

Midwife-Healers in Canadian Mennonite Immigrant Communities: Women who “made things right”

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For Mennonites who immigrated from Pennsylvania to Upper Canada beginning in the early nineteenth century and for those who arrived from the Russian Empire later that century and from the Soviet Union beginning in the 1920s, the community midwife served multiple purposes: not only did she assist at numerous births when hospital deliveries and physicians were rare or inaccessible, but she also provided a wide range of essential health care services that were crucial to individuals and families experiencing the trauma of uprooting and the challenges of rural settlement. Community and family studies profile some of the more prominent midwives in early Mennonite settlement communities, supplementing the information found in the midwifery journal of Mennonite immigrant Sarah Dekker Thielman. While women such as Sarah did hold characteristics that fit the image of the “neighbour” midwife, a concept that has dominated historical portrayals of women who assist at childbirth, their personal lives and chosen career paths exhibited a great deal more diversity.

Chez les Mennonites qui ont immigré de la Pennsylvanie au Haut-Canada au début du XIX^e siècle et chez ceux qui sont arrivés de l’Empire russe plus tard durant ce siècle et de l’Union soviétique au début des années 1920, la sage-femme du village s’acquittait de rôles multiples : non seulement aidait-elle souvent les femmes à accoucher là où les hôpitaux et les médecins étaient rares ou inaccessibles, mais elle offrait également une foule de services de santé essentiels qui étaient cruciaux pour les personnes et les familles aux prises avec le traumatisme du déracinement et les défis de l’établissement en milieu rural. Des études sur les communautés et les familles dressent le profil de certaines des plus éminentes sages-femmes des premiers établissements de pionniers mennonites, étoffant l’information trouvée dans le journal de sage-femme de l’immigrante mennonite Sarah Dekker

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Thielman. Si des femmes telles que Thielman correspondaient bel et bien à l'image typique de la sage-femme du « voisinage », un concept qui a dominé la représentation historique des femmes aidant à l'accouchement, leur vie personnelle et leurs choix de carrière logeaient à l'enseigne d'une diversité beaucoup plus grande.

SARAH DEKKER was born in 1878 in a German-speaking Mennonite village in South Russia (present-day Ukraine). Her family later moved further east to a Mennonite settlement called Samara, near the Volga River. She married David Thielman in 1911, and they moved to another settlement called Barnaul in Siberia (Asiatic Russia). She gave birth to three sons, one of whom died in childhood. They moved to Canada in 1929, in the final year of a significant migration that saw about 21,000 “Russian” Mennonites re-establish themselves mainly in Ontario and the Prairie provinces in the 1920s. The Thielmans settled first in Glenbush, Saskatchewan, then moved to Beamsville, Ontario, in 1941. In the early years of the twentieth century, Sarah had gone to St. Petersburg to be trained as a midwife, and in 1909, still a single woman, she began recording the births at which she assisted in a midwife’s journal, a carefully hand-written document in German gothic script.¹ Along with the short entries offering factual information about each birth, Sarah’s journal includes detailed, hand-drawn sketches of the female reproductive anatomy and about 30 pages of “teaching material” that describes outcomes, procedures, and complications related to childbirth. While her journal does not approach the descriptive and reflective nature of the famous late-eighteenth-century *Midwife’s Tale* of Martha Ballard, it does offer important information about Sarah’s knowledge and training as a midwife. When the journal entries end in 1941, Sarah had assisted at 1,450 births, or at least these were the ones recorded. After moving to Ontario, she ceased her labour as a midwife, but continued offering her chiropractic and other healing skills to the local community.² As a multi-faceted health care provider, Sarah was sometimes referred to as a *Zurechtmacherin*, meaning “one who puts things back” or “makes things right.”³

While I have learned only little, to this point, about Sarah Dekker Thielman’s life in general, her career as a midwife offers a useful example for investigating and understanding the history of midwifery in Canada and also the significance of women with her professional skills

1 Winnipeg, Centre for Mennonite Brethren Studies [hereafter CMBS], Sarah Dekker Thielman personal collection, vol. 1057.

2 Biographical information for Sarah Dekker Thielman is taken from the following sources: “Biographical Sketch,” in CMBS, Sarah Dekker Thielman personal collection, vol. 1057; Obituary of Sarah Thielman, *Mennonitische Rundschau*, February 17, 1968, p. 11; Alfred H. Redekopp, *Jacob Thielmann and Helena Kroeker: A Family History and Genealogy of their Descendants* (Winnipeg: A. H. Redekopp, 1988).

3 Letter from Katherine Jantz, October 4, 2004.

in immigrant communities of the early twentieth century. In “rethinking the history of midwifery in Canada” in 2004, Lesley Biggs suggests that a more varied analysis is necessary and that “no singular history of midwifery exists, but rather many.”⁴ She observes that the concept of the “neighbour” midwife has dominated historical portrayals of women who assist at childbirth. The idea of a neighbourhood of women with informally obtained skills and knowledge who assisted each other in childbirth in a rural, pioneering context has, Biggs argues, created a homogeneous portrait of historical midwifery. As others have noted, it has also induced an image of “traditionalism” that has served the political goals of the contemporary midwifery movement.⁵ Biggs encourages historical research that will move us in the direction of understanding the differences and variety — regional, racial, age, ethnic, skill-related, for instance — exhibited among women who labour within the broad category of midwifery. In addition to these identity variables, one should also inquire about the nature of midwifery among immigrants to Canada during the previous two centuries. While literature on the history of immigration to Canada is extensive and published work on immigrant women is growing in volume, there is scant information about childbirth or midwifery among immigrants, either as case study or comparative survey.⁶

4 Lesley Biggs, “Rethinking the History of Midwifery in Canada,” in Ivy Lynn Bourgeault, Cecilia Benoit, and Robbie Davis-Floyd, eds., *Reconceiving Midwifery* (Montreal and Kingston: McGill-Queen’s University Press, 2004), pp. 17–45.

5 Margaret MacDonald, “Tradition as a Political Symbol in the New Midwifery in Canada,” in Bourgeault *et al.*, eds., *Reconceiving Midwifery*, pp. 46–66.

6 The history and present practice of midwifery in Canada have been illuminated primarily with reference to various Aboriginal communities and Newfoundland and Labrador. See, for instance, Cecilia Benoit, “Midwives & Healers: The Newfoundland Experience,” *Healthsharing* (Winter 1983), pp. 22–26, and “Traditional Midwifery Practice: The Limits of Occupational Autonomy,” *Canadian Review of Sociology and Anthropology*, vol. 26 (1988), pp. 633–649; Cecilia Benoit and Dena Carroll, “Aboriginal Midwifery in British Columbia: A Narrative Untold,” in Peter H. Stephenson *et al.*, eds., *A Persistent Spirit: Towards Understanding Aboriginal Health in British Columbia* (Victoria: Department of Geography, University of Victoria, Canadian Western Geographic Series no. 31, 1995), pp. 223–248. In addition to Biggs, “Rethinking the History of Midwifery in Canada,” other histories include: Suzanne Buckley, “Ladies or Midwives? Efforts to Reduce Infant and Maternal Mortality,” in Linda Kealey, ed., *A Not Unreasonable Claim: Women and Reform in Canada, 1880s–1920s* (Toronto: The Women’s Press, 1979), pp. 131–149; C. Lesley Biggs, “The Case of the Missing Midwives: A History of Midwifery in Ontario from 1795–1900,” *Ontario History*, vol. 75 (March 1983), pp. 21–36; Jo Oppenheimer, “Childbirth in Ontario: The Transition from Home to Hospital in the Early Twentieth Century,” in Katherine Arnup, Andrée Lévesque, and Ruth Roach Pierson, eds., *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries* (London and New York: Routledge, 1990); J. T. H. Connor, “‘Larger Fish to Catch Here than Midwives’: Midwifery and the Medical Profession in Nineteenth-Century Ontario,” and Dianne Dodd, “Helen MacMurchy, Popular Midwifery and Maternity Services for Canadian Pioneer Women,” in Dianne Dodd and Deborah Gorham, eds., *Caring and Curing: Historical Perspectives on Women and Healing in Canada* (Ottawa: University of Ottawa Press, 1994), pp. 103–134, 135–162; Wendy Mitchinson, *Giving Birth in Canada, 1900–1950*

