

# Act 32 and Perpetuating Practices of Hawai‘i Nā Pua o Haumea:

## How Hawai‘i’s Midwifery Licensure Law Adversely Impacts Traditional Native Hawaiian Birthing Practices

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I.	INTRODUCTION .....	2
II.	HISTORICAL BACKGROUND: THE PRACTICE OF MIDWIFERY .....	5
	A. <i>The Origins of Midwifery and of Its Downfall</i> .....	6
	B. <i>Midwifery Versus Medical: Competing Models of Care</i> .....	8
	C. <i>The Current State of Midwifery and the Traditional Midwife</i> .....	11
	D. <i>Traditional Native Hawaiian Birthing Practices</i> .....	14
	1. The Pale Keiki and Other Specific Traditional Birthing Practices .....	15
	2. Tension Between Traditional Hawaiian Birthing Practices and Other Medical Regulations in Hawai‘i .....	18
	E. <i>Midwifery Licensure in the United States</i> .....	21
III.	ACT 32: HAWAI‘I’S MIDWIFERY LICENSURE LAW .....	23
	A. <i>History of Midwifery Regulation in Hawai‘i</i> .....	24
	B. <i>Senate Bill 1033 and Community Testimony</i> .....	28
	C. <i>The Passage of Act 32</i> .....	29
IV.	CONSEQUENCES AND INCONSISTENCIES OF ACT 32 AND THE STATUTE’S ADVERSE EFFECTS ON NATIVE HAWAIIAN BIRTHING PRACTICES .....	31
	A. <i>The Midwives Who “Fall Through the Cracks”</i> .....	34
	B. <i>Jeopardizing Home Birth</i> .....	38
	C. <i>No Pathway to Licensure in Hawai‘i</i> .....	41
V.	PERPETUATION OF CHOICE: PROVIDING ACCESS TO MIDWIFERY AND	

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\* J.D. Candidate, Class of 2022, William S. Richardson School of Law. This paper is not intended to take a side or create a divide between midwifery or medical births, nor to say what is better or safe. Nor is this paper intended to say that the practices of traditional midwives are the same as practices performed by Native Hawaiian practitioners. I write this paper for other mothers who do not have the means, time, or energy to thoroughly explore their options; to share my experience and the current laws relating to birth in Hawai‘i; and to empower mothers to make their own decisions in where, how, and with whom they choose to bring their children earthside. With that, thank you to the APLPJ editors for your hard work and commitment to representing the underrepresented through academic legal publication, and for allowing me to share my story. I would also like to thank Professors Linda Hamilton Krieger and Troy Andrade for their guidance and tremendous support. Mahalo to all of those in the birthing community that took the time to share your experiences and mana‘o with me. Mahalo nunui to my ‘ohana for their endless love and tireless faith in me. Mahalo piha to Iokepa and Waiawakuikaahoakaleialiila, for being my reasons for everything. Me ke aloha pau ‘ole.

ENCOURAGING THE PRACTICE OF NATIVE HAWAIIAN BIRTHING TRADITIONS .....	44
A. <i>Reintroduce House Bill 1223 So That Women Are Provided with Information on All of Their Options</i> .....	45
B. <i>To Protect and Perpetuate All Traditional Birth Practices, Furthering the Protection of Native Hawaiian Practices, the Legislature Must Pass Bills Like S.B. 893 and H.B. 2204</i> .....	46
C. <i>Provide a Pathway to Licensure in Hawai‘i</i> .....	49
D. <i>Amend the Hawai‘i Administrative Rules to Allow for a Midwife-Run, Freestanding Birth Center in Hawai‘i</i> .....	50
VI. CONCLUSION .....	52

Hānau ka pēpē, hānau ka māmā  
*Birth results in a mother as well as a baby.*

## I. INTRODUCTION

Birth is a special and remarkable moment for both mother and child. Shortly before beginning law school, I received news that I was pregnant and due in October of 2019. My partner, as a Native Hawaiian, wanted our son to be born on the land that would raise him, and I thought having a home birth would be a meaningful experience for my son and me. As a first-time mother, pregnancy and birth sometimes felt foreign and scary. Anxious about this life-changing event, I felt it important to seriously consider all my options for birth, thus, I was drawn to home birthing because of the cultural importance of birthplace in Native Hawaiian tradition and custom. I wanted my son to be born on the land that he would soon be named after, further connecting him to his birthplace and highlighting his kuleana to the ‘āina . But when I asked my obstetrician (“OB” or “OB-GYN”) what my options were for a home birth, she became dismissive. She warned, “If you do that, we will not see you anymore.” After my doctor’s discouraging response, I felt that sticking with my OB-GYN was my only option, and I gave up the possibility of a home birth.

Toward the end of my pregnancy, after one weekend with a slightly-higher-than-normal blood pressure, my doctor insisted on inducing my labor. When the pitocin<sup>1</sup> did not work for hours, my OB urged me to allow the hospital to pop my water bag to speed up the process. I politely asked my doctor if we could wait one more hour. My OB became agitated, said “fine,” and quickly ended the call. A couple of hours later, I was fully dilated, and upon my OB-GYN’s arrival, my son, Waiawakuikaa, was born shortly after.

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<sup>1</sup> Pitocin, or oxytocin injection, is used for the induction and stimulation of labor. L. M. Hellman et al., *PITOCIN—1955*, 73 AM. J. OBSTETRICS & GYNECOLOGY 507, 507 (1957).

My story is one of many.<sup>2</sup> Pregnant women are constantly pressured to turn to medical regimens and succumb to medical interventions because of the influential push from their OB-GYN. My story demonstrates how many OB-GYNs see pregnancy, and not the woman. No matter how simple my wants or asks, they were at the inconvenience of my OB. Medical professionals often dismiss any thoughts of an alternative birth plan and pressure women to use medical interventions to speed up the process, to accomplish the goal of getting the baby out as quickly as possible.

I was never informed about the option of a midwife. I was completely unaware of anything regarding pregnancy and childcare, and more so, unknowing of the benefits of midwifery for the holistic health of myself and my baby. I was never informed of the option of a midwife by my general physician or my OB-GYN, despite midwives' once being the primary care providers for pregnant mothers and newborn babies.<sup>3</sup> As the medical community grew and became technologically advanced, midwives were suppressed in practice and the American medicine system of care became the norm for expecting mothers.<sup>4</sup> Resulting from that era, the narrative that midwives are "unqualified" or "dangerous" still exists today, and the medical community continues to suppress midwifery while state governments attempt to control midwifery practices, often in ways that diminish the availability of midwives altogether.<sup>5</sup> My experience was not at the fault of my OB-GYN or physician, but the fault of the system that has come to view birth as a dangerous practice and no longer provides women with the tools to explore their options.

The inherent struggle between midwives and Western medicine licensing structures creates a conflict that is starkly visible in indigenous communities with traditional birthing practices. Many common practices of midwives are practices related to traditional birthing practices in indigenous communities. Midwives prioritize holistic health and consider the wellness of both mother and baby, physically, mentally, and spiritually. With colonization and the push for conventional medicine as the primary form of health care, traditional knowledge for all indigenous communities was interrupted. Many of these communities are in the process of trying to revive

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<sup>2</sup> Women often face drastic changes in their birth plan because of the use of different medical techniques or interventions. One study found that women "who have little to no control over the decision-making process as changes are happening tend to use negative adjectives when describing their overall birth experience; for example, 'defeated,' 'frustrated,' and 'traumatizing.'" Katie Cook & Colleen Loomis, *The Impact of Choice and Control on Women's Childbirth Experiences*, 21 J. PERINATAL EDUC. 158, 165 (2012).

<sup>3</sup> See DEBORAH A. SULLIVAN & ROSE WEITZ, LABOR PAINS: MODERN MIDWIVES AND HOME BIRTH 1 (1988).

<sup>4</sup> See *id.* at 6–7, 14. For this article, I use "mothers," "expecting mothers," and "pregnant mothers" interchangeably.

<sup>5</sup> See *id.* at 13–14.

those practices but still run into obstacles in the formalization of those practices.

As part of the push of Western medicine, states began to enact midwifery licensure laws requiring that midwives go through a formal education program to qualify for licensure.<sup>6</sup> The State of Hawai‘i’s new midwifery law imposes formal education and licensing mandates on midwives.<sup>7</sup> Act 32 was undoubtedly implemented to promote public safety and welfare. However, it has consequences which fall on midwives, on a mother’s choice in birth, and on Native Hawaiian traditional midwives and their practices. It creates further barriers to licensure which indirectly creates the potential for impacts on the ability for traditional Native practitioners to perform traditional Hawaiian birthing practices. The Act’s proponents claim that it does not impede a person’s ability to incorporate cultural practices, but the Act is ambiguous on such protections and exemptions and does not provide the public on what a Native Hawaiian cultural practice may consist of or guidance of such.<sup>8</sup> The Act also does not provide insight into the future of what midwifery in Hawai‘i will be and provides no guidance for future legislation on midwifery.<sup>9</sup>

This paper analyzes the recently enacted Act 32, which provides for the licensure of direct-entry midwives, and how the Act’s implications for midwives are especially burdensome for Native Hawaiian families and their cultural practices. This paper is not opposed to licensure of midwives but analyzes the effects such licensure has on the midwifery industry and Native Hawaiian practices—it is intended to caution legislators and the public of the repercussions of licensure on traditional and customary practice of midwifery in Hawai‘i. This paper then provides suggested next steps to ensure that Native Hawaiian birthing practices and mothers’ agency are fully protected. Act 32 creates barriers for midwives in the practice of midwifery, and these barriers are even harsher for Native Hawaiians who desire a traditional birth because of the existing lack of access to traditional midwives. The barriers are presented in the difficulties the Act creates for Native Hawaiian midwives and traditional midwives who are forced to keep their traditional practices separate from their pathway in midwifery.<sup>10</sup> Accordingly, the Hawai‘i legislature must pass formerly introduced bills

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<sup>6</sup> See Raymond G. DeVries, *Midwifery Licensure and Strategies of Dominance*, 7 ALSA FORUM 174, 177 (1983).

<sup>7</sup> See S.B. 1033, 30th Leg., Reg. Sess. (Haw. 2019).

<sup>8</sup> See *id.*

<sup>9</sup> See *id.*

<sup>10</sup> This should not be understood as Native Hawaiian traditional midwives and Traditional midwives being one in the same; Native Hawaiian traditional midwives and traditional midwives are completely separate, as both have different histories, current practices, and world views. Telephone Interview with Pua ‘O Eleili K. Pinto, Native Hawaiian Birth Assistant, Ka Lāhui o ka Pō (Jan. 23, 2021).

and alter the current rules and regulations relating to midwifery to guarantee access to all midwives and promote traditional Native Hawaiian birthing practices as accessible to all Native Hawaiians that choose that pathway for birth.

To understand why Act 32 alone does not perpetuate Native Hawaiian birth practices, it is important to consider the history of midwifery generally and specifically in Hawai‘i. Traditional midwives are important to the union of birth and culture, and Act 32 does not ensure that these midwives may continue to provide services. The following sections of this paper clarify the historical importance of midwives and how legislation has led us to the status of midwives today. Part II of this paper discusses the history of midwifery, and how the practices of midwifery may be heavily contrasted from American medicinal practice. This section also discusses Native Hawaiian birthing practices and how historically, medical regulations have adversely and negatively affected Hawaiian birthing practices. Part III of this paper discusses the legislative history of Act 32 and the implications the licensure has on the state of direct-entry midwifery. Then, Part IV discusses consequences of Act 32 for the practice of midwifery in Hawai‘i and addresses how these consequences are more detrimental for Native Hawaiians engaging in traditional Hawaiian birthing practices. Lastly, Part V provides next steps and avenues the legislature must take in ensuring a woman’s choice in birth and Native Hawaiian birthing practices are preserved.

## II. HISTORICAL BACKGROUND: THE PRACTICE OF MIDWIFERY

Women have been using midwives for prenatal, birth and post-natal care for hundreds of years.<sup>11</sup> Modern midwives are of the most important and routine care providers throughout Europe.<sup>12</sup> There have been tenacious efforts to promote midwifery care in developing countries.<sup>13</sup> The practice of midwifery focuses on the holistic health of the growing baby and learning mother, but despite the holistic health benefits of using a midwifery during

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<sup>11</sup> See HELEN VARNEY & JOYCE BEEBE THOMPSON, A HISTORY OF MIDWIFERY IN THE UNITED STATES: THE MIDWIFE SAID FEAR NOT 3 (2016).

<sup>12</sup> In the United Kingdom and the Netherlands, midwives attend over two-thirds of all births—compared to the U.S. where eight percent of births are attended by midwives. Carissa Stephens, *Midwives Are Growing in Popularity. Here’s What You Need to Know*, HEALTHLINE, <https://www.healthline.com/health/midwives-growing-in-popularity-what-to-know#Benefits-of-midwives> (last visited Mar. 21, 2022).

<sup>13</sup> The United Nations Populations Fund (“UNFPA”) is the United Nations’ sexual and reproductive health agency that has been pushing to promote midwifery in various developing countries. See *About Us*, UNFPA (Jan. 2018), <https://www.unfpa.org/about-us>. UNFPA urges that “[w]ell-trained midwives could help avert roughly two thirds of all maternal and newborn deaths . . . [and] could also deliver 87 per cent [sic] of all essential sexual, reproductive, maternal, and newborn health services.” *Midwifery*, UNFPA (Oct. 4, 2019), <https://www.unfpa.org/midwifery>.

pregnancy, a majority of women in the United States (“U.S.”) birth in hospitals because childbirth in the U.S. is framed as a potentially dangerous event requiring medical intervention<sup>14</sup> and monitoring.<sup>15</sup> As a result of the push that made women fearful of birth and promoted the use of medical intervention, midwives became a more rare form of maternal care.<sup>16</sup> The suppression of midwifery care had the most grave consequences for traditional midwives, impairing both the ability of traditional midwives to carry on traditional practices and the ability of mothers to have traditional births.<sup>17</sup> Native Hawaiians are one of many cultures that cherish pregnancy and birth traditions, the perpetuation of which have been detrimentally affected by the suppression and regulation of midwifery.<sup>18</sup>

#### A. *The Origins of Midwifery and of Its Downfall*

In the U.S., midwives have helped mothers through pregnancy and birth for hundreds of years.<sup>19</sup> Midwives migrated from various other countries and brought their traditional birthing practices with them.<sup>20</sup> For nearly 250 years, prior to obstetricians and gynecologists, traditional midwives were the primary form of care for pregnant women in the U.S.<sup>21</sup> Midwives were trained through experience and observation, and often served alongside physicians prior to technological advancements.<sup>22</sup> It was

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<sup>14</sup> For this paper, I use words “medical intervention” and “intervention” interchangeably. Types of interventions will be explained later in this paper. *See infra* p. 8.

<sup>15</sup> SULLIVAN & WEITZ, *supra* note 3, at 1.

<sup>16</sup> *See* Jessica C.A. Shaw, *The Medicalization of Birth and Midwifery as Resistance*, 34 HEALTH CARE FOR WOMEN INT’L 522, 525 (2013).

<sup>17</sup> *See* Alicia Bonaparte, “*The Satisfactory Midwife Bag*”: *Midwifery Regulation in South Carolina, Past and Present Considerations*, 38 SOCIAL SCI. HIST. 155 (2015). Through the seventeenth to twentieth century, in many southern states, “granny midwives or grannies were older black women who passed Central and West African herbal knowledge to younger women, which fostered cultural reproduction and rebellion against seventeenth-century dominant Western medical practices.” *Id.* at 157. With licensure requirements and midwifery regulation, granny midwives were labeled “unsafe”, and practice began to dwindle. *See id.* at 160.

<sup>18</sup> Traditional midwives and Native Hawaiian traditional midwives have very different histories. Note that this article is not intended to say that the suppression of MW and NH MW, as if they are one in the same, but because laws today suppress the general practices, more specific practices areas are affected as well.

<sup>19</sup> JUDITH PENCE ROOKS, MIDWIFERY AND CHILDBIRTH IN AMERICA 12 (1997); Sarah Anne Stover, *Born by The Woman, Caught by The Midwife: The Case for Legalizing Direct-Entry Midwifery in All Fifty States*, 21 HEALTH MATRIX 307, 313 (2011).

<sup>20</sup> *See* DeVries, *supra* note 6, at 96, 180 (noting that traditional Mexican birth attendants, or “partera,” historically provided significant care to pregnant women in Texas); Bonaparte, *supra* note 17, at 157.

<sup>21</sup> ROOKS, *supra* note 19, at 11.

<sup>22</sup> *Id.* at 61; Stover, *supra* note 19, at 313–14.

not until the late nineteenth century did women begin to drift towards using Western medicine as a primary form of pregnancy care, largely due to the anti-midwifery agenda of obstetricians.<sup>23</sup>

As part of their anti-midwifery agenda, obstetricians appealed to pregnant mothers by framing midwifery as a dangerous form of care attributable to the lack of formal education akin to medical doctors.<sup>24</sup> Physicians exaggerated the dangers of childbirth, framing complications as a common event that only obstetricians would be able to address, and only trained men within easy reach would be able to prevent certain death for a mother, baby, or both.<sup>25</sup> Interventions became a routine process of giving birth, and over time, changed how society framed birth experiences.<sup>26</sup> The normalization of medical interventions led to the more common use of these interventions, and this led to women feeling less confident in their ability to have a natural birth and disempowering women in birth generally.<sup>27</sup> The midwifery industry suffered because of the preference for an increasingly medicalized birth.<sup>28</sup> Midwives have attempted to combat this fear that the medical industry has instilled in women by prioritizing a woman's choice

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<sup>23</sup> See Chris Hafner-Eaton & Laurie K. Pearce, *Birth Choices, the Law, and Medicine: Balancing Individual Freedoms and Protections of the Public's Health*, 19 J. HEALTH POL. POL'Y & L. 813, 815–16 (1994); Stover, *supra* note 19, at 315.

