Trajchtmoakas, *Parteras*, and Midwives: 100 Years of Maternal Care in the Campos Menonitas of Chihuahua, Mexico

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Across the Mennonite diaspora, midwives have long been fixtures in village (*Darp*) life and, over the centuries, have played an important role in establishing and sustaining Low German–speaking Mennonite communities. Among religious, separatist, immigrant populations in isolated geographic locations, midwives are often the only line of defense between life and death for pregnant women (Martens & Harms, 1997). The formal and informal models of midwifery training and practice established among Mennonites in Russia and Canada influenced childbirth practices in subsequent migrations across the Americas (Epp, 2010, 2012). After each new round of migration, similar socio-political, economic, and cultural dynamics between Mennonite communities and external governing authorities concerning colony autonomy sparked reactions to Mennonite midwifery practices (Stoesz, 2014). For example, in Mexico, attitudes, practices, and regulations surrounding the role of midwifery in childbirth changed over time from acceptance of traditional practices, to reactionary prohibitions, to broader acceptance of a spectrum of traditional and medicalized practices.

Since the beginning of Mennonite settlement in the Cuauhtémoc region of Chihuahua, Mexico, in 1922, Mennonite midwives from traditional and non-traditional communities have played a vital role in community life and have been at the centre of the region's changing dynamics. Official medical record-keeping was sparse in the first decades of settlement in Mexico, as was also the case in the Russian empire and Canada in the late 19th and early 20th centuries respectively (Stoesz, 2014). Yet there is a rich collection of oral history testimony that bears witness to a strong tradition of midwifery in each of Cuauhtémoc's three cultural groups, the *Tres Culturas* from which the region derives its name. Mennonite, mestiza, and Indigenous Rarámuri midwives in each community, though distinct, are powerful advocates for women marginalized due to their language, ethnicity, and/or socio-economic status. They serve as public health professionals and educators in some of the most at-risk and underserved regions for maternal, infant, and child health. Midwives often operate on the fringes of official community structures while subverting taboos surrounding reproductive health and pregnancy. By creating support networks among women, midwives act as agents of community solidarity and at times serve as intercultural bridge-builders between communities that have historically experienced tensions for a variety of cultural, economic, and socio-political reasons.

I Never Wrote it Down: Mennonite Midwives in Post-Revolutionary Mexico (1922–1980s)

At first glance, Catalina Schroeder and Susana (Fast) Shellenberg, two Mennonite midwives practicing in the Tres Culturas region of Chihuahua from the 1920s to the 1980s, appear to embody the differences and tensions existing between the large Old Colony and small Russländer Mennonite communities in Mexico. However, despite their different countries of origin, dress, approaches to education, and religious and cultural practices, they were part of a shared legacy of immigrant Mennonite midwives whose practice was invaluable to communities across the diaspora. Discussing this history, Marlene Epp (2012) notes, "Mennonite women, trained and practicing as midwives while living in Siberia, or in other parts of the Russian Empire or later Soviet Union, carried their knowledge and skills to Canada and Paraguay, where their labour was crucial to the survival and success of immigrant communities." For almost 60 years, during a time when midwifery was declining precipitously in Mexico and around the world, they built bridges between

communities by providing maternal care to women of all ethnic, cultural, and religious backgrounds in the region surrounding Cuauhtémoc. Despite challenges from the Mexican government, they built a foundation upon which later midwives in the Tres Culturas region could integrate medicalized maternal care models and culturally informed public health practice alongside traditional midwifery care to improve maternal and infant health outcomes and advocate for all women.

Catalina Schroeder received a formal education in midwifery in present-day Ukraine before fleeing violence and religious persecution along with thousands of other Mennonites in the 1920s. While the vast majority would immigrate to Canada, Catalina, along with her husband and young family, arrived in Mexico in 1926. They initially landed in the state of Veracruz. After many delays, including the loss of newly issued government documents in a fire, the family relocated to Chihuahua with a small number of other Low German–speaking Mennonite refugees from the Soviet Union. They hoped to settle alongside the 5,000 Low German–speaking Old Colony Mennonites from Canada who settled in Chihuahua starting in 1922, after being granted unique protections under Mexican law (what the Mennonites called their *Privilegium*) by President Álvaro Obregón (Renpenning Semadeni, 2018). These privileges included educational autonomy and exemption from compulsory military service.

