “Sometimes she told me what to do while she was attending to the woman. I learned by observing her, by listening to her, and doing the things that she told me to do. She used to call me when she examined a pregnant woman. She could tell if the baby was near or far from being born” Mophuthing.

Motloung and Mokwena first learned from their own home birthing experience facilitated by their aunt and mother-in-law, respectively.

> “Mo ke thoma go belega, bommane be ba ile mashimong. Se ke a kwa gore byalo ke nako. Ke moka ka gata lepharo. Ka roma bana ba bitse mogatsa malome. O tlile a mpelegisha. Ke fo kwa se sengwananyana se se a hololа. Ke moka mo se ke belegiye, bokokwana ba ntjhutisa go belegisa” Motaung.
>
> (When I was in labour for the first time, my mother was in the fields. I asked the children to run and call my aunt, who helped me to deliver. In no time, the baby was wailing. Later, they taught me how to help other women.)
>
> *“*Ke tsogiye ke re ke ya moshomong. Mamazala a fo ntebelela a re dula gae. Morago ke mo a beya sponge, kobo le plastic mo godimo. A beya le di towel, metji, sesepa, sekere le hlale. Ke gore o mpone gore ke kgauswi. Mola ge ke tshwerwe ke leshoko, a nthusha gore ke belege ngwana. Ka moka dilo tse a reng ke di dire, ne ke di lebelela. E be e le training ya mathomo. Ka morago ke mo mamazala se a ntjhutisa go belegisa” Mokwena.
>
> (I woke up in the morning with the intention of going to work. My mother-in-law looked at me and told me not to go. This means she could see that I am not far. She prepared for labour, put out a floor bed, scissors, water, soap, and cotton to tie the umbilical cord. Later when I had contractions, she helped me to deliver the baby. I observed everything that she said I must do. I regard that as my first lesson. Later, she gave me more lessons.)

Two of the elders started to practise by chance. Monareng was raised by a mother and grandmother who helped other women to give birth. Even though she was not planning on following in their footsteps, one day she was called to help a neighbour who was in labour.

> “I was called to my neighbour’s house. The roads were bad after heavy rains. To get an ambulance you needed to walk a distance to a spot where the road was not so bad.

> What if the woman delivered while walking to the road to get an ambulance? We could not take a chance. I did everything that I saw my grandmother do when I was at home. The woman gave birth without any problem" Monareng.

Motloung was 22 years old when she facilitated her first delivery.

> "I used to observe elders helping a woman to give birth. One day my elders were absent and there was a woman in the compound who was in labour. I helped her to give birth, I cleared the baby's throat, I measured the umbilical cord with my finger – the same way that I saw my grandmother doing. I tied the umbilical cord twice. Just as she was giving birth to the placenta, my grandmother came back. She checked the mother and the baby and found that I had done the right thing. After we had cleaned up the baby and the mother, she taught me how to check the placenta and how to do the rituals. Afterwards, she started to give me lessons. She was very experienced" Motloung.

Motshweneng is 78 and has been practising as a midwife for more than 30 years. She delivered her nine children at home. She was taught by her aunt, who died long before she was born.

> "Ke rutilwe ke rakgadi yo o seleng a tlholegile ke ise ke bonwe. O ne a bua a re go tla tsholwa ngwana wa mosetsana mo lapeng mme e tla nna ngaka. Ke rutilwe ke mme o, o ne a mpontsha boteng ba mmele wa motho wa moimana. Le jaanong jaana, ba tlang ka mathata, ke lala ke bontshiwa gore motho yo o tsogang a tla ka moso o tla a ntse jaana. Pele motho a tla, ke setse ke montshitswe. Fa go na le bothata, rakgadi wa tlhagella a tle go nthusa" Motshweneng.
>
> (I was taught by my aunt who died before I was born. She once said a girl will be born in this family and she will be a healer. When she started to teach me, she showed me (in dreams or sometimes when I am just closing my eyes) the inside of the body of a pregnant woman from the beginning to the end. Even today, I see women who will come for a consultation the next day. I see their problem before they come to me. When there are complications, my aunt comes to help me.)

Some of the elders have some knowledge of herbs that was passed from one generation to the other.

"Nna ke thusha ka sehlare. Maybe mosadi o imile and o fela a kreya di miscarriage. Ke a kgona go mo tlema gore ngwana a gole" Mokwena.

(I help with herbal medicine. For example, if a woman has repeated miscarriages, there are herbs I can give to her which will ensure that the baby grows to term.)

Motloung was one of the three women who used herbs during pregnancy. According to Motloung, the ones who come early are those who have a problem of miscarriages, while those who consult her later in the pregnancy come to prepare for labour.

"Kune mbita le siiphekayo le ibopha sisu until 8 months. Na uthi 8 months, ngimunika umuthi wa ku khumula. Uma unatsha lomutshi u uma lapha emnyango. Angitshi sintu a sivumi ukutshi uma u ne sisu u ume e mnyango. Nyalo uma u natsha lomutshi o uma emnyango. Se ukhuluma nalo mtwana ukutshi angaphuma" Motloung.

(There are some herbs that we give to a woman who has a problem with miscarriages. When she is eight months pregnant, we give her another mixture, to open the birth channel. When she drinks the medicine, she stands at the door. Normally, it is taboo for a pregnant woman to stand at the door, but in this case, she must do it to communicate to the unborn child that it can come out.)

When asked about using herbs during pregnancy, Motshweneng said it is not necessary to use herbs if there are no complications. She also cautioned against using certain herbs if you do not know their side effects because you can cause complications.

"Fa motho a imile go sena mathata, ga go tlhokege gore a fiwe moriana go fitlhella mo dikgweding tsa bofelo. Fa motho a na le bothata ba go fetelwa ke mpa, a ka nosiwa moriana wa go tiisa mpa kwa tshimologong. Kwa morago a be a fiwa wa go bula ditsela. Fela botlhokwa ke gore meriana e mengwe e ka baka mathata. Jaanong batho bone ba e dirisa fela. Sekai, o fitlhela gore ngwana wa diega ka ntlha ya gore ga a ise a retologe gore a lebane le kgoro. Bana ba bangwe ba fitlha ba ema mo kgorong sebaka. O tshwanetse o laole pele, fa o fetsa o mo tlhatlhobe. O ka se neele motho meriana o sa itse gore go diragala eng ka fa teng" Motshweneng.

(There is no need to use herbs if the woman is healthy and the pregnancy does not have any complications. You can give some herbs if the woman has a problem of miscarriage. In the beginning, you give herbs to strengthen the body and pregnancy.

At the end of the pregnancy, from eight months, you give other herbs to open the way. The most important thing is for people to know the dangers of all the herbs they are using. You cannot just give herbs when you do not know what is happening in the woman's body. You must first check by divination and physical examination.)

Except for Motshweneng and Motloung, who also practise as traditional healers, all the Indigenous midwives interviewed mentioned that they are not paid for their services. Motloung charges ZAR 200 for antenatal services and ZAR 500 for helping women to give birth. Only a few Indigenous midwives offered some form of antenatal services that consisted of go sidila (pregnancy massage). Not all the elders interviewed performed massages. To them, it is a specialised skill.

"My mother knew how to massage the woman. She could tell the position of the baby by looking at the shape of the woman's tummy. If the baby is not in a good position, she would massage the woman for a few weeks until the baby turns. She would also know by the shape of the belly that the baby has turned" Mophuthing.

"Go sidila moimana ga go bobebe. O tshwanetse o itse methapo ya mmele. Moimana fa a le kgwedi di le pedi kgotsa di le tharo ga a sidilwe. O ka simolla ka kgwedi ya bone. Fa o sidila ga o tobetse fela ebile ga o phushe ditho tsa mmele. O sidila methapo ka fa thoko gore popelo yona e ipuse ka bo yona fa e le gore e kwa thoko. Le go retolla ngwana go ntse jalo. Tshidilo ga ya tshwanna go nna malatsi a le mantsi. O tshwanetse gore o tlogele mmele o ipakanye ka bo ona" Motshweneng.

(Massaging a pregnant woman is not easy. You need to know the ligaments that hold the womb. You only start with pregnancy massage from four months and not earlier. When you massage, you do not just rub or press anywhere. You start on the side massaging the ligaments so that the womb can move itself. The same principle applies when you want to encourage the baby to turn. Also, you must not massage too long for too many days. You need to give the body time to correct itself.)

Motlhaping mentioned that it is important to speak to the baby in the uterus when you do the massage. The baby begins to hear its clan names while still in the womb. Even though the massages are physical, speaking to the unborn child creates a spiritual bond between the baby, parents, and ancestors. This is aligned with the view of birth as a physiological and spiritual phenomenon.

From the above, training of Indigenous midwives consists of four steps:

- *Observation:* Observation of the actions of *grandmothers* or mothers or ancestral spirits
- *Theory:* Instruction given by grandmothers or mothers or ancestral spirits
- *Supervision:* Helping the woman to give birth under the supervision of the elder
- *Independent practice:* Supporting the woman to give birth on her own.

From the above, I conclude that steps used in training of midwives (biomedical and Indigenous) are the same. They involve observation, theory, practise under supervision, followed by independent practice. In Section 3.8.1, I outlined how the medicalisation of childbirth framed Indigenous midwifery as backward, unprofessional, and unsafe. Words such as uneducated or unskilled are used to describe Indigenous midwives. Extracts above reveal that Indigenous midwives have specialist knowledge based on experiential learning, which is based on practical tools to support women during childbirth and includes spiritual rituals. Other than learning through observation and doing, Indigenous midwives also believe that birthing knowledge is embodied knowledge. These are skills that biomedical midwives are not taught during their training. From the above, I have also shown how the biomedical model of childbirth was used as a colonial tool in Africa (Marks, 1994; van Heyningen, 1989). While feminists and birth activists continue to advocate against the medicalisation of childbirth and its impact on obstetric violence, there has been little attention on coloniality and its role in obstetric violence.

## 6.4. Care during pregnancy and labour

The care during pregnancy and labour theme is subdivided into the following: 1) preconception rituals, 2) preparation for labour, 3) support during delivery, and 4) management of complications.

## 6.5. Preconception rituals

According to Motshweneng, preparation for pregnancy and labour starts before the baby is conceived. In her view, a child is not just a physical body. It is also a soul. Before a woman gets pregnant, elders in the family would invoke the spirit of fertility on her behalf. In other words, the soul is asked to be born.

> “Bogologolo bagolo ba ne ba ya ko legageng ba kopa koo. Motlhomongwe legaga le lebane le seolo. Ba ka kopa le mo seolong. Mo malatsing a gompieno ngwana o sa ntse a kopiwa. Go ka nna ga diriwa secheso. Fa e le wena o kopelang mongwe thari, e tla re fa o phahla, o ka utlwa popelo ya gago e tlola. Wena mokopi o tla be o itse gore kopo ya ngwana e fitlhile” Motshweneng.
>
> (Old people used to perform preconception rituals at a cave or anthill. Currently, some people perform fire rituals as a way of asking for a child. The elder who is doing the asking may sometimes feel her womb move during the ritual. This could mean that the request for a baby has reached the ear of the ancestors.)

Pregnancy and childbirth are considered magical phenomena deeply rooted in people’s cultural and spiritual beliefs (Ohaja & Anyim, 2021). By inviting the soul to be conceived, elders honour the connection between women, birth, land, and spirit. In Setswana, the word womb is *popelo,* which comes from the verb *bopa* (to create). A person who creates is called *mmopi*. God is also called Mmopi in Setswana. Performing the ritual in a cave or anthill connects the living, the departed, and the unborn. The latter forms one of the key tenets of African spirituality.

### 6.6. Preparation for labour

Elders have diverse ways of counting the months. One way is to insert matchsticks in a thatch roof over the door at the full moon from the time of the cessation of periods. Once the sticks reach nine, elders start preparing for labour. In terms of the spiritual preparation of labour, two rituals were mentioned. One is a water ritual referred to as *go thuba mokgope*. It involves a process of breaking a calabash full of water as a signal that the family is ready to receive the new member. Another one is letting a chicken egg roll down a woman’s pregnant abdomen until it lands between her legs adjacent to the vulva. Once it breaks, the belief is that the baby is welcome into the world.

> “O nyaka lekata la kgogo, le theoga mo mpeng, ke moka mo le fihla go lebana le molomo wa bosadi, le a thubega. Ke moka o budiye” Mokone.
>
> (You can use an egg and let it roll down a woman’s abdomen until it lends between her legs. Once it breaks, we believe that the pathway is open.)

On a practical level, elders prepare a birth kit that comprises the essentials they will need. This includes wood to make fire, old blanket, sheet, and plastic to prepare a floor bed, water to bathe the baby and mother, disinfectant, scissors, and cotton to cut and tie the cord, towels, and baby clothes. In a case where the woman does not have running water, they ensure that there is enough water stored at home. Fire is an integral part of birthing for different reasons – to provide warmth, to boil water and herbal preparations when required, and to facilitate rituals that may require fire or ash.

Various signs of labour were mentioned, such as the breaking of water, bleeding, onset of contractions, and loss of appetite. Elders agreed that birthing women exhibit different symptoms. For instance, some do not experience the rupture of the water; others do not have severe contractions. One of the elders narrated a story of how she once assisted two women whose babies were born in intact sacs. It is believed that a baby born in an intact amniotic sac has a unique gift.

### 6.7. Support during labour

All the elders mentioned that they do not shave the woman. Neither do they give an enema before delivery. They also do not perform vaginal examinations except when there is a complication. Positions used vary between squatting, kneeling, or sitting up with back support. According to Mophuting, choice of position depends on the birthing woman.

> "It depends on the woman. If she is tired, she can lie down. Others lie on their side. Sometimes the woman can sit as a corner supported by the wall. Most of the time, I position myself in front of the woman and I tell her to hold on to me as if we are pulling together. This helps to give her strength to push. As soon as the head emerges, I focus on the baby. The first thing is to clear the baby's airway" Mophuting.

Based on interviews with women who gave birth at home and on interviews with Indigenous midwives, the kneeling position was the most common.

> "Go chechisa ka go kgothama" Mokone.
>
> (Giving birth in an upright position speeds up the process.)

All the elders allowed and encouraged the presence of birth companions.

> “If you give birth at home, other members of the family can be present to give you support” Mophuting.

Comparing her own experience of birthing in a hospital, Motloung said that the presence of family members at home is good for the birthing woman.

> “When you give birth in a hospital, nurses leave you alone for a long time. They give you a bell and tell you to ring it when you need them but when you do, they do not come. If they come, they will shout at you. If you are alone, who will help you? If there is someone close to you, they will give you support and courage” Motloung.

In contrast, Mokwena gave a description of an experience of giving birth at home with Indigenous midwives.

> “Bokokwana ba dula gaufi le wena, o mongwe a fela a hlola gore hlogo e fihlile gore o phushe. Babangwane ba go solanya, ba go bulabudisa. O ka sa kwalele mo o belega le bokokwana. A go na stitch” Mokwena.
>
> (Elders stay close to you. One of them will keep checking if the head is visible so that you can push. Others will wipe the sweat off your face whilst they talk to you and support you.)

Two or three women often support a woman giving birth. One is in front, holding her, encouraging her to push while watching for the head. The other woman behind her supported her. If there is a third woman, her role is to make invocations to ancestral spirits for the safe delivery of the baby. One of the elders confirmed that assisting a woman in giving birth is not an easy job because anything can happen. Once the contractions become strong, the birthing woman may become uncooperative. The role of the midwife is to be strong and firm.