<sup>24</sup> See Stover, *supra* note 19, at 315. It takes approximately twelve years of schooling, internship, and residency work to become an OB-GYN. *How to Become a Gynecologist*, HOSPITALCAREERS.COM, <https://www.hospitalcareers.com/career-paths/how-to-become-a-gynecologist/> (last visited Apr. 14, 2022). An individual must first obtain their bachelor's degree (four years), and medical degree (four years), and then complete four years of residency work. *Id.*

<sup>25</sup> SULLIVAN & WEITZ, *supra* note 3, at 10.

<sup>26</sup> Shaw, *supra* note 16, at 527 (citing Judith Lothian, *Birth Plans, the Good, the Bad, and the Future*, 35 J. OBSTET. GYNEC. & NEONATAL NURSING 295 (2006); Sarah Munro et al., *Decision Making in Patient-Initiated Elective Cesarean Delivery: The Influence of Birth Stories*, 54 J. MIDWIFERY & WOMEN'S HEALTH 373 (2009); Diana C. Parry, "We Wanted a Birth Experience, Not a Medical Experience": *Exploring Canadian Women's Use of Midwifery*, 29 HEALTH CARE FOR WOMEN INT'L 784 (2008)).

<sup>27</sup> *Id.* at 528 (citing Veronique Bergeron, *The Ethics of Cesarean Section on Maternal Request: A Feminist Critique of the American College of Obstetricians and Gynecologists' Position on Patient-Choice Surgery*, 21 BIOETHICS 478 (2007); Judith Lothian, *Birth Plans, the Good, the Bad, and the Future*, 35 J. OBSTET. GYNEC. & NEONATAL NURSING 295 (2006); Nancy K. Lowe, *Context and Process of Informed Consent for Pharmacologic Strategies in Labor Pain Care*, 49 J. MIDWIFERY & WOMEN'S HEALTH 250 (2004)).

<sup>28</sup> See *id.*

set out in her birth plan<sup>29</sup> when the medical model of care often overrides that plan.<sup>30</sup>

#### B. *Midwifery Versus Medical: Competing Models of Care*

The midwifery model of care contrasts sharply with the American medicine model of care. The midwifery model of care considers the holistic health of the baby and the mother, with no individual more important than the other.<sup>31</sup> The medical model of pregnancy care views the mother and the baby are viewed as “conflicting entities with conflicting needs.”<sup>32</sup> Under this model, pregnancy is a condition, external to the woman, which causes her symptoms like an ailment.<sup>33</sup>

In a medicalized childbirth, interventions are commonplace, and mothers are often encouraged to partake in interventions.<sup>34</sup> Interventions are often used and include but are not limited to: elective induction, spinal analgesia, general anesthetic, forceps, vacuum delivery, cesarean section, episiotomy, and continuous electronic fetal monitoring.<sup>35</sup> Pain, for example, is viewed as something to be eliminated by the use of intervention (like an epidural anesthetic).<sup>36</sup>

The obstetric model of care focuses on pathology and prioritizes prevention, often leading to obstetric intervention as a commonality in childbirth.<sup>37</sup> The obstetrician is the person who delivers the baby, the mother is simply a means for helping the doctor deliver the baby, and the relationship between doctor and patient is limited to issues regarding the pregnancy, nothing more.<sup>38</sup> Pregnancy and birth presupposes a series of

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<sup>29</sup> A birth plan is a way for a woman to document a plan for birth, which outlines her wishes and preferences in labor, birth, and post-partum. See Amy Cassell, *How to Make a Birth Plan*, BABYCENTER (Oct. 27, 2021), [https://www.babycenter.com/pregnancy/your-body/calculators-birthplan\\_10328792](https://www.babycenter.com/pregnancy/your-body/calculators-birthplan_10328792).

<sup>30</sup> See Shaw, *supra* note 16, at 529; Suzanne Hope Suarez, *Midwifery is Not the Practice of Medicine*, 5 YALE J.L. & FEMINISM 315, 324 (1993).

<sup>31</sup> See Stover, *supra* note 19, at 320.

<sup>32</sup> Suarez, *supra* note 30, at 336.

<sup>33</sup> *Id.*

<sup>34</sup> See Shaw, *supra* note 16, at 527.

<sup>35</sup> See *id.*

<sup>36</sup> *Id.* at 531.

<sup>37</sup> Susan Corcoran, *To Become A Midwife: Reducing Legal Barriers to Entry into the Midwifery Profession*, 80 WASH. U.L.Q. 649, 653 (2002).

<sup>38</sup> See *Midwife vs. Medical Models of Care*, BIRTH LINK, <https://birthlink.com/midwife-vs-medical-models-of-care/> (last visited Apr. 11, 2022).



risks that medical doctors must systemize, control, and fit into a time frame.<sup>39</sup>

The midwifery model of care is much more holistic and focuses on the woman as a whole person, ensuring a mother's overall well-being, as well as that of the baby.<sup>40</sup> A pregnant woman is recognized as the primary decision-maker in her pregnancy and birth, and the role of the midwife is to "identify problems, provide information, give options and support the woman to make the best decisions."<sup>41</sup> Midwives allow women to have the choice to give birth outside of a hospital, whether that be at-home or in a midwife-run birth center.

Midwives typically assist women through a natural birth, without interventions. Instead of eliminating pain, "pain is often viewed . . . as a natural step toward birth that has the purpose of opening the birth canal and preparing the body for delivery."<sup>42</sup> Unlike doctors, "[m]idwives do not 'deliver' babies, but instead . . . 'catch' the baby"<sup>43</sup> as the mother labors, necessarily recognizing the woman's body as delivering the baby.<sup>44</sup>

"Midwives seek to empower women by supporting a woman's right to control all decisions related to her body, her pregnancy, and her birth."<sup>45</sup> The midwifery model of care focuses on building rapport between the midwife and the mother. The overall goal of a midwife is to continuously identify and treat complications without medical interventions to allow the mother to have a safe, physically, and emotionally healthy birth experience.<sup>46</sup>

Additionally, the midwifery model of care provides overall beneficial implications for pregnant and birthing women.<sup>47</sup> According to the World Health Organization ("WHO"), the full package of midwifery care

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<sup>39</sup> Michael Pike, *Restriction of Parental Rights to Home Births Via State Regulation of Traditional Midwifery*, 36 BRANDEIS J. FAM. L. 609, 609–10 (1997).

<sup>40</sup> See Corcoran, *supra* note 37, at 653–54.

<sup>41</sup> Stover, *supra* note 19, at 320.

<sup>42</sup> Shaw, *supra* note 16, at 531.

<sup>43</sup> Midwives recognize that they are not the individual actively in labor and deliver, pushing a fetus through the birth canal, and this acknowledges a woman as the mechanism which delivers the baby and as the primary actor in birth. Stover, *supra* note 19, at 320.

<sup>44</sup> *Id.*

<sup>45</sup> Shaw, *supra* note 16, at 531 (citing Diana Parry, "We Wanted a Birth Experience, Not a Medical Experience": *Exploring Canadian Women's Use of Midwifery*, 29 HEALTH CARE FOR WOMEN INT'L 784 (2008); Amber T. Pewitt, *The Experience of Perinatal Care at a Birthing Center: A Qualitative Pilot Study*, 17 J. PERINAT. EDUC. 42 (Summer 2008)).

<sup>46</sup> See Stover, *supra* note 19, at 320–21; Shaw, *supra* note 16, at 531.

<sup>47</sup> See THE MIDWIVES MODEL OF CARE, <https://mana.org/about-midwives/midwifery-model> (last visited Mar. 21, 2022).

could avert eighty percent of all maternal deaths, stillbirths, and newborn deaths could be averted with the full package of midwifery care.<sup>48</sup> Also, fewer artificial interventions are used since the midwifery model of care uses interventions as a last resort.<sup>49</sup> About one out of three women giving birth are subject to cesarean delivery, an artificial intervention process and nearly all women undergo continuous electronic fetal monitoring during birth.<sup>50</sup> Medical interventions are imposed to avoid risk, but, like with any medical procedure, the “safety of the woman in labor and her infant is affected when routine medical interventions compromise the woman’s ability to labor naturally.”<sup>51</sup> Additionally, when birth becomes medically managed, women lose their confidence in their ability to give birth naturally give birth, and their doctors become the primary decision-makers or, at the very least, an influential party in the woman’s decisions.<sup>52</sup> The midwifery model of care allows the woman to assert her own choices in her pregnancy and birth and recognizes that childbirth results in the well-being of mother and child, both growing together in new territory.<sup>53</sup> All midwives are

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<sup>48</sup> See MIDWIFERY EDUCATION AND CARE, <https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/maternal-health/midwifery/maternal-health-83-percent-midwifery-care> (last visited Mar. 4, 2022).

<sup>49</sup> Joanne Rouse, *Indiana’s Midwifery Statute and the Legal Barriers That Will Render It Unworkable*, 48 IND. L. REV. 663, 670 (2015).

<sup>50</sup> See NAT’L CTR. FOR HEALTH STATS., [https://www.cdc.gov/nchs/nvss/births.htm?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fnhchs%2Fbirths.htm](https://www.cdc.gov/nchs/nvss/births.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fnhchs%2Fbirths.htm) (last visited Mar. 21, 2022); Shaw, *supra* note 16, at 523.

<sup>51</sup> Shaw, *supra* note 16, at 527. For example, there are various risks and dangerous events that may result from a cesarian section. Babies born by c-section are more likely to develop transient tachypnea (breathing difficulties). *C-Section*, MAYO CLINIC (June 12, 2020), <https://www.mayoclinic.org/tests-procedures/c-section/about/pac-20393655>. For mothers, c-sections increase the risk of infection, postpartum hemorrhage, and blood clots. *Id.* Also, mothers who give birth by c-section are more likely to need c-section for future children, experience more pain and have a longer recovery than women who give birth vaginally. *Id.*

<sup>52</sup> See Shaw, *supra* note 16, at 528. For example, when cesarian sections became safer to perform, they became a norm for addressing challenging births, which prior to c-sections, were attended by skilled medical professionals. Veronique Bergeron, *The Ethics of Cesarean Section on Maternal Request: A Feminist Critique of the American College of Obstetricians and Gynecologists’ Position on Patient-Choice Surgery*, 21 BIOETHICS 478, 485 (2007). Many North American hospitals instituted mandatory c-sections for babies in the breech position (baby is positions bottom nearest the birth canal) or for women who have had a previous c-section. *Id.* Women who could have still attempted a vaginal birth were pressured into c-sections under hospital rules and instilled with fear that their baby may be at risk because of the difficulties presented at birth. See *id.* C-section was not a last resort, instead, an easy remedy to a challenging birth. This means that C-sections were not used only in the rare cases of emergency, but as a frequent practice when minor difficulties arose during birth.

<sup>53</sup> See Stover, *supra* note 19, at 321 (quoting ROOKS, *supra* note 19, at 373). The

different in their procedure and practice, with varying credentials, but they all use the midwifery model of care as the basis of their practice.<sup>54</sup>

### C. *The Current State of Midwifery and the Traditional Midwife*

There are a variety of kinds of midwives practicing in the U.S. today, all of whom are regulated differently by each state.<sup>55</sup> The main distinction between midwives today centers on their level of education and apprenticeship.<sup>56</sup> There are two categories of midwives generally, Certified Nurse Midwives (“CNM”), and direct-entry midwives, the sole contrast between these categories being that the former has a nursing degree.<sup>57</sup> Direct-entry midwives encompass Certified Professional Midwives (“CPM”), Certified Midwives (“CM”), and Traditional Midwives, all of who are midwives by virtue of midwifery schooling, apprenticeship, or a combination of both.<sup>58</sup>

The first category of midwives, Certified Nurse Midwives, have completed nursing school, are registered nurses, and focused on midwifery

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medical model of care fails to recognize that a baby is not the only being, being born. When a baby is born, a woman becomes a different person, a mother. The medical model of care does not properly address the needs of the mother, being a new mother. Mothers are told how to care for their new baby, but not often told of how to take care of themselves as new mothers.

<sup>54</sup> All the agencies which provide midwifery recognition are based on the midwifery model of care. *See, e.g., Midwives Model of Care*, NAT’L ASSOC. OF CERT. PRO. MIDWIVES [NACPM], <https://nacpm.org/about-cpms/midwifery-model-of-care/> (last visited Mar. 21, 2022); *The Midwives Model of Care*, MIDWIVES ALL. N. AM. [MANA], <https://mana.org/about-midwives/midwifery-model> (last visited Mar. 21, 2022).

<sup>55</sup> *See* STATE BY STATE, <https://mana.org/about-midwives/state-by-state> (last visited Mar. 21, 2022). Midwives have become increasingly popular in rural areas. *See* Sofia Jeremias, *The Rise of Midwives in Rural America*, DESERETNEWS (Sept. 1, 2021), <https://www.deseret.com/2021/9/1/22650628/the-rise-of-midwives-in-rural-america-nurse-midwifery-maternal-death-rate-medicine>. Obstetric care has become increasingly difficult to access because of financial burdens and geographic inaccessibility, so midwives may provide care for individuals in rural areas that would not have access, otherwise. *Id.* Midwives have also been increasingly utilized in rural communities because of the fear of worse outcomes for women of color in the medical system and in cultures that do not view birth as a medical procedure. *See id.* In 2018, infant mortality rates were the highest among African Americans (at 10.75 deaths per 1,000 live births) and Native Hawaiians and other Pacific Islanders (at 9.39 deaths per 1,000 live births). Danielle M. Ely & Anne K. Driscoll, *Infant Mortality in the United States, 2018: Data From the Period Linked Birth/Infant Death File*, NAT’L VITAL STAT. REPS., vol. 69, no. 7 (July 16, 2020) <https://www.cdc.gov/nchs/data/nvsr/nvsr69/NVSR-69-7-508.pdf>.

<sup>56</sup> Telephone Interview with Lea Minton, Certified Nurse Midwife, Hawai’i Midwife Alliance (Feb. 3, 2021).

<sup>57</sup> *See* Stover, *supra* note 19, at 317–18.

<sup>58</sup> *Id.* at 318; *see Types of Midwives*, MIDWIVES ALL. N. AM., <https://mana.org/about-midwives/types-of-midwife> (last visited Mar. 5, 2022).

in their graduate education.<sup>59</sup> CNMs operate similarly to obstetricians, providing services primarily within the hospital or birth clinics, and purchase liability insurance.<sup>60</sup> CNMs are nurses as well as midwives, and are not typically barred by midwifery licensure requirements because of their status as nurses.<sup>61</sup> CNMs are certified by the American Midwifery Certification Board (“AMCB”) and are able to practice legally in all fifty states.<sup>62</sup> “CNMs are independent practitioners in most states, however a few states require physician supervision.”<sup>63</sup>

The next category of midwives, direct-entry midwives, are “recognized as legal practitioners in some U.S. States.”<sup>64</sup> Direct-entry midwives have not attended nursing school, and instead received training through an alternate route.<sup>65</sup> Judith Rooks, a leader in the midwifery community with a storied career in midwifery and public health, described direct entry midwifery as follows:

The midwife strives to support the woman in ways that empower her to achieve her goals and hopes for her pregnancy, birth[,] and baby, and for her role as mother. Midwives believe that women’s bodies are well designed for birth and try to protect, support, and avoid interfering with the normal processes of labor, delivery, and the reuniting of the mother and newborn after their separation of birth.<sup>66</sup>

Direct-entry midwives are much less medicalized than CNMs, taking more of a natural, rather than a technological approach in birth, particularly because of the lack of a nursing degree.<sup>67</sup>

Within the category of direct-entry midwives are Certified Midwives. CMs are similar to CNMs, with a graduate degree in midwifery but do not go through nursing school and, therefore, are not nurses.<sup>68</sup> CMs

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<sup>59</sup> Telephone Interview with Lea Minton, *supra* note 56.

<sup>60</sup> *Id.*

<sup>61</sup> *Id.*

<sup>62</sup> *Legal Status of U.S. Midwives*, MANA <https://mana.org/about-midwives/legal-status-of-us-midwives> (last visited Mar. 22, 2022); Rouse, *supra* note 49 at 670.

<sup>63</sup> *Legal Status of U.S. Midwives*, *supra* note 62.

<sup>64</sup> *Id.*

<sup>65</sup> Telephone Interview with Lea Minton, *supra* note 56.

<sup>66</sup> MARY M. LAY, *THE RHETORIC OF MIDWIFERY GENDER, KNOWLEDGE, AND POWER* 5 (2000).

<sup>67</sup> *See id.*

<sup>68</sup> *See id.* at 4.

are under the same national certification as CNMs, the AMCB.<sup>69</sup> CMs primarily work in hospitals or birthing clinics, but may assist with home birth depending on whether they went through training to assist in community births.<sup>70</sup> CMs and CNMs may both assist births in any setting, in the hospital or at home, but primarily in the hospital since that is where most women give birth.<sup>71</sup>

Another type of direct-entry midwife is the Certified Professional Midwife.<sup>72</sup> CPMs have historically been trained through apprenticeship training, but now may also be trained through an accredited midwifery school.<sup>73</sup> Presently, with the creation of more accredited midwifery programs, there are CPMs who are midwives solely through apprenticeship, and also midwives who have solely gone through midwifery school.<sup>74</sup> CPMs are nationally certified by the North American Registry of Midwives, and are permitted to practice in states that license them.<sup>75</sup> Thirty-five states have legally authorized CPMs to practice, while the other fifteen states leave CPMs at risk of criminal prosecution for practicing without a license.<sup>76</sup>

Finally, there are Traditional Midwives (“TMs”).<sup>77</sup> Traditional midwives incorporate tradition, whether cultural or religious, into their midwifery practice and typically become a midwife through apprenticeship.<sup>78</sup> Traditional midwives “believe that they are ultimately accountable to the communities they serve; or that midwifery is a social contract between the midwife and client/patient and should not be legislated

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<sup>69</sup> See *id.* at 8; AM. MIDWIFERY CERT. BD. [AMCB], <https://www.amcbmidwife.org/about-amcb> (last visited Mar. 22, 2022).