In an interview exploring his grandmother Catalina's history, Walter Rempening Rico (pastor of Templo Ebenezer, a Spanish-speaking Mennonite congregation in Cuauhtémoc) shared how his grandmother, grandfather, and their young children settled in the city of Cuauhtémoc. They were quickly integrated into many aspects of local Mexican culture because Russländer Mennonites were not allowed to live in close proximity to the Old Colony Mennonites due to their less traditional lifestyle, dress, and educational approach. Despite being prohibited from living inside Old Colony communities, his grandmother Catalina worked tirelessly as a *Trajchtmoaka* (chiropractor), herbalist, and midwife. She was highly sought after to deliver babies for traditional Mennonite women and was admired in traditional, non-traditional, and mestizo communities throughout the region (Rempening Rico, 2018). The high birth rate in the large geographic area and the low number of formally or informally trained midwives available to practice led Catalina to work across denominational, ethnic, and linguistic lines.

This same demand also created space for informally trained Old Colony midwives like Susana Shellenberg to conduct a prolific practice. Susana, born in Canada at the turn of the 20th century, immigrated to Mexico with her husband Heinrich and young daughters

in 1927. As an Old Colony woman, Susana, unlike Catalina, lived in a traditional *Darp* established north of the city of Cuauhtémoc in the years after the initial 1922 migration from Canada. In Canada, Susana had trained as a midwife and herbal healer with two Orthodox Jewish women. She continued her work upon her arrival in Mexico. In 2019, her great-granddaughter Susanna Thiessen, also a midwife, was interviewed about her great-grandmother's legacy by a member of Casa Geburt, a midwifery and doula training school and birthing centre located in the Campos Menonitas (Mennonite settlements), about twenty minutes north of Cuauhtémoc:

> At that time there were no doctors in the Cuauhtémoc area. Immediately she began caring for the sick. After a few years in Mexico, she also began to provide midwifery services. She served in the Mennonite Campos as well as on the Mexican ranches. Sometimes people would come looking for her in the middle of the night on a horse and buggy to take her to attend deliveries or heal the sick. Many times, people were so poor that they couldn't even offer her coffee. She attended many deliveries where she received no payment of any kind. She also took baby clothes and blankets because she knew that people did not have anything to warm their babies.

The practice of giving little or no payment for midwifery services parallels trends in rural Russia and Canada in the late 19th and early 20th centuries (Werner & Waito, 2008) and reflects socio-economic realities and gender dynamics in the early years of Mennonite settlement in Mexico. It created conflict with licensed physicians, who felt they had to unfairly compete with midwives who were charging less.

Outside of Catalina's and Susana's budding midwifery practices, which served women in remote and often harsh conditions, Mexico was in turmoil. The years after the 1922 arrival of Canadian Mennonites in San Antonio de los Arenales (present-day Cuauhtémoc, Chihuahua) were part of the intense period of national, political, and social reorganization that followed the Mexican Revolution. Pancho Villa's soldiers in the north and Emiliano Zapata's soldiers in southern and central Mexico had returned home to conditions similar to those present under the dictatorship of Porfirio Díaz. They continued to push for further agrarian reform through armed revolt and political action. Some of this took place in, and near, the Campos Menonitas. One of the results was the creation of La Colonia Doscientos (The Two Hundred Colony), so called because of the 200 pesos paid to each *agrarista* family in exchange for giving up claims to lands now occupied by Mennonites (Domínguez, 2015).