> “Tsina uma sebeletisa ekhaya sikhuluma nawe kahle, ngiyakutshela ngitsi uyabona nyalo, ngilesikhatsi sokutsi sisebente. One mistake, simbulele lomntwana. Ubestrong, utolwa naye lomama, angitshi uva buhlungu” Motloung.
>
> (When we help a woman to give birth, we make her understand that with any mistake, the baby’s life can be in danger. The midwife must be strong because giving birth is painful.)

Motshweneng explained her process of supporting women in labour.

> “Fa ke bidiwa, ke simolla ka go laola. Ke be ke mo tlhola mo mpeng gore ngwana o robetse jang le gore a tlhogo e setse e ile kwa tlase. Morago ke a mo tlhola gore tlhogo e setse e bonala ka fa sesading. Fa e bonala, ke a mo tshegetsa ke mo thusa gore a phushe. Fa tlhogo e sena go tswa, fa go sena mathata, o tla bona ena ngwana a retologa gore legetla la kwa godimo le tswe pele. Morago mmele otlhe o tla be o tswa. O tabogela gore o mo ntshe tse di ka mo ganong. O tla utlwa jaanong a lla. Morago o a mo phuthela, le emela setlamorago. Ka nako di tswa gelyk, thata jang fa ngwana a belegwa ka kgetsana e e sa thubegang. Fa samorago se tswile, o ripa lelana, o le bofa gabedi” Motshweneng.
>
> (When I am called to assist a woman, the first thing I do is perform a spiritual divination. Thereafter I check the abdomen to see how the baby is lying and where the head is. I also check the strength of the contractions and whether the head is visible at the mouth of the vagina. If it is visible, I support the woman to push. Once the head comes out, if there are no complications, you will see the baby turning by itself to allow the shoulder that is at the top to be born first. After the shoulders, the whole body comes out. The first thing is to clear out the mucus. Then the baby starts crying. We make sure that the baby is well wrapped as we help the woman to push the placenta. Sometimes the baby and the placenta come out together, especially if the baby is born with an intact sac. After the birth of the placenta, you cut the cord and tie it twice.)

The umbilical cord is cut after the placenta has been born. Some wait for the pulsation to stop. If the placenta is delayed, the midwife cuts the cord and clamps it to prevent it from going back into the woman’s body. The cord is cut with various objects that include razors, scissors, the outer sheath of a sugar cane plant, or a sharp blade. The birthing woman must always ensure that they have a new razor to use during delivery. If not, other instruments like scissors will be boiled to sterilise them. To tie the cord, they use thread, hemp, strong cotton, or any strong plant fibre. The cord is tied twice. The midwives measure the length with their fingers. They first tie the part closer to the baby and then another tie furthest away before they cut.

### 6.8. Management of complications

Several elders mentioned that they had assisted women in delivering twins and/or breech deliveries.

> "Nna ke belegisitse matwin. Ba mpitsiye ba re se o ntshiye metsi. Ke moka ge ke segela ke mo hlola ke bona hlogo. Se ke mo dudisa gabutji gore a phushe. Se ngwana wa tjwa. Se ke bona gore go sa na le ngwana ka mpeng. Mo ke hlola ke a se bona, Se ke thusha mmane o gore a phushe futhi" Motlhaping.
>
> (I once helped a woman deliver twins. When they called me, they told me that her water broke. When I arrived, I examined her and found that the head was visible. I helped her to position herself properly and she pushed the baby out. As I was attending to the baby, I could see that there was something else in the belly. When I checked, I saw the head. She pushed out the other baby.)

Because of her extensive experience as an Indigenous midwife, Motshweneng encountered various complications.

> "Ke ne ke belegise mosadi o mongwe a imile ma twin. O mongwe o tlile a eme ka dinao. Ke bone fela ka maotonyana. Ke be ke mo tlogela ngwana a itswela. Morago ka fetola legetla gore magetla a seke a tswalela kgoro. Ngwana a be a belegwa. O mongwe o tlile sentle… Ka letsatsi le lengwe o mongwe o tlile ka maoto mme mabogo one a le kwa tlhogong. Bona, ha gone kene ka ipotsa dipotso. Sengwe sa re tsenya menwana, ka busa letsogo. Ke be ke goga le lengwe. A tla, gwa simolla legetla, ka le lere… Go ne go se bobebe. Re ne re le kgakala le spetlele" Motshweneng.
>
> (I once helped a woman give birth to twins. One was breech. I saw the little feet emerging. I left the baby to come out on its own. Later I grabbed the shoulder to make sure that it came out. This was followed by the rest of the body. The second one came normally… In a separate incident, I was confronted with a breach with hands on its head. Something said insert the fingers to release the hands. Later I aligned the shoulder so that the rest of the body can come out. It was one of the most difficult births. We were far from the hospital.)

In responding to the question, what do you do when women sustain perineal tears? Motshweneng mentioned that it depends on the degree of the tear. If it is small, she treats it

with aloe, and it heals on its own. If it is serious, she sends the woman to a hospital. Motshweneng is the only Indigenous midwife in the sample who has a collaborative working relationship with the local clinic and hospital. All the elders agreed that no one should take a chance and attempt to deliver a woman at home if there is a complication. In their view, a collaborative working relationship with the hospital is necessary. The biggest challenge was a lack of transport to take the women to a hospital.

> "Sometimes when you call an ambulance it comes late. By the time they come the baby is already born. We do not have a relationship with the midwives at the hospital. Referral is one way; we are the ones who refer women to the hospital as if we do not have any knowledge" Mophuthing.

Mophuthing also mentioned incidents of abuse of Indigenous midwives by biomedical midwives.

> "Many old women who work as Indigenous midwives also experience bad treatment at the hospital. When they take the baby and mother to a hospital to be checked they are abused verbally. They tell you that you must not bring your dirty work to the hospital" Mophuthing.

Negative attitudes and perceptions of Indigenous midwives by biomedical midwives is a well-researched phenomenon (Graham & Davis-Floyd, 2021b; Gurara et al., 2020b; Ngunyulu et al., 2020b). Interestingly, this negative framing of Indigenous midwives by biomedical midwives is not different from their colonial description as uninformed, dirty, unskilled, and a danger to society.

### 6.9. Go baya botsetse: Postnatal care

The most urgent thing, all the elders mentioned, is to clear the baby's airway so that it can breathe with ease. Following the cutting of the cord, the baby is bathed and wrapped in baby blankets. Breastfeeding is encouraged from the onset and the baby is kept close to the mother. A premature baby is smeared with a special oil and wrapped in castor oil plant leaves and kept warm. The Indigenous midwife may stay for a few days after the birth to support the mother and baby. The women interviewed confirmed that if the mother does not live too far, they often do postnatal visits. The aim of the visits is to check on the health of the mother

and the baby, as well as teach the mother to bathe and breastfeed the baby. Sometimes they also help with household chores.

It is the responsibility of the midwife to ensure that the placenta is complete. Thereafter, she hands over the placenta to the family. They decide on the best way to dispose of it, as guided by their cultural beliefs. Often, the grandmother has the responsibility of carrying out placenta rituals. Many grandmothers bury it; some grandmothers mix the placenta with herbs and others with ash before burial. While there were slight differences in rituals to bury the placenta, the most common is the secrecy of the burial place and ensuring that the placenta is buried facing up.

> "Bagolo ba ne ba re mosadi a ka tswalega ka ntlha ya gore thari ga ya epelwa sentle" Motshweneng.
>
> (Our elders used to say a woman can stop giving birth in the future if the placenta ritual is not done properly.)

The ritual of burying the placenta is believed to create a connection between the newborn and ancestors. It is also a process of centering the new baby on the land.

> "When they bury it, they speak to the ancestors for example, lona ba ga mang mang,[52] re tilisitse ntlo ya ngwana wa lona. In the past when there were no mobile phones, the place they buried the cord was like a telegram. When they want to communicate with you and you are far away, they go to the spot where the placenta and the dried umbilical cord stump was buried. Where you are, you will feel it in your navel. That is why they say bakubiza ngenkaba (they connect with you through your umbilicus). For example, if they want to tell you about death in the family, they go there. You feel it in your belly. When that happens, all you want to do is go home even when they threaten that you will lose your job, you just leave. When you arrive and they tell you about the death, you will then say I felt it in my blood" Mophuthing.

Elders also confirmed that these rituals can be misused to bring harm to others. That is the reason the burial place must not be known by everyone.

[52] Calling the clan names

*"*Khubyana ya motho e tshwana le lebitla la kgoshi. Ga le tsebe ke mang le mang" Mophuthing.

(The place where the stump of the cord and the placenta are buried is like a king's grave. It is a secret and sacred place.)

After birth, the mother and the baby are isolated for periods that range between two weeks to two or three months. The main reason is to allow the mother to rest and bond with her child. During that time, the mother and baby will undergo rituals that fortify and prepare them for life outside of the birthing hut. At the end of the isolation period, there is a ritual called *go ntsha ngwana ntlung* (taking the baby out of the baby hut and introducing them to the world). According to Motaung, this is often done at full moon. Children in the homestead are the ones who lead the ceremony. They are taught to sing the Moon song. As they sing the song, they pull the baby lying on a blanket or a traditional mat out of the hut. Elders ululate and supervise the children's performance in the ceremony.

"Kiriyeee, kiriyeeee mogwera wa go ke kgwedi. Kiriyeeee, kiriyeeee, mogwera wa go kgwedi… Bananyana ba tlhakela ngwana mo a tjwa" Motaung.

The key message of this song is that the moon is the child's best friend.

Families have different naming protocols. Some name them after their paternal or maternal grandparents. Others give babies names that reveal significant cosmic events that surround their birth. There are other babies who are said to cry for a specific name. When a baby cannot sleep and cries incessantly, the father is tasked with the responsibility of communicating with the elders to enquire about an appropriate name to give to the child. In certain cases, the family consults the diviner, who will then reveal the spirit after whom the baby needs to be named. Motaung shared a story of how one of her grandchildren was given the wrong name. The baby was crying non-stop, and her clothes were always damp with sweat. It turned out that she was supposed to be named after one of her great-grandmothers, who was a water healer. The baby settled after they had performed the naming ceremony.

Even though the midwife does not typically participate in the naming of the baby, Mophuthing argues that sometimes, if the name is negative, you can give advice.

> "When I helped a disabled woman to give birth, they wanted to give her the name Dikeledi.[53] I said to them, no, this is not the right name. We must celebrate that the baby is healthy. Why don't we give her a positive name? They wanted to call her Dikeledi because the mother suffered when she was pregnant. I said to them the baby's life is not known so we cannot assume that she is also going to have a difficult life" Mophuthing.

Overall, rituals are used to protect the mother and the baby. Many Africans believe that the baby has come from the spiritual world. By performing rituals, elders help the infant to connect to the ancestors.

### 6.10. Medicalised birth as a site for obstetric violence

Elders confirmed having heard stories of physical abuse of birthing women in hospital. Mophuthing narrated a story of how her daughter was abused during childbirth.

> "I remember the time my daughter was in hospital. The nurses were watching Muvhango[54] on television. When they went to check on her, they found that she had already given birth. They shouted at her for not calling them. What made me terribly angry is that they still cut her, even when the baby was out. I wanted to make noise at the hospital, but my relatives said it was no use because they had already done it. I wanted to ask them why they cut and stitched her because she gave birth on her own" Mophuthing.

Motloung also shared a story where a woman gave birth on her own in a hospital and the baby died. The community went on strike at the hospital, demanding that the baby be given back to the mother. Before then, the hospital took the baby away to hide the story and evidence of the injuries.

From what the elders said, it was clear that obstetric violence is not a new phenomenon. Rather, it is normalised as part of routine care. Many women collude with the normalisation of this violence. Framed within the belief that women must *bekezela* (endure pain like real

[53] Meaning tears.

[54] Local television series

women). Many women grit their teeth to prove they are strong women and suffer in silence until they are discharged. The focus is going home with a healthy child.

To respond to increasing levels of violence during childbirth, elders recommend collaboration between Indigenous and biomedical midwives.

> "We can learn from one another. The problem comes when they think they are the only ones who must teach us. Birth is not just about a baby coming out of a vagina" Mokwena.
>
> "The problem is the hospital is based on white people's culture. Young nurses in our hospitals are not interested in their culture. Futhi these young ones, they are ones who have no respect" Mophuthing.

Motshweneng outlines what they can teach biomedical midwives.

> "Ee, ke nnete, baoki ba betsa bomme ba belegegang. Bontsi jwa bone bo tla kwa go nna ka ntlha ya gore ga ba batle go bediwa kwa sepetle. Fa o le mmelegisi, o tshwanetse o itshokele motsetse. O dula le ena, o ntse o mo lekola. Gongwe ba bangwe ba tshwerwe ke tlala kgotsa lenyora. O mo direla motogonyana kgotsa ditlhatlego. Baoki ga ba tshwanna go fella batsetse pelo. Batho ba belega ka mekgwa e farologaeng. Bothata ba sepetlele ke gore ga gona nako, batho ba dula ba le mo lebelong ba lelekisitse madi. Jaanong ga ba kitla ba belegisa motsetse sentle" Motshweneng.
>
> (It is true, nurses beat up women in hospitals. Many of the women who come to me do not want to go to hospital because they are afraid of being beaten. If you are a midwife, you need to be patient. The problem is in the hospital there is no time. Everyone is always in a rush chasing profit. It is a business so there is no time to focus only on one woman.)

The shift of birth from the home, where birth was a sacred social event attended by other women, to a hospital, where birthers are subjected to machines and healthcare practitioners contributes to the dehumanisation of childbirth (Davis-Floyd, 1994). The medical construction of birth as a pathology has been instrumental in maintaining medical hegemony over birthing. In South Africa, healthcare is starkly divided between private and public sectors. Most beneficiaries of private healthcare are affluent members of society with healthcare insurance

(Burger & Christian, 2020). In the case where the driver of healthcare is profit, there is a greater chance that women may be subjected to neglect and mistreatment.

Motshweneng also warned against the long-term psychological impact of violence during childbirth.

> "Jaaka o betsa mmagwe, ngwana le ena o a utlwa. O a tshoga a be a boela ka fa teng. Fa mme a nna le letshogo, le ngwana wa tshoga. Jaanong bana ba belegwa ba na le letshogo. Ga go a siama ka ntlha ya gore ngwana o tla tshela ka letshogo go ya go ile. Fa o le mmelegisi, o itse gore o na le seabe mo tlhakatlhakong ya lefatshe ka go betsa motsetse" Motshweneng.
>
> (As you beat up the mother, the baby can feel it too and this ends up in fear. When the baby gets afraid, it is reluctant to be born. When the mother is afraid, the baby will also be afraid. So, this means many babies are born with fear. If you are a midwife and you beat up a birthing mother, you must know that you contribute to a sick society because babies are born with fear.)

According to Motloung, midwives in hospitals must be taught about the psychology of birth.

> "Giving birth is a powerful thing that you cannot explain. God created a woman in the most amazing way. To give birth to a full human being is a mystery. Yes, we know how it happens but when you think about it deeply, you cannot find an answer. When you give birth, there is something in your mind that must shift for you to push the baby out. It is a mystery; it is as if you live in this world for a few seconds. Nurses must be taught about this" Motloung.

The altered state of mind referred to in the above quote is a normal adaptive brain function which occurs during normal birth. This adaptive brain function makes it possible for women to deliver successfully (Dahan, 2020).