Even while the much-examined “decline” of midwifery in Canada was escalating in the first half of the twentieth century, midwives in rural and ethnic communities continued to fulfil an essential semi-public function. In early Mennonite immigrant settlements, whether along the Grand River in southwestern Ontario, on the Prairies, or, in later eras, on Pelee Island in Lake Erie or the Fraser Valley of British Columbia, the midwife-healer was a central community figure.⁷ Given that many new immigrant groups as well as long-resident ethnic groups in both Canada and the United States retained the services of midwives longer than in so-called “English” communities, it is actually surprising that there have been few particularized studies of midwives or birth practices within identifiable immigrant groups.

In her 1995 study of the professionalization of childbirth in Wisconsin, Charlotte G. Borst acknowledges that the relationship between midwifery and immigrant communities was an important one that has not been adequately explored.⁸ In her survey of childbirth in Canada in the first half of the twentieth century, Wendy Mitchinson proposes, “Midwifery lasted longest in cohesive communities that were isolated from the pressures of modern industrialized society as a result of geographic or cultural separation.”⁹ This was certainly true for first-generation and sometimes second-generation Mennonite immigrants to Canada. As further evidence of the linkage between midwifery and cohesive communities, various studies have noted that immigrant women predominated among midwives in both the United States and Canada during the era of high migration from Europe in the late nineteenth and early twentieth centuries.¹⁰ Susan L. Smith has also demonstrated the significant place that Japanese midwives held in immigrant communities in Hawaii until the mid-twentieth century.¹¹ For some immigrant groups, the practices and

(Toronto: University of Toronto Press, 2002), especially chap. 3; Judith Bender Zelmanovits, “‘Midwife Preferred’: Maternity Care in Outpost Nursing Stations in Northern Canada, 1945–1988,” in Georgina Feldberg *et al.*, eds., *Women, Health and Nation: Canada and the United States Since 1945* (Montreal and Kingston: McGill-Queen’s University Press, 2003); Cecilia Benoit and Dena Carroll, “Canadian Midwifery: Blending Traditional and Modern Practices,” in Christina Bates, Dianne Dodd, and Nicole Rousseau, eds., *On All Frontiers: Four Centuries of Canadian Nursing* (Ottawa: University of Ottawa Press, 2005), pp. 27–41.

⁷ For background on the time period and locale of early Mennonite immigrant settlements in Canada, see Frank H. Epp, *Mennonites in Canada, 1786–1920: The History of a Separate People* (Toronto: Macmillan of Canada, 1974), especially chap. 2–3, 8.

⁸ Charlotte G. Borst, *Catching Babies: The Professionalization of Childbirth, 1870–1920* (Cambridge: Harvard University Press, 1995).

⁹ Mitchinson, *Giving Birth in Canada*, p. 92.

¹⁰ See, for instance, Diane C. Vecchio, *Merchants, Midwives, and Laboring Women: Italian Migrants in Urban America* (Champaign: University of Illinois Press, 2006); Borst, *Catching Babies*; Mitchinson, *Giving Birth in Canada*.

¹¹ Susan L. Smith, “Medicine, Midwifery, and the State: Japanese Americans and Health Care in Hawai’i, 1885–1945,” *Journal of Asian American Studies*, vol. 4, no. 1 (February 2001), pp. 57–75,

functions of community midwives were among a range of cultural and belief traditions that were maintained, sometimes modified, through the process of leaving the “homeland” for new horizons.

For Mennonites who immigrated from Pennsylvania to Upper Canada beginning in the early nineteenth century and for those who arrived from the Russian Empire later that century and from the Soviet Union beginning in the 1920s, the community midwife served multiple purposes: not only did she assist at numerous births when hospital deliveries and physicians were rare or inaccessible, but she also provided a wide range of essential health care services that were crucial to individuals and families experiencing the trauma of uprooting and the challenges of rural settlement. While women such as Sarah Dekker Thielman did hold characteristics that fit the image of the neighbour midwife as described by Biggs, their personal lives and chosen career paths exhibit a great deal more diversity.

In addition to Sarah’s wonderful and rare midwifery journal, information for this article is drawn first of all from community and family studies that profile some of the more prominent midwives in early Mennonite settlement communities. As a historically minded and for the most part literate community, Mennonites have produced an extensive canon of published and unpublished writings that include church and community histories, personal memoirs and diaries, family genealogies, historical periodicals, and community newspapers. Most of these are housed in Mennonite libraries and archives; in Canada, the largest of these are in Winnipeg, Manitoba, and Waterloo, Ontario.¹² While only a few of these sources contain material focused explicitly on midwives, careful mining of this rich wealth of information (of which I have only skimmed the surface) reveals abundant “scraps of information in the margins”¹³ that offer glimpses into the lives and work of Mennonite women who “caught babies.”

Migration and Midwifery

Mennonites are a small, Christian ethno-religious group with origins in the radical reformation of sixteenth-century Europe whose religious beliefs emphasize believers’ baptism as adults, nonresistance or pacifism, and a

and *Japanese American Midwives: Culture, Community, and Health Politics, 1880–1950* (Urbana: University of Illinois Press, 2005).

12 Specifically, these are the Mennonite Heritage Centre and Mennonite Historical Library located at Canadian Mennonite University, Winnipeg; the Centre for Mennonite Brethren Studies, Winnipeg; and the Mennonite Archives of Ontario and Library, located at Conrad Grebel University College, Waterloo.

13 Quoted in Glenda Strachan, “Present at the Birth: Midwives, ‘Handywomēn’ and Neighbours in Rural New South Wales, 1850–1900,” *Labour History*, vol. 81 (2001), p. 16.

continuum of responses to separation from or involvement in the world. Given their historic desire to resist acculturation and militarism in various national and societal contexts, they developed a notable history of migration and resettlement; indeed, Mennonites have been described by some scholars as diasporic in nature.¹⁴ Sarah Dekker Thielman's ancestral background included Dutch beginnings, followed by migrations in the seventeenth and eighteenth centuries to Prussia and then southern Russia. Her family and other Mennonites repeatedly moved long distances within the vast terrain of the Russian Empire (later the Soviet Union) and, following the Bolshevik revolution, civil war, and the First World War, immigrated to Canada.