<sup>70</sup> Telephone Interview with Lea Minton, *supra* note 56.

<sup>71</sup> *Id.*

<sup>72</sup> *Legal Status of U.S. Midwives*, *supra* note 62.

<sup>73</sup> Telephone Interview with Lea Minton, *supra* note 56.

<sup>74</sup> *Id.*

<sup>75</sup> See *About NARM*, N. AM. REG. OF MIDWIVES [NARM], <https://narm.org/about/the-cpm-credential/history-of-the-development-of-the-cpm-credential/> (last visited Mar. 22, 2022).

<sup>76</sup> *Legal Status of U.S. Midwives*, *supra* note 62; see also *Legal Recognition of CPMs*, NAT’L ASSOC. CERT. PRO. MIDWIVES [NACPM] (Jan. 30, 2022), <https://nacpm.org/about-cpms/who-are-cpms/legal-recognition-of-cpms/>.

<sup>77</sup> Traditional midwives carry specific cultural traditions, thus, there are many different kinds of traditional midwives with very distinct worlds views and practices in birth. Telephone Interview with Pua ‘O Eleili K. Pinto, *supra* note 10.

<sup>78</sup> See *id.*; *Types of Midwives*, MIDWIVES ALL. OF N. AM. [MANA], <https://mana.org/about-midwives/types-of-midwife> (last visited Mar. 13, 2021); *Becoming a Midwife*, MIDWIFERY EDUC. ACCRED. COUNCIL [MEAC], <https://www.meacschools.org/becoming-a-midwife/> (last visited Apr. 21, 2022).

at all; or that women have a right to choose qualified care providers regardless of their legal status.”<sup>79</sup>

#### D. *Traditional Native Hawaiian Birthing Practices*

In the Native Hawaiian culture, *kānaka* (humans), *kūpuna* (ancestors), *akua* (gods), and *‘āina* (the land or natural environment) are interconnected at birth.<sup>80</sup> There are abundant *mo‘olelo* (stories) and *‘oli* (chants) that reveal this relationship between human beings, gods, and the land.<sup>81</sup> The *Kumulipo*, Hawaiian creation chant, consists of 2,000 lines telling of the birth of man and woman, coral polyp and starfish, the high chiefs and stragglers, the goddess *Haumea*.<sup>82</sup> The chant begins with *pō* (darkness, realm of the gods), the source of all those in *ao* (light, consciousness) earthly existence.<sup>83</sup> Native Hawaiian Professor *Lilikalā Kame‘eleihiwa* states the importance of birth in Hawaiian culture precisely, “every aspect of the Hawaiian conception of the world is related by birth, and as such, all parts of the Hawaiian world are one indivisible lineage.”<sup>84</sup>

*Haumea* is the Hawaiian goddess of fertility and has been referred to as the patroness of childbirth.<sup>85</sup> In the story of *Muleiula*’s childbirth, *Muleiula* was in labor, preparing for a cesarean section operation, when *Haumea* appeared and said, “In our land babies are born naturally without cutting open the mother.”<sup>86</sup> *Haumea* told *Muleiula* that the remedy would

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<sup>79</sup> *Types of Midwives*, MANA, *supra* note 78.

<sup>80</sup> See KUMULIPO, A HAWAIIAN CREATION CHANT (Martha W. Beckwith ed., 1951).

<sup>81</sup> See, e.g., *id.* Another Native Hawaiian *mo‘olelo* portraying the relationship between humans, ancestors, gods, and the land is the story of *Hāloa*. It is important to note that there are many versions of this story. One version is written as such: *Papahānaumoku* (earth mother) and *Wākea* (sky father) have a child named *Ho‘ohōkūkālani*. *Wākea* mates with his daughter *Ho‘ohōkūkālani*, and they have a child named *Hāloa*. *Hāloa* was born stillborn, and they buried him in the *‘āina*. From *Hāloa*’s gravesite grew a plant or the *kalo*. *Ho‘ohōkūkālani* conceived again, giving birth to the first man, *Hāloanaka*. *Hāloanaka*’s *kuleana* was to take care of his elder brother, *Hāloa* or the *kalo*, and *Hāloa* to reciprocate that care by providing for his younger brother. This demonstrates the interconnected relationships in Native Hawaiian culture, the gods watch over the *‘āina* and *kanaka* (Native Hawaiian people), and the *‘āina* and *kanaka* are siblings, having to take care of one another in a reciprocal relationship. See MO‘OLELO: HĀLOA HO‘OKUA‘ĀINA, <https://www.hookuaaina.org/mo%ca%bbbolelo-haloa/> (last visited Feb. 12, 2022).

<sup>82</sup> KUMULIPO, *supra* note 80, ll. 13-15, 18, 528-29, 1771 (highlighting a few examples of the many living creatures born in the *Kumulipo*).

<sup>83</sup> See *id.*

<sup>84</sup> LILIKALĀ KAME‘ELEIHIWA, NATIVE LAND AND FOREIGN DESIRES: PEHEA LA E PONO AI? 2 (1992).

<sup>85</sup> MARTHA BECKWITH, HAWAIIAN MYTHOLOGY 285, 289 (1970).

<sup>86</sup> *Id.* at 283. Like many Native Hawaiian *mo‘olelo*, this is one of many versions.

be to eat the blossom, Kanikawī Kanikawā, of the plant Kalauokekahuli.<sup>87</sup> This mo‘olelo portrays the interplay between birth, the gods, and the land, and an example of how Native Hawaiians may have handled birth.<sup>88</sup>

In the Native Hawaiian culture, birth was a communal event and a woman’s diet was a major consideration throughout pregnancy and in birth.<sup>89</sup> “Prenatal care was practiced long before the advent of Western medicine.”<sup>90</sup> Mothers relied on the natural environment to provide lā‘au lapa‘au (medicine).<sup>91</sup> Other things a mother ate, whatever her food cravings, gave insight into the kind of person the child would become.<sup>92</sup> Ho‘oponopono (to correct or make right), the process of mediating problems, was implemented in the family prior to the baby’s arrival because familial issues were seen as impacting the baby’s birth journey.<sup>93</sup> Native Hawaiians considered all energies that surrounded a pregnant mother in birth, and this awareness of all elements was a normal obstetrics practice in the traditions of Native Hawaiian birth traditions.

#### 1. The Pale Keiki and Other Specific Traditional Birthing Practices

In ancient Hawai‘i, the pregnant woman's whole family was versed in helping her give birth.<sup>94</sup> For example, a makua kāne (father) could take charge of the delivery, aided by other adult members of the family.<sup>95</sup> “If the ‘ohana lacked a member trained in obstetrics, then a pale keiki . . . or kahuna pale keiki would be engaged.”<sup>96</sup> A pale keiki<sup>97</sup> went beyond the duties considered of a “midwife;”<sup>98</sup> they were normally trained by family and

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<sup>87</sup> *Id.*

<sup>88</sup> This mo‘olelo is not intended to imply that a natural birth was the preferred way for Native Hawaiians to give birth. Native Hawaiians performed C-sections for specific functions, other mo‘olelo telling of Haumea performing such operations during birth. This highlights Oiwi ability to navigate when a medical intervention is needed and when it may be diverted, as a skill set of Haumea. Telephone Interview with Pua ‘O Eleili K. Pinto, *supra* note 10.

<sup>89</sup> See 2 MARY KAWENA PUKUI & CATHERINE A. LEE, NANA I KE KUMU LOOK TO THE SOURCE 2–6 (2014).

<sup>90</sup> *Id.* at 3.

<sup>91</sup> See *id.* at 14–16, 20.

<sup>92</sup> *Id.* at 5.

<sup>93</sup> *Id.* at 11–12.

<sup>94</sup> See *id.*

<sup>95</sup> *Id.* at 3.

<sup>96</sup> *Id.*

<sup>97</sup> Pale keiki is defined as “to deliver a child” and “midwife. See MARY KAWENA PUKUI & SAMUEL H. ELBERT, HAWAIIAN DICTIONARY 311 (1986).

<sup>98</sup> Pale keiki also navigated dreams, managed communal ties, performed la‘au

became pale keiki because of their family lineage.<sup>99</sup> The pale keiki and family members, together, would act as an obstetric team when a mother went into labor.<sup>100</sup> This team was “concerned, not only with the safe delivery of a healthy child, but with the emotional support of the mother in labor, and the psychic forces that could aid or injure mother and child.”<sup>101</sup>

Currently, there are no known practicing pale keiki in Hawai‘i.<sup>102</sup> Native Hawaiian birthing practices were one of many traditions impacted by colonization, and though there may be an abundance of stories and information on pale keiki and Native Hawaiian birthing practices, that information could not be accessed in a timely matter for the purposes of this paper.<sup>103</sup> Pale keiki, like many other Native Hawaiian practices, has become hidden or even obsolete over time because of colonization and western influence. Further, most families are not as versed in birth as they would be under this tradition, and it is a rarely occurring practice for fathers to be hands-on in assisting the birth of their child.<sup>104</sup>

Pale keiki may have not survived the transition to the current Western medical atmosphere in Hawai‘i, but there are many other practices relating to birth that Native Hawaiians partake in. Lā‘au lapa‘au plays an important role in pregnancy and childbirth. Pregnant women may be given a combination of natural ingredients to aid the mother in contractions or act as a lubricant for the baby's journey outside of the womb.<sup>105</sup> Lomilomi (Native Hawaiian massage) may also be incorporated during pregnancy and birth to help with pain.<sup>106</sup>

Like many indigenous cultures, there are also many Native Hawaiian traditions in birth relating to food. It is important for a mother to have her cravings fulfilled.<sup>107</sup> Native Hawaiians believe that it is not the

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lapa‘au, incorporated ancestral knowledge and incorporated cosmic ties, and much more. Telephone Interview with Pua ‘O Eleili K. Pinto, *supra* note 10.

<sup>99</sup> *Id.* The higher study a pale keiki was, they would be considered a “kahuna pale keiki.”

<sup>100</sup> *Id.*

<sup>101</sup> *Id.*

<sup>102</sup> Telephone Interview with Cami Wong, Student Midwife, Native Hawaiian Traditional Midwifery (Feb. 3, 2021); Telephone Interview with Wahinehula Kaeo, Student Midwife, Native Hawaiian Traditional Midwifery (Feb. 18, 2021).

<sup>103</sup> See Pua ‘O Eleili K. Pinto, *Pua Kanikawī Kanikawā: The Intimacy of Hawaiian Childbirth* (May 2019) (Master of Arts in Hawaiian Studies, University of Hawai‘i at Mānoa) (on file with the editors).

<sup>104</sup> Telephone Interview with Pua ‘O Eleili K. Pinto, *supra* note 10.

<sup>105</sup> Joy Kobayashi, *Early Hawaiian Uses of Medicinal Plants in Pregnancy and Childbirth*, 22 J. TROP. PEDIATR. 260, 261 (1976).

<sup>106</sup> PUKUI & LEE, *supra* note 89, at 9, 17.

<sup>107</sup> *Id.* at 5.



mother craving these foods, but the baby within her, and oftentimes cravings were analyzed to reveal certain traits or the nature of the coming child.<sup>108</sup> Upon delivery, it is important that a mother eat a well-balanced meal, typically of kalo (taro), some kind of protein, and vegetables.<sup>109</sup> A well balanced meal that nourishes a mother will ensure her physical health in labor.<sup>110</sup> Native Hawaiians, like midwives, also recognized the importance of caring for the holistic health of the mother.<sup>111</sup> It was not good practice to tell a mother to “think only of the baby.”<sup>112</sup> A mother too has needs and desires that must be pampered in pregnancy.

The holistic health of the family is also an important part of Native Hawaiian birth. Ho‘oponopono was often incorporated before the birth of the baby to ensure a mother was at peace and the environment of people that the baby was being born into, harmonious.<sup>113</sup> Ho‘oponopono “allowed a woman to ventilate her . . . hurts and hostilities . . . to clear the way for the baby.”<sup>114</sup> Native Hawaiians believe babies to be susceptible to energies, and it was important that families or any individuals to be around the baby were filled with positive energy, as not to pass bad energy on to the baby.<sup>115</sup>

In Native Hawaiian culture, there was also an emphasis on birthplace and the connection of a newborn to the land they are directly born on. When a Native Hawaiian child is born in this ‘āina, it is believed that the child has kuleana (responsibility) to the land.<sup>116</sup> The birth of a child on the land where they live creates an intimate relationship between the child and the land, like that between Hāloa and Hāloanaka, where the two must

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<sup>108</sup> *Id.*

<sup>109</sup> Telephone Interview with Pua ‘O Eleili K. Pinto, *supra* note 10. Notably, Native Hawaiian ancestral food went beyond nutrients, as the importance of these foods were not based on health benefits alone, but also connections to the gods and much more.

<sup>110</sup> *Id.*

<sup>111</sup> See PUKUI & LEE, *supra* note 89, at 8-9.

<sup>112</sup> *Id.* at 9.

<sup>113</sup> *Id.* at 11-12.

<sup>114</sup> *Id.* at 21.

<sup>115</sup> See *id.* at 11. In the birth of my own son, his father’s family encouraged us to keep him home for the first few months after he was born. They also insisted we put a hat on him if we were to take him outside of the house. The po‘o (head) of a baby is open at birth, and in Native Hawaiian culture, that openness leaves the baby susceptible for bad energies to enter through the top of the baby’s head. So, Waiawa was kept home, exclusively, for the first three months of his birth to avoid any bad energies which may enter his body.

<sup>116</sup> Telephone Interview with Kaiulani Sharon Odom and Puni Jackson, Native Hawaiian Birth Assistants, Ka Lāhui o ka Pō. (Feb. 24, 2021).

care for one another.<sup>117</sup> Though this native practice has been obscured over time, the importance of birth place for Native Hawaiians is evident in the preservation of the stones of Kūkaniloko. Just outside of the town of Wahiawā, a place named Kūkaniloko was once known as the birth site for chiefs, where their mothers labored on large smooth stones.<sup>118</sup> For Native Hawaiians, birthplace is not only a place where a child is born, but represents the relationship created between the child and the land and/or represents the importance of their lineage.

Native Hawaiian birth traditions include a variety of cultural practices which address the health of not just the baby and mother, but that of the land and the family as well. Though colonization and the movement toward allopathic medicine obscure many of these traditions, Native Hawaiians continue to fight to incorporate these traditions and, in some instances, work to innovate and revitalize cultural practices.<sup>119</sup> Further, Native Hawaiians have faced adversity and prejudice in continuing their traditional birth practices and have been met with friction by hospitals because of previous legislation which impacted their traditional practices.

## 2. Tension Between Traditional Hawaiian Birthing Practices and Other Medical Regulations in Hawai‘i

Native Hawaiian traditional birthing practices have been in tension with dominant western medicine and medical regulations in Hawai‘i throughout history, where western medicine has dominated all health spaces. The medical evolution in Hawai‘i has led to the overuse of medical systems and interventions in Hawai‘i, and a movement towards birth independent from culture. Native Hawaiians have been confronted with

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<sup>117</sup> See MO‘OLELO: HĀLOA HO‘OKUA‘ĀINA, <https://www.hookuaaina.org/mo%ca%bboulelo-haloa/> (last visited Mar. 22, 2022).

<sup>118</sup> See About Kūkaniloko, KŪKANILOKO.ORG, <https://kukaniloko.weebly.com/about-k362kaniloko.html> (last visited Feb. 22, 2022). To be clear, Kūkaniloko was not for commoners nor a common birthing place. I mention Kūkaniloko as an example, to highlight the importance of birth to specific areas.

<sup>119</sup> Ka Lāhui O Ka Pō is one group that has worked tirelessly to help Native Hawaiians incorporate Native Hawaiian traditional practices in pregnancy and birth. See *Birthing a Nation*, KA LAHUI O KA PO, <https://www.rootskalihi.com/ka-lahui-roots-kkv> (last visited April 6, 2022). They provide an eight week birthing series to help families reclaim ancestral practices and cultivate connection. They describe their program as allowing

[p]articipants [to] feel strengthened in their cultural roots, more confident in their own choices, and [a] deeper connection in their personal relationships. Mākuakāne especially find strength and confidence through this class as they connect more profoundly with traditional kuleana and ‘ike of fatherhood, learning how they fit into the processes of pregnancy and childbirth.

*Id.*

resistance from the medical community in their fight to bring back their traditional practices in birth.<sup>120</sup>

The Native Hawaiian birth tradition of ‘iwe (placenta) was one of the traditions that faced harsh conflicts and resistance from the medical field. Traditionally, after a baby was born, the ‘iwe would be buried,<sup>121</sup> and sometimes, with a tree planted in its burial place. Hawaiians believe that the proper care of the ‘iwe, ensures the child’s lifelong health and well-being.<sup>122</sup> Additionally, it is done to literally deepen the next generation connection to ‘āina and feed many generations to come.<sup>123</sup> The ‘iwe is typically buried in a place with a special connection to the child, connecting the child to his or her homeland, and to prevent the child’s spirit from wandering.<sup>124</sup> Traditionally, the ‘iwe would then be buried, and today, it is usually carried out by the father or family members.<sup>125</sup>

‘Iwe has a deep significance for Native Hawaiians. A child’s ‘iwe is often referred as the child’s honua (foundation).<sup>126</sup> This honua is a place of safety within the mother, supplying the baby with everything it needs to survive.<sup>127</sup> This metaphorical meaning is emphasized by the kanu (bury, plant) of the ‘iwe into the honua (other meanings include land, earth, world).<sup>128</sup> The “role of the child’s honua while it is inside its mother’s womb is the same as the role of [the] honua” we walk on.<sup>129</sup> The State of Hawai‘i disregarded the importance of ‘iwe for Native Hawaiians in policies governing ‘iwe.