To counter obstetric violence, elders advocate for a model of care that cares for the totality of being through body, mind, and soul. This calls for a different epistemology of birthing that combines the need for physiological, cultural, and spiritual safety. Risk is not only limited to 'safe' physical death. It also includes preventing the loss of cultural and spiritual ways of being in the world for mothers and babies. Within an Indigenous model of birth, birth is a

physiological, as well as cultural and spiritual rite of passage. The role of the midwife extends beyond catching the baby to providing psychological and spiritual support.

### 6.11. Conclusion

In this chapter, I presented findings from interviews with Indigenous midwives. This chapter helps to deepen our understanding of Indigenous epistemology of birth that perceives birth not only as a physiological phenomenon but as a social, cultural, and spiritual event. In this regard, the role of Indigenous midwives expands beyond catching babies to that of leading an array of pregnancy, childbirth, and postnatal rituals and ceremonies. In their support of women, Indigenous midwives provide holistic care from preconception, pregnancy, delivery, and postpartum. Elders confirmed that they had heard stories of physical abuse of women during birth.

The shift from home to hospital contributed to the dehumanisation of childbirth (Davis-Floyd, 1994). The medical construction of birth as a pathology has contributed to enforcing and maintaining the medical hegemony over childbirth. The question that arises is*, is obstetric violence embedded in the biomedical model of childbirth?* In other words, *is it possible to call for interventions to reduce obstetric violence without dismantling the biomedical model of birth that was exported and used as a colonial tool in Africa?* These and other related questions will be discussed in detail in Chapter 8.

In the next chapter, I present a reflexive review of my research journey. The aim is to share my positionality as a researcher, how I impact the research, how the research impacts me, including key lessons and moments of vulnerability and enlightenment. Overall, the chapter is aimed at dissecting the idea of ancestral knowledge of Indigenous midwives as knowledge to learn from to counter obstetric violence.

**CHAPTER 7: Struggling to be re-born: a reflexive review of my research journey.**

*Figure 10: Conducting interviews under a mango tree, Bushbuckridge, Mpumalanga*

## 7.1. Introduction

In the previous chapters, I presented findings from interviewing 28 women (ten who gave birth at a healthcare facility, ten who gave birth at home, and eight Indigenous midwives). In this chapter, I present a reflexive review of my research journey. The purpose of this chapter is two-fold: 1) to outline my positionality and its impact on the study, 2) to give an account of how I was impacted by the study, 3) to share discomforting and enlightening moments of the research journey, and 4) to share lessons learned from an extended, in-depth conversation with an elder whose ancestors and mine conspired and made it possible for us to interact over a period of two days.

I begin the chapter by navigating my positionality. The term 'positionality' describes an individual's worldview and the position they adopt in the research process (Holmes, 2020). Researchers should be aware of their own situatedness (Dinçer, 2019). This involves being conscious of one's positionality and how such positioning affects the research process and outcome. By weaving my own story as a biomedical midwife who was trained in a missionary hospital during apartheid South Africa with my interaction with Indigenous midwives, I navigate the discomforting tension of inhabiting two worlds in opposition: African spiritual and Western medical. Building on the work of Pillow (2003) and Chadwick (2021), I reflect on

some of the embodied discomforts that arose during my research journey (Chadwick, 2021; Pillow, 2003). In writing about "discomfort as epistemic resource" (Chadwick, 2021, p.559), Chadwick (2021) argues that discomfort and disconnection help the researcher to reflect on how feelings can be conceptualised as methodological tools. These reflections of discomfort occur when practising reflexivity during full immersion into irresolvable dilemmas that come with the production of knowledge (Pillow, 2003).

The biggest challenge faced by Indigenous researchers is to be caught between two research paradigms (Wilson, 2008). Scientific knowledge is embedded within European imperialism and colonialism (Rewi et al., 2022). In contrast, Indigenous paradigms have ontological, epistemological, and axiological assumptions that emanate from Indigenous people's cultures, histories, philosophies and lived experiences (Chilisa et al., 2017).

> "Navigating scientific research is a complex journey unique to every Indigenous scholar" (Rewi et al., 2022, p. 8).

Because research privileges Western knowing, Indigenous researchers face the challenge of dual purposes. Firstly, Indigenous researchers need to convince the academic community about the value of Indigenous knowledge, and secondly, they also serve as advocates against the hegemony of Western theoretical discourse (Rewi et al., 2022).

After writing about my positionality within a specific historical and cultural milieu, I reflect on my insider-outsider status within the context of an Indigenous research framework. The chapter ends with sharing the outcome of an in-depth interview with one of the elders who was not on my original list of interviewees. At the end of my data collection process in Mpumalanga, a Facebook friend referred me to an Indigenous midwife who lives in the Northern Cape. Even though she lives far from my initial site of research, I travelled over 1200 kilometres round trip to spend two days with her in Magojaneng village near Kuruman in Northern Cape. Listening to her narrate her experience as an Indigenous midwife was like paging through a midwifery textbook. The encounter was one of the highlights of my research journey.

## 7.2. Who am I as a researcher?

The principle of reflexivity allows the researcher to respond to the questions: *Who am I? What values do I bring to this project? How do I impact the research?,* and *how does the research*

*impact me?* (Lederach, 2016). By answering the question, *Who am I*? I attempt to situate myself and this study within a particular historical context in South Africa.

I was born at Holy Cross Nursing Home, a Catholic nursing home in Lady Selborne, Pretoria. Lady Selborne was a portion of a Pretoria farm purchased by a coloured[55] syndicate. Named after Lady Beatrix Maud Cecil, the wife of Lord Selborne, who was Governor of the Transvaal and Orange River until 1910, Lady Selborne was established in 1905 as one of the few freehold townships where Africans could own land (Kgari-Masondo, 2008). The question of access to land in South Africa is described as one of the key cornerstones of apartheid, which began with white colonial land dispossession in the Cape Colony. Even though the Native Land Act of 1913 is commonly known for land dispossession, there are many other acts, which were instrumental for land dispossession.[56] For instance, the Glen Grey Act of 1894 which was drafted by Cecil John Rhodes and his secretary William Milton, introduced tax for African men to force them to work on white farms. This Act came about because of Cecil John Rhodes' speech in parliament in 1894.

> "Every black man cannot have three acres and a cow, or four morgens and a commonage right. We have to face the question and it must be brought to them that in the future nine-tenths of them will have to spend their lives in daily labour, in physical work, in manual labour."[57]

One of the goals of land dispossession was to destroy African autonomy and entrench racial capitalism. More than a century after Cecil John Rhodes' speech, the situation of African men and women has not changed much.

In Lady Selborne in 1914, a year after the passing of the Native Land Act of 1913, a concession was made by the Secretary of Justice to transfer portions of the land to Berliner Missionsgeselschaft. This allowed for missionary-aided projects in the area (Kgari-Masondo,

[55] During apartheid, people were divided into three groups: Europeans (white people), Indigenous people (Africans or Black people), and coloured people (mixed race people).

[56] SA History. www.sahistory.org.za.

[57] The Glen Grey Speech. A transcription of Cecil John Rhodes' speech on the Second Reading of the Glen Grey Act to the Cape House Parliament of July 27, 1894, p. 8 www.sahistory.org.za.

2008). Holy Cross Nursing Home was established by the Congregation of the Sisters of the Holy Cross in 1932 in a tin shack that served the Lady Selborne community. Other than providing health care, including maternity services, Holy Cross became one of the training sites for Native nurses. By introducing Western biomedicine, the Congregation of the Sisters was part of the government's strategy of breaking down the resistance of Indigenous people (Marks, 1994).

My mother grew up in Lady Selborne, where my grandparents, Horphen Ramatlhodi Tladi and Hermina Mamoabi Tladi (née Setshedi) owned a piece of land at 394 Alexander Street on the corner of Achilles. My grandfather was born in Makapanstad and later purchased land in Lady Selborne in the 1930s, where he lived until his premature death in 1946. It was a sudden death. He was killed by *ga le phirime,* a potion commonly used in beer. My grandmother Mamoabi was born in Makapanstad in 1894, the same year that Cecil John Rhodes made the speech cited above. When they moved to Lady Selborne, she worked as a domestic worker in Pretoria West. She died of a stroke in a taxi on her way to work at the age of 73. The thought of my grandmother dying in a taxi on her way to work is a stark reminder of the origin of domestic work during the colonial era when enslaved women were used as servants. Later, this became work, even though the workers themselves were not protected by any legislation. Adult African men and women were called boys and girls respectively. Even though they were not allowed to stay in the cities, they could only be there not as full humans but as pairs of hands needed to service the wants of the white population. My maternal ancestral lineage includes Maretela, totem crocodile; Setshedi, totem monkey; Tladi, their original totem was an elephant, which later changed to warthog.

My father, Rantebo, was born in Kgomo Kgomo village in North West and was the youngest son of my grandmother, Mmatshilo Motsei (née Moloisane) and my grandfather, Ramoloi Motsei. My grandmother's mother, Mankoko Matlala, came from the Matlala royal house in Limpopo. She married Ramogomotsi Moloisane, my great-grandfather. My ancestral lineage on my father's side is Matlala, totem swallow; Moloisane, totem cow; and RaMotsei, a Manyane, totem baboon.

> "Mogolo kenosi wa ba Manyane maya bokgolwa go ya go tlhama lesika la ba RaMotsei. Ke kgakgathiba ya bo Serake serakalela letsibogong la bo Nkoto. Setlola mafura a phofu, mafura a kgama, mafura a sebata segolo ntswe a tshwene a le teng. Setlola

> mafura a motlhouwane a ntseng le a tlola mekokotlo pale badidi ntswe a tlola ke poo Ramokololo" Manyane.
>
> The paragraph above, which is untranslatable, is an excerpt from my family praise poem. It is not just a poem. It is a historical account of where my people came from.

Often, when you engage with elders and they ask you a question, 'who are you?,' they are not asking 'what is your name?' They are interested in your identity expressed through your totem and family praise poem that delineates your lineage. It pleases them to hear you quote surnames and totems that link you to your origins.

My mother, Boitumelo Motsei (née Tladi), was also born in Makapanstad in 1933. She moved to Lady Selborne with her parents when she was young. Later in her adult years, she trained as a nurse and midwife. This means that by the time she gave birth to me, she was already trained in biomedical birthing practices. It was therefore only natural that she would go to Holy Cross Nursing Home for delivery. Like all mothers who give birth in healthcare facilities, she followed Eurocentric birthing rituals and ceremonies. Davis-Floyd (1990) argues that the technological biomedical model of birth enforces obstetric rituals designed to make birth appear safe through technological means. In her view, the response of the science of obstetrics has been "(1) to work out carefully a strong consistent philosophical rationale for the management of birth which interprets birth specifically and exclusively in terms of the technological model, and (2) to develop a set of ritual procedures which could be uniformly applied to the natural process of human production, similar to the production of any other technological artefact" (Davis-Floyd, 1990, p179)

After she gave birth to me, my mother did not take the placenta home. The biomedical model of childbirth classifies the placenta as medical waste. Yoshizawa and Hird (2020) reported that there are over 50 million kilograms of human placenta material produced annually worldwide. (Yoshizawa & Hird, 2020). The common form of disposal is incineration. However, research shows that placentas are used for scientific research purposes.

> "At one of the hospitals where we conducted our study, we observed that a research coordinator monitors the caesarean-section schedule, identifying soon-to-be-delivered placentas, and notifying researchers via email. If they really want to ensure that they get a placenta, researchers wait outside the operating room. Once birthed, medical staff place the placentas in a basin, and then double-bag them in clear plastic. A sticker placed on the bag indicates the birthing patient and her identifying information" (Yoshizawa & Hird, 2020).

By defining the placenta as medical waste, Yoshizawa and Hird (2020) argue that the medical and scientific community do not see any need to seek informed consent to use the placenta for research (Yoshizawa & Hird, 2020). In most cases, a woman's privacy and anonymity is also compromised.

In contrast to medicalised childbirth, an Indigenous model of birth views the placenta as a sacred organ necessary for spiritual centering of the newborn (Motsei, 2022; Naidu, 2013; Ohaja & Anyim, 2021; Simmonds, 2017). In the previous chapter, women who gave birth in a hospital mentioned that they did not ask to take the placenta home for various reasons: some did not know what to do with it, others did not know that they could ask for the placenta, the rest mentioned that the Western medical system would not allow them to perform any childbirth rituals. Those who chose to give birth at home mentioned that they prefer to bury their placenta at home as a way of centering their children to the land. In my case, my mother did not take my placenta home. This means my original home was not buried in the land in which I was born. Now the question I ask myself is *do I feel I belong to this land even though my placenta was not buried in it?* My answer is yes. I was fortunate to be born in a family of spiritual healers. My aunt, Mme Morongwa, a spiritual teacher, and healer, helped to centre me to the land by teaching me various rituals and later passing on the daunting duty of continuing with the family legacy of healing.

Other than being born in a Catholic nursing home, I am a product of an education system founded on Hendrick Verwoerd's mission of limiting the Black child to being "hewer of wood and drawer of water."[58] Founded on the Bantu Education Act 47 of 1953 during apartheid,

[58] https://www.sahistory.org.za

the aim of Bantu education was to entrench racial segregation, as well as train the native to serve the master. In his speech in 1954, Hendrik Verwoerd outlined this intent.

> "There is no place for him in the European community above the level of certain forms of labour. Within his own community, however, all doors are open. For that reason, it is of no avail for him to receive a training which has its aim of absorption in the European community, where he cannot be absorbed" (Quoted in Christie & Collins, 1982, p. 68).

As a psychology and sociology scholar who once served as Chair of Psychology at Stellenbosch University,[59] Verwoerd understood what Steve Biko spoke about many years later, that "the most potent weapon in the hands of the oppressor is the mind of the oppressed" (Biko, 2004). Decades after the passing of the Act, education in post-apartheid South Africa is still not geared towards the mental, cultural, and spiritual liberation of the African child. Eskia Mphahlele was one of the educationists (Mphahlele, 2010) who went into exile in the late 1950s because of his opposition to Bantu Education. When he returned in the 1990s, he found that nothing much had changed.

> "White institutions have been traditionally preoccupied with conserving 'standards' of Western civilisation and/or a tribal culture. Outside of institutions, Black and whites have been preoccupied with surviving each other, with whites dictating the terms and rules of the game all the way" (Mphahlele, 2010, p. 41).

After writing my Matric at Hebron High School in Pretoria North, where I was taught by white teachers, I trained as a nurse and midwife in a Swiss Mission Hospital in the then Transvaal province. In hindsight, I am disturbed that I was trained to disregard the birthing knowledge of my elders and uphold the colonial narrative that positions biomedicine as superior and the hospital as a safe place to give birth. As I weave together these colonial layers of being born in a Catholic nursing home, being a product of Bantu Education, being trained as a nurse in a missionary hospital, and undertaking research with Indigenous midwives, I am aware of my painful journey of self-reflection.

There were moments in the research journey where I was caught between a colonised midwife, and a decolonising one, all in one person. This state of intense discomfort was

[59] Ibid

triggered by reading about an Indigenous birthing practice in Algeria in which an elder would delay birth for a few minutes at a time when half of the child's body was out of the mother's body (Flack, 1947). This was described as an enlightening moment for the child to experience what it is like to be halfway between being born and not being born. Reading this sent me on a precarious slope of an in-between space. I wrote about the intensity of this trauma at the beginning of my methodology chapter. To continue my research journey, I inhabited space as a place of emergence. Like all forms of emergence, the struggle of being born and transcending from being colonised to decolonising is an ongoing journey. Given the above, the question is, *why did I choose this study?* I find that a more fitting question is, *why did this study choose me?*

According to a common convention, people do research to understand others. People do research to understand themselves better (Janesick, 2007).