The immigrant group of the 1920s was preceded by a protracted movement of Mennonite families from Pennsylvania to the Niagara Peninsula and present-day Waterloo Region in Ontario beginning in the late eighteenth century (including Amish-Mennonites arriving directly from Europe), and by the migration of about 7,000 Mennonites from southern Russia to Manitoba and Saskatchewan in the last decades of the nineteenth century. The largest wave of Mennonites — approximately 21,000 — who immigrated from the Soviet Union began arriving in Canada in 1923, a movement that continued until the end of the decade, when Canada's doors closed at the same time as exit from the Soviet Union became nearly impossible. Sarah Dekker Thielman's family was among the last to leave. When she arrived in Canada in 1929, the country was on the brink of a devastating economic Depression. The northern Saskatchewan community where she, her husband David, and their two sons settled was rural, sparsely populated, and poor. The first Mennonite homesteaders who had arrived just three years earlier were pessimistic about their prospects: "How pathetic and pitiful that beginning was. Because of the great poverty, we could not see how it would all turn out, or if we could eventually make a comfortable living."¹⁵ Difficulties eking out a living, however, did not stop women from giving birth. Especially given the large size of Mennonite immigrant families, Sarah Dekker Thielman's midwifery skills were undoubtedly very welcome.

For immigrants who settled in remote rural areas of the country — some, like the Mennonites, deliberately choosing such isolation — immigrant

14 See, for instance, Terry R. Martin, who describes Mennonites as a "mobilized diaspora," in "The Russian Mennonite Encounter with the Soviet State, 1917–1955," *The Conrad Grebel Review*, vol. 20, no. 1 (Winter 2002); Royden K. Loewen, *Diaspora in the Countryside: Two Mennonite Communities and Mid-Twentieth Century Rural Disjuncture* (Toronto: University of Toronto Press, 2006). See also Marlene Epp, "Pioneers, Refugees, Exiles, and Transnationals: Gendering Diaspora in an Ethno-Religious Context," *Journal of the Canadian Historical Association*, vol. 12 (2001), pp. 137–153.

15 Quote in Marlene O. Martens, ed., *Returning Thanks to God: Hoffnungsfelder Mennonite Churches, 1928–2003* (Hoffnungsfelder Mennonite Churches, 2003), p. 4.

“baby-catchers,” as they were sometimes called, were more plentiful than doctors and more likely to be available when a woman’s labour began. For many early immigrant women, childbirth could be an isolating and indeed dangerous experience, and conditions for giving birth were extremely primitive in some locales. For instance, Russian immigrant Margaret Loewen Isaac gave birth to her first child in November 1874 in a hut built of reed grass where the temperature was minus seven degrees Celsius.¹⁶ Given such circumstances, a woman and her midwife had to be prepared for death as fully as they had to be prepared for birth.

Prior to the Second World War, maternal mortality rates in Canada were high¹⁷ — indeed higher than in most other Western countries except the United States — and childbirth-related death was second only to tuberculosis as a cause of female deaths. A comprehensive one-year survey conducted beginning in mid-1925 found a rate of 6.4 maternal deaths per thousand live births in Canada; more specifically, 1,532 women died in childbirth in that one-year period.¹⁸ Interestingly, there were notable ethnic differences in statistics on maternal mortality. For instance, Russian-Canadian women (which possibly included Mennonite immigrants from Russia) had a higher than average rate of 8.4 maternal deaths per thousand. Sarah Dekker Thielman was “fortunate” to have had only six of 1,450 women die when in her care, and, of these, two appear to have died a few days after giving birth of unrelated illness, specifically tuberculosis and “galloping consumption.” That many more women may have been near death is implied by Sarah’s written comments such as: “mother survived,” “mother kept alive with great effort,” or “mother improved after removal” of decomposing placenta (after the midwife was called three days following the birth).¹⁹ The number of infant deaths in her records was higher — 141 out of 1,450, or 9.7 per cent — and the rates overall in Russia/Soviet Union were about the same as in Canada. Of these infant deaths, 78 are also listed as abortions or miscarriages (it is not clear how she differentiated these), indicating death of a fetus as opposed to a full-term or near full-term child.²⁰ Whether the mother’s or the baby’s life was in danger, Sarah appears to have been well trained to respond to irregularities, as the material that accompanies her birth records provides instruction on how to deal with such complications as post-delivery bleeding, high fever and pulse, cyanosis of the infant, and ectopic pregnancy.²¹

16 Daisy Isaac Penner, “Margaret Loewen Isaac (1855–1930),” *Preservings*, vol. 12 (June 1998), p. 73.

17 See Mitchinson, *Giving Birth in Canada*, Figure 3, p. 263.

18 *Ibid.*, p. 261.

19 CMBS, Sarah Dekker Thielman personal collection, vol. 1057, Birth Records.

20 *Ibid.*

21 CMBS, Sarah Dekker Thielman personal collection, vol. 1057, Teaching Material to Accompany Birth Records.

Referring to the late nineteenth and early twentieth centuries, Nanci Langford notes, “Perhaps no other aspect of life on the Prairies endangered women as much as did the birthing of their children.” This reality was so great that, in one case, Langford says, a woman readying herself for giving birth also laid out her wedding gown in readiness for her burial.²² One Mennonite recalled the cemetery next to her childhood home in Manitoba, in which “many young mothers and infants lay buried, mute testimony to the harshness of the pioneer years.”²³ While there is no definitive evidence that the assistance of midwives reduced infant or maternal mortality, knowing that a skilled midwife lived only a few farmsteads away, would come instantly when summoned, and would stay for as long as required to ensure the comfort of mother and child would have eased the inevitable fear of childbirth experienced by rural immigrant women.

The fact that midwives were fairly plentiful and midwife-assisted childbirth common among Mennonites for perhaps longer than in the general population relates to a number of factors: their rural isolation, their strong kinship relationships, their desire for separation from non-Mennonite services and institutions, and their preference for health care providers who shared their language, religion, and ethnicity. It also may well have related to the sheer number of births that took place in Mennonite households. Until about the 1970s, Mennonite birth rates were 40 to 50 per cent higher than national rates in North America, at which point they began to decline to meet societal averages.²⁴ Mennonite women, especially rural immigrants, sustained pregnancy and childbirth in numbers that are amazing to women in the twenty-first century. For instance, Barbara Schultz Oesch’s family was the second Amish-Mennonite family to migrate directly from Europe to Wilmot Township, Upper Canada, in 1824. She gave birth to 18 children altogether, 15 of them in Canada, and still outlived her husband John Oesch by 30 years.²⁵ Sarah Dekker Thielman’s birth records reveal that, of the 1,450 births she attended, 64 were cases in which the mother had already delivered 10 or more babies (though she did not record this information in each case).²⁶

22 Nanci Langford, “Childbirth on the Canadian Prairies, 1880–1930,” in Catherine A. Cavanaugh and Randi R. Warne, eds., *Telling Tales: Essays in Western Women’s History* (Vancouver: University of British Columbia Press, 2000), p. 150.

23 Hilda Lohrenz Bergen, *Immigrants’ Daughter* (Edmonton: Published by author, 1997), p. 5.

24 J. Howard Kauffman, “Mennonite Family Life as Christian Community,” in Phyllis D. Airhart and Margaret Lamberts Bendroth, eds., *Faith Traditions and the Family* (Louisville, KY: Westminster John Knox Press, 1996), pp. 40–41.