Many saw President Álvaro Obregón (1920–1924) as a force in quelling the unrest and navigating the unification and modernization of Mexico while negotiating increased trade relations with the United States. However, in the years following his tenure, an armed conflict (La Cristiada, 1926–1929) broke out in the western and central regions of the country (excluding border states such as Chihuahua) between the anticlerical forces of President Plutarco Calles, who advocated for a secular state and the application of the punitive "Calles Laws," and the Cristeros, who supported the Catholic Church. In 1928, Álvaro Obregón was re-elected president, but he was assassinated soon after for his support of Calles and his anti-Catholic policies. A peace between Calles's forces and the Cristeros was negotiated in 1929 through a complex web of international negotiations including a United States ambassador, the Knights of Columbus, and Vatican representatives (Gonzáles, 2002).

The 1930s ushered in a period of relative stability. In 1931, the State Sanitation Service (Servicio de Sanidad de los Estados) was established to build health infrastructure and access in rural areas (Rodríguez de Romo & Rodríguez Pérez, 1998). The election of Lázaro Cárdenas in 1934 marked a growing drive to modernize Mexico and focused special attention on its rural areas. This period of reorganization, albeit tumultuous, shaped the economic, socio-political, and religious dynamics in Mexico that exist to this day and gave rise to some of Mexico's modern institutions such as the *ejido* public land system, the national public health and pension system, and the Mexican Social Security Institute (IMSS), which has existed in a variety of iterations since it was established in 1943.

It was in these years of reorganization following the Mexican Revolution that the government, prompted by legal complaints filed by two recently arrived doctors, ordered Susana Shellenberg to stop delivering babies and providing herbal remedies to the local communities of Cuauhtémoc, Cusihuiriachi, and Santa Rita. This confrontation was the result of a perfect storm of contemporary socio-political and religious dynamics unfolding at the national level. It also reflected the shift in sentiments about midwifery and traditional healing that coincided with the development of the national public health system of Mexico and its focus on modernization of medical treatment in rural areas (Rodríguez de Romo & Rodríguez Pérez, 1998).

Susanna Thiessen (2019) spoke about how her great-grandmother Susana Shellenberg experienced these tumultuous times:

> Doctors began to arrive in Cuauhtémoc, including Dr. Cazale and Dr. Barba Cornejo. The city had grown over time. There were people who

> were jealous of the kind of help Susana was providing and filed a legal complaint against her with the government. She had to stop helping people for a while until some Mexicans came to her defense saying, 'This woman saved the lives of our families and we want her to continue helping people." Mexicans fought for Susana until after a while the government gave her permission to work freely.

Despite ongoing tensions surrounding land disputes between mestizos and Mennonites and accusations that the government was giving preference to Mennonites as a religious group in a state that sought secular rule, Susana Shellenberg's relationship with the local mestizo community was so strong that they came to her defense and demanded that she be allowed to continue practicing. The local community's support for her reveals how many within the rural population resisted embracing the modern medical infrastructure they felt was being forced upon them by the national government. To avoid further unrest in an already sensitive socio-political, economic, and religious environment, the government conceded to the demands of Cuauhtémoc residents. Susana was allowed to continue practicing.

Although mestizo residents defended Susana and the government granted her special permission to continue practicing, her story is representative of a broader history in disparate locales. Some 30 years earlier in Manitoba, as licensed physicians began practicing in rural communities and Canadian medicine professionalized, a strikingly similar case was brought against Katharina Thiessen, a Mennonite midwife trained in Russia. She was charged with practicing medicine without a license. After a long series of court battles, Katharina was ultimately able to continue her practice. Over the years, however, midwives were largely replaced by licensed practitioners in Canada (Werner & Waito, 2008). Midwifery was viewed as a threat to professional medical practice. The female-centred maternal model provided by midwives was replaced by an almost exclusively male professional medical establishment. At the time, pregnancy and childbirth were viewed through the lens of pathology and women did not have a voice or position within this new modern medical system (Stoesz, 2016).