For example, “[i]n 2005, the State of Hawai‘i Department of Health began enforcing a policy that classified the ‘iwe as infectious waste.”<sup>130</sup> So, when a Native Hawaiian family asked to take the ‘iwe of their newborn home, the hospital declined because of the policy that said that ‘iwe were

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<sup>120</sup> See, e.g., Tara Godvin, *Hawaiians Await Bill on Access to Placenta*, STAR BULLETIN (Apr. 17, 2006), <http://archives.starbulletin.com/2006/04/17/news/story01.html>.

<sup>121</sup> PUKUI & LEE, *supra* note 89, at 16.

<sup>122</sup> Melody Kapilialoha MacKenzie, *Hawaiian Custom in Hawai‘i State Law*, in 13 & 14 Y.B.N.Z. JURIS. 112, 149 (2010 & 2011).

<sup>123</sup> Telephone Interview with Pua ‘O Eleili K. Pinto, *supra* note 10.

<sup>124</sup> *Id.*

<sup>125</sup> Native Hawaiian Legal Corporation, *Hospital destroys babies’ ‘iwe without warning*, KA WAI OLA (July 1, 2017) <https://kawaiola.news/ea/hospital-destroys-babies-iwe-without-warning/> (last visited May. 3, 2022).

<sup>126</sup> *Id.*

<sup>127</sup> *Id.*

<sup>128</sup> See *id.*

<sup>129</sup> *Id.*

<sup>130</sup> MacKenzie, *supra* note 122, at 149.

toxic waste.<sup>131</sup> Another couple filed a lawsuit in the U.S. District Court for the District of Hawai‘i, contesting the policy as a violation of the right to religious freedom under the U.S. Constitution and the guarantee of Hawaiian traditional and customary practices.<sup>132</sup> When this mother had given birth, the federal court ordered the ‘iowe to be frozen and stored at the hospital while the suit was pending, but when the ‘iowe disappeared from the hospital, the court dismissed the lawsuit.<sup>133</sup>

Native Hawaiian families joined together and went to the State Legislature demanding relief. In 2006, the State enacted Act 12, which “allow[ed] a hospital to release the ‘iowe to the mother or her designee after a negative finding of infectious or hazardous disease.”<sup>134</sup> A draft of the bill stated that “the State has the obligation to assure that religious and cultural beliefs and practices are not impeded” without strong reason.<sup>135</sup> Further, a “final committee reviewing the bill noted that ‘the rich ethnic and cultural practices of Native Hawaiian traditions are essential to sustaining the Hawaiian culture, and need protection.’”<sup>136</sup> Senate Bill 2133 (“S.B. 2133”) was enacted as Act 12, now under section 321-30 of the Hawai‘i Revised Statutes (“HRS”) as stated:

Upon negative findings of infection or hazard after appropriate testing of the mother, the human placenta may be released by the hospital to the woman from whom it originated or to the woman's designee. The department shall establish a release form which shall stipulate appropriate measures for the safe release of human placenta.<sup>137</sup>

Though this may have been a success and represented that the State Legislature may be utilized to create legislation to perpetuate Native Hawaiian traditional birth practices, the enactment of Act 12 did not end the problems Native Hawaiian families were facing in bringing their child’s ‘iowe home.

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<sup>131</sup> See Godvin, *supra* note 120.

<sup>132</sup> MacKenzie, *supra* note 122, at 149 (citing Complaint, N.S. and E.K.N. v. Hawaii, Civ. No. 05-00405 HG (D. Haw. June 24, 2005)).

<sup>133</sup> MacKenzie, *supra* note 122, at 149 (citing N.S. and E.K.N. v. State of Hawaii, Civ. No. 05-00405 HG (D. Haw. June 24, 2005)).

<sup>134</sup> MacKenzie, *supra* note 122, at 150 (citing S.B. 2133, 23d Leg., Reg. Sess. (Haw. 2006)).

<sup>135</sup> S.B. 2133 SD 2 HD 2 CD 1, 23d Leg., Reg. Sess. (Haw. 2006).

<sup>136</sup> MacKenzie, *supra* note 122, at 150 (citing S. COMM. ON HEALTH, STAND. COMM. REP. NO. 3185 on H.B. 2057, H.D. 2, 23d Leg., 1st Sess. (Haw. 2006)).

<sup>137</sup> HAW. REV. STAT. § 321-30 (2021).

Despite the law, hospitals often either refuse to allow women to take home their child's 'iewe or often lose the 'iewe.<sup>138</sup> Hospitals have no uniform standard for giving the 'iewe to families. Some families have had to deal with having their child's 'iewe being contaminated by the hospital putting it in formaldehyde,<sup>139</sup> or must deal with the 'iewe being passed around throughout the hospital and touched by many hands.<sup>140</sup> Hospitals still do not see 'iewe as sacred or meaningful, but rather as toxic waste or bodily waste, evident by the experience that Native Hawaiian families face in taking home their child's 'iewe.<sup>141</sup>

Native Hawaiian Midwives, therefore, are important for ensuring traditional Hawaiian practices, like the safe delivery of the 'iewe, are carried out properly. With the intimacy of using midwife in birth, and the rapport established between mother and midwife, a mother may feel content in knowing that her child's 'iewe is being delivered safely and preserved properly. Traditional practices through Native Hawaiian midwives, however, are also impacted by harmful gaps in the State of Hawai'i's health legislation. The requirement for midwifery licensure, which restricts direct-entry midwives and traditional midwives, is one significant barrier to the continuation of Native Hawaiian traditional birthing practices. With less traditional midwives and direct-entry midwives, who are more familiar with incorporating culture into birth, traditional practices are more difficult to incorporate into birth.

#### E. *Midwifery Licensure in the United States*

The U.S. is among one of the few developed countries that do not integrate any midwifery as a primary form of care for expecting mothers. In developed countries outside of North America, midwifery is the primary form of maternity care, and obstetricians usually deal with mothers at high-

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<sup>138</sup> Telephone Interview with Pua 'O Eleili K. Pinto, *supra* note 10.

<sup>139</sup> Formaldehyde is a toxic chemical mostly known for use in building materials and modern-day embalming fluid for the preservation of dead bodies.

Formaldehyde is a colorless, flammable, strong-smelling chemical that is used in building materials and to produce many household products. It is used in pressed-wood products, such as particleboard, plywood, and fiberboard; glues and adhesives; permanent-press fabrics; paper product coatings; and certain insulation materials. In addition, formaldehyde is commonly used as an industrial fungicide, germicide, and disinfectant, and as a preservative in mortuaries and medical laboratories.

NAT'L CANCER INST., *Formaldehyde and Cancer Risk*, NIH (June 10, 2011), <https://www.cancer.gov/about-cancer/causes-prevention/risk/substances/formaldehyde/formaldehyde-fact-sheet>.

<sup>140</sup> Telephone Interview with Pua 'O Eleili K. Pinto, *supra* note 10.

<sup>141</sup> *See id.*

risk for complications or who otherwise require special medical attention.<sup>142</sup> For example, “[i]n the Netherlands, over a third of all births are planned home births with a midwife in attendance.”<sup>143</sup> The British parliament also issued a report strengthening midwives as the “primary maternity care providers.”<sup>144</sup> In addition, “New Zealand has given midwives powers similar to family physicians, including autonomous private practice, prescription writing and hospital privileges.”<sup>145</sup> In New Zealand and Britain, the infant mortality rate is substantially lower than that of the U.S.<sup>146</sup> Despite this, the U.S. has continued to promote medical obstetrics as the primary form of care, and has made it more difficult for midwives to achieve licensure if they do not meet a standard of formal education.<sup>147</sup>

The U.S. is appearing to move in the direction of midwifery as a common practice because of an increase in licensure statutes. Each state has laws that govern the practice of midwifery within its borders, primarily including CNMs and selectively allowing direct-entry midwives, if at all.<sup>148</sup> CNMs are registered nurses, and therefore licensed as nurses.<sup>149</sup> What licensure allows of CNMs, however, varies by state, some allowing CNMs to practice as advanced nurse practitioners or allowing CNMs to be registered solely as midwives.<sup>150</sup> In terms of direct-entry midwives, currently only thirty-five states have a law licensing direct entry midwives.<sup>151</sup> Fifteen states lack a direct entry midwife licensure law, and therefore do not regulate direct entry midwives.<sup>152</sup> Therefore, despite the influx of statutes and laws requiring licensure, the regulation of the industry under the guise of “public safety” does not promote the use of midwifery,

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<sup>142</sup> Marsden Wagner, *Midwifery in the Industrialized World*, 20 J. SOC. OBSTET. & GYNAECOL. 1225, 1232 (1998).

<sup>143</sup> *Id.* at 1233.

<sup>144</sup> *Id.*

<sup>145</sup> *Id.*

<sup>146</sup> See Marian F. MacDorman et al., *International Comparisons of Infant Mortality and Related Factors: United States and Europe, 2010*, 63 NAT’L VITAL STAT. REPS. 1, 1 (2014), [https://www.cdc.gov/nchs/data/nvsr/nvsr63/nvsr63\\_05.pdf](https://www.cdc.gov/nchs/data/nvsr/nvsr63/nvsr63_05.pdf).

<sup>147</sup> See Kerry E. Reilley, *Midwifery in America: The Need for Uniform and Modernized State Law*, 20 SUFFOLK U.L. REV. 1117, 1124 (1986).

<sup>148</sup> STATE BY STATE, <https://mana.org/about-midwives/state-by-state> (last visited Mar. 24, 2022).

<sup>149</sup> See Reilley, *supra* note 147, at 1121–23.

<sup>150</sup> See STATE BY STATE, *supra* note 148.

<sup>151</sup> See STATE BY STATE, <https://mana.org/about-midwives/state-by-state> (last visited Mar. 24, 2022).

<sup>152</sup> See *id.*

makes it harder for many midwives to practice, and decreases midwife access to mothers.

The direct entry midwives, and thereby mothers who would like access to them, harmed most by these policies are traditional midwives. As mentioned previously, many traditional midwives trained primarily through apprenticeship, and many state licensure statutes require that, to become licensed, midwives have some degree of formal western education and certification.<sup>153</sup> Native Hawaiian midwives typically fall into this category as do other indigenous midwives.<sup>154</sup> Native Hawaiians in Hawai‘i are one of many indigenous populations whose traditional practices are being impacted by midwifery licensure law.<sup>155</sup>

### III. ACT 32: HAWAI‘I’S MIDWIFERY LICENSURE LAW

The Hawai‘i State Legislature has attempted to implement a midwifery licensure act for decades.<sup>156</sup> It is important to emphasize here, that any type of legislation around midwife practices is inherently prohibitive for traditional midwives because these are practices that do not fit within a western legal framework or licensing scheme.

Various studies led up to the eventual Act 32, the modern Hawai‘i midwife statute, none of which included impacts on traditional Native Hawaiian birthing practices or Native Hawaiian midwives.<sup>157</sup> With Act 32,

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<sup>153</sup> See, e.g., Bonaparte, *supra* note 17, at 156 (discussing how midwifery laws enforced and mandated training sessions in South Carolina as a means of curtailing and replacing midwifery practice, consequently reducing the presence of black granny midwives in the state).

<sup>154</sup> See, e.g., *In Mexico, Midwives Offer Care Rooted in Ancestral Tradition*, PARTNERS IN HEALTH (May 5, 2021) <https://www.pih.org/article/mexico-midwives-offer-care-rooted-ancestral-tradition>. In Mexico, Mexican traditional midwives are understood to be born with the gift of midwifery, with knowledge that is “almost like doing magic.” *Id.* In this article, the author writes of a new generation of midwives using “ancestral tradition to usher in new life,” and recognizes joining ancestral tradition with a woman’s choice in choosing the most comfortable way for her to give birth. *Id.* “To change the world, you have to change the way we are born.” *Id.*

<sup>155</sup> See e.g., Catherine Pearson, *Meet the Midwife Starting the First Native American Birth Center*, HUFFPOST (Nov. 2, 2015, 1:05 PM), [https://www.huffpost.com/entry/meet-the-midwife-starting-the-first-native-american-birth-center\\_n\\_5626889de4b08589ef4939e8](https://www.huffpost.com/entry/meet-the-midwife-starting-the-first-native-american-birth-center_n_5626889de4b08589ef4939e8). Native Americans have also struggled with preserving and perpetuating their birth traditions because of western medicine and state regulation. See *id.* Traditions for Native Americans may include: burning sage to cleanse the space, drumming sessions, and/or a mother’s blessing way, a sacred ceremony. See *id.* All of these traditions are impacted by midwifery regulation, because with fewer available midwives, women must give birth in hospitals where traditions like those named above, may not be carried out. See *id.*

<sup>156</sup> Telephone Interview with Cami Wong, *supra* note 102.

<sup>157</sup> See, e.g., OFF. OF THE AUDITOR, ST. OF HAW., REP. NO. 89-21, SUNSET EVALUATION REPORT: REGULATION OF MIDWIVES (Dec. 1989),

“[i]t must be remembered that [any] regulation of traditional midwifery limits, alters, and otherwise adversely impacts traditional Native Hawaiian healing, because the central traditional practice in question is birth, not midwifery.”<sup>158</sup> Native Hawaiian practices in birth revolve around the unique instances of each birth with midwives playing a key role in the incorporation of cultural and personal values. Native Hawaiian traditions are thereby suppressed when midwives are regulated, as that typically means such practices must fit within a specific statutory framework.

#### A. History of Midwifery Regulation in Hawai‘i

Hawai‘i first began regulating the practice of midwifery in 1931 when the Territorial Legislature enacted Act 67, which required midwives to register with the Board of Health (“BOH”).<sup>159</sup> In 1941, the Hawai‘i Territorial Legislature sought to safeguard public health by further regulating midwifery, enacting Act 87.<sup>160</sup> “Act 87 made it illegal to practice midwifery without a certificate of registration or a permit.”<sup>161</sup>

It was not until 1988 that Hawai‘i created more midwifery legislation, when the Legislature added a midwifery licensing program administered by the Department of Health (“DOH”) under Chapter 321.<sup>162</sup> A year later, the Hawai‘i State Auditor performed the *Sunset Evaluation Report: Regulation of Midwives*,<sup>163</sup> which recommended that regulation of midwives be continued.<sup>164</sup> The regulatory program under Chapter 321 at

<https://files.hawaii.gov/auditor/Reports/1980-1989/89-21.pdf>.

<sup>158</sup> *Testimony on S.B. 1033, S.D. 2, H.D. 1 Before the H. Comm. on Health*, 30th Leg. 108–11 (Haw. 2019), [https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033\\_SD2\\_TESTIMONY\\_H\\_LT\\_03-19-19\\_PDF](https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033_SD2_TESTIMONY_H_LT_03-19-19_PDF) (statement of Laulani Teale, Master of Pub. Health) (opposing S.B. 1033).

<sup>159</sup> OFF. OF THE AUDITOR, ST. OF HAW., REP. NO. 89-21, SUNSET EVALUATION REPORT: REGULATION OF MIDWIVES (Dec. 1989), <https://files.hawaii.gov/auditor/Reports/1980-1989/89-21.pdf>. A sunset evaluation, also referred to as a sunset review, is an “evaluation of the need for the continued existence of a program or an agency.” See Wash. Joint Legis. Audit & Rev. Comm. [JLARC], *What is a Sunset Review?*, WASH. ST. LEGIS. (2021), <https://leg.wa.gov/jlarc/Documents/WhatisaSunsetReview.pdf>.

<sup>160</sup> See OFF. OF THE AUDITOR, ST. OF HAW., REP. NO. 89-21, SUNSET EVALUATION REPORT: REGULATION OF MIDWIVES 7-8 (1989), <https://files.hawaii.gov/auditor/Reports/1980-1989/89-21.pdf>.

<sup>161</sup> *Id.* at 8.

<sup>162</sup> See *id.* at 1.

<sup>163</sup> *Id.*

<sup>164</sup> See *id.* at 15; see also OFF. OF THE AUDITOR, ST. OF HAW., REP. NO. 99-14, SUNRISE ANALYSIS OF A PROPOSAL TO REGULATE CERTIFIED PROFESSIONAL MIDWIVES (1999), <https://files.hawaii.gov/auditor/Reports/1999/99-14.pdf> [hereinafter SUNRISE ANALYSIS].



that time, “required that no one except physicians could practice midwifery unless licensed by the State as a nurse midwife.”<sup>165</sup>

When the DOH repealed the midwifery statute, the purview of nurse-midwife regulation transferred from the BOH to the Board of Nursing (“BON”).<sup>166</sup> At that time then as a result of the statute change, the only midwives who were allowed to legally practice in the State of Hawai‘i were CNMs because the BON licensed all nurses who also practiced midwifery. Hawai‘i no longer had laws regulating midwifery other than the BON administrative licensing purview.<sup>167</sup>

There were various efforts to reintroduce midwifery licensure legislation to allow licensure of midwives other than CNMs. In 2014, the legislature introduced Senate Bill 2569 (“S.B. 2569”). In this bill, the legislature recognized the use of midwifery in Hawai‘i and intended to establish a home birth board to serve as an advisory board for licensure.<sup>168</sup> Under the proposed SD1 of S.B. 2569, the board would have granted a license to midwives who provided certification as a CPM by NARM, filed a board approved application for licensure and paid the fee, and provided documentation of successful completion of board approved MEAC accredited courses.<sup>169</sup> This bill allowed licensure of more midwives by encompassing CPMs, but still failed to recognize traditional midwives. This bill was stalled shortly after its introduction, passing a second reading and land referred to the Ways and Means Committee.<sup>170</sup>

The legislature attempted to introduce midwifery licensure related legislation again in 2016 with House Bill 1899.<sup>171</sup> H.B. 1899 starts off by saying, “The legislature finds that the Hawaiian Islands have a culture and traditional heritage that includes midwifery care.”<sup>172</sup> At the time, there was no legislation regulating midwives and this bill sought to do a study on the possibility of licensure for CPMs.<sup>173</sup> In this bill, the legislature intended to conduct a study on the qualifications and training of midwives, to include a determination of whether licensure or continuing education requirements were necessary, to evaluate alternative forms of regulation, to evaluate the cost impact on the state of requiring licensure, and to review other related

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<sup>165</sup> See Sunrise Analysis, *supra* note 164, at 3–4.