25 Lorraine Roth, *The Amish and Their Neighbours: The German Block, Wilmot Township, 1822–1860* (Waterloo: Mennonite Historical Society of Ontario, 1998), p. 44.

26 CMBS, Sarah Dekker Thielman personal collection, vol. 1057, Birth Records.

Large families seemed especially common among rural Mennonites who migrated from Russia to Manitoba in the late nineteenth century. Judith Klassen Neufeld, the youngest in a family of 15 children, was five years old when she immigrated and would herself bear 10 children over 19 years. One historian has noted that Mennonite families who arrived in Manitoba in the late nineteenth century actually increased in size when they were transplanted from the “Old World” in Russia to the “New World.” A decline in the age of marriage for *Kleine Gemeinde* (a Mennonite subgroup, meaning “little church”) women from an average of 22 in Russia in the 1850s to 19.3 in Manitoba in the 1890s was a significant factor contributing to a higher birth rate in the first generation of settlement.²⁷ For instance, Maria Stoesz Klassen, an 1874 Russian immigrant to southern Manitoba, bore 16 children, 12 of whom were girls. Immigrant midwife Maria Reimer Unger herself bore 13 children.

High birth rates reflected a number of factors, including a desire for group survival and numerical increase, attitudes towards sexuality that encouraged ignorance about fertility management, and also official condemnation of birth control by church leaders well into the second half of the twentieth century. Mennonite women were not unlike other Canadian women in having limited knowledge about how to regulate their pregnancies; or, at least, that knowledge was securely lodged in private and informal realms. Many early-twentieth-century Mennonite women, such as those interviewed by Katherine Martens and Heidi Harms for their oral history collection on childbirth, asserted that they knew nothing about birth control.²⁸ Women did what they could to space childbirth by insisting on abstinence during their fertile times (if they knew when those were) and by hoping their husbands would practise withdrawal. While such things were officially not talked about, women secretly also learned from each other such methods as vinegar douches after intercourse, the use of herbs, or vaginal sponges. One might speculate that midwives passed along advice about fertility management, but sources are generally silent on this topic. Combined with ignorance on the part of women was discouragement, sometimes outright prohibition, of the use of birth control. Based on their literalist reading of the Bible, church leaders pointed to scriptural passages that commanded God’s people to be fruitful and multiply. Typical were such admonitions by male leaders that “To refuse to multiply is rebellion against the divine order in the moral

27 Royden K. Loewen, “‘The Children, the Cows, My Dear Man and My Sister’: The Transplanted Lives of Mennonite Farm Women, 1874–1900,” *Canadian Historical Review*, vol. 73, no. 3 (1992), pp. 344–373. See also Royden K. Loewen, *Family, Church, and Market: A Mennonite Community in the Old and the New Worlds, 1850–1930* (Toronto: University of Toronto Press, 1993).

28 Katherine Martens and Heidi Harms, *In Her Own Voice: Childbirth Stories from Mennonite Women* (Winnipeg: University of Manitoba Press, 1997).

universe”²⁹ and that it “was women’s ordained responsibility to bear children willingly and rear them in the fear of the Lord.”³⁰ As long as birth rates were this high among Mennonite immigrants, the midwife remained a central service provider.

Skill and Training

One significant question of debate surrounding the history of midwifery revolves around the level of training and skill held by women who “caught babies.” Because birth itself was viewed as a “natural” activity and because many midwives were self-trained or informally trained, the skill required to assist a woman in labour has also been viewed as “natural,” something that every woman surely must carry inside herself. This kind of essentialist thinking has contributed to the predominant portrayal of midwives as women who had given birth themselves, had obtained their childbirth knowledge informally through experience or as apprentices, and assisted at a relatively small number of childbirths throughout their lifetimes, mainly within their own neighbourhood of family and friends — hence the dominant notion of the “neighbour” midwife. Because childbirth was perceived (incorrectly) as something all women could do, by virtue of their biological nature, it followed that assisting women in childbirth also came naturally to women. If that were the case, this type of health care activity was not categorized as “labour” or “work” in any kind of professional sense.

While self-trained or informally trained “neighbour,” “lay,” or “traditional” midwives³¹ were also present and utilized in Mennonite immigrant communities, the formally trained midwife was nevertheless common. Sarah Dekker Thielman’s career, like that of other Mennonite midwives, reveals that professional training and skill in childbirth procedures were common among women practitioners, even within immigrant communities of the nineteenth and early twentieth century, and was valued by women giving birth. Such training may in fact have been more common among immigrants, whose homelands offered greater access to institutions with obstetrical and related programmes than did early rural Canada.³²

In Sarah’s case, she left home as a single young woman in the first decade of the twentieth century to obtain midwifery training in

29 C. F. Derstine, *Manual of Sex Education* (Kitchener, ON: Published by author, 1942), p. 122.

30 B. Charles Hostetter, “The Wife’s Part in Happy Home Building,” *The Canadian Mennonite*, vol. 2 (September 3, 1954), p. 6.

31 Cecilia Benoit and Dena Carroll’s survey of Canadian midwifery focuses on the “traditional” and “lay” aspect of midwifery in settlement communities. See “Canadian Midwifery: Blending Traditional and Modern Practices.”

32 Susan L. Smith notes that many Japanese immigrant midwives in Hawaii had obtained training at midwifery schools in their home country. See “Medicine, Midwifery, and the State,” p. 63.

St. Petersburg, several thousand kilometres from her family. Katherina Born Thiessen, born in 1842 in South Russia, studied midwifery, bone-setting, and naturopathy in Prussia in about 1860, also studying to “catch babies” well before she bore any of her own. After immigrating to Canada in the 1880s, she sought further medical training in Cincinnati, Ohio, in 1895. Eventually, her expanded “practical” medical practice and newly built house included a reception area, pharmacy, operating room, and overnight rooms for her patients. Elizabeth Harder Harms, after training for two years in the city of Riga, Latvia, was certified as a midwife in 1912, and the following year was hired to be the “official village midwife” in the Mennonite village of Schoenfeld in present-day Ukraine. When Elizabeth immigrated with her husband to Canada in 1925, she continued to practise community midwifery, although her husband did not consider it proper for her to work in a hospital when she was offered such a job.³³

Marie Braun immigrated with her parents in 1924 from the Soviet Union to Kitchener, Ontario, where she found work in a shirt factory but also delivered babies in people’s homes. She had trained as a nurse-midwife at the Morija Deaconness House/Institute in the predominantly Mennonite village of Halbstadt in present-day Ukraine. The Morija Institute, which opened in 1909, offered a three-year nurse’s training course; students wore different uniforms at different levels of training and, according to one account, “Similar to nuns, they wore the uniform at all times and often remained single.”³⁴ Also trained at Morija was Kathe Neumann, who arrived in Canada in 1948 with her sister and the five children of their brother, who had died in a Soviet labour camp with his wife. She was addressed as Sister Kathe and wore a uniform consisting of a starched white head covering and apron and black dress, a garb she wore even to church in British Columbia. While her niece found this habit very odd, it undoubtedly reinforced Kathe’s professional stature, for herself and for others.³⁵ Another small indication of the perceived professionalism inherent in a midwife’s labour is the reference to Manitoba midwife Anna Toews, in an obituary in 1933, as an “obstetrician,”

33 Irma Epp, Lillian Harms, and Lora Sawatsky, “Midwifery: A Ministry,” in Leonard Neufeldt, ed., *Village of Unsettled Yearnings: Yarrow, British Columbia: Mennonite Promise* (Victoria: TouchWood Editions, 2002), pp. 17–22.