In Mexico, these distinctions were especially pointed. Following the Mexican Revolution, any opposition to modern medical practice was understood as a barrier to medical progress and considered to be a threat to the creation of national identity and a stable, modern, industrial, secular state. María Graciela Freyermuth Enciso has explored how the international phenomenon of the medicalization of childbirth presented itself in Mexico at the intersection of national identity creation and the building of modern medical infrastructure. With the creation of the national public health system, the IMSS

required physicians seeking licensure to engage in a short period of training in rural settings. A portion of their duties was dedicated to the regulation of midwives. Freyermuth Enciso argues: "Midwifery almost became extinct in Mexico. . . . Midwives were criticized by doctors and did not have a say in that transition" (CIESAS, 2019). Exploring these dynamics from a similar perspective, Ana Cristina Rosado Medina (2018) writes,

> The post-revolutionary state tasked public health administrators (infant hygienists) with reorienting the behaviour of mothers[,] . . . limiting the practice of midwives, who throughout history women had sought out to give birth, and were considered part of a "dark past" associated with superstition and unhealthfulness. . . . In short, the purpose was to limit the practice of these midwives whom the physicians and public health administrators believed raised the risk of infant mortality and conditions that were a result of badly completed and unhygienic procedures. They created the image of the criminal midwife who through ignorance and imprudence was acting against the interests of the state: the future citizens of the post-revolutionary state. In this way, these women became possible transgressors, and Mexican mothers were suspicious subjects due to the historic complicity between themselves and the midwives. (pp. 28–29)

Although Susana Shellenberg continued to work as a midwife and herbal healer for the rest of her life, she was a notable exception to this overarching trend. In Mexico, the vacuum left by the systematic dismantling of traditional midwifery practice was often inadequately filled due to lack of resources, particularly in rural areas. This created additional pressures on the few remaining practicing midwives, like Catalina Schroeder.

Describing her great-grandmother Susana Shellenberg's prolific work after she was given permission by the government to start practicing again, Susanna Thiessen (2018) noted,

> My great-grandmother continued her work out of her home, where she had a small clinic and cared for patients freely. Sometimes people had problems, kidney disease, and she cared for them for weeks at home. At first, she ordered products for her natural remedies from Germany, but there was a problem with delivery and she began placing orders with Mexican companies. She needed these herbs to care for sick patients. Sometimes, she would sell a little of the medicine, but very cheap, because many times the people did not have money. She had two books of medicinal recipes and made many of the remedies herself. She worked into her old age. She was 80 years old when she attended her last birth and it was the birth of her great-grandson, her granddaughter's son. The mother of this child said that this child who was born with his great-

> grandmother was stronger than the other children who were born in hospitals with doctors.

Near the end of her life, Susanna was asked about the number of babies she helped deliver and she replied, "How many births have I attended? I don't know. I never wrote it down. For me, it's good enough that God knows" (Thiessen, 2018).

By the time of Susana Shellenberg's death in the 1980s, births in the Tres Culturas region, with the exception of the most rural and marginalized women of mestiza, Mennonite, and Rarámuri origin, were almost exclusively attended to in hospitals. The vast majority of deliveries were performed by Caesarean section. This was in line with national trends. Although the Mexican national health system has dramatically improved health outcomes in many areas such as the prevention and treatment of infectious diseases, maternal and infant mortality rates, particularly in rural areas of Mexico, remain so high that the World Health Organization, federal, state, and local governments, and health workers in the public, private, and nonprofit sectors continue to seek the development of models of community health and culturally sensitive maternity care that improve mortality outcomes (MacArthur Foundation, 2019).

She Came Back to Help: Aganetha Loewen Wiens as a Bridge Builder between Medicalized Births and Traditional Midwifery (1980s–Present)

The 1960s and 1970s were a turbulent time within the Mennonite communities in the Tres Culturas region. Communities were divided by the introduction of previously prohibited electricity and running water. Excommunications for putting rubber tires on tractors and buying cars and trucks were so common that the colony lands directly adjacent to the outskirts of Cuauhtémoc were settled by excommunicated people and became known as the Quinta Lupita Colony. For poor and landless youth in the colonies (sometimes referred to as "Mennonite cowboys"), semi-truck driving became a path to economic and social freedom. With new access to vehicles, families began joining migrant farm worker circuits in the US and Canada and earning more in a few months than they could in years in Mexico (Klassen, 2018). As a result of automobility and transnational labour networks, the Campos were less isolated from the broader world and the growing urban centre of Cuauhtémoc. Trade between mestizos and Mennonites exploded when it was no longer limited to the distance a horse and buggy could travel.