> "Why do we want to hear the stories of individuals? Why do we take pains to record on tape and even transcription about the past? Why do researchers undertake such projects? We do this to understand the lives of those we interview in order to understand ourselves and the world" (Janesick, 2007, p. 112).

Janesick's view on research speaks to me. At a personal level, my choice of this topic is an act of healing and liberation. I am a biomedically trained nurse and midwife, an African spiritual healer, a writer, and a storyteller with a keen interest in integrating Indigenous teachings with modern innovation. I undertook my nursing and midwifery training at a rural hospital in the Transvaal province in the late 1970s. Long before nursing, I attended primary and higher primary school in Mathibestad village in Hammanskraal district, north of Pretoria. Growing up in a village comes with several advantages. Before you even step into a classroom, you are enrolled in a form of ethnic education. In his book, *Facing Mount Kenya,* Jomo Kenyatta argues that such education facilitates healthy character formation and self-identity (Kenyatta, 1995). By the time the child goes to what he refers to as a European school, she is already rooted in basic knowledge of her clan tradition. With an intact background in ethnic education emanating from growing up in a village, as well as being chosen to carry the legacy of spiritual healing within my family of origin, it was only natural that I would later gravitate toward rural development facilitation. It is from my development work on gender and gender violence in

rural villages of Sekhukhune in Limpopo that my interest in exploring research on Indigenous midwifery was heightened.

As a mother, I had the privilege of experiencing the services of Indigenous midwives during my pregnancies. This was initially shared in my book, *Hearing visions seeing voices* (Motsei, 2004).

> "In all my pregnancies, I have combined Western medicine with traditional healthcare [...] I have, throughout my entire reproductive life, participated in traditional ceremonies and rituals led by healers and elders in my family. There is no need for Africa to be ashamed of its own healers and only to consult them away from prying eyes in the dark of the night. For me, visiting a healer is no different from visiting a specialist in a modern consulting room. While the Western and traditional health systems each have a unique role to play in my life, however, I find myself using Western medicine less and less" (Motsei, 2004, p. 137).

As a trained biomedical midwife, I reflect on ways in which I was complicit with the processes of dehumanising childbirth. As I read through the literature on obstetric violence, I was struck by the way in which biomedical midwifery training colluded with the disempowerment of birthing women. I look back at my life as a young woman who, at age 17, was initiated into the Western model of birthing. Just like Matron von Vliet and Sister Botteron, the Swiss nursing tutors who trained me, I advocated for the superiority of a colonial model of childbirth. In my training, there was never any mention of Indigenous midwifery. As fate would have it, many decades later, I found myself researching the role of Indigenous midwives as a counter to obstetric violence in the same geographical area where I was trained to uphold the superiority of Western birthing practices. I am saddened that I have lost time. Many custodians of this knowledge were still alive when I trained as a midwife in the same area. I cannot help but imagine the kind of information I would have gathered if I were not taught to be indifferent to my own knowledge at a time when many of the custodians of this knowledge were still practising actively.

When I look back, I ask myself the question, *to what extent did I collude with the erasure of the knowledge of Indigenous midwives?* Drawing from the work of George Sefa De, I engaged in an internal reflection on my complicity (Dei, 2000).

> "In thinking of Indigenous knowledges as resistance knowledge, we must acknowledge how easy it is to be complicit in the reproduction of hegemonic Eurocentric and colonised knowledges in the academy. By failing to speak about Indigenous knowledges we have become complicit in the continued marginalisation and negation of such knowledges in the academy" (Dei, 2000, p. 18).

Once again, I was burdened by a deep sense of loss. I felt like a baby struggling to be re-born. Undertaking this study was therefore a form of re-birth.

### 7.3. Insider-outsider position

In this section, I continue with a reflection on my situatedness in the research by focusing on the insider-outsider position within the Indigenous research paradigm. Kahuna (2000) refers to insider research as one in which researchers conduct research with populations of which they are members (Kahuna, 2000). This relates to characteristics such as ethnicity, sexual identity, gender, language, geographical location, and experiential base (Asselin, 2003; Hayfield & Huxley, 2015). There are several advantages that have been linked to an insider position. This includes easy acceptance by the groups, a situation which may result in greater depth of data gathered (Dwyer & Buckle, 2009).

> "One's membership automatically provides a level of trust and openness in your participants that would likely not have been present otherwise" (Dwyer & Buckle, 2009, p. 58).

Whether a researcher is an insider or outsider is an important factor in the research process because it impacts the knowledge co-created between the researcher and the participants (Griffiths, 1998). Dwyer and Buckle (2009) argue that being an insider is advantageous when developing research questions, designing, recruiting participants, and collecting and analysing data. This is because insiders are more familiar with the lives of the participants who are, as a result, more willing to share their experiences.

While familiarity has been identified as an advantage, Dwyer, and Buckle (2009) caution that it is possible that a researcher's perceptions may be clouded by assumptions of similarity. This may make it difficult for the researcher to separate their own views from those of participants. While being an insider may enhance the quality of data, knowing too much about the subject under investigation may raise issues of objectivity (Kahuna, 2000). Kahuna (2009)

further points out that participants may have high expectations of the insider researcher because of their shared characteristics. This may put undue pressure on the researcher. Given the above postulations, bias may be a consequence. The notion of bias is challenged by Rose (Rose, 1985, p. 77), who argues that "There is no neutrality. There is only greater awareness of one's biases." Holmes (2020) also argues that one can never be fully objective because "no matter how much reflexive practice a researcher engages in, there will always be some form of bias or subjectivity" (Holmes, 2020, p. 4). Similarly, Horsburgh (2003) argues that because the researcher is an integral component of research, total detachment is unattainable (Horsburgh, 2003). The best way for the insider researcher is to collect data with a heightened sense of awareness (Asselin, 2003). By engaging in the process of reflexivity, the researcher acknowledges that her decisions and choices will impact the context and content of the subject under investigation.

In writing about reflexivity within the context of Indigenous research, Lederach (2016) argues that the principle of reflexivity allows researchers to interrogate their beliefs, values, and identities. Lederach (2016) further argues that upholding the principles of responsibility and reciprocity is crucial. Responsibility entails weighing the potential benefits and harm of the research, while reciprocity speaks to ensuring that research findings are useful for research participants and their communities (Lederach, 2016). Indigenous scholars have a dual responsibility; they are responsible to academic communities and their own communities (Mcivor, 2010).

> "We are held accountable to Elders, wisdom-keepers, leaders, family members, and fellow community members for what we write and teach" (McIvor, 2010).

Now to answer the question, *am I an insider or outsider researcher?* In my attempt to answer this question, I was guided by Banks (1998), who defines four instead of two research positions. These are Indigenous insiders (socialised in Indigenous culture and supports values, beliefs and knowledge of her community); Indigenous outsiders (socialised in Indigenous culture and assimilated by oppositional community whose values, beliefs, and knowledge she is now a part of); external insider (socialised within another community and rejects values, beliefs, and knowledge of her own community); and external outsider (socialised within a different group and as a result, she has little understanding of the culture she is researching) (Banks, 1998). I situate myself in the in-between space between Indigenous insider and

Indigenous outsider. Growing up in a family of healers. I was socialised in the values and beliefs of African culture and spirituality. However, being taught in Western education both at school and during my nursing training, I was assimilated into a culture that upholds the superiority of Western knowledge, including the biomedical model of birthing. In carrying out this research, there was a danger that I could use the biomedical lens to analyse data gathered with Indigenous midwives. To counter this possibility, I adopted the stance of a supplicant learner. Ngunjiri (2006) defines a supplicant learner as willing to replace her "expert" status with a child-like persona in a researcher-participant relationship (Ngunjiri, 2006). Dana Sacco (2010) concurs.

> "The Indigenous researcher's position as learner requires humility and deference to the social protocols of community members who choose to participate" (GAIL DANA-SACCO, 2010, p. 66).

Other than acknowledging one's positionality, in Indigenous research, participants must be included in the research in a way that is respectful, responsible, and reciprocal (Kennedy et al., 2022). This is because the crux of Indigenous research relies on relational accountability, as well as respect for other people's way of knowing (Kwame, 2017). Relational accountability requires consistent reflexive self-study (Kovach, 2009). Relational accountability involves reflexive identification of self-location in terms of purpose and privilege (Latulippe, 2015).

> "Relational accountability reveals privilege and fosters humility, responsibility, and accountability. Reflexive self-study compels important questions such as to whom am I accountable? To what extent have I been invited to engage Indigenous knowledges and for what purpose?" (Latulippe, 2015, p. 7).

To do Indigenous research well, McIvor (2010) argues that the researcher must be willing to expose herself: "With exposure, private details are shared, bringing with it an open invitation for judgement and scrutiny (McIvor, 2010). Exposure comes with vulnerability. With vulnerability comes the courage to delve into inner selves not valued in academic research.

### 7.4. The dilemma of translation

One of the most challenging dilemmas I experienced during the research was when I reached the stage where I was required to translate data from the five languages of the participants (Setswana, Sepulana, SiSwati, Xitsonga, and Sepedi) into English. At first, my mind clamped

up against the idea. Once again, I was filled with a deep sense of loss and rage. Language creates reality (Farquhar & Fitzsimons, 2011). In the Western research paradigm, reality is tied to the notion of Europe as a universal source of knowledge (Mignolo, 2011). By presenting itself as the originator of history, the West erased other histories (Vázquez, 2019).

> "It is colonisation that enables the West and Europe to understand itself as the locus of enunciation, as a place that holds the power of representation" (Vázquez, 2019, p. 2).

Being expected to write this thesis in English has implications that must be recognised. Firstly, English is the language of the coloniser, which has been adopted as the language of instruction and a carrier of knowledge in institutions founded on the notion of Western knowledge as superior. Secondly, writing this thesis in English, including translating women's voices from African languages, is for the convenience of the examiners in the same way that the supine birthing position is adopted for the convenience of the healthcare practitioners. Writing in English means the examiners of this thesis are probably not Black, or if they are, they do not speak an African language. Other than being examined for my research capabilities, my competence as a researcher is also measured by my ability to articulate myself in English. It is, in my view, not different from Indigenous midwives, whose knowledge of birthing is measured by their ability to grasp biomedical concepts.

In writing about the coloniality of translation, Vazques (2019) argues that translation can result in appropriation, incorporation, and erasure. My experience during analysis was that translation diminished the deeper meaning of some of the phrases.

> "Translation, when at the service of the anthropocentric monoculture of the West, is implicated in the generalised conditions of worldlessness and earthlessness, in other words, the loss of worlds and the loss of earth" (Vázquez, 2019, p. 2).

To mitigate the feeling of loss that emanated from translation, I included all the languages in the body of the findings chapter.

### 7.5. Honouring Indigenous research protocols

Wilson (2008) describes research as a process of being connected to all around you: ancestors, family, land and the cosmos (Wilson, 2008). A key component of Indigenous

research is respect for elders as repositories and custodians of knowledge. For the greater part of my life, I have had the privilege of working with elders in various parts of the country. I have learned about Indigenous protocols, not from any text but from observing, listening, and paying attention to how elders interact with the young and old. One of the crucial points of interaction with elders is participating in greetings that demonstrate respect for the soul that resides in the body of the other. An encounter that made an indelible mark on me happened at the Modjadji Royal Kraal in Limpopo in 2003. I had been there to research the significance of rocks and water in African healing. After we had arrived in the morning, accompanied by some of the elders from the village, we sat outside, waiting to be welcomed. After a few minutes, an old woman emerged, who may well have been over 90 years old.

> "As she came to us, we watched with our mouths half open as her frail body slowly went down to greet us with the palms of her open hands clenched together, after taking her woollen hat off exposing a scalp covered with a few silvery hair strands. This elderly stateswoman put her walking stick aside, took her hat off to lie slightly on her side, covering her face with her wrinkled hands to greet us" (Motsei, 2020).

This encounter challenged my view as a feminist who was largely taught by Western theories to express power by standing out to ensure that you are seen and speaking out to ensure that you are heard. The elder cited above showed me a different kind of power. From the outside, her gesture resembles a form of submission. From the inside, I learned that the greatest form of power comes from knowing who you are. The encounter was the beginning of my search for Indigenous feminist theories. I have outlined this in detail in my methodology chapter.

Other than greetings, another way of connecting with elders is participating in a ritual of go phahla.[60] In three instances, the participants started with a ceremony in the form of a libation or *go phahla* to initiate an open line of communication with the ancestors and ask the ancestors to guide the interview process. This is based on the belief that knowledge does not necessarily reside in the individual but in the collective, which includes ancestral spirits.

[60] *Go phahla* is a process of opening a line of communication with ancestors. Reasons to do the process include to give thanks for blessings, to introduce a new addition to the family, and to ask for intervention in the case of adversity.

In other instances, the interview was preceded by a participant welcoming me with her family praise poem. The following is an excerpt from Ngoato's praise poem. Ngoato is a healer who lives and practises in Bushbuckridge. She gave birth to four children, all at home, on her own. She was taught to deliver babies by her grandmother.

Ngoato: Agee Ngoato
Ke maduma go reta
Ke bona ba tjwa shakwaneng
Ke bona bomapolwapolwane
Ba chaba se ba se bonnego
Mmatshilo: Nna re ba Motsei, re batshweneng
Ebile ke setlogolo sa bakone ba Matlala a Thaba
Ke motho wa bo Makgabo a Mosima
Ke maila go kgwatsha,
Wa renge go loma ke nta a ruruge.
Ngoato: Nna re bina khura. Ke rena. Ge nka dula fase ga sehlare sa khura ke a lwala.

In the lines above, which are, in my view, untranslatable, Ngoato welcomes me to her healing hut with a few lines of her family praise. I responded by sharing my lineage and my totems, a baboon, and a bird. She in turn told me that her totem is a castor oil plant. This was the first time I learned about people whose totem is a castor oil plant. At that point, I remembered what another elder told me, that a premature baby was kept in a basket covered with castor oil plant leaves.

Whenever I went to interview the healers, I took a cloth to cover myself as a form of respect. I took the picture below just after completing my interview with Ngoato in Bushbuckridge. During the interview, one of the initiates had a visitation. We had to stop the interview and join other healers in the drumming ritual. My research encounter included participation in rituals that had nothing to do with the topic under investigation. Participating in rituals and other activities that were led by healers and elders is in line with principles of respect and reciprocity.

*Figure 11: Conducting interviews in an ancestral healing hut, Bushbuckridge, Mpumalanga*

### 7.6. *E mo mading* (It is in the blood): Ancestral knowledge as research data

In writing about research as a form of colonisation, Coburn (2013) cautions against scholarly research that contributes to the colonial imagination of the Indigenous "other" as inferior (Coburn, 2013). One way of resisting centuries of colonial scholarship, Coburn (2013) further argues, is for Indigenous researchers to include dreams, intuition, rituals, and ceremonies as data. Historically, these have been excluded from codified texts of Western research.

In this section, I present ancestral knowledge and spiritual insights that emerged during my interaction with one of the elders, Mme Kebelediwang Manyeke. I came across this name during the initial stages of my doctoral journey when I was doing a search on Indigenous midwives in South Africa. I was intrigued by her views, which were recorded in the proceedings of the 2019 Traditional Birth Attendants Conference held in Durban.