34 Anne Konrad, *And in Their Silent Beauty Speak: A Mennonite Family in Russia and Canada, 1790–1990* (Toronto: Published by author, 2004), pp. 415–417.

35 *Ibid.*, pp. 159, 422–423. Kathe Neumann was part of a post-Second-World-War migrant group that consisted mainly of women and children, a large proportion of Mennonite men having disappeared during the Stalin purges or on the war front. About 4,000 of these Soviet Mennonite refugees went to South America, where trained midwives were even more essential than in Canada during this period. For more detail on this migrant group, see Marlene Epp, *Women without Men: Mennonite Refugees of the Second World War* (Toronto: University of Toronto Press, 2000).

though other biographical information notes that the source of her knowledge and training is unknown.³⁶

The stereotype of the “neighbour” midwife or “handywoman” assumes that the midwife’s skills were obtained or enhanced by her personal experience of marriage and childbirth; indeed, some of the literature on midwifery reinforces a perception that the more children a woman bore herself, the more she was respected as a midwife. The training and work experience of Maria Braun and Kathe Neumann, both single women, suggests otherwise, however. Similarly, Margarete Dueck apprenticed as a nurse-midwife with a Mennonite doctor in Ukraine, then immigrated to Winnipeg with her family in 1927. She initially earned money doing housework, but, according to her obituary, “had no satisfaction” and so spent the next decade working as a nurse and midwife in Africa and South America until she returned to Canada to care for her mother, followed by marriage in 1963.³⁷ As noted already, Sarah Dekker Thielman was also a single woman when she embarked on a career in midwifery. Thus another common image — the “granny” midwife of middle age or older — does not hold true for many Mennonite midwives in early Canada.³⁸

The few personal archival collections of women who worked as midwives include medical textbooks, obstetrical manuals, and more general books of medical knowledge, further evidence that they sought technical knowledge beyond the personally experiential or that obtained through apprenticeship. Sarah Dekker Thielman’s drawings of the female reproductive system and her manual of instruction for childbirth indicate a high level of knowledge of the many aspects of labour and delivery. Included are sections titled “The Anatomy of the Uterus,” “The Procedure of Catheterization,” “When there is a Threat of Uterine Perforation,” and “The Diagnosis of Twins,” for instance, as well as technical instructions on external and internal examinations, how to adjust the position of the fetus, and how to prevent perineal tears.³⁹ The contents of midwives’ medical bags, a few still extant in archives and family collections, also points to a profession with standard tools of the trade.

36 Delbert Plett, *Johann Plett: A Mennonite Family Saga* (Steinbach, MB: Crossway Publications, 2003), pp. 188–194.

37 Obituary of Margarete Siemens Dueck, *Mennonite Brethren Herald*, April 20, 1990, p. 27.

38 Diane Vecchio also challenges the prevailing notion of the midwife as “an older, mature women” by noting that most Italian immigrant midwives in Milwaukee, Wisconsin, began practising in their early twenties. See “Gender, Domestic Values, and Italian Working Women in Milwaukee: Immigrant Midwives and Businesswomen,” in Donna R. Gabaccia and Franca Iacovetta, eds., *Women, Gender, and Transnational Lives: Italian Workers of the World* (Toronto: University of Toronto Press, 2002), p. 176.

39 CMBS, Sarah Dekker Thielman personal collection, vol. 1057, Teaching Material to Accompany Birth Records.

For example, Helena Klassen Eidse's brown leather medical bag contained such items as pills for fever, liquid medicine to stop haemorrhaging, scissors and ties for the umbilical cord, needle and thread, olive oil for greasing the birth passage, rubbing alcohol, and other medical items not related to childbirth.⁴⁰

The training and work experience of these women demonstrate that an important aspect of the labour of midwives in immigrant communities was its transnationality. Like the professionally trained Italian immigrant midwives in Milwaukee profiled by historian Diane Vecchio,⁴¹ many of the Mennonite health practitioners who immigrated from southern Russia in the late nineteenth and early twentieth centuries transplanted their skills, having received professional training at schools and hospitals in Europe and within the Russian Empire. For a diasporic group such as the Mennonites, the possibility of continuing one's labour across oceans and national boundaries was important to maintaining group cohesion and to the central role of a woman's skills within that group. For instance, Sarah Dekker Thielman, trained in St. Petersburg, was able to take her practice to Siberia, to the Canadian Prairies, and finally to Ontario. She may well have had less adaptation to make in terms of her practice than her husband and other mainly farming menfolk in her community, who were compelled to modify their knowledge and skills for a new climate, national economy, and agricultural context.

Catching Babies and Treating Maladies

In the 1870s approximately 7,000 Mennonites left southern Russia and became the first white immigrants to settle areas along the Red River in southern Manitoba. These nineteenth-century Mennonite settlers, aware of the vital need for a trained midwife to assist with the numerous births that occurred in the community, brought a midwife from a Mennonite community in Minnesota to provide a few weeks of training to several Canadian women. Furthermore, the sheer number of births at which some Mennonite midwives assisted confirms that, for these particular women, midwifery was a career and not just an occasional caring, volunteer act for a neighbour or relative. Thus historian Charlotte Borst's conclusion about the small practices of immigrant midwives⁴² does not hold true for all Mennonite baby-catchers, some of whom had very prolific careers: Sarah Dekker Thielman, who delivered over 1,400 infants in a 32-year period; Anna Toews, who delivered 942 babies; Aganetha Reimer, who assisted at close to 700 births; and others. A midwife who caught about 1,000 babies in a 25-year career would have averaged

40 Lori Scharfenberg, "Helena Eidses' Medical Bag," *Preservings*, vol. 9 (December 1996), p. 53.

41 Vecchio, "Gender, Domestic Values, and Italian Working Women in Milwaukee," pp. 160–185.

42 Borst, *Catching Babies*.

40 births per year, a significant number given the rural distances and challenging weather conditions of Canada.

Midwives also spent a considerable amount of time with their “patients” both before and after the birth, and most saw their role as greater than only the delivery of babies. Sarah Dekker Thielman was known to stay with a household for several days following birth until the mother was well enough to care for herself and her family.⁴³ Katherina Hiebert regularly brought bedding, baby clothes, and food along to deliveries, and she seemed to have no qualms about prescribing roles for husbands of women in childbirth. One story is told that, just after a baby was born, the woman’s husband brought the cow to the door, demanding that his wife milk it as it was her duty. Katherina apparently gave him a good scolding and instructed the woman to stay in bed.⁴⁴ Aganetha Barkman Reimer’s services included baking biscuits and making chicken noodle soup, in addition to the tasks surrounding the childbirth. Midwives also offered women knowledge about non-medicinal methods to deal with the harshness to their bodies of almost constant childbirth: these included chamomile tea to ease cracked nipples during breastfeeding and rubbing pig fat on bellies and legs to “loosen everything” in anticipation of labour.⁴⁵ Chamomile was also put in the bathwater of newborn babies to prevent heat rash and given to postpartum mothers to promote healing.