This increased mobility did not typically extend to women in the colonies, particularly young, single women like Aganetha Loewen Wiens. Aganetha grew up in a traditional Old Colony community during these tumultuous years. Feeling the buzz of this movement around her, she was determined to continue her education beyond sixth grade. Although she did not speak Spanish, she insisted on attending the only accredited high school in the area at the time in the town of Álvaro Obregón, where she was the only Mennonite in the school. She recounts:

> I did it practically without speaking any Spanish and the whole school was in Spanish. I struggled a lot in those first few months to understand the teachers. Sometimes, I found out later that they assigned homework. But I had some nice classmates who saw that I was struggling and came up and asked if I understood what homework we were supposed to do. It was an extraordinary experience. (Loewen Wiens, 2018)

Aganetha continued to push the boundaries of what was acceptable in her community. After completing high school, she was one of the first young Mennonites to move to Chihuahua City to attend college.

> I had the idea of going to Chihuahua to study nursing. I had many obstacles, especially from my family; there was no financial support, nothing. No one supported me when I had this idea, but there was a teacher from the Campo 101 school who gave me financial support and support in every sense of the word to be able to study there. During those years I learned that, yes, change is possible, yes, that it is possible to live in a different way. Then I said to myself: yes, you can, if you want, everything is possible. (Loewen Wiens, 2018)

Aganetha became a nurse and married a mestizo doctor she met at the hospital during her year of government-assigned social service. She also trained to be a midwife under the supervision of some of the few remaining traditional practitioners. Ana María Carrillo (1999) refers to this era in the second half of the 20th century as "the death of the midwife." The combination of modern medical knowledge and skills practiced alongside traditional midwifery allowed Aganetha and her husband to navigate complex needs within a context where many lacked access to both modern medical infrastructure and traditional midwifery care. Aganetha described the dynamic in the traditional Ojo de la Yegua Colony where she and her husband moved and opened a clinic in the 1980s:

> It was a very traditional community. When we started there, there was no road or electricity. . . . We had a practice where we had a room where

> we attended births. The women were very isolated. I had been rejected because I left the community. But they came for medical attention. That was not rejected. They accepted that. There was no problem. Many, many people came. Those who did not know Spanish had a hard time going to the doctor. That's why they looked for us. We had the advantage of being able to communicate with them in their language. (Loewen Wiens, 2018)

When Aganetha began delivering births in the Campos Menonitas in the 1980s it was almost impossible for Mennonite women, traditional or non-traditional, to have formal medical training. Those who wanted it had to go to Chihuahua City. During this period, from the 1980s to the early 2000s, the gap between the Spanish-speaking medical establishment and Low German–speaking Mennonite women remained wide. The presence of almost exclusively male physicians within the IMSS and private systems further decreased trust and access. At the same time, traditional childbirth and postpartum practices in Mennonite culture, such as home births and breastfeeding, became less common. This was in part due to increased attention to the enforcement of personal bodily morality standards attention and taboos surrounding sexual education and practices. These negative associations surged even as previously controversial topics such as the use of electricity and vehicles that had once dominated community discourse declined. The latter became more accepted even in the most traditional colonies. Some who came of age in the colonies at this time speculate that because colony authorities no longer had as much control over community members' comings and goings and exposure to external influences, the focus of community rhetoric and enforcement turned increasingly inward toward the body. Such findings are preliminary and would be a topic for additional research. In addition to these internal factors impacting traditional birthing practices and breastfeeding rates, global external factors like the previously discussed medicalization of birth and decreases in breastfeeding left many Low German–speaking Mennonite women, particularly in more conservative communities, without adequate access to prenatal and postpartum care from the Spanish-speaking medical establishment or from the few remaining traditionally trained Mennonite midwives (Carl-Klassen & Klassen, 2020).