> "The area I come from has one clinic, which does not operate over weekends or at night. I have safely delivered many babies in my bedroom, including breech babies,

but despite my extensive experience, doctors and nurses question my ability to do the work because I do not have a certificate."[61]

After reading this, I tried to trace her with no success. Buried in the pressure of drafting a research proposal for ethics clearance, I forgot about her until the day I received a Facebook inbox message from a healer I had never met asking if I had met Mme Kebelediwang. I called her immediately after a brief online exchange with a stranger who gave me Mme Kebelediwang's number. I first explained who I was, where I got her contact details and a brief overview of my research. She responded to me as if we had known each other for ages. The more I spoke to Mme Kebelediwang on the phone, the more I felt that I had to drive to the Northern Cape to see her. For financial and logistical reasons, I did not plan to do interviews in any other province except Limpopo or Mpumalanga. The two are near to where I am located. I managed to get a consultancy that paid me. My son and I drove six hours to where she lives. Naturally, we got lost until we encountered three villagers on a donkey cart. They gave us accurate directions on how to get to Mme Kebelediwang's village.

*Figure 12: Mode of transport, Magojaneng village, Northern Cape*

[61] Traditional Birth Attendants Conference, Department of Science & Technology and University of KwaZulu-Natal Centre for Indigenous Knowledge Systems, 5-6 June 2019.

As soon as we arrived, the heavens opened with a drizzle. When I knelt in front of her, she laughed and said, “Ao Mmatshilo ngwanaka, badimo ke bao ba go amogela ka mosarasarana.”[62] As is customary, we bought gifts on the way, including some groceries. The first thing we did was to phahla[63] in her home. She called everyone in the yard to her ndumba[64] to welcome us. In my mind, I had hoped that we would begin the interview on the same day. She mentioned, however, that we first need to engage in a fire ritual so that I can be aligned with the task at hand.

I spent one and a half days with her in her *ndumba* in freezing weather. We warmed ourselves with hot coals on a piece of corrugated iron. Occasionally, we paused the interview to get more coal from the fire outside.

*Figure 13: Homemade heater in a healing hut, Magojaneng village, Northern Cape*

[62] Ancestors are welcoming you with a drizzle.

[63] Give thanks to the ancestors.

[64] Healing hut.

The first half day was filled with sharing of meals, rituals, and general conversation that allowed us to get to know each other better. One of the most memorable coincidences was when she introduced me to her 100-year-old mother. Kneeling in front of her, I explained who I was by reciting my family praise. Suddenly, there was jubilation in the room because we share the same totem and one of the surnames in my maternal lineage also featured in their family praise. Gleefully, the elder held my hand and said, "*O gorogile gae ngwanake*" (this is your home). We ended the day with a fire ritual in the freezing cold and rainy night. I still remember the chill in my bones. I remember too, the sensing of energies that emerged during the ritual. Out of respect for the sacredness and secrecy surrounding some African spiritual practices, I choose not to share the details of the ritual.

The next day, she started with a libation, calling all her ancestors and mine, inviting them to join and guide us through the interview. Just as we were about to commence with the interview, a van arrived to bring a woman who was pregnant with twins. She came for an antenatal checkup. Mme Kebelediwang told me that the woman had been struggling to conceive and she treated her infertility with herbs. I read this 'coincidence' of a pregnant woman arriving just as we were about to start the interview as a sign from our collective ancestors. Mme Kebelediwang asked the woman a few questions about her health and later asked her to lie on the bed in her *ndumba*. She first inspected the shape of the abdomen. After warming her hands by rubbing them together, she started palpating the abdomen to feel the position of the babies. She invited me to feel the heads: one was a normal presentation with head down and the other was a breech. She then explained that from seven months of pregnancy, the babies would start turning and preparing for exit. After examination, Mme Kebelediwang advised the pregnant woman to eat healthy food like *morogo* (Indigenous spinach) and *mabele* (sorghum).

After the woman left, we started our interview. Instead of me being the one to ask the questions, she asked me questions.

> KM: Leina la Mmatshilo ke la bongaka kgotsa ke la tlholego?
>
> (Is the name Mmatshilo your natural name or the name you were given as a healer?)
>
> MM: Ke leina la tlholego. Ga kena leina la bongaka. Tota nkare ke filwe maina a le mmalwa ke bagolo ba ke tsamayang ke kopantshwa le bona.

(It is my natural name. I do not have one name that I was given as a healer. I meet diverse kinds of elders who give me various names.)

KM: Nte ke shebe ha… (o sheba mo leboneng). Sheba, leina la gago la Mmatshilo ke la tlhago ebile ke la sedimo. Akere o reeletswe"?

(Let me see… [she studies the flame of the candle] Look here… [she points to the flame] … the name Mmatshilo serves both purposes. It is your natural name, and it is also your healer's name. Are you named after anyone?)

MM: Eng, ke reeletswe basadibagolo ba le babedi.

(Yes, I was named after two old women.)

KM: Ao jang heh? Sheba, leina la Mmatshilo le paka sengwe. Tshilo e gongwe le gongwe, o e fitlhela gotlhe, ga gona mo go sa silweng go fepa batho. Jaanong, leina la gago le tlhalosa eng? Akere o tsamaya dinaga di le dintsi, o a sila, o a baakanya, o dira gore dilo di nne feini. Jaanong, batho ba ba ntsi ga nkitla ba rata go sila ga gago. Bangwe ga ba kitla ba rata fa o dira tiro ya gago. Jaanong leina la Mmatshilo ke la tlhago ebile ke la bongaka. O tla nna o sila mo o fetang teng. Mo o fetang teng go nna boleta. Nna ke bidiwa Kebelediwang. Gone jaanong thupa e bets anna, ga e betse motho yo o mphileng leina le. Motho yoo ene ga a kgwathe, go kgwatha nna. Lebaka ke gore bongaka ba me ke bo filwe fa ke belegwa. Nna ga ke ise ke tsamaye ke ye go thwasa. Ke rutilwe ke badimo.

(Two elders, how did that happen? Look here, your name comes from *tshilo*.[65] *Tshilo* is a stone that you find everywhere. There is no place where there's no grinding of corn to feed people. You have a nomadic soul. You are never in one place. You are just like *tshilo* that is found everywhere. Your gift is not easy… you grind hard things. Some people will not like you for that reason, that you reveal and grind things that are hidden. It was not an accident that you were given the name Mmatshilo… You make hard and rough things smoother and finer. It is not an easy job. My name is Kebelediwang. This means, why am I being punished? The sad part is the one who is punished is me and not the one who gave me this name. I received my gift of healing

[65] *Tshilo* is a little rock used to grind corn.

when I was born. I did not go to *thwasa*. Everything that I do and know, I was taught by my ancestors.)

MM: Go thwasa ke eng?

(What does to *thwasa*[66] mean?)

KM: Go thwasa ke go ya go rutiwa bongaka. Bongaka ba go tswa kwa lowe dingaka di ne di sa rutiwe bongaka ke di gobela. Ba ne ba Bulelwa hela gore sedimo e nne sone se se go rutang. Dilo tsa methwaso ke dilo tsa segompieno. Mara fa ke lebella sentle, ke ipotsa gore a go a kgonega gore motho a go rute bongaka. O ruta ke motho, o a thwasa. O ruta ke sedimo sa mang?

(In the past, healers were not taught to practise their healing gift by people. This kind of initiation is a practice that emerged with modernity. In the past, healers and elders in your clan led a ceremony that connected you to ancestors who must teach you everything about your gift. When I look at what is happening today, I ask myself, if you are taught by another human being, whose ancestors are you learning from?)

The conversation continued for some time, with her asking me several questions. When my turn came, I asked, who taught you to become a midwife?

KM: "Ke rutilwe ke rakgadi yo o seleng a tlholegile ke ise ke bonwe. O ne a bua a re go tla tsholwa ngwana wa mosetsana mo lapeng mme e tla nna ngaka. Ke rutilwe ke mme o, o ne a mpontsha boteng ba mmele wa motho wa moimana. Le jaanong jaana, ba tlang ka mathata, ke lala ke bontshiwa gore motho yo o tsogang a tla ka moso o tla a ntse jaana. Pele motho a tla, ke setse ke montshitswe. Fa go na le bothata, rakgadi wa tlhagella a tle go nthusa."

(I was taught by my aunt who died before I was born. She once said a girl will be born in this family and she will be a healer. When she started to teach me, she showed me (in dreams or sometimes when I am just closing my eyes) the inside of the body of a pregnant woman from the beginning to the end. Even today, I see women who will

[66] Traditional healing apprenticeship

come for a consultation the next day. I see their problem before they come to me. When there are complications, my aunt comes to help me.)

MM: How does she teach you?

KM: O nthuta mo moweng. Ke tla be ke robetse boroko bo la bao go utlwa ekete o a choukega, e seng boroko ba tlhago. Rakgadi o tla be a tlhaga a tlhagisa gore ngwana o tlholega jang le gore o gola jang mo popelong. Le bone b aba tlang ka mathata, ke lala ke bontshitswe gore go motho yo o tla tsogang a tla ka moso. Pele motho o tla, ke sets eke mmontshitswe. Le jaanong dilo di le dintsi ke rutiwa ke ene rakgadi. Fela fa go nale bothata, wa tlhagella go tla go nthusa.

(She teaches me in spirit. Sometimes I fall asleep, not real sleep. Then I see her coming and putting a screen on the wall. She shows me the inside of a pregnant woman from the time the baby starts to form to nine months. Since I started practising, when I am faced with a woman who is having a difficult birthing experience, my aunt is the one who comes to tell me what to do. I can also see who will come to me for consultation before they arrive.)

Once again, the interview changed course. She suggested that we speak about how children were raised in the past, how pregnancy was prevented, and how elders used to ask ancestors for a baby in the case where a woman was struggling to fall pregnant. She believes that preparation for pregnancy and labour starts before the baby is conceived. In her view, a child is not just a physical body, it is also a soul. Before a woman gets pregnant, elders in the family would invoke the spirit of fertility on her behalf. In other words, the soul is asked to be born.

KM: Bogologolo bagolo ba ne ba ya ko legageng ba kopa koo. Motlhomongwe legaga le lebane le seolo. Ba ka kopa le mo seolong. Mo malatsing a gompieno ngwana o sa ntse a kopiwa. Go ka nna ga diriwa secheso. Fa e le wena o kopelang mongwe thari, e tla re fa o phahla, o ka utlwa popelo ya gago e tlola. Wena mokopi o tla be o itse gore kopo ya ngwana e fitlhile."

(Old people used to perform preconception rituals at a cave or anthill. Currently, some people perform fire rituals as a way of asking for a child. The elder who is doing the asking may sometimes feel her womb move during the ritual. This could mean that the request for a baby has reached the ear of the ancestors.)

I asked her to describe how she works with a woman in labour.

> KM: Fa ke bidiwa, ke simolla ka go laola. Ke be ke mo tlhola mo mpeng gore ngwana o robetse jang le gore a tlhogo e setse e ile kwa tlase. Morago ke a mo tlhola gore tlhogo e setse e bonala ka fa sesading. Fa e bonala, ke a mo tshegetsa ke mo thusa gore a phushe. Fa tlhogo e sena go tswa, fa go sena mathata, o tla bona ena ngwana a retologa gore legetla la kwa godimo le tswe pele. Morago mmele otlhe o tla be o tswa. O tabogela gore o mo ntshe tse di ka mo ganong. O tla utlwa jaanong a lla. Morago o a mo phuthela, le emela setlamorago. Ka nako di tswa gelyk, thata jang fa ngwana a belegwa ka kgetsana e e sa thubegang. Fa samorago se tswile, o ripa lelana, o le bofa gabedi.
>
> (When I am called to assist a woman, the first thing I do is perform a spiritual divination. Thereafter I check the abdomen to see how the baby is lying, where is the head, etc., I also check the strength of the contractions and whether the head is visible at the mouth of the vagina. If it is visible, I support the woman to push. Once the head comes out, if there are no complications, you will see the baby turning by itself to allow the shoulder that is at the top to be born first. After the shoulders, the whole body comes out. The first thing is to clear out the mucus. Then the baby starts crying. We make sure that the baby is well wrapped up as we help the woman to push the placenta. Sometimes the baby and the placenta come out together, especially if the baby is born with an intact sac. After the birth of the placenta, you cut the cord and tie it twice.)

She also spoke about rituals and taboos and their value in pregnancy and childbirth. What amazed me was when she described various kinds of breech deliveries she was faced with in her 40 years of practising as an Indigenous midwife. When she described how she managed the delivery of a breech with extended arms, I could see in my mind's eye Matron Sambo, who taught us midwifery when I was still a young nurse in Bushbuckridge. When Mme Kebelediwang demonstrated what she did, I remembered that the intervention had a medical name, but I could not remember it. There are other moments when she described incidents when I could remember a medical term for incidents she mentioned.

I spent a full day in conversation with her, with breaks between. I would not refer to this as an interview because she also asked me questions. The conversation would have been best

captured on camera because sometimes she used actions and sound. I find it exceedingly difficult to translate the entire conversation from Setswana to English. I have shared many of her responses to the questions that have relevance to the research question in the previous chapter, using the name Motshweneng.

A few weeks later, we met at Tlholego Ecovillage in the North West. We were part of a dialogue on Indigenous midwifery organised by Afrika Ikalafe and the Black Women's Institute in the United States of America. Before we started the dialogue, she led a water ritual, inviting the midwives that came before us. This time, the conversation was focused on her life, from the time she was born to the present. After our conversation, we performed another water ritual. As she was making incantations, I poured water out of a calabash. The water formed the shape of a mother holding a baby, which was another amazing experience. When she saw that, she laughed so loud, saying "*Hee wena* Mmatshilo*, o gevaarlik ngwanyana."*

*Figure 14: Water ritual, Tlholego Ecovillage, North West*

An extended interview with Mme Kebelediwang is one of the highlights of my research journey. I positioned myself within Indigenous epistemology as a researcher and a learner. I was mindful of the importance of honouring the principles of Indigenous research: respect, responsibility, and reciprocity. Borrowing from McIvor (2010), I was aware that as an Indigenous researcher, I am accountable to elders for what I write (McIvor, 2010). As a healer, I positioned myself as a supplicant learner. I drove away from my interaction with Mme

Kebelediwang thinking of the words of Wilson (2008) (Wilson, 2008), that research is when you are connected to all around you: yourself, family, ancestors, land, and the cosmos. One thing from this interaction is that my relationship with the elders will continue beyond doctoral research. I see this as a journey of lifelong learning. Throughout my research journey, I longed for two-pronged supervision, firstly, supervision by an academic scholar, and secondly, supervision by a spiritual teacher and healer to whom I could always go for spiritual healing and reflection. My time with Mme Kebelediwang renewed my respect and hunger for more instruction on ancestral knowledge that has largely been wiped out by colonialism and apartheid. Participating in and being taught about birthing rituals in my own language of Setswana felt like a re-birth.

As I share my story in this chapter, I am aware that it does not belong to me alone.

I carry
untold voices
of generations who came before me.
I am a bearer
of voices
of the unborn, the living and the departed
they speak
but they are not heard.
Some carry the label illiterate
because they cannot read the alphabet
My mission is
to amplify their voices
and voices of women in my bloodline
My grandmothers Mamoabi and Mmatshilo
My mother Boitumelo
My aunt and spiritual teacher Mme Morongwa
My daughter Kgalalelo
When our ancestors lost the land
their descendants lost the language.