<sup>166</sup> *Id.* at 4.

<sup>167</sup> See *id.*

<sup>168</sup> S.B. 2569 SD1, 27th Leg., Reg. Sess. (Haw. 2014).

<sup>169</sup> *Id.*

<sup>170</sup> See S. COMM. ON HEALTH, COM. & CONSUMER PROT. & JUD. & LAB., 27TH LEG., REG. SESS., STAND. COMM. REP. NO. 2432 ON S.B. 2569, S.D. 1, (Haw. 2014).

<sup>171</sup> H.B. 1899, 28th Leg., Reg. Sess. (Haw. 2016).

<sup>172</sup> *Id.*

<sup>173</sup> See *id.*

issues.<sup>174</sup> Essentially, the legislature wanted to determine whether licensure laws regulating CPMs were warranted.<sup>175</sup> This bill resulted in the *2017 Sunrise Analysis*:<sup>176</sup> *Regulation of Certified Professional Midwives* (“2017 Sunrise Analysis”).<sup>177</sup>

Consequently, the 2017 Sunrise Analysis only reinforced the stereotype that midwives were dangerous, stating that “[t]he nature of the maternity and prenatal services provided by midwives may endanger the health and safety of women and newborns under the midwife’s care.”<sup>178</sup> This study discounted H.B. 1899 for not being strict enough and posing licensure as optional, and instead concluded that stricter and mandatory licensing should be adopted.<sup>179</sup> The study relied on Hawai‘i’s Regulatory Licensing Reform Act<sup>180</sup> in finding that the “entire midwifery profession should be subject to mandatory licensure.”<sup>181</sup> Again, this study failed to consider any of the impacts on culture or tradition, alleging that public health and safety concerns substantially outweigh any negative effects arising from regulation.<sup>182</sup> The study relied on the statistic of 2.59 deaths per 1,000 home births as posing a danger to the public, and as the reason for

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<sup>174</sup> *Id.*

<sup>175</sup> *See id.*

<sup>176</sup> A Sunrise Analysis is “a review of whether it is necessary for a legislature to enact legislation to regulate an . . . unregulated profession or occupation in order to protect the health, safety, or welfare of the public.” DEAN SUGANO, LEGIS. REF. BUREAU, REP. NO. 6, 2002, *SUNRISE REVIEWS: REGULATORY STRUCTURES AND CRITERIA* (2002), [https://lrb.hawaii.gov/wp-content/uploads/2002\\_SunriseReviews.pdf](https://lrb.hawaii.gov/wp-content/uploads/2002_SunriseReviews.pdf). The Hawai‘i’s Regulatory Licensing Reform Act “requires the Auditor to conduct sunrise reviews.” *Id.* Specifically, the Auditor must “analyze new regulatory measures being considered for enactment that, if enacted, would subject unregulated professions or vocations to licensing or other regulatory controls.” *Id.*

<sup>177</sup> *See* OFF. OF THE AUDITOR, ST. OF HAWAI‘I, REP. NO. 17-01, *SUNRISE ANALYSIS: REGULATION OF CERTIFIED PROFESSIONAL MIDWIVES* (2017), <https://files.hawaii.gov/auditor/Reports/2017/17-01.pdf> [hereinafter 2017 *SUNRISE ANALYSIS*].

<sup>178</sup> *Id.*

<sup>180</sup> HAW. REV. STAT. § 26H-6 (1977). The Hawai‘i’s Regulatory Licensing Reform Act established general policies for the regulation of all professions and vocations in Hawai‘i. The Act outlines when licensing is necessary, how regulation shall be implemented, that regulations shall be avoided if costs are artificially increased, regulation shall be eliminated when there is no further benefit to consumers, regulation shall not unreasonably restrict entry into the profession by qualified persons, and the imposition of fees. *Id.* § 26H-2.

<sup>181</sup> 2017 *SUNRISE ANALYSIS*, *supra* note 177, at 11.

<sup>182</sup> *See id.* at 8.

why midwives must be regulated.<sup>183</sup> However, the research failed to acknowledge that infant mortality rates were much higher than measured by the Center for Disease Control and Prevention, at 5.58 deaths per 1,000 live births.<sup>184</sup> Ultimately, the study recommended that the legislature require mandatory licensure of all midwives that follow strict western requirements.<sup>185</sup>

Following the 2017 Sunrise Analysis, House Bill 2184 (“H.B. 2184”) was introduced to the legislature in 2018. The purpose of the bill was “to regulate midwives engaged in the practice of midwifery care by establishing licensure requirements and regulatory requirements.”<sup>186</sup> The bill alleged to “empower consumer choice, reduce access disparities, enhance provider availability, and improve quality of maternal child health care.”<sup>187</sup> This bill essentially excludes direct entry midwives from licensure, and again, any legislation of midwife licensing inherently causes barriers for non-western midwives' practices. H.B. 2184 was ultimately deferred by the Consumer Protection and Commerce Committee. The legislation following H.B. 2184—Senate Bill 1033—replicated H.B. 2184 and became the current codified midwifery licensure bill.<sup>188</sup>

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<sup>183</sup> See *id.* at 10 (citing Melissa Cheyney et al., *Outcomes of Care for 16,924 Planned Home Births in the United States*, 59 J. MIDWIFERY & WOMEN'S HEALTH 17, 23 (2014), <https://onlinelibrary.wiley.com/doi/epdf/10.1111/jmwh.12172>). Studies comparing midwifery care and physician care found that midwives provide comprehensive care with excellent health outcomes and with the use of fewer interventions. Anne Z. Cockerham & Tekoa L. King, Commentary, *One Hundred Years of Progress in Nurse-Midwifery: With Women, Then and Now*, 59 J. MIDWIFERY & WOMEN'S HEALTH 3, 3–7 (2014). Additionally, the study cited to did not actually discern the true risks related to place of birth because of “the low absolute number of events and the lack of a matched comparison group.” Melissa Cheyney, *supra*, at 26.

<sup>184</sup> See KENNETH D. KOCHANNEK ET.AL., NO. 395, MORTALITY IN THE UNITED STATES, 2019, NCHS DATA BRIEF (2020), <https://www.cdc.gov/nchs/data/databriefs/db395-H.pdf>. This data was collected based on death certificates filed in the United States, and does not indicate whether all of these deaths occurred within hospitals or outside of hospitals. See *id.* The United States ranks among one of the countries with high infant mortality rates, just below Chile (7.0), Turkey (9.2), and Mexico (12.1). See UNITED HEALTH FOUND., AMERICA'S HEALTH RANKINGS ANNUAL REPORT, 2019,019, <https://www.americashealthrankings.org/learn/reports/2019-annual-report/international-comparison>. In countries that rank much lower than the United States, like the United Kingdom (3.9) and Netherlands (3.6), midwives greatly outnumber OB-GYNs. See *id.*; Tikkanen, Roosa et.al., *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries*, The Common Wealth Fund (Nov. 18, 2020) <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries>.

<sup>185</sup> 2017 SUNRISE ANALYSIS, *supra* note 177.

<sup>186</sup> H.B. 2184, 29th Leg., Reg. Sess. (Haw. 2018).

<sup>187</sup> *Id.*

<sup>188</sup> See S.B. 1033, 30th Leg., Reg. Sess. (Haw. 2019) .

B. *Senate Bill 1033 and Community Testimony*

Senate Bill 1033<sup>189</sup> was introduced in 2019, because of the apparent “growing public concern over non-credentialed and uncertified individuals calling themselves ‘midwives’ who have been allowed to market themselves and provide midwifery services as a business.”<sup>190</sup> The Senate Committees on Commerce and Consumer Protection and Health stated:

This measure protects the health and safety of women and unborn infants and is not a prohibition on a woman's ability to choose the birth attendant of her choice; it is about licensure of a profession. Licensure will provide consumers with increased access to midwifery care from providers who are skilled professional midwives. Through licensure, midwives will be able to work to their fullest scope and within a collaborative health care system. It is vital that all women have access to safe, qualified, highly skilled providers in all aspects of the birthing process.<sup>191</sup>

The committee insisted that S.B. 1033 was a measure necessary to protect the health and safety of women and newborns, despite countless mothers who wrote testimony in opposition of this bill, in fear they were being deprived their ability to make free choices in their birth.<sup>192</sup>

Many members of the community wrote in opposition and support of the bill. Those in support of S.B. 1033 were concerned with the safety and health of mothers and babies, and suspected that some midwives practicing in the community may be incompetent.<sup>193</sup> Those who wrote in opposition were concerned for various reasons; the most prominent being the prohibition of traditional midwives, the effect of the legislation on Native Hawaiian traditional birth practices, and how the requirements for licensure under S.B.1033 will impact choices and access for expecting mothers.<sup>194</sup> Mothers wrote testimony vouching for midwives, urging the

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<sup>189</sup> *Id.*

<sup>190</sup> S. COMM. ON COM., CONSUMER PROT. & HEALTH, 30TH LEG., REG. SESS., STAND. COMM. REP. NO. 659 ON S.B. 1033, S.D. 2, H.D. 1, (Haw. 2019).

<sup>191</sup> *Id.*

<sup>192</sup> See *infra* text accompanying note 196.

<sup>193</sup> See, e.g., *Testimony on S.B. 1033, S.D. 2, H.D.1 Before the H. Comm. on Health*, 30th Leg., Reg. Sess., at 9–10 (Haw. 2019), [https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033\\_SD2\\_TESTIMONY\\_H LT\\_03-19-19\\_.PDF](https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033_SD2_TESTIMONY_H LT_03-19-19_.PDF).

<sup>194</sup> See e.g., *Testimony on S.B. 1033, S.D. 2, H.D. 1 Before the H. Comm. on Health*, 30th Leg., Reg. Sess., at 108–11 (Haw. 2019), [https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033\\_SD2\\_TESTIMONY\\_H LT\\_03-19-19\\_.PDF](https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033_SD2_TESTIMONY_H LT_03-19-19_.PDF) (statement of Laulani Teale, Master of Publ. Health) (opposing S.B.

legislature not to pass the bill because traditional midwives would be forbidden from practice under S.B. 1033, despite practicing for decades and assisting hundreds of successful births.<sup>195</sup> Current midwives wrote how detrimental this licensure would be to the midwifery community, causing a divide between those who do and do not qualify for licensure, depriving mothers of many midwives who trained by apprenticeship or other non-western knowledge center.<sup>196</sup> Regardless of the overwhelming testimony, S.B. 1033 was passed and enacted as Act 32.<sup>197</sup>

### C. *The Passage of Act 32*

In April 2019, S.B. 1033, now known as Act 32, was passed.<sup>198</sup> Act 32 generally covers homebirths because it governs CPMs<sup>199</sup> and CMs,<sup>200</sup> who are not qualified to work in hospitals in Hawai‘i.<sup>201</sup> The Act defines a “midwife” as “a person licensed under this chapter.”<sup>202</sup> “Midwifery” is further defined as the provision of one or more of the following services:

Assessment, monitoring, and care during pregnancy, labor, childbirth, post-partum and interconception periods, and for newborns, including ordering and interpreting screenings and diagnostic tests, and carrying out appropriate emergency measures when necessary; Supervising the conduct of labor and childbirth; and Provision of advice and information regarding the progress of childbirth and care for newborns

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1033); *id.* at 311 (statement of Ramona Hussey, Former Att’y & Homebirth Mother); *id.* at 692–93 (statement of Ye Nguyen, Licensed Naturopathic Physician).

<sup>195</sup> See *id.* at 311 (statement of Ramona Hussey, Former Att’y & Homebirth Mother) (opposing S.B. 1033).

<sup>196</sup> See e.g., *Testimony on S.B. 1033, S.D. 2, H.D. 1 Before the H. Comm. on Health*, 30th Leg., Reg. Sess., at 100–01 (Haw. 2019), [https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033\\_SD2\\_TESTIMONY\\_H\\_LT\\_03-19-19\\_.PDF](https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033_SD2_TESTIMONY_H_LT_03-19-19_.PDF) (statement of Rachel Struempf, Direct Entry Midwife & Pres. of Haw. Midwifery Council).

<sup>197</sup> S.B. 1033, 30th Leg., Reg. Sess. (Haw. 2019).

<sup>198</sup> *Id.*

<sup>199</sup> Act 32 defines a Certified Professional Midwife as “a person who holds a current and valid national certification as a certified professional midwife from the North American Registry of Midwives, or any successor organization.” *Id.*

<sup>200</sup> Act 32 defines a Certified Midwife as “a person who holds a current and valid national certification as a certified midwife from the American Midwifery Certification Board, or any successor organization.” *Id.*

<sup>201</sup> Telephone Interview with Lea Minton, *supra* note 56.

<sup>202</sup> S.B. 1033, at 6. This definition limits the interpretation of a “midwife” to the confines of the act itself, despite midwifery long predating licensure laws and performing services well beyond monitoring of a mother and child, as the act states. This definition completely dismisses the historical significance of midwives.

and infants.<sup>203</sup>

Under section 11 of the Act, licensed midwives are given the authority to purchase and administer certain legend drugs<sup>204</sup> and devices. Act 32 makes no specific mention of home birth or traditional midwives, despite the impact it has on both practices.

Act 32 provides licensure for applicants that produce the following: an application for licensure, the required fee, and proof of certification as a Certified Professional Midwife or Certified Midwife.<sup>205</sup> For CPMs, an applicant must provide proof of successful completion of a formal midwifery education and training program that is either an educational program accredited by the MEAC or a midwifery bridge certificate issued by the NARM who obtained a certificate before January 2020 through a non-accredited pathway or have maintained licensure in a state that does not require accredited education.<sup>206</sup>

There are numerous exemptions to licensure under section 6, which include the following: Certified Nurse-Midwives,<sup>207</sup> professionals certified to work within another area of practice that overlaps with midwifery, students enrolled in a midwifery educational program, persons rendering aid in an emergency with no fee, and healing practices by traditional Hawaiian healers.<sup>208</sup> Act 32 also exempts a separate category of birth attendants until July 2023.<sup>209</sup> Midwives under this separate exemption are not allowed to use legend drugs or devices, may not advertise that they are a licensed midwife, and must disclose to each client that the midwife does not possess a professional license, that their education and qualifications whether it had not been reviewed by the state, that they may not administer legend drugs, any determination that they have committed misconduct or are criminally or civilly liable for conduct related to midwifery, and an

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<sup>203</sup> *Id.*

<sup>204</sup> A legend drug is “medication that cannot be obtained legally without a prescription from a licensed health care provider.” *Legend Drug*, THE FREE DICTIONARY, <https://medical-dictionary.thefreedictionary.com/legend+drug> (last visited Mar. 22, 2022). An example of a legend drug that a mother may want to obtain during labor is Butorphanol, which helps with pain management during contractions. *See Stadol (Butorphanol) During Labor*, VERY WELL FAMILY (June 14, 2021), <https://www.verywellfamily.com/stadol-in-labor-4768117>. Another commonly used legend drug is Pitocin, which helps induce labor. *See Pitocin Induction: The Risks and Benefits*, Healthline (July 10, 2020), <https://www.healthline.com/health/pregnancy/pitocin-induction#takeaway>.

<sup>205</sup> S.B. 1033, 30TH LEG., REG. SESS., 13–14 (Haw. 2019).

<sup>206</sup> *Id.* at 14.

<sup>207</sup> *See generally* HAW. REV. STAT. § 457 (2014) (statute governing CPM licensing).

<sup>208</sup> S.B. 1033, at 9–12.

<sup>209</sup> *Id.* at 10.

emergency plan for being transported to the hospital.<sup>210</sup> This exemption was created to “allow this community to define themselves and develop common standards” with the intent “to enact statutes that will incorporate [these] birth practitioners and allow [this category of midwives] to practice to the fullest extent under the law.”<sup>211</sup> The Act, however, provides no guidance for this “community” in setting common standards or defining themselves, or how to ensure their future qualification for licensure under the Act. This and the following section highlight the law's inability to cohesively regulate traditional practices, and the harm it causes in terms of an expecting mothers access to the services of midwife she chooses.

#### IV. CONSEQUENCES AND INCONSISTENCIES OF ACT 32 AND THE STATUTE'S ADVERSE EFFECTS ON NATIVE HAWAIIAN BIRTHING PRACTICES

Act 32 insists that it “will continue to allow a woman to choose where and with whom she gives birth.”<sup>212</sup> Considering the implications and consequences of Act 32, this is simply untrue, and it is clear that the Hawai'i State Legislature enacted Act 32 without considering how the practice of midwifery and the community who use midwifery services would be affected.

Under the licensing scheme of the Act, individuals who have become midwives through the route of apprenticeship, alone, will not qualify for licensure.<sup>213</sup> The Act has acknowledged that midwives may receive certification even if they have gone through a non-accredited pathway but provides that if the individual has not received certification through NARM by January 2020, they would not be eligible for licensure.<sup>214</sup> The legislature created the separate exemption for these midwives, but then claimed it was an effort to “allow this community to define itself,” basically meaning that the state is giving these midwives three years to meet the qualifications of licensure; that means going to school (if one can afford it) and tracking experiential hours.<sup>215</sup>

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<sup>210</sup> *Id.* at 10–12.

<sup>211</sup> *Id.* at 3.

<sup>212</sup> *Id.* at 2.

<sup>213</sup> *See id.* at 13–14.

<sup>214</sup> *Id.* at 14.