Aganetha's training as a nurse along with her cultural and linguistic background enabled her to gain the trust of women in the community and affirm their cultural and religious practices. This allowed her to mitigate the aforementioned barriers and provide maternal care to women who otherwise would not have had access.

Marlene Epp (2012) has stressed the importance of these factors in other historical contexts:

> Cultural signifiers were equally important; aside from the obvious one of language, these included a common knowledge of kinship relationships and collective history. A midwife who shared the ethnicity of the mother would have known exactly how to prepare the foods that would have comforted and nourished the woman and her family in the aftermath of birth, as well as particular cultural and religious norms that influenced how one expressed the physical pain and extremes of emotion that accompany childbirth.
>
> While the midwifery skills of Mennonite women contributed to ethnic cohesion within their own religious communities—indeed were crucial to the existence of separatist communities—and thus helped to maintain definitional and identity boundaries for the Mennonites, such skill also drew them outside of those boundaries towards interaction with their neighbours. (p. 212)

For Aganetha, running the clinic with her physician husband provided a framework for acceptance within the professionalized, male-dominated medical establishment and gave her credibility in an environment that was increasingly skeptical of midwifery. Her training as a nurse provided her with skills and knowledge not available to previous generations of traditional midwives. Her work prefigured later movements in maternal health care that would incorporate modern medicine with care, skills, support, and advocacy provided by midwives and doulas to give women a voice in pre- and post-natal care and the delivery process. In Mexico, this move toward a norm of more mother-focused birth came to be known as the fight for *partos humanizados* (humanized births) (Saena Izunza, 2020). During the time Aganetha and her husband ran their clinic in the Ojo de la Yegua Colony, Mennonite women wanted hospital deliveries but had no access to them in their remote location. Aganetha was able to bridge the gap between the medicalization and professionalization of maternal care and midwifery by providing Mennonite women with culturally appropriate health care in their language that they could not receive anywhere else.

After her husband's death in 1998, Aganetha continued to run the clinic and pharmacy and attend deliveries on her own. She eventually closed her practice in the Ojo de la Yegua Colony and moved to Swift Current Colony, where she continues to practice to this day. During an interview, Aganetha excused herself to tend to a patient who announced their arrival in the driveway with the honk of a car horn. After about 15 minutes, Aganetha returned and poured herself more coffee before sitting down to finish the interview. Reflecting

on how her work as a nurse and midwife has changed over the course of nearly 40 years, she smiled and said:

> I still work here. I still do what I love and use what I learned. I have one pharmacy and I love working there and seeing people in the office. Recently, there has been one birth after another. Children are still being born here and I love attending births. In the 35–40 years since I went to school, things have gotten much better. The mentality is more open. It is no longer so closed. (Loewen Wiens, 2018)

Aganetha became a nurse and midwife against the wishes of her family and community during tumultuous times of change and reform in Mennonite colonies. Today, there is greater diversity of religious expression, more educational opportunity, and greater access to health care, which would not exist without the work of women who left the traditional church (by excommunication or by their own choice, like Aganetha) and later returned to their communities to serve and support the women who remained.

A New Movement of Midwives and Doulas: Casa Geburt Birth Centre and Midwifery School (2015–Present)

After almost half a century of decline, midwifery is experiencing a resurgence in the Mennonite communities of Chihuahua and throughout Mexico. This is especially true in rural and Indigenous communities. A 2019 report by the MacArthur Foundation stated:

> In recent years, more than 30 organizations—from small grassroots, indigenous groups to large governmental agencies and nonprofits—have collaborated to bring back midwifery in hopes of improving access to quality care for mothers and babies and fulfilling women's reproductive rights.
>
> The movement seeks to help midwives become more respected, fairly paid, and recognized as a safe, reliable alternative that many women find more comfortable and dignified than current hospital methods, especially in rural areas.
>
> Through education and advocacy, the number of training programs has increased to more than a dozen, and the number of clinics working with midwives has nearly doubled. (MacArthur Foundation, 2019)