Loss of land and language
is a loss of knowing.
Writing this in English and not Setswana.
is a reminder of the loss.

## 7.7. Conclusion

This chapter is a chronicle of an attempt to situate my research journey in the cultural and spiritual context within which it occurs. In my awareness of a need to assume the role of a supplicant learner, I am also conscious of my biases and possible complicity with oppressive systems. I indicated earlier that undertaking this research made me reflect on my training as a biomedical midwife. I have shown in Section 5.2.2.2. how some 'normal' hospital procedures and protocols such as unconsented medical or surgical interventions disregard and disrespect women's autonomy.

Aside from reflecting on the past, this chapter brings to the fore birthing knowledge outside of what is regarded as 'formal' practice. By centering my extended conversation with an elder in Setswana, I challenge the Western construction of knowledge and knowledge-holders. In Section 3.9.1. I have shown how the dominant narrative of maternity care uses words such as uneducated, illiterate, or unqualified to refer to Indigenous midwives. By practising unconscious bias, biomedical practitioners fail to recognise that their lack of knowledge of Indigenous birthing is a form of illiteracy.

More than making sense of the interview, I reflect on how the positions of researcher and researched are not linear but circular. In the end, the relationship between the researcher and researched is responsible for the collective construction of knowledge. In outlining who I am as a researcher and how my positionality impacts the research and vice versa, I became conscious that my learning will continue beyond awarding a degree. In other words, this dissertation is the end of my doctoral journey, but my work in this field has just begun.

In the next chapter, I discuss the findings, recommendations, limitations and conclusions of this research and their implications to the research question.

## CHAPTER 8: Discussion, Conclusion and Recommendations

### 8.1. Introduction

In this dissertation, I set out to explore the role of Indigenous midwifery as a counter to obstetric violence. In my literature search, I came across many research studies on obstetric violence in South Africa (Chadwick, 2017, 2021; Chadwick et al., 2014; Chadwick, 2016; Dutton & Knight, 2020; Hastings-Tolsma et al., 2021; Jewkes et al., 1998; Kruger & Schoombee, 2010; Lappeman & Swartz, 2019; Odhiambo & Mthathi, 2011; Rucell, 2017). However, I have not been able to find one that focused on the role of Indigenous midwives in countering obstetric violence.

To explore the research question, 'what can we learn from Indigenous midwives to counter obstetric violence,' I employed a descriptive and exploratory qualitative design using a thematic analytical framework. Adopting Indigenous feminist theory and Indigenous research methodology as my theoretical and conceptual framework, I undertook semi-structured individual interviews with 28 rural women sampled into three groups: 1) 10 women who gave birth in a healthcare facility assisted by biomedical healthcare practitioners, 2) 10 women who gave birth at home assisted by Indigenous midwives, and 3) eight Indigenous midwives who attend to women in labour in their communities.

The findings of this study were presented in three chapters. In Chapter five, I presented findings of interviews with two groups of women i.e., those who gave birth in healthcare facilities and those who gave birth at home. In Chapter six, I presented findings of interviews with Indigenous midwives. In Chapter seven, I shared a reflexive overview of my research journey as an attempt to contextualise cultural and spiritual dimensions within which Indigenous co-creation of knowledge occurs. In this chapter, I present a discussion of findings by drawing from the experience of participants as well as weaving relevant literature to strengthen the discussion and recommendations.

In summary, the study revealed that women who gave birth in health-care settings experienced abandonment and neglect, denial of choice of birthing position, lack of support after delivery, unconsented medical procedures (induction, episiotomy, and insensitive vaginal examinations), abusive care and lack of cultural safety. Some women reported that episiotomy was repaired without any anaesthesia. A few reported that they were subjected

to episiotomy after the baby had been delivered. Those who gave birth at home under the care of Indigenous midwives reported positive experiences of childbirth. These include presence of care and support during delivery, free choice of birthing position, no experience of vaginal examinations, active participation in the birthing process, care and support after childbirth, holistic care that transcends the physical, as well as participating in childbirth rituals and ceremonies. None of them reported that they had been abused during childbirth. However, they confirmed that they had heard stories of violence subjected to women during childbirth in healthcare facilities. Because of the small sample, I can therefore not conclude that women who give birth at home are not subjected to any form of violence. Interviews with Indigenous midwives deepened the conception of birth beyond physiology to include social, cultural, and spiritual care. In their support of women, Indigenous midwives provide holistic care from preconception, pregnancy, delivery, and postnatal period. Just like those who gave birth at home, elders confirmed that they have heard stories of violence subjected to women who are giving birth in healthcare facilities.

## 8.2. Discussion

### 8.2.1 Presence during labour

Women who gave birth in a healthcare facility experienced abandonment and neglect before, during and after delivery. In contrast, those who gave birth at home reported constant and continuous care from the elders. Those who gave birth both at home and in a healthcare facility reported that their experience of home birth was positive as compared to giving birth in a clinic or hospital. In their provision of care, Indigenous midwives provided physical, psychological, cultural and spiritual care. In some cases, this is made possible by the fact that within an Indigenous model of birth, a woman is cared for by two or three women. While one is in front waiting to catch the baby, the other is holding the mother from the back giving support. If there is a third and older woman in the room, her role is to make invocations to ancestral spirits for the mother's health and wellbeing and safe arrival of the baby. It is not possible to offer such care in healthcare settings because of institutional reasons that include lack of privacy, staff shortage, poor working conditions as well as over medicalisation of birth. In hospital healthcare providers work in different shifts. This makes it difficult for a woman to be attended to by the same team throughout different stages of labour. Research done in South Africa reveals that providing constant and consistent support could reduce risks and

complications during pregnancy and labour (Maputle, 2018). Lack of support in healthcare facilities makes birthing women feel unsafe (Zitha & Mokgatle, 2020). By abandoning women, midwives expose them to complications.

Abandonment of women during childbirth has been increasingly identified as a form of mistreatment (Abuya et al., 2015; Chadwick et al., 2014; Freedman et al., 2014; Malatji & Madiba, 2020). Further, research reveals that neglect and abandonment disempower and dehumanise the woman who is giving birth. Other than dehumanising the woman, neglect also suppresses her emotions and agency (Merino et al., 2018). This forces her to submit to the authority of the healthcare practitioner. Medical model of childbirth positions the healthcare practitioner as the one who knows and the role of the woman is to follow orders, often in silence. This means, the biomedical model of birth and its related procedures has the potential to hide various forms of violence against women during childbirth. In other words, some elements of a biomedical model of childbirth, which are ostensibly put in place to ensure the safety of the woman and baby, can be invasive and violent.

### 8.2.2. De-medicalised birth

#### 8.2.2.1. Choice of birthing position

All the women who delivered in a healthcare facility (except those who ended up giving birth on their own), gave birth lying on their back on a bed. In contrast, those who gave birth at home did so in an upright position e.g., squatting or kneeling. Even though the South African Maternity Guidelines endorse alternative birth positions, healthcare providers continue to enforce lithotomy positions for their convenience (Musie et al., 2019). The supine and lithotomy positions do not exist in isolation but originated as part of the medicalisation of childbirth. Choice of birthing position is also related to birth setting and design. In this study, women complained about hospital beds being too high. Giving birth in a supine position was introduced by the French barber-surgeon in 1598 who claimed that lying down was more comfortable and will therefore induce labour.[67] This came with an introduction of the first hospital birthing beds which were not different from those meant for sleeping. From the mid-1800s, medical designers raised the beds and added leg harnesses and stirrups. Over time,

[67] https://thereader.mitpress.mit.edu/birthing-furniture-an-illustrated-history/

many types of technological obstetric beds have become the standard in hospital births. This evolution of birthing furniture is marked to be designed for the convenience of the health care practitioner as opposed to the woman who is giving birth because it encourages extensive use of unnecessary medical interventions such as episiotomy (DiFranco & Curl, 2014). Beds can be considered instruments that interfere with the natural birthing process (De Jonge et al., 2004)

In contrast to women who gave birth in a healthcare facility, those who gave birth at home did so on ordinary beds covered with plastic and old blankets or on a specially created floor bed. Floor beds made it easy and possible for women to change from one position to another. This also made it easy for the Indigenous midwives to provide support for the birthing woman. It is my view that advocating for a change in birthing position should be accompanied by a process of decentralising biomedicine in childbirth. This creates space for respect for women's embodied knowledge of birthing.

#### 8.2.2.2. Non-interventionist care

Women who gave birth in a healthcare facility spoke about being coerced to hand over their bodies to professionals and machines. This created a sense of alienation from the birthing process. In some of the stories, women related ways in which midwives disregard their knowledge of pregnancy and birth. A few were turned away from hospital only to end up in active labour at home a few hours later. Mme Ngoato challenged the nurses about their proposed expected date of delivery when she returned to the clinic the next day to show them the baby who was, according to the midwives, expected after some time. In contrast, women who gave birth at home spoke about their active involvement in birth. One of the common statements they made was the fact that the body knows how to give birth and it therefore does not require unnecessary intervention. Indigenous midwives confirmed that they do not normally do vaginal examinations unless there is a complication. Neither do they break the water artificially. Instead, they wait for the water to break naturally. As a result, there are some babies who are born in intact amniotic sacs. It is believed that babies who are born in intact sacs carry special gifts. Because their practice is not driven by the profit motive which treats birthing as an industry, Indigenous midwives have time and patience.

A few of the Indigenous midwives shared stories of how they manage complications that include breech deliveries or helping a woman to give birth to twins. In the case of perineal tears, one of the elders mentioned that it depends on the degree of the tear. A small tear is treated with herbs such as aloe while a woman who suffers a serious tear is sent to hospital. All elders agreed that it is important to not take chances if there is a possibility of a complication. It is a known fact that some women who give birth at home experience serious complications such as excessive bleeding, retained placenta and third degree tears. Such complications also occur in hospitals. A collaborative relationship between a healthcare facility and Indigenous midwives and vice versa is therefore necessary.

### 8.2.3. Cultural safety

Of the ten women who gave birth at home, seven have never set foot in a hospital. Their reasons given for choosing home birth with Indigenous midwives include choice of birthing position, not being subjected to abusive care and unconsented medical procedures such as vaginal examinations and episiotomy. The most important part of giving birth at home, women reported, is to participate in childbirth rituals and ceremonies. Out of the ten women who gave birth in a healthcare facility, only one shared a positive experience. However, she mentioned that even though the midwives were kind to her, birthing in hospital felt foreign because she did not understand the language they used and they did not explain hospital procedures.

In writing about the ritual of hospital birth, Davis-Floyd (1990) contends that every woman who gives birth in a hospital is subjected to hospital rituals (Davis-Floyd, 1990). These include being stripped of your identity by taking off your clothes and wearing a hospital gown and being examined vaginally to check cervical dilation. A woman may be induced if progress is deemed slow according to standard hospital practice. Such a woman may have an Intravenous drip and electronic foetal monitoring device attached to her body. When she is ready to give birth, she is moved to the labour room, put in a supine position, and the vagina is cut to expedite birth. The main function of such rituals is to preserve the superiority of biomedicine (Davis-Floyd, 1990). It is my view that a woman who undergoes hospital rituals is safe in the sense that she gives birth to a physically healthy baby. This does not mean that the mother feels culturally safe. A physically safe birth can be culturally unsafe. Wood and Schwass (1993) define culturally unsafe care as “any actions (or omissions) that demean, diminish or

disempower the cultural identity and well-being of the individual" (Wood & Schwass, 1993, p. 5). Even though women who gave birth in a healthcare facility did not know much about childbirth rituals, they felt that there is a need to learn more about such practices. Those who gave birth at home were taught by Indigenous midwives. Participating in the rituals and ceremonies was an important part of transitioning to motherhood.

### 8.2.4. Medicalisation as a site for obstetric violence

Women who gave birth in a healthcare facility reported being abused physically, dragged, pinched and treated with disdain and disregard. Other than physical violence, they reported that rude and disrespectful language was the norm. Not only were the women treated with disrespect, but they were also not greeted by the midwives. In other words, they were made to feel invisible. Given the value of greetings in African culture, absence of greetings was the women's first experience of invisibility and disrespect. Greetings mean more than asking about people's well-being. By being framed in plural e.g., *sanibonani* (plural) and not *sawubona* (singular) or *dumelang* (plural) and not dumela (singular), greetings are meant to send a message that the person who is being greeted, and his/her ancestors, are being seen and acknowledged.

Women who gave birth at home reported that they did not experience any violence while giving birth in the presence of elders. Few had experienced giving birth at home and in hospital. Two of those who first gave birth in hospital and experienced violence decided to never go back to a hospital for subsequent births. Other than protecting themselves from the violence in a healthcare facility, other reasons given for their choice of home birth was that elders are more present and caring. In addition, home births happen in familiar environments and women are therefore not exposed to what they regard as foreign hospital procedures. Even though home birthers in this study reported that they themselves did not experience violence during home birth, they confirmed that they heard of stories of violence against women who are giving birth in health care facilities. Indigenous midwives also confirmed that women are being abused in hospitals.

Indigenous midwives emphasised that caring for a woman is not only based on delivering a healthy baby. It is important for the mother to be seen, supported, and recognised. Indigenous midwives confirmed that once the contractions become strong, the woman may

become uncooperative. The role of the midwife, they reported, is to be firm but not harsh. It helps that within an Indigenous model of birth, a woman is supported by more than one caregiver. This may not be possible in the healthcare system which is often crippled by staff shortage and lack of basic equipment and services.

Research on obstetric violence reveals the links between women's birthing experience and factors such as age, marital status, ethnicity, and socio-economic status (Malatji & Madiba, 2020). In Section 2.3, I outlined the origins of medicalisation of childbirth in the West as well as implications of its exportation to developing countries on birthing practice in those countries. Traditionally, childbirth was an exclusive responsibility of women who learned the art of midwifery through observation and experiential learning. Over time, childbirth was taken over by men through a process of medicalisation of childbirth. For medicalisation of childbirth to flourish, the following needed to happen (Vernon, 2015):

- Reinforce the metaphor of a body as a machine and the conception of a woman's body as inferior and defective.
- Define childbirth as a pathology that requires medical attention.
- Position scientific knowledge as authoritative and medical profession as superior.
- Controlling licensure for midwifery practice.

Many scholars and practitioners who have been vocal against the medicalisation of childbirth advocated for the humanisation of childbirth as a solution. Wagner (2001) describes the humanisation of childbirth as an approach that understands that the woman is a human being and not a machine (Wagner, 2001). The most important question to ask is: *is it possible to humanise a medicalised body?* I base this question on the fact that medicalisation occurs at different levels as described by (Sonika & Amarjeet, 2015) below:

**At a conceptual level,** birth is defined as a medical condition; medical vocabulary is used to describe progress, and technology is used to measure such progress. This justifies the use of medical interventions during childbirth. Very often, as we have seen in this study, such interventions are performed without informed consent. In this study, women who gave birth in health facilities reported that they were not given any information or explanation about medical interventions. Instead, they were told what to do. Women who asked questions

opened themselves up to the possibility of being abused verbally. Silence and conformity is therefore a way of protecting themselves from being subjected to obstetric violence.

**At an institutional level,** medical procedures and protocols which are centred on the hierarchy between professional caregivers are described as part of routine care. In this study, women who gave birth in health care facilities were subjected to unconsented medical procedures that include induction, episiotomy and invasive vaginal examinations. Those who complained about the pain during vaginal examinations faced the possibility or reality of being abused verbally. One of the women reported that the midwife examined her vaginally while she was talking on the phone.