<sup>215</sup> *See id.* at 10. It takes approximately three years to complete curriculum for a certified midwifery program. *See FAQs*, NAT'L MIDWIFERY INST. INC. [NMI], <https://www.nationalmidwiferyinstitute.com/faqs> (last visited Apr. 21, 2022). In Hawai'i, the number of homebirths annually makes up a very small portion of total birth. *See HAW. HOME BIRTH TASK FORCE, A REPORT TO THE GOVERNOR AND THE LEGISLATURE OF THE STATE OF HAWAII PER ACT 32, SESSION LAWS OF HAWAII (2019)*, <https://humanservices.hawaii.gov/wp-content/uploads/2020/01/FINAL-12.10.19-HHBTf-Report-12.11.19.pdf>. In 2018, there were 302 home births, compared to 16,649

Even if a midwife in Hawai‘i were to attempt to meet the requirements for licensure, the Act imposes requirements without providing any means or a pathway to achieve licensure within the State of Hawai‘i.<sup>216</sup> There are midwifery schools in the U.S., but they are outside of Hawai‘i and come at a high cost.<sup>217</sup> Second, there are not enough available preceptors in Hawai‘i that accommodate the need for training midwives, which would allow student midwives to finish their apprenticeship hours and qualify for licensure.<sup>218</sup> Third, the licensure law does not align with the actual practices of midwifery, nor does it properly protect a mother’s ability to have a homebirth if she so chooses.

The consequence is that traditional midwives trained in Native Hawaiian practices tend to have taken the apprenticeship route, and therefore would be barred from practice by 2023 under the current language of Act 32. With less access to midwives and the ability to give birth at home, coupled with the lack of education and advocacy for native birth practices, Native Hawaiian women may have a harder time incorporating traditional practices in birth. The attempt to protect Native Hawaiian traditional birth practices with the exemption stated in section 6 of Act 32 does not do enough to ensure that these practices are not only fully protected but perpetuated as well.

In addition to the impractical standard for licensure, the definition of “midwifery” in the Act that defines the practice of midwifery could also define the practice of: obstetrics, ordering and interpreting screenings and diagnostic tests, supervising conduct of labor, advise, and inform progress of childbirth.<sup>219</sup> The act fails to account for the true work of midwifery services that tend to the wholesome care of the mother, the services that midwives provide in informing and advising family members, and the

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hospital births. *Id.* To become a CPM, midwives are required to observe and assist in a number of births. Candidate Information Booklet, N. AM. REGISTRY OF MIDWIVES [NARM] (Dec. 2021), <http://narm.org/pdf/CIB.pdf>. With these apprenticeship requirements and the small number of homebirths in Hawai‘i, it may take a student midwife in Hawai‘i even longer to become certified or may even force a student midwife to travel to the contiguous United States in order to complete these requirements.

<sup>216</sup> *Testimony on S.B. 1033, S.D. 2, H.D. 1 Before the H. Comm. on Health*, 30th Leg., Reg. Sess., at 108–11 (Haw. 2019), [https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033\\_SD2\\_TESTIMONY\\_HLT\\_03-19-19\\_.PDF](https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033_SD2_TESTIMONY_HLT_03-19-19_.PDF) (statement of Laulani Teale, Master of Pub. Health) (opposing S.B. 1033).

<sup>217</sup> *See id.*

<sup>218</sup> *Testimony on S.B. 1033, S.D. 2, H.D. 1 Before the H. Comm. on Health*, 30th Leg., Reg. Sess., 56–60 (Haw. 2019), [https://www.capitol.hawaii.gov/session2019/testimony/SB1033\\_HD1\\_TESTIMONY\\_FIN\\_03-29-19\\_.PDF](https://www.capitol.hawaii.gov/session2019/testimony/SB1033_HD1_TESTIMONY_FIN_03-29-19_.PDF) (statement of Kristie Duarte, individual) (opposing S.B. 1033).

<sup>219</sup> *See* S.B. 1033, 30th Leg., Reg. Sess., 6 (Haw. 2019).



holistic health monitoring of both mother and baby.<sup>220</sup> Act 32 does not acknowledge the relationship a midwife makes with a mother, and only accounts for the tasks of midwives with respect to treatment and screenings.<sup>221</sup>

Further, Act 32 adversely affects the implementation of Native Hawaiian birthing practices and the ability to innovate traditional practices to revitalize them are constricted. Despite Act 32's attempt to reconcile the impacts on Native Hawaiians by an exemption, the act fails to consider that any and all regulation of traditional midwifery "limits, alters, and otherwise adversely impacts traditional Native Hawaiian healing because the central traditional practice in question is birth, not midwifery."<sup>222</sup> Papa Ola Lokahi, the organization that is empowered to enforce this exemption, does not have mechanisms to extend protection to Native Hawaiian traditional midwives for birth-related practices, such as lā'au lapa'au, ho'oponopono, and lomilomi.<sup>223</sup> Act 32 also jeopardizes Native Hawaiian birthing practices because it is ambiguous as to what constitutes a Native Hawaiian birth practice.<sup>224</sup> The exemption fails to account for the ability of the legislature to alter the exemption and the act by any means in 2023.<sup>225</sup>

As discussed in the previous section, there is neither a pathway to licensure nor a sufficient number of preceptors, and more specifically,

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<sup>220</sup> See Shaw, *supra* note 16, at 532; Stover, *supra* note 19, at 320-21.

<sup>221</sup> See *Testimony on S.B. 1033, S.D. 2, H.D. 1 Before the H. Comm. on Health*, 30th Leg., Reg. Sess., at 610 (Haw. 2019), [https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033\\_HD1\\_TESTIMONY\\_FIN\\_03-29-19\\_.PDF](https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033_HD1_TESTIMONY_FIN_03-29-19_.PDF) (statement of Ramona Hussey, Former Att'y & Homebirth Mother) (opposing S.B. 1033); S.B. 1033, 30TH LEG., REG. SESS. (HAW. 2019) at 6, 15-16.

<sup>222</sup> See *Testimony on S.B. 1033, S.D. 2, H.D. 1 Before the H. Comm. on Health*, 30th Leg., Reg. Sess., at 610 (Haw. 2019), [https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033\\_HD1\\_TESTIMONY\\_FIN\\_03-29-19\\_.PDF](https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033_HD1_TESTIMONY_FIN_03-29-19_.PDF) (statement of Ramona Hussey, Former Att'y & Homebirth Mother) (opposing S.B. 1033); S.B. 1033, 30TH LEG., REG. SESS. (HAW. 2019) at 6, 15-16.

<sup>223</sup> *Testimony on S.B. 1033, S.D. 2, H.D. 1 Before the H. Comm. on Health*, 30th Leg., Reg. Sess., at 111 (Haw. 2019), [https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033\\_SD2\\_TESTIMONY\\_HLT\\_03-19-19\\_.PDF](https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033_SD2_TESTIMONY_HLT_03-19-19_.PDF) (emphasis omitted) (statement of Laulani Teale, Master of Pub. Health) (opposing S.B. 1033).

<sup>224</sup> Although, in some cases ambiguity may be beneficial. Ambiguity may allow for broader interpretation, since the practices are not specifically outlined or defined. It truly depends on the particular circumstances in which the ambiguity arises. See Telephone Interview with Kim Ku'ulei Birnie, Communications Papa Ola Lokahi (Feb. 4, 2021).

<sup>225</sup> See *Testimony on S.B. 1033, S.D. 2, H.D. 1 Before the H. Comm. on Health*, 30th Leg., Reg. Sess., at 51 (Haw. 2019), [https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033\\_HD1\\_TESTIMONY\\_FIN\\_03-29-19\\_.PDF](https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033_HD1_TESTIMONY_FIN_03-29-19_.PDF) (statement of Sara Kahale, individual) (opposing S.B. 1033).

traditional Native Hawaiian preceptors in the State of Hawai‘i.<sup>226</sup> It is important for Native Hawaiian traditional midwives to be able to stay in Hawai‘i to train in midwifery and in Native Hawaiian practices, which can only be learned in Hawai‘i.<sup>227</sup> Lomilomi, ho‘oponopono, lā‘au lapa‘au and any other Native Hawaiian practices incorporated in childbirth are rooted in Hawai‘i. Hawai‘i is home to Native Hawaiian practices and the individuals who may teach them, a midwife simply cannot go to school in the contiguous U.S. and learn Native Hawaiian practices there.

Finally, Act 32 also does not consider that many traditional Native Hawaiian births are attended by midwives of other ethnicities, who are restricted by Act 32, thereby impacting Native Hawaiian birthing abilities.<sup>228</sup>

The legislature has deprived the community of a portion of midwives who may be well trained by apprenticeship to assist multiple births. Depriving the community of any number of midwives deprives women of the choice to birth with these midwives, and detracts Native Hawaiian birthing practices, which are primarily done with traditional midwives.

#### A. *The Midwives Who “Fall Through the Cracks”*

Licensure of any profession, despite being implemented for the public good, has consequences for those in the profession and for consumers, and these consequences are harsher for indigenous populations and culture. Professional licensure is considered a form of consumer protection, but birth is a normal biological process and does not pose a risk to consumer safety.<sup>229</sup>

Licensure is rooted in the theory that one must be qualified by way of formal education in order to be proficient in any specific practice.<sup>230</sup> Seemingly, licensure is not only imposed to protect the public, but protect the integrity of the medical industry and prestige associated with attending formal schooling.<sup>231</sup> With this, the midwifery industry is forced to sacrifice

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<sup>226</sup> *Testimony on S.B. 1033, S.D. 2, H.D. 1 Before the H. Comm. on Health*, 30th Leg., Reg. Sess., at 28–29 (Haw. 2019), [https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033\\_HD1\\_TESTIMONY\\_FIN\\_03-29-19\\_](https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033_HD1_TESTIMONY_FIN_03-29-19_) (statement of Laulani Teale, Master of Pub. Health) (opposing S.B. 1033).

<sup>227</sup> *See id.* at 108.

<sup>228</sup> *See id.* at 111.

<sup>229</sup> *Testimony on S.B. 1033, S.D. 2, H.D. 1 Before the H. Comm. on Health*, 30th Leg., Reg. Sess., at 33 (Haw. 2019), [https://www.capitol.hawaii.gov/session2019/testimony/SB1033\\_HD1\\_TESTIMONY\\_FIN\\_03-29-19\\_.PDF](https://www.capitol.hawaii.gov/session2019/testimony/SB1033_HD1_TESTIMONY_FIN_03-29-19_.PDF) (statement of Rachel Struempf, Direct Entry Midwife & Pres. of Haw. Midwifery Council).

<sup>230</sup> *See id.* at 32–33.

<sup>231</sup> *See id.*

qualified midwives who are midwives by apprenticeship, and have been practicing prior to the implementation formalized schooling for midwifery.<sup>232</sup>

Under section 8 of Act 32, to qualify for licensure, midwives must first provide an application for licensure, the required fees, and proof of unencumbered<sup>233</sup> certification as a CPM or CM.<sup>234</sup> CPMs must also provide proof of successful completion of a formal midwifery education and training program that is either accredited by the MEAC or a certificate issued by the NARM.<sup>235</sup> Accordingly, any midwife who has become a midwife through the apprenticeship route alone, and has not gone through some form of formal education, would not be eligible for licensure.<sup>236</sup>

Realistically, a midwife who has become a midwife through apprenticeship and, over her career, has delivered one hundred babies with a well-established reputation in the community, would not qualify for licensure, but a newly practicing midwife who just completed school and received a certificate from NARM, would be eligible for licensure.<sup>237</sup> Act 32 does not account for midwives who have not gone through formal schooling, a normal pathway to becoming a midwife for centuries, that would be completely outlawed under this law.<sup>238</sup> These midwives would be penalized for practicing midwifery, despite how qualified they may be.<sup>239</sup>

The licensing scheme of Act 32 also restricts CMs to practice solely with homebirths.<sup>240</sup> CMs are equally trained in midwifery as CNMs and are recognized as midwives by the AMCB as CNMs are, the only difference is that CMs do not have a nursing degree.<sup>241</sup> Despite CMs being as qualified as CNMs to practice midwifery, this bill reduces CMs to the same status as

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<sup>232</sup> *Testimony on S.B. 1033, S.D. 2, H.D. 1 Before the H. Comm. on Health*, 30th Leg., Reg. Sess., at 38–39 (Haw. 2019), [https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033\\_HD1\\_TESTIMONY\\_FIN\\_03-29-19\\_.PDF](https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033_HD1_TESTIMONY_FIN_03-29-19_.PDF) (statement of Les DeBina, individual) (opposing S.B. 1033).

<sup>233</sup> Unencumbered certification is certification free of disciplinary limitations, often limited and under a Board, which monitors those who earn certificates unless the certification is revoked. Mary Trentham, *Discipline 101 What is an Unencumbered License?*, 22 ARK. ST. BD. NURSING [ASBN] 16 (Feb./Mar. 2018), [https://epubs.thinknurse.com/publication/?m=6575&i=483240&view=articleBrowser&article\\_id=3039870&ver=html5](https://epubs.thinknurse.com/publication/?m=6575&i=483240&view=articleBrowser&article_id=3039870&ver=html5).

<sup>234</sup> S.B. 1033, 30th Leg., Reg. Sess., 13–14 (Haw. 2019).

<sup>235</sup> *Id.* at 14.

<sup>236</sup> *See id.*

<sup>237</sup> Telephone Interview with Cami Wong, *supra* note 102.

<sup>238</sup> *Id.*

<sup>239</sup> *Id.*

<sup>240</sup> *See* S.B. 1033, 30th Leg., Reg. Sess. (Haw. 2019).

<sup>241</sup> Telephone Interview with Lea Minton, *supra* note 56.

CPMs.<sup>242</sup> This is harmful because it discourages CMs from practicing in Hawai‘i because of the tight restrictions imposed on their midwifery practices, being limited to home births alone.<sup>243</sup> At the time of this paper, there are no practicing CMs in Hawai‘i.<sup>244</sup>

Further, not only does the Act create difficulties for CPMs and CMs to practice, but Act 32 has also made it more difficult to perpetuate Native Hawaiian practices. As previously stated, Act 32 has an exception carved out for Native Hawaiian practitioners, but the exception is vague, leaving room for error and the possibility that Native Hawaiian traditional midwives may be penalized in their practice. The exemption states,

Nothing in this chapter shall prohibit healing practices by traditional Hawaiian healers engaged in traditional healing practices of prenatal, maternal, and child care as recognized by any council of kupuna convened by Papa Ola Lokahi. Nothing in this chapter shall limit, alter, or otherwise adversely impact the practice of traditional Native Hawaiian healing pursuant to the Constitution of the State of Hawaii.<sup>245</sup>

Essentially, Papa Ola Lokahi serves as the agency which conducts kupuna councils who may affirm what is or is not a traditional Hawaiian healing practice as to be exempted under this exemption.

Papa Ola Lokahi is a leader in Native Hawaiian health and has previously worked to address Native Hawaiian health topics in the law.<sup>246</sup> Papa Ola Lokahi worked with Congress in creating the Native Hawaiian Health Care Act.<sup>247</sup> In that Act, a traditional Hawaiian healer is defined in the Native Hawaiian Health Care act as “a practitioner—who—is of Hawaiian ancestry, and has the knowledge, skills, and experience in . . . personal health care of individuals.”<sup>248</sup> The practitioner’s “knowledge, skills, and experience [must be] based on demonstrated learning of Native Hawaiian healing practices acquired by—direct practical associations with Native Hawaiian elders, and oral traditions transmitted from generation to generation.”<sup>249</sup>

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<sup>242</sup> See S.B. 1033, at 13.

<sup>243</sup> Telephone Interview with Lea Minton, *supra* note 56.

<sup>244</sup> *Id.*

<sup>245</sup> S.B. 1033, at 12.

<sup>246</sup> See PAPA OLA LOKAHI, <http://www.papaolalokahi.org/> (last visited Mar. 25, 2022).

<sup>247</sup> See 42 U.S.C. §§ 11701-11714.

<sup>248</sup> *Id.* § 11711(10)(A).

<sup>249</sup> *Id.* § 11711(10)(B).

The Kupuna Councils designated in recognizing traditional healing practices as falling under the exemption are overseen by Papa Ola Lokahi. Kupuna Councils were “established to distinguish practitioners of Hawaiian healing traditions from medical clinicians in Hawai‘i, and provide protections of such healing practices as assured by the Hawai‘i State Constitution.”<sup>250</sup> There are Kupuna Councils spread across the Hawaiian islands, consisting of “practitioners of traditional Native Hawaiian healing kupuna masters that serve in advisory capacities for their communities and shall include at least three members that are Native Hawaiian.”<sup>251</sup> Kupuna Councils do not recognize individual Hawaiian healing practitioners, but Native Hawaiian healing practices themselves.<sup>252</sup>

These Kupuna Councils set the precedent for what should be considered by the legislature, a traditional Hawaiian birthing practice. If a kupuna council were to say that a specific birthing practice performed by a traditional Native Hawaiian midwife were not a traditional Hawaiian healing practice, that midwife would be penalized under Act 32, because he or she would not fall under the exception for Native Hawaiian practices. This is dangerous for the Native Hawaiian culture and Native Hawaiian midwives because many birthing practices, which may be specific to one family or place, may not be known by the individuals on kupuna councils. Native Hawaiian birthing practices today are often hard to find, or specific to a family or person, and if the kupuna councils do not recognize such a practice, not only is the midwife at risk for penalization, but the traditional practice may be discredited as well.

The exemption does not do enough to protect the revitalization of Native Hawaiian birth traditions. Act 32 is a regulatory mechanism that impacts the innovation necessary to keep Native Hawaiian Traditions alive. Native Hawaiians often must innovate to keep their practices alive because they have become too obscured or lost over time after suppression. ‘Ōlelo Hawai‘i (Hawaiian language) was once nearly lost because of laws banning the language.<sup>253</sup> In the revitalization of ‘Ōlelo Hawai‘i, Native Hawaiians created charter schools with the freedom to “explore innovative pedagogical methods.”<sup>254</sup> The exemption for traditional healing practices under Act 32 does not allow for this kind of innovation for Native Hawaiian traditional practices. The exemption is set up as recognizing practices that are

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<sup>250</sup> *Kupuna Councils - An Overview*, PAPA OLA LOKAHI, <http://www.papaolalokahi.org/kupuna-councils-an-overview.html> (last visited Mar. 24, 2022).