Even those midwives who were formally trained and recognized for their skills were for the most part willing to work cooperatively with physicians to ensure the best possible outcome for both mother and infant. As a number of writers have noted, the historical and contemporary literature on midwifery frequently focuses on the relationship between midwives and physicians, often assuming a dynamic of hostility between the two. Many early investigations emphasized a struggle of turf wars in which midwives — whether trained formally or informally — and physicians educated in medical schools each tried to claim superior skill in assisting a woman in childbirth. More recent studies, however, suggest that the dynamic between midwives and doctors was more complex, more variable, and at times mutually beneficial when it came to maximizing support for women in childbirth.⁴⁶ In sparsely settled rural areas, for instance, there may have been more of an alliance between midwives and doctors, as both tried to serve families with high fertility rates across large distances.

43 Recollection of Martin Arendt, as conveyed by Saskatchewan historian Dick Epp in an e-mail message, January 31, 2006.

44 Regina Doerksen Neufeld, “Katherina Hiebert (1855–1910): Midwife,” *Preservings*, vol. 10 (June 1997), p. 15.

45 Luann Good Gingrich, “A Mother’s Garden: Planting Seeds of Hope” (unpublished manuscript, 1997), pp. 3, 5.

46 See especially Mitchinson, *Giving Birth in Canada*. The debate is also explored in Deborah Gorham, “Birth and History,” *Histoire sociale/Social History*, vol. 17, no. 34 (November 1984), pp. 383–394.

For instance, Sarah Dekker Thielman, though herself an experienced and highly trained practitioner, called for the assistance of a physician at difficult births on a few occasions. Within the 30 pages of “teaching material” that precedes Sarah’s journal of birth records are notes describing birthing complications that required the involvement of a doctor. For example, she stated that, in the case of a second- or third-degree perineal tear, “a physician must be notified”; in a section titled “The Main Responsibilities of the Midwife,” Sarah wrote, “The midwife must not wait to call the doctor until the fetal heartbeat is absent, because a child dies quickly.” While offering detailed advice on how to manage an ectopic pregnancy (a product of conception developing outside the womb), she also stated that, when a woman’s condition becomes critical (evidenced by restlessness and yawning), then “the midwife must call for help quickly.” A separate section of the introductory material titled “When is a Physician Needed?” lists 13 complications that range from “Persistent vomiting during pregnancy” to “Every miscarriage with bleeding” to “chills during the postpartum period.”⁴⁷ Information in the journal’s birth records confirms that a physician was present to assist or take over from Sarah at some of the challenging births, though more common was the arrival of a second midwife to help. Of the 1,450 births recorded in Sarah’s journal, 22 explicitly indicate the presence of another attendant, six of whom were physicians, 15 other midwives, and one a male name described as a “birth assistant.”⁴⁸ Furthermore, in the often cooperative relationship between midwife and physician, it could also be true that physicians on occasion summoned midwives for assistance. For example, in reference to Manitoba midwife Katherina Born Thiessen, it has been said, “Morden [Manitoba] doctors called her to help with baby deliveries when they were desperate.”⁴⁹ If there were at times clashes of authority, experience, and perhaps gender between midwife and physician, there were also numerous relationships of reciprocity and exchange of skill.

The scarcity of doctors in rural immigrant communities also meant that the skills midwives carried with them through the migration experience commonly went well beyond catching babies. Few studies of midwifery have examined the extensive nature of the medical and healing services offered by women whose primary vocation was attending the birth of babies, though a recent article about “lay nursing” in Canada points out that “nursing and midwifery are hard to separate” in accounts of early

47 CMBS, Sarah Dekker Thielman personal collection, vol. 1057, Teaching Material to Accompany Birth Records.

48 CMBS, Sarah Dekker Thielman personal collection, vol. 1057, Birth Records.

49 Shirley Bergen, “Dr. Katherina Born Thiessen: A Woman Who Made a Difference,” *Mennonite Historian* (September 1997), p. 8.

caregiving.⁵⁰ Birthing was often the primary, but rarely the only, health service offered by women described as midwives, practitioners who often learned the healing arts in their country of origin. Sarah Dekker Thielman, in the midst of an obviously very busy midwifery practice, was called on for many treatments other than assisting at childbirth. Sarah's great-niece recalled, "When there was an injury, sprain, or sore back, we drove to [see] Tante Sarah who performed chiropractic, massage therapy and midwifery. She had wonderfully warm hands. Her eyes were keen and very observant."⁵¹ Her grand-daughter recalled that cars were often lined up in the driveway, with people waiting to see Sarah at her Ontario home.⁵² A parallel can be seen in the description of Sarah as a *Zurechtmacherin* (literally, "one who puts things back" or "makes things right")⁵³ and the names given to some Aboriginal midwives who, in particular locales, were referred to not as a midwife, but as the woman "who can do everything."⁵⁴ Another example is that of Agnes Meyer Hunsberger, mother of 14 and immigrant from Pennsylvania to present-day southwestern Ontario in 1800, who was "remarkably gifted in the healing art" and "answered all calls as physician or nurse." According to a family genealogy of 1896, she visited the sick on her "favorite chestnut mare, a most intelligent beast [that] carried her safely through the wilderness at all hours of day or night on the errands of mercy."⁵⁵ Women sometimes began their practices by assisting at childbirth, but, once their skills and acumen were verified, people would seek them out for other services such as pulling teeth, tending to injuries, and offering advice and treatment for various maladies that included stomach ailments, headaches, irregularity, and nervous disorders.

Conversely, in some cases a wider healing practice would gradually incorporate midwifery services. Bone-setting, a precursor of twentieth-century chiropractic, in particular, was a common accompaniment to a midwifery practice. Few rural midwives within Mennonite settlements were just birth attendants. According to one historian, with trained medical personnel virtually non-existent in early rural immigrant communities and hospitals and doctors many kilometres away, "the most important medical person in the community was the midwife."⁵⁶ Perhaps because

50 Judith Young and Nicole Rousseau, "Lay Nursing from the New France Era to the End of the Nineteenth Century (1608–1981)," in Bates *et al.*, eds., *On All Frontiers*, p. 18.

51 Letter from Katherine Jantz, October 4, 2004.

52 Telephone conversation with Irene Dyck, December 2006.

53 Letter from Katherine Jantz, October 4, 2004.

54 Mitchinson, *Giving Birth in Canada*, p. 345, n. 81.

55 Lorraine Roth, *Willing Service: Stories of Ontario Mennonite Women* (Waterloo: Mennonite Historical Society of Ontario, 1992), p. 210.