Writing about her experience of vaginal examination during labour, Shabot (2021) argues that because of its invasive nature, vaginal examination can become violent (Shabot, 2021). Linking invasive and unconsented vaginal examination as a form of obstetric violence, Shabot argues that women lack epistemic resources to recognise the practice of vaginal examination as violent and to refuse the examination. As a result, many women cannot refuse a vaginal examination.

Other than insensitive vaginal examinations, women who gave birth in a healthcare facility were subjected to unconsented episiotomies. All the women who gave birth at home were not cut. This does not discount the possibility that some of the women who give birth at home may experience serious vaginal tears. Fear of episiotomy featured as one of the reasons women choose to give birth at home. Zaami et al (2019) contends that performing these procedures without consent and medical evidence is a form of obstetric violence (Zaami et al., 2019). Included in these are those that are imposed as routine care without any scientific evidence. Three women reported that they were cut after they had delivered the babies on their own whilst in hospital. Other women confirmed having heard of episodes of women being cut after they have delivered babies. One key limitation of this study is that it relies on a small sample of women's self-reports on a matter which I consider to be grievous. Given that unconsented episiotomy is a matter of grave concern, cutting the mother after the baby is already born requires in-depth investigation and reporting. This is, in my view, a serious form of violence that requires further research.

### 8.3. Recommendations

Based on the findings, I argue that responses to obstetric violence must 1) decentre biomedical model of childbirth in low-risk pregnancies, 2) decolonise midwifery by recentring Indigenous knowledge of birthing, and 3) integrate cultural safety in the definition of safe birthing practice.

#### 8.3.1. Decentering biomedical model of childbirth

In recommending decentering of biomedicine in childbirth, I am guided by the different levels in which medicalisation occurs. At a conceptual level, the medicalisation of birth has taken over the body. Machines and professionals have also taken over the process of giving birth. In this study, women who gave birth in healthcare facilities spoke about being alienated from their bodies. Those who gave birth at home reported that they were actively involved in the birthing process.

The process of birth is different in Indigenous models of birth. Firstly, it does not regard pregnancy and labour as a condition that requires medical intervention. As a result, the Indigenous midwife allows for the unfolding of women's embodied knowledge of birthing. The embodiment of birth speaks to the role that the body plays in giving birth. Secondly, birth is not only regarded as a physical event but as a spiritual rite of passage. Through physical, cultural and spiritual support, Indigenous midwives cater for the body, mind, and soul. At an institutional level, Indigenous midwives do not subject women to unnecessary medical interventions such as insensitive vaginal examinations and episiotomies. In addition, because of the belief that birth is a social phenomenon, a woman who is giving birth is cared for by two or more caregivers with distinct roles. From what I learned from Indigenous midwives; the following recommendations are necessary to pave the way for decentering biomedicine:

**a) Legislative/policy interventions**

- Review of the South African Maternity Guidelines focusing on the exclusion of Indigenous midwives in the guidelines.
- Review of the roles and responsibilities of Indigenous midwives as stipulated in the South African Traditional Act of 2007.
- Formulate clear policy on the role of Indigenous midwives both in facility and homebirth.

**b) Institutional policies and procedures**

- Formulate institutional policy on inclusion of obstetric violence awareness as part of antenatal care with a focus on awareness campaigns for women and practitioners. This includes mechanisms for reporting following an occurrence.

**c) Education and training of caregivers**

- Introducing history and coloniality of the biomedical model of childbirth as part of the curriculum for midwives and doctors. This should include historical evolution of childbirth, exportation of biomedical models during colonialism, erasure of Indigenous model of birthing, hierarchy of knowledge as well as dissection of concepts such as integration and collaboration within the context of dismantling such hierarchy.
- Training of health care practitioners on cultural competence care of women. The most important aspect is to make a distinction between cultural competence and cultural safety.

**d) Management of pregnancy and delivery**

- Women are free to choose their preferred birthing position, depending on whether they have complications or not.
- Not being subjected to unnecessary medical interventions. This includes freedom of movement during labour without being strapped to a bed or tied to an intravenous infusion even when there is no medical indication for such.
- In the case where interventions are necessary, they should be performed appropriately with full disclosure of the reasons, alternative interventions, possible complications/side-effects, and outcome.
- Respect for cultural and spiritual needs of women during childbirth.
- Allow labour companions. This is often not possible in the South African context because maternity wards do not provide privacy. In some wards, curtains are either torn or absent. It is my view that a long-term recommendation of decentering biomedical hegemony in childbirth is to stop building maternity wards as part of hospitals. Pregnant women are not sick, they are not patients, they only need intervention where there are complications. Future birthing homes/centres must be built independently and designed to create room and privacy for labour companions to perform their preferred cultural and/or spiritual rituals and ceremonies.

**e) Upholding women's rights to information and consent**

- Informed consent: Consent speaks to respect for the patient's right to make choices and decisions. The right to consent in South Africa is codified in Section 7 of the National Health

Act of 2003. According to this Act, healthcare providers must provide patients with the following: 1), health status, 2) available diagnostic and/or treatment options, 3) alternative interventions, benefits, and risks, and 4) the right to refuse treatment. Further, the Act stipulates that healthcare practitioners must use a language and vocabulary that can be understood by the patient, given their literacy level. This means, for consent to be valid, it must be informed and given voluntarily. In this study, women reported that they were not given any information or explanation about the medical interventions they were subjected to. Women who asked questions opened themselves to the possibility of being abused. Where consent was obtained, women were just told where to sign. Naturally, this act fails to protect those who do not understand English, Afrikaans or any other language of the healthcare practitioner which is different from theirs. In addition to that, the general populace does not understand medical vocabulary. Given that South Africa has a low literacy rate, there is a likelihood that the full requirements of the law in relation to consent may not be fully applied because of literacy levels and different cultural beliefs. Ultimately, education and economic empowerment of girls and women is a necessary precondition to respectful birth outcomes. Overall, medical practices and procedures that are useful should be performed with full disclosure and informed consent. Those that are not necessary but used because they are regarded as routine care must be stopped.

### 8.3.2. Decolonising midwifery by re-centering knowledge and practice of Indigenous midwives

In chapter 3, I reviewed Indigenous midwifery with an eye of history to trace socio-political factors responsible for suppression of knowledge of, and silencing voices of Indigenous midwives in Africa. Included in this is contextualisation of the naming of Indigenous midwifery within a colonial development discourse. Such an exploration is preceded by a historical analysis of the use of the biomedical model of birthing as a colonial tool in South Africa. During colonialism, biomedicine was declared scientific and superior and a Western theoretical framework about disease causation was incorporated into medical education and practice (Mc Leery, 2015). Following colonialism, architects of apartheid health built on the foundation of the British colonial government.

Centuries after colonialism, the superiority of the biomedical model of childbirth is upheld while Indigenous birth is described as risky. Modern and Western are still elevated as superior

while African and traditional are looked down upon. It is my view that the practice of Indigenous midwifery is a form of anti-colonial resistance which helps to re-assert the validity of Indigenous knowledge as knowledge we can learn from and employ as a counter to obstetric violence in South Africa. To learn from Indigenous midwives, we will need to review the coloniality of dominant birthing knowledge and confront our unconscious bias. This includes subverting dominant paradigms that come under the banner of modernity.

To imagine what decolonised childbirth would look like, I draw on the following lessons learned from Indigenous midwives which were confirmed by (Anderson & Staugard, 1986):

- **Non-interventionist approach:** Indigenous midwives allow birth to take its physiological course. In this study, Indigenous midwives confirmed that they do not perform vaginal examinations when there are no complications. None of the women who gave birth at home had episiotomies. Those who experienced mild tears were treated with aloe.
- **Holistic nature of birth:** Indigenous midwives believe that birth is not only a physiological event but also as a cultural and spiritual rite of passage. A woman is supported by more than one woman. One of the older midwife's contributions may be limited to making incantations to the gods for safe delivery. The role of the midwife extends beyond assisting with physical birth to provide psychological support as well as participating in various rituals, if necessary.
- **Choice of preferred position:** The woman is free to choose a position in which she feels comfortable. This may include kneeling (with her back supported by one or two women), squatting (one woman may support her from the back while the other kneels in front of her), or half-sitting, holding on to a rope and supported by the husband behind her back.
- **Care of the placenta:** Just like the birthing of the baby, the placenta is delivered with little interference. In case of a delay, some midwives may massage the abdomen. Others believe that massaging the abdomen may cause retention of the placenta. A woman is supported to be in a sitting position to help facilitate the expulsion of the placenta. In an absence of complications, the umbilical cord is cut after the placenta is delivered. Others milk the cord towards the infant before tying it.
- **Childbirth rituals and ceremonies:** After delivery of the baby and the placenta, the mother and the baby are bathed and kept comfortable. To treat the perineum, the mother sits on top of a bucket of hot water with herbs in it. Postpartum rituals, which includes burial of the placenta and naming ceremonies are necessary to centre the baby with the land and its ancestral spirits.

None of the pregnancy and childbirth rituals are included as part of government pregnancy and maternity care. Under the heading, Community Participation, The South African Guidelines on Maternity Services proclaims that women and communities must be empowered to contribute actively to improving maternal health. Yet, the role of Indigenous midwives is excluded. This means healthy birth outcomes are exclusively in biomedical terms. The term traditional birth attendant is only mentioned once, in one short line, under the heading: Exclusions. Exclusion of an entire body of knowledge is epistemic violence. Perez (2019) defines epistemic violence as different ways in which violence is exercised in relation to the production and recognition of knowledge (Pérez, 2019). This includes different ways in which embodied knowledge of birthing is suppressed (Dotson, 2011), or ways in which other people's knowledge is suppressed, erased and not acknowledged (Brunner, 2021).

I argue that a review of the exclusion of Indigenous birthing knowledges in Maternity Guidelines is a critical step in decolonising maternity services in South Africa. Failure to do so upholds what Campo (2014) refers to as reinforcement of Western cultural values (Campo, 2014). To decolonise maternity care, there is a need for emphasis care that does not "demean, diminish or disempower the cultural identity and well- being of the individual" (Churchill et al., 2020).

Building on the work of Chadwick (2019) who argues that obstetric violence functions as a form of "epistemic violence in which the privileged embodied knowledge of labouring/birthing person is systematically suppressed" (Chadwick, 2019, p. 32), I conclude that suppression of, and an exclusion of an entire body of Indigenous birthing knowledge from National Guidelines on Maternity Care is a form of obstetric violence. This raises a question about the role of the State as a perpetrator of obstetric violence. It is beyond the scope of this thesis and my scope of knowledge and expertise to extrapolate on this conclusively. It is, in my view, a critical matter that requires further research.

### 8.3.3. Include cultural safety in the definition of safe birthing.

Caring for a woman who is giving birth requires different caring modalities. This includes three domains of cultural safety i.e., relationships and communication (relates to respect for women's choices); sharing of knowledge and information about the birth process, and respect for Indigenous values, practices, and approaches to birth (Churchill et al., 2020). A midwife

who practises cultural safety is one who embodies Indigenous ways of knowing and caring. The role of such a midwife transcends catching a life baby. It includes leading childbirth rituals that include protection of the birth space. It is clear from the findings of this study that medicalised birth is not equipped to provide cultural safety and spiritual care.

While the overall objective of maternity care is to prepare and support the woman for birth, such preparation is done within the context of a technocratic, interventionist biomedical model of childbirth (Davis-Floyd, 2001). This presents a paradox in which all births are categorised as risky (Magee & Askham, 2008). By constructing birth within the framework of risk, this reinforces the view of the woman's body as a birth machine which requires technological surveillance and intervention. This continues to place the health care provider in a position of authority and control over a woman's choices and decisions (Lothian, 2012).
In contrast, the conception of birth in Indigenous model of birth views birth as a natural and social event. As indicated earlier, other than ensuring that birth is physiologically safe, Indigenous midwives provide cultural safety for the mother and baby. Cultural care starts before conception through the performance of preconception rituals (See section 6.4.1.). By inviting the soul to be conceived, elders begin to prepare for its birth. Cultural safety continues during pregnancy, delivery, and post-partum.

Based on the findings, I argue that maternity care in South Africa is culturally unsafe. A study on the experience of midwives in South Africa revealed that midwives lack cultural knowledge and hospitals do not have any policy on culturally competent care (Moeta et al., 2019). Midwives also reported that the design of the hospital makes it impossible to accommodate diverse cultural practices. To ensure a culturally safe maternity care, government policy must be reviewed with an aim of deconstructing safety for a diverse population.

I recommend several ways in which cultural safety can be integrated in the definition of safe birthing:

- Review the exclusion of Indigenous birthing practice in the South African Maternity Guidelines as outlined in Section 8.3.2. earlier.
- Indigenous midwifery summit to help Indigenous midwives to organise themselves, share knowledge and make resolutions about how they can/will be involved in maternal health care in South Africa.

- National Dialogue between biomedical and Indigenous midwives to discuss areas of convergence and divergence. This will include an opportunity for each group to reflect on their attitude towards the other.
- Include a module on cultural competence in Midwifery training taught by the custodians of Indigenous midwifery.
- Challenge refusal for relatives to accompany their relatives during birth. In the case where there is no privacy, hospitals will need to install curtains. This is not an ideal situation. As I mentioned earlier, the design of hospitals do not cater for a culturally safe birthing experience.
- Cultural safety must be included in antenatal care as part of the birth plan. The woman must be supported in setting out her desired cultural and spiritual needs.
- Encourage home birth for low-risk women who do not want to give birth in hospital.
- Review the policy and/or legislation related to women requesting to take their placenta home for cultural/spiritual purposes.
- The architecture, physical design (both external and internal), and natural environment of birthing centres need to create healing spaces that will accommodate different physiological, cultural, and spiritual rituals and ceremonies (both biomedical and Indigenous). To decolonise childbirth, the physical, cultural, and spiritual birthing space must change. The architecture of the birth space is as important as legal provisions and institutional procedures that govern childbirth practices.

### 8.4. Limitations

This study has several limitations. One of the most critical is lack of time and resources to immerse myself in the day to day lives of the participants. The findings would be enriched by a process of cultural immersion. According to Indigenous research framework, a research relationship often continues beyond the report. I am looking forward to immersing myself more in the work, to expand and deepen lessons learned in this study.

Another limitation is that I did not interview biomedical midwives to get a sense of the challenges, constraints and limitations that they encounter in conducting their work. To gain access to biomedical midwives, I had to obtain permission from the Department of Health. Changing the sample would have also meant that I should revise my research proposal for review by the University Ethics Committee. These delays would have extended the research

beyond the time permissible to complete a doctoral degree. I admit that failure to include the views and experiences of midwives working in health care settings presents a biassed perspective. I accept this as a significant limitation of the study and I therefore recommend further research on this topic.

Adopting Indigenous research paradigm also came with challenges and limitations. In the initial research proposal, I had planned to collect data using individual interviews. My experience in the field was different. It was common for family members or neighbours to invite themselves to the interview. In her critique of individual interviews, Chilisa (2012) argues that standardised interviews lean towards western methodological frameworks which are based on the belief of the individual knower. Upon my return from the first round of interviews, I explored the possibility of changing individual interviews to sharing circles identified by Lavellee (2009) as an Indigenous narrative research method which is often used for ceremonies, healing, research, and data sharing (Lavallée, 2009). Because of limited time available to complete the research, I was advised to continue with individual interviews but focus on documenting responses from the main participants.