<sup>251</sup> *Id.*

<sup>252</sup> *Id.*

<sup>253</sup> Shari Nakata, *Language Suppression, Revitalization, and Native Hawaiian Identity*, 2 DIVERSITY & SOC. JUST. FORUM 14, 15 (2017).

<sup>254</sup> *Id.* at 22.

commonly known or practiced, leaving no recognition for instances where traditions have been innovated to reflect an obscured traditional practice, or practices particular to a specific family or place. The standard is high for traditional Hawaiian practices, and there may be birth traditions that are not widely known by the broader community, creating a chilling effect for the revival of Native Hawaiian birthing practices.

### B. *Jeopardizing Home Birth*

Act 32 shapes midwifery to be more medicalized than it truly is. Act 32 essentially defines midwifery as someone who can order lab work and administer legend drugs and devices, but many women turn to midwifery to avoid such procedures.<sup>255</sup> Many home-birth mothers actively choose non-medicalized births, and trained midwives who are trained aligned to follow a non-medicalized birth plan.<sup>256</sup> Act 32 blatantly dismisses the practice of midwifery separate from medical practice, assuming that licensure is necessary to ensure that midwives must be licensed to prescribe medications and “interpret[] screening and diagnostic tests.”<sup>257</sup> But this is not what some mothers turn to midwives for, quite the opposite for mothers who choose a homebirth, with a traditional midwife, without any medical interventions.<sup>258</sup> Act 32 fully governs what midwives qualify to assist in homebirths, but does not accurately protect women’s ability to home birth.

The Hawai‘i Home Birth Task Force was created under Act 32, with the task to investigate issues relating to direct entry midwives and home births.<sup>259</sup> The task force performed data collection and reporting on home births, and the education, training and regulation of direct entry midwives.<sup>260</sup> The legislature created this task force to portray as if they intend to monitor homebirths in order to create legislation support home

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<sup>255</sup> *Testimony on S.B. 1033, S.D. 2, H.D. 1 Before the H. Comm. on Health*, 30th Leg., Reg. Sess., at 610 (Haw. 2019), [https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033\\_HD1\\_TESTIMONY\\_FIN\\_03-29-19\\_.PDF](https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033_HD1_TESTIMONY_FIN_03-29-19_.PDF) (statement of Ramona Hussey, Former Att’y & Homebirth Mother) (opposing S.B. 1033); *see* S.B. 1033, 30th Leg., Reg. Sess., 15–16 (Haw. 2019).

<sup>256</sup> *See Testimony on S.B. 1033, S.D. 2, H.D. 1 Before the H. Comm. on Health*, 30th Leg., Reg. Sess., at 610 (Haw. 2019), [https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033\\_HD1\\_TESTIMONY\\_FIN\\_03-29-19\\_.PDF](https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033_HD1_TESTIMONY_FIN_03-29-19_.PDF) (statement of Ramona Hussey, Former Att’y & Homebirth Mother) (opposing S.B. 1033).

<sup>257</sup> *See* S.B. 1033, 30th Leg., Reg. Sess., 6, 15–16 (Haw. 2019).

<sup>258</sup> *Testimony on S.B. 1033, S.D. 2, H.D. 1 Before the H. Comm. on Health*, 30th Leg., Reg. Sess., at 610 (Haw. 2019), [https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033\\_HD1\\_TESTIMONY\\_FIN\\_03-29-19\\_.PDF](https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033_HD1_TESTIMONY_FIN_03-29-19_.PDF) (statement of Ramona Hussey, Former Att’y & Homebirth Mother) (opposing S.B. 1033); *see* S.B. 1033, at 1.

<sup>259</sup> S.B. 1033, at 24.

<sup>260</sup> *Id.*

births, but the task force was designed to dissolve in June of 2020.<sup>261</sup> Act 32 went into effect in July of 2019 and, despite the impact this licensure law will have on midwives and home births, the legislature has not elected to monitor the impact Act 32 may have in the future, as the legislature has elected to dissolve the Home Birth Task Force in July of 2020.<sup>262</sup> If the Hawai‘i State Legislature truly intended to center Act 32 around preserving mothers ability to seek out alternative to hospital births, the Hawai‘i Home Birth Task Force would have been designed to do so during the period Act 32 was in effect, not immediately prior.

The exemption to licensure under section 6, subsection 5 of Act 32 exempts midwives who do not use legend drugs or devices, and discloses a number of factors to clients, in summary, that the midwife is not licensed. But this exemption is only valid until July 2023.<sup>263</sup> Accordingly, midwives, regardless of whether they use legend drugs or devices, will not fall under this exemption after July 2023. It is likely that the legislature will plainly outlaw midwives that fall under this exemption after 2023 because the intent of Act 32 is to have all practicing midwives licensed by 2024.<sup>264</sup> Therefore, in the long-term, Act 32 will force midwives to go through formal schooling or certification to be eligible, despite their qualifications and experience as a midwife, with no intent to compromise in the licensure of midwives who took the apprenticeship route to midwifery.<sup>265</sup>

Midwives are vital for mothers who choose home birth, and access to traditional midwives is important for Native Hawaiian birthing practices. Traditional midwives of any ethnicity are not protected under Act 32. The Committee on Commerce, Consumer Protection, and Health stated that one of the purposes and intents of S.B. 1033 included exempting “traditional birth attendants and Native Hawaiian healers from licensure requirements.”<sup>266</sup> Despite this purpose and intent outlined by the committee, there is no such exemption for traditional birth attendants within Act 32, and traditional midwives are not protected from penalization for lack of licensure. Any reduction in the number of traditional midwives who can provide homebirth services is a detriment to Native Hawaiian birthing traditions.

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<sup>261</sup> *See id.*

<sup>262</sup> *See id.* at 10, 24.

<sup>263</sup> *Id.* at 10.

<sup>264</sup> *See* STAND. COMM. REP. NO. 1035 ON S.B. 1033 (2019); S. COMM. ON COM., CONSUMER PROT. & HEALTH, 30TH LEG., REG. SESS., STAND. COMM. REP. NO. 659 ON S.B. 1033, S.D. 2, H.D. 1, (Haw. 2019).

<sup>265</sup> *See* S. COMM. ON COM., CONSUMER PROT. & HEALTH, 30TH LEG., REG. SESS., STAND. COMM. REP. NO. 659 ON S.B. 1033, S.D. 2, H.D. 1 (Haw. 2019).

<sup>266</sup> *Id.*

“All women have a cultural background, which shapes how she speaks, how she raises her children if she chooses to have any, how she keeps a home and births a baby.”<sup>267</sup> Many indigenous populations share the same main concept of birth, that birth is a spiritual experience that is a part of sacred cultural practices and teachings.<sup>268</sup> These teachings informed mothers of the dietary changes needed for new mothers and what ceremonies were to be performed.<sup>269</sup> Native Hawaiians, like many other indigenous populations, have traditional teachings and practices which are principal in the birth of a child; and many of these practices may not be easily incorporated within the hospital setting, which is why many Native Hawaiian mothers choose home births.

For example, in lā‘au lapa‘au, a pregnant mother may be given la‘au ho‘ohānau keiki (birthing potion) to help with labor pains, or she may be given lau kahi to aid the proper position of the baby.<sup>270</sup> In the hospital, women are discouraged, and sometimes forbidden, from consuming anything but water or ice.<sup>271</sup> The reason behind this common policy is in the case that the laboring mother needs to undergo general anesthesia, any consumed foods could lead to pneumonia because of the aspiration of stomach contents.<sup>272</sup> This reasoning, is based on the expectation that the mother will require anesthesia, and fails to consider the importance of food and herbal medicines inherent to traditional practices.

If Native Hawaiian women choose to birth at home, but there are not any or enough traditional midwives to assist them, then it will only frustrate a mother’s ability to homebirth and incorporate traditional practice. Also, with fewer traditional midwives, Native Hawaiian will struggle to incorporate birthplace traditions.<sup>273</sup> Without enough midwives, Native Hawaiian women will not be able to give birth to her child on the land that will raise the child and will not be able to live the tradition of establishing kuleana for the child to the land he or she is born on.<sup>274</sup>

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<sup>267</sup> Marlis Bruyere, *Cultural Birthing Traditions in the First Nations Peoples of Canada: Are Traditions Being Displaced by Modern Medicine?*, 27 INT’L J. CHILDBIRTH EDUC. 39, 39 (2012).

<sup>268</sup> *See id.*

<sup>269</sup> *Id.*

<sup>270</sup> Kobayashi, *supra* note 105, at 260.

<sup>271</sup> Robin Elise Weiss, *Eating and Drinking During Labor*, VERYWELL FAMILY (June 24, 2021), <https://www.verywellfamily.com/should-we-eat-or-drink-in-labor-2752955>.

<sup>272</sup> *Id.*

<sup>273</sup> Telephone Interview with Kaiulani Sharon Odom and Puni Jackson, Native Hawaiian Birth Assistants, Ka Lāhui o ka Pō. (Feb. 24, 2021).

<sup>274</sup> *Id.*



The Native Hawaiian people and culture are harmed when the state chooses to regulate and not perpetuate. The Native Hawaiian culture is already fighting to preserve and rediscover traditional birthing practices. Act 32 does not protect traditional midwives, many of whom have become midwives through apprenticeship.<sup>275</sup> Native Hawaiian mothers who decide to have a cultural birth need traditional midwives, of any culture, because traditional midwives are equipped with traditional knowledge and practices and how these practices arise in birth, which may make it easier for such midwives to follow Native Hawaiian traditions in birth.<sup>276</sup>

### C. *No Pathway to Licensure in Hawai‘i*

Act 32 effectively eliminates the only pathway of training for midwifery licensure in Hawai‘i—apprenticeship.<sup>277</sup> Now, an individual who is a resident Hawai‘i who would like to become a midwife must travel to the contiguous U.S. and pay out of state tuition at mainland midwifery institutions. Midwives who have become midwives by apprenticeship would not qualify for licensure, and since there are no midwifery schools in the state of Hawai‘i, those who would like to become midwives in Hawai‘i would not be able to do so under the only option available to them within the state, apprenticeship.<sup>278</sup> This leaves aspiring midwives with a single option, to look to the mainland U.S. for a midwifery school or program.

It is necessary for Hawai‘i to have a pathway for professions that may be so intertwined with the local cultures, especially for the Native Hawaiian culture, to preserve cultural traditions and practices. The William S. Richardson School of Law (“WSRSL”) and John A. Burns School of Medicine (“JABSOM”) at the University of Hawai‘i at Mānoa demonstrate how a professional education institution in Hawai‘i were vital to preserve Native Hawaiian traditions and customs. WSRSL was created in 1971 after Chief Justice William S. Richardson (“CJ Richardson”) pushed for the creation of a law school in Hawai‘i to create Hawai‘i lawyers.<sup>279</sup> CJ Richardson recognized what a unique and special place Hawai‘i was, and without Hawai‘i’s own law school within the state, Hawai‘i would only be filled with attorneys from other states.<sup>280</sup> CJ Richardson also considered the

<sup>275</sup> Telephone Interview with Wahinehula Kao, *supra* note 102.

<sup>276</sup> *Id.*

<sup>277</sup> *Testimony on S.B. 1033, S.D. 2, H.D. 1 Before the H. Comm. on Health*, 30th Leg., Reg. Sess., at 34, 131 (Haw. 2019), [https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033\\_HD1\\_TESTIMONY\\_FIN\\_03-29-19\\_.PDF](https://www.capitol.hawaii.gov/Session2019/Testimony/SB1033_HD1_TESTIMONY_FIN_03-29-19_.PDF) (statement of Mari Stewart, Birth Believers) (opposing S.B. 1033).

<sup>278</sup> *See id.*

<sup>279</sup> *Time Line*, U. HAW. MANOA WILLIAM S. RICHARDSON SCH. OF L. HAW., <https://www.law.hawaii.edu/time-line> (last visited Mar. 24, 2022).

<sup>280</sup> *See* Carol S. Dodd *The Richardson Years, 1966-1982*, UNIV. HAW. FOUND. 73

cultural importance of having Hawai'i lawyers to ensure that there individuals in the profession who were familiar with the many cultures that exist in Hawai'i, primarily, the Native Hawaiian culture, were well equipped and informed to deal with cultural issues within the profession.<sup>281</sup> It is necessary to have Hawai'i lawyers work on legal issues that impact Native Hawaiian practices to ensure that these issues are dealt with by those who are affected by the outcomes of such legal decisions.<sup>282</sup>

JABSOM demonstrates the efforts of state officials to create Hawai'i based professionals. In an article written by Dr. Darrell Kirch, the President, and CEO of the Association of American Medical Colleges, emphasized the important role JABSOM plays for the medical field in Hawai'i:

The School's basic mission is to teach and train high-quality physicians, biomedical scientists, and allied health workers for Hawai'i and the Pacific. Its major purpose is to provide an opportunity for a medical education previously unavailable to residents of Hawai'i and other Pacific nations.<sup>283</sup>

The existence of JABSOM has allowed for individuals from the state of Hawai'i to stay home and pursue a professional career in the place they come from. It has also allowed individuals to learn in-state to prepare future physicians for the unique clientele in Hawai'i and furthers that commitment that JABSOM has to the people in Hawai'i.

Without a midwifery school in Hawai'i, legislators are opening the door to having the midwifery industry in Hawai'i run by out-of-state individuals. Birth is a life event deeply infused with Native Hawaiian traditions and practices. Those who are trained to provide services to the Native Hawaiian community should be exposed to Native Hawaiian traditions and culture, which may only be attained by a midwifery school within the state. Otherwise, when the only midwives available are ones completely unfamiliar with any Native Hawaiian traditions and practices, Native Hawaiian women will be less likely to use midwives in their births,

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(1985). CJ Richardson recognized that a "foreign system of laws and government . . . had been imposed upon [Hawai'i] people," who considered "haole law" (haole meaning foreign) trivial. *Id.* CJ Richardson knew that Hawaiians needed to "work within the system to change the ills of the past." *Id.*

<sup>281</sup> *See id.*

<sup>282</sup> *See, e.g.,* Pele Defense Fund v. Paty, 837 P.2d 1247 (Haw. 1992). In *Pele Defense Fund v. Paty*, the Hawai'i Supreme Court upheld the petitioners' traditional and customary gathering rights. *Id.* Traditional and customary gathering rights are vital to continuing Native Hawaiian traditions and customs. *See id.*

<sup>283</sup> *JABSOM's Mission & Distinctive Features*, JOHN A. BURNS SCH. OF MED.: VALUS, MISSION, & MISSION, <https://jabsom.hawaii.edu/about-us/values-vision-mission/>.

and therefore, be unable to carry out much of their traditions in their pregnancy and birth. It is not only important to have a pathway of education in Hawai'i for midwives, but it is also important for student Native Hawaiian traditional midwives to have a preceptor within the state that may help them accomplish their apprenticeship hours incorporating Native Hawaiian culture.

A traditional Native Hawaiian midwife preceptor is necessary in preserving traditional Hawaiian birthing practices. In validating the apprenticeship pathway in the education and training of midwives, NARM recognizes Registered Preceptors to supervise CPM candidates to allow for registration through NARM.<sup>284</sup> A NARM Registered Preceptor must meet a number of requirements:

The Registered Preceptor must be credentialed as a Certified Professional Midwife (CPM), Certified Nurse Midwife (CNM), Certified Midwife (CM); or must be a licensed practitioner legally recognized by a state/jurisdiction to provide maternity care. A preceptor must have an additional three years of experience after credentialing or fifty primary/co-primary births beyond entry-level CPM requirements. Additionally, they must also have ten continuity of care births beyond entry-level CPM requirements. A preceptor must have attended a minimum of ten out-of-hospital births in the last three years.<sup>285</sup>

There are currently eight preceptors in Hawai'i, none of whom are practicing Native Hawaiian traditional midwives. Without a Native Hawaiian traditional midwife as a preceptor, and the lack of a pathway to licensure in Hawai'i, Native Hawaiian midwives are forced to navigate the system of midwifery and their tradition separate from one another.<sup>286</sup> For example, in midwifery training, midwives are taught how to help a mother in labor with pain management, emotionally and physically.<sup>287</sup> In Native Hawaiian tradition, a Native Hawaiian midwife may offer lā'au lapa'au or lomilomi to help with the pain, practices unique to Native Hawaiian tradition which are not done or incorporated in midwifery school.<sup>288</sup> A Native Hawaiian midwife would be unable to incorporate such practices under the guidance and supervision of her midwifery training.

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<sup>284</sup> *NARM Preceptors*, NARM, <https://narm.org/preceptors/> (last visited Mar. 24, 2022).

<sup>285</sup> *Id.*

<sup>286</sup> Telephone Interview with Wahinehula Kao, *supra* note 102.

<sup>287</sup> See Shaw, *supra* note 16, at 531.

<sup>288</sup> See PUKUI & LEE, *supra* note 89, at 12-13, 17.

There is a divide between the tradition and birthing practices, although the intention of traditional midwifery is to join worlds of tradition midwifery, in a mother's birth.<sup>289</sup> In an interview with a Native Hawaiian student midwife, she spoke about the struggle she has endured from her traditional community and her midwifery education community.<sup>290</sup> The Native Hawaiian traditional community judges her for going to school, being the more "colonized" pathway to being a midwife.<sup>291</sup> The midwifery community judges her for incorporating too much tradition into midwifery, for straying away from the standardized practices taught in midwifery school.<sup>292</sup> Native Hawaiian cultural practices like herbal teas or topical ointments applied in birth made through *lā'au lapa'au* and *ho'oponopono*, to ensure that a family is in harmony before the arrival of a baby, are foreign to general midwifery practices. These are traditional practices, special to Native Hawaiian culture, which a general midwife may not know to implement or be familiar with. Native Hawaiian culture ensures that all is harmonious for a mother and baby when a child is born, but it is important that a midwife's traditional and midwifery training be in harmony as well, to ensure the full incorporation of culture and holistic care.