Located at Campo 6½ in Manitoba Colony approximately 20 kilometres north of Cuauhtémoc, Casa Geburt Birth Centre and Midwifery School is part of this movement to provide humanized births that respect and empower women. Founded by Katia LeMone, a midwife and public health practitioner with over 30 years of

experience, Casa Geburt is at the centre of reproductive and maternal care in the Tres Culturas region. Originally from New Mexico, Katia moved to the Tres Culturas region in 2015 to train doulas and midwives at the request of members of the Mennonite community. Katia, and the midwives trained at Casa Geburt, exemplify the transnational exchange of knowledge, skills, and training that has been so often key to promoting maternal and infant health and wellness in diasporic immigrant communities, particularly those that are geographically isolated and/or maintain high levels of ethnic, cultural, and linguistic separation to maintain high levels of group identity and cohesion.

Though Katia's midwifery training and practice at Casa Geburt combine medicalized and traditional methodologies in relating with Mennonite women, its origins are in traditional midwifery practiced by Indigenous women in Chihuahua. Katia shared how her decision to become a midwife and train midwives stemmed from an encounter she had with a Rarámuri woman in Chihuahua in the late 1970s:

> In 1979, I was living in Parral and I met a Tarahumara [Rarámuri] woman on the street and she invited me to her house. We were talking and drinking tea and she asked me if I wanted to see her "instruments." She showed them to me and said: "I am a *partera*. I help women give birth." I was very interested and when I returned to the United States, I volunteered in El Paso with some friends who were training to be midwives. At that time, I had a life-changing experience during childbirth. It was difficult and I decided that I not only wanted to be a midwife, but I also wanted to train midwives. Women did not have and do not have access to the care they need. I wanted to be an advocate for women and give them what they need. The important thing is that women support women. (LeMone, 2018)

In her midwifery practice in New Mexico in 2008, Katia's first client from the Campos Menonitas in Chihuahua was a *Trajchtmoaka* who was well known in the community. By 2014, Katia had delivered babies for over 20 Mennonite women from the Campos.

> After a few years [of attending births], they invited me to come to the Campos Menonitas and give some training classes in the community. The first time I came for 10 days to train doulas, but in December 2015, I moved to Campos to train midwives because there was a lot of demand for the course. My goal was to train women who could later train others in Low German. We have had two classes graduate from the midwifery training course so far. The first class had 15 participants and all of them were Mennonites, both liberal and conservative. There were students from such conservative communities that I was surprised that they wanted to come train with us. In the second class we had seven

> Mennonites, two women from the Rarámuri People and a mestiza woman. In the second class I tried to integrate health training to build relationships with churches and the community. (LeMone, 2018)

Katia shared the challenges, successes, and future goals of Casa Geburt's work in Campos Menonitas and the Tres Culturas region and discussed how midwives with the same linguistic and cultural background as patients can help improve maternal and infant health outcomes:

> We have really high maternal mortality rates and in this environment the midwives and doulas have to be promoters of public health. We have big goals. I could not have imagined what we have been able to achieve. In 2016, we opened the Casa Geburt Birth Centre and Midwifery School. We have alliances with the Mexican Midwifery Association and some hospitals. We want every woman to have quality care in her mother tongue. This is what I would love to see. There is always the goal of raising more Mennonite women to be educators, midwives, childbirth educators, breastfeeding educators, doulas. Raise those ranks so that we have a doula for every woman. A midwife that all women can feel comfortable with. And then, the Tarahumara [Rarámuri] community and work with them. Developing our program so that more of our programs can be in Spanish and Tarahumara [Rarámuri]. More of them may be in Low German. Those are the things that are really important to us. The ultimate goal would be to have an operating school with dormitories that is associated with the birth centre, where women from any of these communities could enter and receive care from women in their community. (LeMone, 2018)

Clara Enns, a seamstress and midwife in Swift Current Colony, was one of the first graduates of Casa Geburt's midwifery training program in 2016. She discussed the role that midwives can play in lowering Caesarean-section (C-section) delivery rates in Mexico. Mexico has one of the highest C-section rates in the world, more than double the rate recommended by the World Health Organization (WHO). Longitudinal studies by the WHO, the US National Institutes of Health, and the IMSS have repeatedly shown that high rates of C-section delivery are linked to adverse infant and maternal outcomes and that comprehensive practitioner and public health system interventions are needed to lower rates and improve outcomes (Uribe-Leitz et al., 2019).