56 Royden K. Loewen, *Blumenort: A Mennonite Community in Transition, 1874–1982* (Steinbach, MB: Blumenort Mennonite Historical Society, 1983), p. 219.

of their knowledge of the human body, some midwives also performed the job of undertaker, declaring a person dead and then preparing the body for burial.⁵⁷ For instance, Anna Toews's reputation as a "competent midwife" and "respected person in the medical field was so widespread that she was often called to certify the deaths of people."⁵⁸ Likewise, Anganetha Dyck Bergen was a Saskatchewan immigrant woman who had no formal training but wore the hat of nurse, midwife, and undertaker as needed in her rural community; the latter task involved confirming a death as well as cleaning, dressing, and preparing bodies for burial.⁵⁹

Another example of this variety of roles is Katherina Hiebert, who became possibly the first midwife to serve the pioneer women of southern Manitoba after immigrating from Russia in 1875. Hiebert received recipes for herbal treatments from neighbouring Aboriginal women and was known to roam the woods and meadows collecting "Swedish bitters, chamomile, and thyme."⁶⁰ Assisting French, English, and Mennonite women, she was mainly self-taught, ordering medical books from Germany and the United States as well as receiving advice from Aboriginal women. In a widely spread community of large families, midwives were kept busy, and it is said that "almost every day somebody called for Katherina." Her daughter recalled, "She was always away, day and night, summer and winter, tending the sick."⁶¹ Another midwife, Elizabeth Harder Harms, found herself providing a wide array of medical care when she moved to the immigrant community of Yarrow, British Columbia, in the early 1930s. She mixed her own pharmaceutical compounds and created a successful remedy to treat a unique infection under the fingernails, caused by strong cleaning solutions, that plagued Mennonite women who worked as domestic help in Vancouver.⁶² One might posit that, especially for close-knit and sometimes insular immigrant communities like the Mennonites, midwifery as a multi-functional skill set was important to preserve group self-sufficiency in health care with respect to the surrounding society.

Though not pursuing a lucrative career by any means, the midwife brought a meagre income into her household that made life slightly less difficult for Mennonite immigrant families, many of whom could just

57 I have explored this "confluence" of life and death in the career of midwives in another article, "Catching Babies and Delivering the Dead: Midwives and Undertakers in Mennonite Settlement Communities," submitted for publication.

58 Plett, *Johann Plett: A Mennonite Family Saga*, pp. 188–194.

59 Margaret Klassen Neufeld, "My Grandmother was an Undertaker: A Tribute to Anganetha Dyck Bergen Baerg (1859–1942)," *Mennonite Historian*, vol. 24, no. 1 (March 1998), pp. 2, 9.

60 Regina Doerksen Neufeld, "Katherina Hiebert: Manitoban Pioneer Midwife," *Mennonite Historical Bulletin*, vol. 61 (July 2000), p. 4.

61 Neufeld, "Katherina Hiebert (1855–1910): Midwife," p. 14.

62 Epp et al., "Midwifery: A Ministry," p. 20.

barely sustain themselves, whether they were early pioneers or survivors of the Depression. There is little evidence of how much Mennonite midwives charged for their services. Some were satisfied with payment in the form of chickens or garden produce, especially during hard economic times, while others had set fees. One family history tells of an unnamed midwife in rural Saskatchewan whose payment for delivering a baby was a sack of flour.⁶³ Many were likely willing to take whatever was offered, while the “neighbour” midwife or relative might expect nothing at all. In her memoir, immigrant Maria Klassen describes her fortune at being a neighbour of Agatha Schellenberg, midwife in rural Saskatchewan in the 1930s: “For us it is handy that Agatha lives next door for she is a well-reputed mid-wife. We trust her because she has delivered hundreds of babies including our other three.” Schellenberg was also described as a “caring and efficient helper” who was willing to come at any time of day or night. Schellenberg did not charge a specific amount but took what was offered. Maria’s husband Johan paid her \$6, \$8, and \$7 respectively for three of their children.⁶⁴

Helena Klassen Eidse began to assist at deliveries when she was only 13 years old, when a local physician enlisted her as an interpreter when he was called to German-speaking Mennonite homes in Manitoba. Gradually, he trained her in the basics of medical care, and she went on to a 63-year career as a midwife, chiropractor, nurse, and undertaker. Initially she charged 25 cents per delivery, but in later years that sum rose to \$2. Recalling that some people were indignant when she charged money for her services, apparently Helene had remarked that it seemed “babies aren’t worth salt on an egg.”⁶⁵ For some new immigrants, the cost of midwife and doctor was prohibitive enough that women opted to manage their children’s births themselves, with the assistance of neighbours or family members. Gertrude Epp was pregnant with her first child when she and her husband immigrated to Canada in 1924. That child was born in Ontario with the help of a neighbour, since the midwife arrived too late. When the child was only three weeks old, the family ventured west to a farm in southern Manitoba. When Gertrude’s next child was born a year and a half later, they had to pay the attending doctor \$30, an enormous sum for the newcomers. Too poor to continue paying that amount, Gertrude enlisted the help of her sisters-in-law for the births of her next four children. In each case, her preparations arose from what she had learned at previous births, including boiling a piece

63 Ruth Heinrichs, *A History of Susanna Neudämder and Isaak Zacharias, 1900–1930* (n.p., n.d.), p. 18.

64 Hilda J. Born, *Maria’s Century: A Family Saga* (Abbotsford, BC: Published by author, 1997), p. 35.

65 Lorilee G. Scharfenberg, “Helena (Klassen) Eidse (1861–1938),” *Preservings*, vol. 8 (June 1996), pp. 51–54.

of binder twine with which to detach the cord. Her eighth child was born in the hospital, because by then they had “a bit more” money.⁶⁶

Ethnicity and Religiosity

While technical training and skill on the part of midwives were important in Mennonite settlement communities, ethnic identity was also (perhaps equally) valued. In her review of the historiography on midwifery in Canada, Biggs also calls for a greater understanding of the manner in which ethnicity intersected with the professional identity of midwives. She suggests that the “reasons for the persistence of midwifery in some communities can be attributed to a preference for a birth attendant who spoke the native language of the birthing mother and who had an understanding of her cultural and religious traditions.”⁶⁷ The importance of an ethnic bond between midwife and woman in labour has been pointed out by Diane Vecchio in her study of Italian midwives in an immigrant enclave in Milwaukee around the turn of the twentieth century.

For ethno-religious groups like the Mennonites, the cultural identity of a woman’s labour attendant may have been a factor of equal, or sometimes greater, consideration, alongside sex, vocational training, or personal experience of childbearing. A survey of the 1,450 birth records in Sarah Dekker Thielman’s journal quickly reveals a large majority of ethnic Mennonite names, though it is interesting that the non-Mennonite names are more prevalent in the Canadian setting than in the Siberian locale.⁶⁸ A profile of midwife-healer Katherina Born Thiessen notes that, even after some local physicians sought a court order to prevent her from providing health care services because she had no medical licence, Mennonites continued to seek her expertise “because they trusted her and she spoke their language, Low German.”⁶⁹ In addition to language, other ethnic signifiers shared by a midwife and the woman in labour (along with her household) would have included a common awareness of kinship relationships and collective memory of immigrant and settlement experiences. 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 inevitably accompany childbirth.

Beyond common cultural traditions, the Mennonite immigrant midwife and Mennonite immigrant woman in labour would have spoken a common

66 Martens and Harms, *In Her Own Voice*, p. 98.

67 Biggs, “Rethinking the History of Midwifery,” p. 18.

68 CMBS, Sarah Dekker Thielman personal collection, vol. 1057, Birth Records.

69 Bergen, “Dr. Katherina Born Thiessen,” p. 8.

religious language and, given the intensity and sometimes life-threatening nature of childbirth, could have uttered words and phrases together that were not just of the same dialect, but also emerged from a similar faith sensibility. That a certain common spiritual demeanor was required of both midwife and undertaker is suggested, though not stated explicitly, in the following description of Barbara Shuh, a turn-of-the-century midwife and cheesemaker in southwestern Ontario: “In her role as a mid-wife ministering at the birth of a child she rejoiced with the family. When the death of a loved one in the home was imminent, Barbara . . . without hesitation, joined the family in their walk through the valley of sorrow.”⁷⁰ As one who shared the ethno-religious identity of the families she served, Barbara would have identified with the domestic and personal theology that framed both birth and death experiences.