## 8.5. Recommendations for further research

### 8.5.1. Review of South African Maternity Guidelines

As mentioned above, I recommended research and review of South African Maternity Guidelines (Section 8.2.4. and Section 8.3)

### 8.5.2. Violence and harassment against biomedical midwives

As indicated earlier, one of the limitations of this study is the fact that I did not interview biomedical midwives about their perspective of obstetric violence. In addition, given that many nurses/midwives are women, they could also be subjected to violence, both at home and at the workplace. Other than including gender-based violence and workplace violence/bullying as part of the curriculum and policies, there is need for more research on violence, harassment, and bullying against midwives working in maternity wards.

### 8.5.3. Registration of births

According to the South African Birth and Death Registration Act of 1992, a child must be registered within 30 days of their birth. Any registration that happens after 30 days is declared as late registration, and it involves requirements that include biometrics of the child, affidavit giving reasons for late registration, fingerprints of parents, identity document or passport of parents and proof of birth. If the baby was born in a hospital, a medical practitioner or healthcare provider who attended the birth is required to fill up a form. If the baby was born at home, parents must provide proof of birth affidavit. These requirements discriminate against mothers who choose to observe postpartum ceremonies, which include isolating the mother and the baby for a period that ranges between two to three months.

Section 9(3) of the Constitution prohibits the State from discriminating against anyone on the grounds of religion, belief, and culture. Section 31 entitles persons belonging to a cultural, religious, or linguistic community to a) enjoy their culture, practise their religion or linguistic community. Women who gave birth at home complained about the government's requirement to register the baby within 30 days. For them, such a requirement is a violation of their right to enjoy and practise their culture. To allow women to practise their postpartum cultural rituals, it is my view that the requirement for birth registration should be extended to a period of 60 to 90 days after delivery.

### 8.5.4. Roles, regulation, and remuneration of Indigenous midwives

Indigenous midwives (referred to in the Act as Traditional Birth Attendants) are together with other traditional healers regulated through the Traditional Health Practitioners Act, 2007. The Act identifies four types of healers i.e., diviner, herbalist, traditional birth attendant and traditional surgeon. There is a dispute amongst healers that there are other types of practitioners which are not included in the Act. However, this is a topic which has no relevance to the research question. As far as Indigenous midwives are concerned, there is no section in the Act that details their role. The emphasis of the Act is on registration of healers as well as serving the interest and protection of the users of the service. In the section above, I recommended an Indigenous midwifery summit followed by a dialogue between the two types of midwives i.e., biomedical and Indigenous. There is enough research on their need to collaborate. However, calls for collaboration do so without dismantling the colonial hierarchy

of knowledges. Unlike traditional healers who are remunerated for their services, Indigenous midwives are not paid for their contribution to maternal health in South Africa.

### 8.5.5. Harmful childbirth rituals and ceremonies.

In this study, Indigenous midwives shared information about pregnancy and childbirth rituals. For instance, cutting the umbilical cord is perceived as a spiritual act because it marks the first separation between the mother and the child. It is for this reason that the cutting of the umbilical cord is perceived as a sacred ceremony. Other rituals and ceremonies include isolation after childbirth, burial of the placenta, birth songs and naming ceremonies. In Section 3.5.3. I cautioned against the possibility that some of the rituals may be harmful either physically, psychological, or spiritually. For instance, the lyrics of the birth songs are discriminatory in a sense that they tend to value a boy child more than a girl. This reinforces derogatory treatment against a woman who, in the in-law's eyes, has failed to give birth to an heir. There are many other rituals which has the potential of putting the life of the mother and/or baby at risk. There is a need for more research to investigate how Indigenous rituals and ceremonies contribute to women's oppression and how this is linked to obstetric violence.

## 8.6. Conclusion

South Africa adopted a Western biomedical model of medicine as its primary model of health care. Adoption of this model brought with it the medicalisation of childbirth. I have demonstrated how biomedicine was centred in childbirth from the time of ancient Greek societies to modern day Europe. In ancient societies, men's perception of women was influenced by religion and mythology. This enabled the process of men's takeover of childbirth from women as well as shifting the location of birth from home to institutions (Kuoni, 2021; Marino, 2010). This was influenced by urbanisation and industrialisation, factors which necessitated the need to build hospitals (Gallagher, 1988). Founded on the metaphor of the body as a machine, obstetrics flourished and resulted in medicalisation of childbirth. This was followed by technological interventions during pregnancy and labour (Davis-Floyd, 1994). The medicalisation of childbirth introduced medical interventionist procedures such as induction of labour, insensitive vaginal examinations, routine intravenous infusion, episiotomy, and coerced caesarean sections. Stories shared by women who gave birth in

healthcare facilities reveal that women have normalised violence during childbirth. Physical abuse is often used to gain compliance. Verbal abuse was also common in the form of ridicule, humiliation and disparaging comments about women's age, class, sexual history, or number of children. Some women were chastised that if they enjoyed sex, they must then bear the brunt of painful childbirth. Many endured being treated as if they were not human.

In writing about the global and South African context of obstetric violence, I attempted to show that this is a complex phenomenon which lies at the intersection of biological, cultural, political, structural, economic and many other factors within which both the victim and perpetrator exist. The perpetrator is not limited to an individual. Instead, it includes conceptual, systemic, institutional, cultural, and other dominant social paradigms. By introducing biomedical midwifery, colonial medicine positioned itself as authoritative knowledge. Because of its interventionist nature, the biomedical model of childbirth spurred obstetric violence.

In this study, I have also demonstrated how the Western biomedical model of birth was used as a colonial tool, a factor which was instrumental in suppressing and erasing Indigenous midwifery. While many feminists advocated for the humanisation of childbirth as the solution, there has been little attention to the role of Indigenous midwives in countering obstetric violence. By adopting an Indigenous feminist perspective, I argue that current efforts aimed at responding to obstetric violence need to acknowledge centuries of colonialism, apartheid, obstetric racism, land dispossession and other forms of oppressions which resulted in suppression of Indigenous knowledge in general, and Indigenous birthing practice in particular. Failure to do so contributes to ongoing silencing of, and erasure of the knowledge of Indigenous midwives.

The main aim of the study was to explore lessons we can learn from Indigenous midwives to counter obstetric violence. Even though a lot has been written about obstetric violence globally and nationally, the voice, knowledge and practices of Indigenous midwives are excluded. Many of the proposed solutions are focused on improving and/or humanising biomedical birth by way of formulating policies, training of personnel, creating accountability and reporting mechanisms to prevent or respond to obstetric violence. This continues to uphold biomedical hegemony at the expense of Indigenous midwifery. The African epistemology of childbirth views pregnancy and childbirth as a physiological, social, cultural,

and spiritual phenomenon. Based on the lessons learned from Indigenous midwives, a comprehensive response to obstetric violence need to 1) decentre biomedical model of childbirth especially in low-risk pregnancies, 2) decolonise midwifery by recentring Indigenous knowledge of birthing, and 3) integrate cultural safety in the definition of safe birthing practices.

### 8.7. Closing ritual

As I bow out of the end of the beginning of this journey, the next critical question is “where to from here? “I have been blessed with opportunities to engage with elders in their different roles as healers, midwives and leaders of rituals and ceremonies. Just after submission of this dissertation for examination, I will spend time in a village in Venda closer to the border of Zimbabwe delivering babies with local Indigenous midwives who live miles away from the nearest clinic or hospital. Beyond that, I have also been invited by Indigenous midwives in another province to learn about the herbs. The next steps of this journey keep unfolding organically. I am looking forward to being continuously transformed by this initiation process. My dream is to convert this dissertation into a book for public readership. For now, I end this journey by honouring the dispossessed land in which many African women’s placentas have been buried.

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## Appendix A: Information sheet and consent form

**Consent Form**

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YUNIBESITHI YA PRETORIA

**Title of Study**

**Humanising Childbirth in South Africa: The role of indigenous midwives in countering obstetric violence**

**Who I am and why I am here?**

Dumelang. My name is Mmatshilo Motsei. I am a Doctoral student in the Department of Sociology at the University of Pretoria. As partial requirements of my studies, I am undertaking a research project entitled Humanising Childbirth in South Africa: The role of indigenous midwives in countering obstetric violence. The main aim of the project is to identify indigenous midwifery practices that can help us to respond to violence against women who are giving birth.

**Request for your participation**

To assist me in gathering the information required to complete the project I am requesting your permission to conduct an interview with you that should last no longer than 1 hour 30 minutes. In addition, I will be grateful for your permission to audio-record the interview. On the next page there is a place for you to sign (or make an "X" sign) as an indication that you give permission for me to conduct the interview and, if you are willing, to audio-record it.

Please understand that you are not being forced to take part in this study and the choice whether to participate or not is yours alone. If you choose not take part, there will also be no penalties and you will NOT be prejudiced in ANY way. If you agree to participate, you may choose to withdraw at any time during the interview. Furthermore, if at any point in the interview you feel uncomfortable with a question asked, you are not forced to answer it and you have the option to decline to respond to the question.

Your participation will cost you nothing and there will be no direct benefits to you.

**Confidentiality**

All the information you provide in this interview will be kept highly confidential and in all dissemination of the study results pseudonyms will be used to protect your identity. The information will only be used for academic purposes such as writing the dissertation, presenting in local and international conferences, writing journal articles, books, or book chapters. However please note that the following:

- The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the Research Ethics Committee of the Faculty of Humanities and the University of Pretoria (all these people are required to keep your identity confidential).
- As per the University of Pretoria policy, the transcripts of your interview will be stored securely and in an anonymised format at the Department of Sociology for a maximum of 15 years.

**Risks/Discomforts**

There are no anticipated risks attached to participating in this study. However, if you feel distressed in any way at any point during the interview or after, please let me know and I will provide you with the details of trained counsellors/social workers at Afrika Ikalafe 0671439974 who will be on standby to offer your services free of charge. You are welcome to send a please call to the number.

If you have any concerns regarding the way the interview was conducted, or any other concern regarding your participation in this study, please contact the Postgraduate Coordinator of the Department of Sociology at the University of Pretoria on 012 420 3744 or by email at Zitha.Mokomane@up.ac.za

**CONSENT**

I hereby agree to participate in the study entitled Humanising childbirth in South Africa: The role of indigenous midwives in countering obstetric violence. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop this interview at any point should I not want to continue, and that this decision will not in any way affect me negatively.

I understand that this is a research project whose purpose is not necessarily to benefit me personally.

I have received the telephone number of a person to contact should I need to speak about any issues which may arise in this interview.

I understand that my answers will remain confidential.

……..

**Signature of participant** **Date**.

I am willing for this interview to be audio-recorded.

……..

**Signature of participant** **Date**….

*Information and consent forms will be made available in the participants' language of choice.*

**Appendix B: Interview guide for women who gave birth in a health facility and at home**

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**Interview guide for women who gave birth at home with indigenous midwives and at a health facility with a biomedical health care practitioner.**

Name

Age

Education

How long have you been living in the village?

What is your occupation?

What is the source of income?

Who do you live with?

Do you have other children? If yes, where were they born and who attended to the deliveries?

What was your experience of earlier pregnancies?

What was your experience of earlier labour/delivery?

Were you adequately prepared for labour in all your pregnancies?

If yes, who or what helped you to prepare for labour?

If no, what would you have liked to know before the onset of labour?

Can you share your experience of your recent labour and delivery?

Was the experience positive or negative? Please explain.

Did you choose the birth position you wanted to adopt during labour?

If you gave birth in a health facility, did you ask to take the placenta home?

If yes, what was the reaction of health workers?

If no, what is your reason?

Was everything which was done to you communicated to you?

If not, what happened? How did that make you feel?

Were any of your cultural or spiritual beliefs respected during labour?

If not, which cultural or spiritual practices would you have liked to experience?

What is your opinion of cultural taboos surrounding pregnancy, labour and post-natal period?

Are you familiar with any cultural, traditional, and spiritual rituals and practices performed during and after delivery?

Have you undergone or witnessed any of these rituals and practices? Please explain.

Do you think it is important to perform childbirth related cultural rituals? Why?

Do you feel women are adequately supported when they give birth? If not, what do you think is missing?

Have you ever witnessed a situation where a woman who is giving birth is subjected to violence? If yes, please tell us more about what you witnessed?

Have you experienced any violence when you were giving birth? If so, would you mind telling us more about your experience?

In your opinion, do you think there is something we can learn from indigenous midwives to make childbirth more humane in South Africa?

Do you have any other suggestions or recommendations for making childbirth more humanised?

## Appendix C: Interview guide for Indigenous midwives

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**Interview guide for indigenous midwives**

Name

Age

Education

How long have you been living in the village?

What is your occupation?

What is the source of income?

Who do you live with?

Do you have other children? If yes, where were they born and who attended to the deliveries?

What was your experience of earlier pregnancies?

What was your experience of earlier labour/delivery?

Were you adequately prepared for labour in all your pregnancies?

If yes, who or what helped you to prepare for labour?

If no, what would you have liked to know before the onset of labour?

Can you share your experience of your recent labour and delivery?

Was the experience positive or negative? Please explain.

How did you become a midwife?

How long have you been practicing?

Who are your clients? How do they know about you?

Have you had any training as a midwife? Who taught you?

Are you passing on any knowledge and skills to anyone? If so, who?

What services do you provide to pregnant women?

Where do you provide your services?

Are you paid for your work? If not, how are you rewarded?

**Ante-natal care**

How do you know that a woman is pregnant?

Do you provide any ante-natal care to pregnant women? If yes, what service do you provide?

At what period in their pregnancy do women come to see you?

How often do you see them?

Are you able to determine the lie of the baby in the womb?

Are you able to change the position of the baby by massaging the abdomen?

**Delivery**

How many deliveries have you supervised in the past year?

How do you know that the woman is ready to give birth?

What position is a woman encouraged to adopt and why?

Describe how you facilitate a birthing process?

Do you give anything for pain?

Do you shave the vulva?

How do you examine the woman to check if she is ready to push?

Other than you, are there other people who are allowed to be part of the birthing process? If yes, who?

Does it help for the woman to have a birthing companion? If yes, how?

Do you have a delivery kit? If yes, what is in the kit and where do you get the supplies?

How do you know if the mother or baby is at risk?

When do you refer them to a health facility?

Do you have any working relationship with a clinic or hospital nearby?

**Postnatal care**

What is done once the baby is born?

How do you remove mucus from the baby's mouth?

When do you initiate breastfeeding?

When do you cut the cord?

What do you use to cut the cord?

Please tell us about how you help with the birthing of a placenta. When is the placenta delivered and how?

Have you ever had a situation where a placenta is retained? What did you do?

What are the rituals associated with the placenta and the stump of the umbilical cord?

Do you visit the mother and the baby after delivery? How often?

Do you perform any rituals for the mother and/or baby?

What are the cultural beliefs associated with pregnancy and delivery?

Do you participate in any naming ceremonies? When is the baby given a name and what is the naming process?

What herbs or plants do you use for pregnancy, labour and postnatal care?

What cultural birthing practices do you know?

What kind of pregnancy and childbirth taboos are you aware of?

Do you think it is important for us to preserve indigenous knowledge about birthing and why?

Have you ever witnessed, or heard of a situation where a woman who is giving birth is subjected to violence? If so, please tell us more about what you witnessed?

In your opinion, what do you think is the contribution of indigenous midwives in countering violence perpetrated against women who are giving birth?

Do you have any recommendations on how we can make childbirth practices in South Africa more humane?