Clara also spoke about the importance of having Low German–speaking midwives and doulas as public health professionals, educators, and advocates in the Tres Culturas region, where taboos surrounding women's bodies and reproductive health are rooted in cultural norms concerning modesty and sexual practices. This results

in low levels of sexual education concerning anatomy, menstruation, and breast and reproductive system function, and creates a general environment of shame and lack of knowledge surrounding pregnancy, childbirth, and postpartum care.

> The return to midwifery is modern in many ways, but also there is a respect and a deep knowledge of the traditional of what used to be. Deep down, that makes sense to a lot of traditional women. In our communities there is a lack of information, a lack of education. Childbirth and women's health in general are not discussed. There is very little knowledge. There is a shame that surrounds it. Women have lost the information they had. Breastfeeding is a completely lost art for many women here. The high rate of C-sections must change. The World Health Organization guidelines are there and we have to change them. Mexico in general has a very, very high C-section rate, and is being pushed and encouraged to change that. We Mennonites are a big part of that. The C-section rate in our communities is much, much higher than it is in general in Mexico. A big part is the language barrier. It may be the largest factor. We have many traumatized women. We want to empower women in our community to recover what they need. (Enns, 2018)

Since its inception in 2016, the work of the Casa Geburt Birth Centre and Midwifery School has gained local and national attention. The centre was featured on the nationally syndicated television program *El Milenio* in 2019. The school has graduated three classes of midwives and continues to train midwives and doulas of traditional and non-traditional Mennonite origins as well as mestizo and Indigenous Rarámuri origins. Graduates of the midwifery and doula programs are assisting in births in their home communities and the Casa Geburt Birth Centre and Midwifery School by providing services in the centre's delivery room, in clients' homes, and in the delivery room at a local maternity hospital through a partnership with Hospital Ángeles in Cuauhtémoc.

The partnership with Hospital Ángeles was featured in the *Milenio* broadcast. It is part of a small but growing national movement of private and public practitioners and facilities offering a hybrid model of midwifery care within a hospital or other clinical settings when hospital birth is unavailable. This model provides a continuum of care that is gaining in popularity and efficacy in Mexico through initiatives like the IMSS-Bienestar program serving Indigenous women in some of the most remote parts of the country. It refers to midwives as the "cornerstone of maternal and infant care" (IMSS, 2022). This sentiment embodies regional, national, and global trends and recommendations concerning maternal and infant health outcomes at the intersection of modern medicine and traditional midwifery practice—a far cry from practices and perceptions

surrounding the role of midwifery in maternal care in the past century.

Conclusion

Although the Tres Culturas region has experienced important socio-political, economic, ideological, and cultural changes in the 100 years since the arrival of the Mennonites in 1922, midwives and their commitment to accompany and advocate for women in all aspects of their reproductive health remain as important as ever. While today's midwives are in many ways far removed from the experiences of Catalina Schroeder, Susana Shellenberg, and their predecessors in Canada and Russia, they embody the same drive and spirit of service. It compels them to continue to challenge reproductive health taboos and navigate cultural dynamics that often prohibit or discourage connections between women from different communities, in order to provide maternal care to women from all backgrounds. The new generation of midwives being identified, equipped, and mobilized in the Tres Culturas region will continue to increase access to patient-centred, humanized births with culturally responsive care and improve maternal and infant health outcomes across all the populations they serve. Moving forward, they are committed to advocating for small- and large-scale changes to public health practices and policies that will make giving birth safer, less traumatic, and more empowering for women.

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