For some midwives, especially those who considered their labour activity to be a lifetime career, their work took on religious dimensions as they considered themselves to be engaged in a kind of “ministry.” Like the African-American “granny midwives” profiled by Detrice Barry and Joyceen Boyle,⁷¹ some Mennonite midwives felt a religious calling to their labour. While Mennonite midwife-healers did not constitute the kind of identifiable “religious order” of nursing that has been profiled elsewhere, neither were they strictly “lay” caregivers; within Mennonite communities, the lines between “religious” and “lay” were blurred, if they existed at all.⁷² Thus, within an ethno-religious community such as the Mennonites, the midwife played a role that went beyond assisting a woman to deliver a baby; oftentimes she also functioned as a spiritual caregiver as well, especially in the birthing room where the presence of a male minister — a man of any kind — was considered inappropriate.

The financial income — albeit modest — and multi-faceted health care activity of midwives were crucial to the successful settlement of the Mennonites, whose immigrant ethos included a desire to conserve distinctive ethno-religious practices in a way that maintained a degree of separation between their communities and other indigenous and settler groups in Canadian society. Yet, while the midwifery skills of Mennonite women contributed to ethnic cohesion within their own religious communities and thus helped to maintain defined identity boundaries for the

70 “Excerpts from Diaries of Barbara (Bowman) Shuh, 1904–1920,” in *Diaries of our Pennsylvania German Ancestors, 1846–1925* (Kitchener: Pennsylvania German Folklore Society of Ontario, 2002), p. 45.

71 Detrice G. Barry and Joyceen S. Boyle, “An Ethnohistory of a Granny Midwife,” *Journal of Transcultural Nursing*, vol. 8, no. 1 (July–December 1996), pp. 13–18.

72 For discussions that differentiate between religious and lay nursing, see essays in Bates *et al.*, eds., *On All Frontiers*, especially Young and Rousseau, “Lay Nursing from the New France Era to the End of the Nineteenth Century” pp. 11–25, and Pauline Paul, “Religious Nursing Orders of Canada: A Presence on All Western Frontiers,” pp. 125–138.

Mennonites, such skill also drew them outside those boundaries towards interaction with their neighbours. Only recently has scholarship on the Mennonite sojourn in the Russian Empire and Soviet Union acknowledged the reality and importance of Mennonite interaction with their neighbours. Given the tumultuous events of the early twentieth century in the Russian Empire and then Soviet Union that brought crisis to Mennonite families and settlements, midwives on occasion found themselves in circumstances that they would never face in Canada. Susanna Epp, trained as a midwife in Prussia in 1906, travelled with four armed men when she was summoned to assist women in labour during the years of revolution and civil war and the anarchy that followed. In one case, Makhnovite anarchists threatened to shoot her if she did not assist at a difficult birth or if the mother died. Susanna insisted that a witness be present, and, although the child was stillborn, she was able to save the mother. Apparently, the Makhnovites then gave her a letter that allowed her to travel unhindered. Susanna immigrated to Canada in 1924 where she "had plenty to do in the nursing field."⁷³

Sarah Dekker Thielman's obituary notes that one of the highlights of her midwifery career in Siberia was being able to assist Russians, Kyrgyzstanis, and other peoples of the region.⁷⁴ In Canada, Katharina Hiebert offered her services to French, English, and possibly Métis women, in addition to Mennonites. Anna Toews, a busy woman who bore 11 children of her own, also assisted Manitoba Métis women in childbirth and "presumably people of other beliefs and backgrounds."⁷⁵ The immigrant midwife thus nurtured ethnic stability among her own people and offered continuity of custom and tradition through the immigrant experience, but she also created a context for positive interactions and relationships to develop with non-Mennonite neighbours in Canada. Midwives helped to maintain ethnic and religious homogeneity in the birthing room, but, significantly, they also served as conduits to the "outside" world.

Conclusion

This brief and preliminary investigation into the careers of Mennonite midwives suggests that the practice of midwifery in early Canadian immigrant communities was an essential ingredient to successful settlement. While midwife-healers have received scant attention in studies of

⁷³ Susanna Epp's story is told in the following sources: Anna Ens, ed., *The House of Heinrich: The Story of Heinrich Epp (1811–1863) of Rosenort, Molotschna and His Descendants* (Winnipeg: Epp Book Committee, 1980), p. 129; "Agatha [Braun] Peters," *Saskatchewan Mennonite Historian*, vol. 3, no. 3 (December 1998), p. 19.

⁷⁴ Obituary of Sarah Thielman, *Mennonitische Rundschau*, February 17, 1968, p. 11.

⁷⁵ Plett, *Johann Plett: A Mennonite Family Saga*, pp. 188–194.

settlement processes or immigrant community identity, one might surmise that, in the context of groups that chose geographic isolation, a significant degree of ethnic separation, and self-reliance on many levels, the many services offered by these women were crucial to the well-being of households and ethnic communities. The professionally and informally trained Mennonite midwife offered a Mennonite woman in labour both the confidence that her birthing assistant was knowledgeable in the techniques of childbirth — including the complications that could arise — and the comfort that a “kindred spirit” in ethnicity and historical sojourn could readily offer. In its capacity to transfer skills from one homeland to another, and also across ethnic boundaries in Canada, the career of the Mennonite immigrant midwife-healer is a key example of transnational and trans-ethnic labour.

According to her 1968 obituary, Sarah Dekker Thielman suffered from depression in the last years of her life. Written by “The Leftbehind Ones,” presumably her family, the brief article in a Mennonite newspaper states, “During this time, the Lord revealed to her the futility of life, and how unfit she was for the heavenly life.”⁷⁶ What a sad testament to a woman who had helped to bring into the world so many new lives and whose professional skills and presence had been anything but futile to communities in Saskatchewan and Ontario. One of Sarah’s nieces, reflecting on the inadequate credit given to her aunt compared to her uncle, said, “[I]t always seemed to me that it [being a preacher] was recognized as being more important, and given more recognition than the healing and midwifery of a quiet wise healer that was Tante Sarah.”⁷⁷

Sarah was quite fit for life in heaven and on earth and, as an immigrant woman, contributed to the shaping of Canada by helping rural, ethnic women to give birth with a little less fear in the midst of the difficulties and isolation that defined their daily existence. Further exploration of the life and work of Sarah Dekker Thielman, as well as other women who “made things right,” will add more to our understanding of midwifery as a complex assemblage of labour skills, shaped in particular by the degree of training acquired, the location of activity, and the ethnicity and other cultural identifiers of the practitioner. As the experience of nineteenth- and twentieth-century Mennonite newcomers reveals, midwives who were also general health practitioners played a central and crucial role in the medical history of early immigrant communities in Canada.

⁷⁶ Obituary of Sarah Thielman, *Mennonitische Rundschau*, February 17, 1968, p. 11.

⁷⁷ Letter from Katherine Jantz, October 4, 2004.