V. PERPETUATION OF CHOICE: PROVIDING ACCESS TO MIDWIFERY AND  
ENCOURAGING THE PRACTICE OF NATIVE HAWAIIAN BIRTHING  
TRADITIONS

The Hawai'i State Legislature passed Act 32 without providing a framework to support midwives and traditional Native Hawaiian practices.<sup>293</sup> The Act alleges to protect a woman's right to give birth wherever and with whomever she wants, but not with a midwife who does not meet the licensure requirements after 2023, nor at home if there are not enough midwives to accommodate at-home births. To ensure that Native Hawaiian birthing practices may be revived and perpetuated, the State of Hawai'i must take steps to protect all experienced direct entry midwives, CPM, CM and traditional. This, in turn, will protect Native Hawaiian birthing practices because it will ensure that there are enough midwives to support at-home births for the maintenance of Native Hawaiian birthing practices, and it will also ensure that Native Hawaiian individuals who are attempting to become midwives made do so alongside their people and culture. The State Legislature must not only be content with allowing the practice of Native Hawaiian traditions, but it must also allow for the

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<sup>289</sup> Telephone Interview with Wahinehula Kaeo, *supra* note 102.

<sup>290</sup> *Id.*

<sup>291</sup> *Id.*

<sup>292</sup> *Id.*

<sup>293</sup> See S.B. 1033, 30th Leg., Reg. Sess. (Haw. 2019).

innovation and revival of these traditions which may accomplished by enacting other laws to facilitate choice in birth and awareness of options.

A. *Reintroduce House Bill 1223 So That Women Are Provided with Information on All of Their Options*

House Bill 1223 (“H.B. 1223”) was introduced in January 2019 to “ensure women have access to both information about the practice of midwifery, including practices that protect or promote traditional native Hawaiian and other indigenous or cultural birth practices, and birth practitioners who follow the midwife model of care.”<sup>294</sup> The bill was introduced in the same session as Act 32, likely as a complimentary bill to Act 32, both relating to the practice of midwifery. The bill sought to provide consumers with access to midwifery care and promote the choice of a birth plan and birth practitioner aligned with their cultural or religious beliefs.<sup>295</sup> The bill’s provisions on midwifery stated;

- (a) Consumers shall have access to multiple routes of midwifery care and midwifery pathways to allow them to choose a birth plan and birth practitioner that supports their cultural or religious beliefs.
- (b) Traditional native Hawaiian and other indigenous or cultural beliefs and practices may be exercised to the fullest extent allowed under applicable federal law.
- (c) Notwithstanding any provision to the contrary in this chapter, birth practitioners shall ensure consumer access to all pertinent birth education information and materials. Such educational materials and midwifery care shall be provided in a form and manner to ensure the consumer is able to comprehend what is being communicated to them.<sup>296</sup>

House Bill 1223 was carried over to the 2020 regular session, but there has been no movement on the bill since, or any other bill introduced to accomplish H.B. 1223’s purpose.

In Act 32, the Legislature provided that the Act would “continue to allow a woman to choose where and with whom she gives birth,”<sup>297</sup> but that is all this was—a statement within the Act. None of the provisions in the Act truly supported a woman’s ability to choose where or with whom to give birth as she pleased. H.B. 1223 would guarantee that choice because it ensures that pregnant mothers are informed of their choices. Many mothers,

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<sup>294</sup> H.B. 1223, 30th Leg., Reg. Sess., 2 (Haw. 2019).

<sup>295</sup> *Id.*

<sup>296</sup> *Id.*

<sup>297</sup> S.B. 1033, at 2.

like myself, may not be aware of their options in giving birth with a midwife or understand the benefits of midwifery. H.B. 1223 ensures that women will have access to information about midwifery, including information about Native Hawaiian cultural birth practitioners and any practitioners who follow the midwife model of care.<sup>298</sup>

Although H.B. 1223 does not outline what actions will be taken to perpetuate midwifery and Native Hawaiian practices, it would be a positive step in the direction of doing so. Act 32, standing alone, fails to protect a mother's choice, and this, in turn, adversely impacts Native Hawaiian birthing practices. H.B. 1223 would guarantee that mothers will "have access to multiple routes of midwifery care and midwifery pathways to allow them to choose a birth plan and birth practitioner that supports their cultural or religious beliefs," and that traditional Native Hawaiian practices will be protected and exercised to the "fullest extent."<sup>299</sup> Reintroducing and passing H.B. 1223 would force the Hawai'i Legislature to keep to its word, and allow for the protection of public health and welfare while still ensuring that mothers will have a choice in their births and traditions.<sup>300</sup> H.B. 1223 would serve to compliment Act 32 and Senate Bill 893, the bill attempting to amend Act 32.

*B. To Protect and Perpetuate All Traditional Birth Practices, Furthering the Protection of Native Hawaiian Practices, the Legislature Must Pass Bills Like S.B. 893 and H.B. 2204*

Senate Bill 893 ("S.B. 893") was introduced in the 2021 legislative session, which sought to amend Act 32.<sup>301</sup> The most important amendment that this bill proposes relates to traditional midwives generally.<sup>302</sup> S.B. 893 defines a "traditional midwife" as:

[A]n autonomous midwife who has acquired the skills to care for pregnant people, babies, and their families throughout pregnancy, birth, and postpartum through a spiritual or cultural lineage, is recognized nationally and internationally by the Midwifery Education Accreditation Commission<sup>303</sup> and Midwifery Alliance of North

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<sup>298</sup> H.B. 1223.

<sup>299</sup> *Id.*

<sup>300</sup> *See* H.B. 1223; S.B. 1033.

<sup>301</sup> S.B. 893, 31st Leg., Reg. Sess. (Haw. 2021) (Act 32 is referred to as § 457J in S.B. 893).

<sup>302</sup> *See id.*

<sup>303</sup> The Midwifery Education Accreditation Commission ("MEAC") is tasked with accrediting midwifery programs and schools. *Accreditation*, MEAC, <https://www.meacschools.org/accreditation/> (last visited Mar. 25, 2022).

America,<sup>304</sup> and does not advertise as a certified or licensed midwife.<sup>305</sup>

The bill also adds to the exemptions that the chapter shall not prohibit healing practices by traditional midwives.<sup>306</sup> S.B. 893 also changes the language of the requirement of a license, and generally provides that a direct entry midwife need not be licensed if the midwife does not intend to use legend drugs and discloses to clients that he or she is not a licensed midwife and has not be reviewed by the state.<sup>307</sup>

S.B. 893's passage would allow for all traditional midwives to be protected from licensure requirements and would allow midwives to practice if they do not intend to administer drugs and do not represent themselves as a licensed midwives.<sup>308</sup> Accordingly, S.B. 893 would permit more midwives to practice. S.B. 893 necessarily defines traditional midwives, allowing all traditions and cultures to fall under the definition, and if passed, be exempted alongside Native Hawaiian traditions.<sup>309</sup> This amendment is vital for Native Hawaiian traditional birth practices because there are not many Native Hawaiian midwives, and many Native Hawaiian mothers turn to general traditional midwives because traditional midwives are more open to incorporating traditional practices during the pregnancy and birth process.<sup>310</sup> S.B. 893 also proposes to amend the definition of a "qualified midwife preceptor" to the following definition: "an exempt or licensed and experienced midwife, or other maternal health professional licensed in the State, who participates in the clinical education of midwives."<sup>311</sup>

This allows for Native Hawaiian midwives and traditional midwives, who may fall under the proposed exemption, to serve as qualified

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For a midwife to be recognized by MEAC, they need to have earned a midwifery certificate of degree at a MEAC-accredited school. *See Compare MEAC Schools*, MEAC, <https://www.meacschools.org/midwifery-schools/compare/> (last visited Mar. 25, 2022).

<sup>304</sup> Midwifery Alliance of North America (MANA) is an organization that seeks to "unite, strengthen, support and advocate for the midwifery community and to promote educational, economic, and cultural sustainability of the midwifery profession." *Who is MANA?*, MANA, <https://mana.org/about-us> (last visited Mar. 25, 2022). For recognition by MANA, midwives are required to follow midwifery principles and professional standards, as well as continuing education. *Standards and Qualifications*, MANA, <https://mana.org/about-us/standards-and-qualifications> (last visited Mar. 25, 2022).

<sup>305</sup> S.B. 893, at 2.

<sup>306</sup> *Id.* at 5.

<sup>307</sup> *Id.* at 4–5.

<sup>308</sup> *See id.*

<sup>309</sup> *See id.*

<sup>310</sup> Telephone Interview with Wahinehula Kao, *supra* note 102.

<sup>311</sup> S.B. 893, at 2.

midwife preceptors. There must be traditional midwives as qualified midwife preceptors so that student-midwives can properly learn how to incorporate traditional practices—if they so choose—during their apprenticeship hours. This would also allow Native Hawaiian student-midwives to fully implement traditional practices in births they observe or care for, while under the guidance of a midwife preceptor who may also be a Native Hawaiian midwife. S.B. 893 properly ensures that Native Hawaiian birth practices, and traditional birth practices generally, are fully protected under the state’s regulation and licensure of midwifery.

More recently, a similar bill, House Bill 2204 (“H.B. 2204”), was pushed through the legislature this year.<sup>312</sup> The bill likely stemmed from the 2021 public apology from the American College of Nurse-Midwives (“ACNM”).<sup>313</sup> In its press release, ACNM stated:

ACNM acknowledges that it can no longer continue to attribute the white washing of midwifery to a lack of qualifications or interest by Black and Indigenous people. This fails to acknowledge that white supremacy acted as suppressor, then law enforcer and “teacher”, [sic] then eliminator and replacer of Black and Indigenous traditional midwives with white midwives.

ACNM leadership acknowledges and apologizes for past and present harms to BIPOC midwives and the organization’s role in perpetuating and maintaining systemic racism in midwifery and healthcare.<sup>314</sup>

H.B. 2204 sought to expressly recognize traditional midwives and incorporate the spirit of the ACNM’s apology by making amendments to Act 32.<sup>315</sup> H.B. 2204 incorporates the definition of a “traditional midwife” to be “a person who adheres to the core competencies of the National Aboriginal Council of Midwives and practices under the Hawaii Home Birth Elders Council.”<sup>316</sup>

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<sup>312</sup> See H.B. 2204, 31st Leg., Reg. Sess. (Haw. 2022).

<sup>313</sup> The American College of Nurse-Midwives is the professional association that represents CNMs and CMs and sets the standard for excellence in midwifery education and practice in the United States. See AM. COLL. OF NURSE-MIDWIVES, <https://www.midwife.org> (last visited Apr. 11, 2022).

<sup>314</sup> Press Release, Am. Coll. Nurse-Midwives, Apology and Truth and Reconciliation Resolution from the American College of Nurse-Midwives Board of Directors (Mar. 30, 2021), <https://www.send2press.com/wire/apology-and-truth-and-reconciliation-resolution-from-the-american-college-of-nurse-midwives-board-of-directors>.

<sup>315</sup> See H.B. 2204, 31st Leg., Reg. Sess. (Haw. 2022).

<sup>316</sup> *Id.*



The bill also sought to amend the exemption section of Act 32 to now provide that the chapter shall not “[p]rohibit healing practices by traditional midwives engaged in traditional healing practices . . . [nor] adversely impact the practice of traditional midwives.”<sup>317</sup> This bill clearly recognized the adverse impact legislation may have on traditional midwives and, in turn, birthing mothers, and that is why the bill sought to make amendments to Act 32 to promote access to and practice of traditional midwives.<sup>318</sup> H.B. 2204, if adopted, would allow for traditional midwives to practice more freely in Hawai‘i and ensure that the chapter “not impede a person’s ability to incorporate or provide cultural practices” in birth.<sup>319</sup> Sadly, as of the time of this paper, H.B. 2204 has yet to make it to a hearing and will likely not pass this legislative session.<sup>320</sup>

C. *Provide a Pathway to Licensure in Hawai‘i*

Hawai‘i must formulate a plan to create a pathway to licensure. Various other institutions have been created with the recognition that it is important for Hawai‘i to have its own professionals. Hawai‘i is recognized as a unique place, home to various cultures, and to make sure Hawai‘i’s midwives can cater to the various cultures and people we have within the state, there should be an institution which may provide a midwifery education. That importance is only further highlighted by the state’s prioritization of preserving the Native Hawaiian culture, and to ensure native Hawaiian birthing practices continue with growing generations, a midwifery education based in Hawai‘i is crucial.

The existence of a law school and medical school in Hawai‘i demonstrates the importance of having an institution in-state to create professionals which understand the dynamics of the state in which they practice. WSRSL and JABSOM were created to demonstrate the commitment to the people of Hawai‘i in the legal and medical fields. Act 32 has a commitment to the women and children of Hawai‘i to ensure safe births while also allowing mothers to have a choice in their birth.<sup>321</sup> A midwifery school or a focus on midwifery within JABSOM is necessary to further the commitment of Act 32 to the pregnant and birthing women of Hawai‘i. Because birth is a life event deeply infused with Native Hawaiian traditions and practices, midwives who are trained to provide services should be getting the training with exposure Native Hawaiian traditions and cultural practices, which can only be attained by a midwifery school here.

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<sup>317</sup> *Id.* (emphasis added).

<sup>318</sup> *See id.*

<sup>319</sup> *See id.*

<sup>320</sup> *See id.*

<sup>321</sup> S.B. 1033, 30th Leg., Reg. Sess., 2 (Haw. 2019).

A midwifery school or focus in Hawai‘i would also allow Native Hawaiian midwives to fully carry out their practices. Lā‘au lapa‘au is based in Native Hawaiian plants and would only be able to be incorporated in birth if a Native Hawaiian traditional midwife were here in the islands near the native foliage. Ho‘oponopono and lomilomi are taught in Hawai‘i by kupuna (elders) or kumu (teachers) with expertise and cannot be learned outside the state of Hawai‘i. It is important for Native Hawaiian traditional midwives to stay in Hawai‘i so that they may fully implement cultural practices, with Native Hawaiian women who choose to incorporate those practices.

D. *Amend the Hawai‘i Administrative Rules to Allow for a Midwife-Run, Freestanding Birth Center in Hawai‘i*

Freestanding birthing centers serve as another option for women who consider using midwifery services in their birth. Birth centers are “facilities designed to provide care to women with low risk pregnancies who want a choice between a hospital and home birth and want to participate in their own care.”<sup>322</sup> Birth centers are separate from hospitals and provide more individualized care centered around a woman’s goals in her pregnancy.<sup>323</sup> Birth centers are typically run by midwives and incorporate the midwifery model of care in practice.<sup>324</sup>

There are no freestanding birthing centers within the state of Hawai‘i. The Hawai‘i Administrative Rules (“HAR”) require birthing centers to have a medical director, or physician, oversee the birth center and “provide the necessary preventative, diagnostic and therapeutic services to patients in order to achieve the objectives of the facility.”<sup>325</sup> In other words, birth centers in Hawai‘i must have a physician on site running the centers, despite the involvement of qualified and experienced midwives on-site.

Under HAR § 11-93-67, the professional staff of a birthing center in Hawai‘i must consist of “licensed midwives and suitably qualified physicians.”<sup>326</sup> The birthing center would also require a governing board, which must include a “medical director,” who would work closely with the center administrator in conducting the center.<sup>327</sup> Under these rules, physicians and OB/GYNs are expected to be heavily involved and an integral part of the center, constricting the ability of midwives to fully implement the midwifery model of care. Birth centers are typically

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<sup>322</sup> *Frequently Asked Questions About Birth Centers*, AM. ASSOC. OF BIRTH CTRS., <https://www.birthcenters.org/page/BirthCenterFAQs> (last visited Mar. 25, 2022).

<sup>323</sup> *Id.*

<sup>324</sup> *See id.*

<sup>325</sup> *See* HAW. CODE R. §§ 11-93-52, -61 (LexisNexis 1986).

<sup>326</sup> *Id.* § 11-93-67.

<sup>327</sup> *Id.* §§ 11-93-57, -61.

freestanding and have a degree of autonomy from medical obstetric care in the formation of policies and management of center operations.<sup>328</sup> The Hawai‘i State Legislature should amend these administrative rules to allow for a midwifery-run birthing center where midwives operate and conduct the center. If a physician must be present at all, an OB/GYN should simply serve as a consultant.

A birth center in Hawai‘i run by midwives would provide mothers an alternative option to hospitals or homebirths in childbirth and allow them to more easily incorporate traditional practices in childbirth. A principal practice of birth centers is to respect and facilitate a woman’s right to make informed choices about her health care and her baby’s health care based on her values and beliefs.<sup>329</sup> Instead of being the primary administrators of a birthing center, physicians and OB/GYNs should merely be consultants and assist midwives in implementing the midwifery model of care.

In California, the midwifery licensure requirements are like that of Hawai‘i’s, the main requirement being that a midwife receive some form of formal didactic education.<sup>330</sup> Birthing centers in California are administered and facilitated by midwives. At the California Birth Center, the director and majority of the staff are midwives.<sup>331</sup> There is only one OB/GYN on the staff who serves as a consultant within the center.<sup>332</sup> Alternatively, the Santa Barbara Midwifery and Birth Center, the staff consists wholly of midwives.<sup>333</sup> Birth centers run by midwives alone, allow for the full implementation of the midwifery model of care. Physicians and OB/GYNs already run the hospital environment, and it is important to allow midwives to create and run birth centers, so women have the choice and opportunity to give birth the way they want and the ability to incorporate traditional practices.

There have been strides in the Native American community in incorporating tradition into birth. For example, Changing Woman Initiative (“CWI”), a non-profit organization founded by a Native American nurse-midwife, has a mission “to renew cultural birth knowledge to empower and reclaim indigenous sovereignty of women’s medicine and life way teachings to promote reproductive wellness, healing through holistic approaches and

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<sup>328</sup> See *Frequently Asked Questions About Birth Centers*, *supra* note 322.

<sup>329</sup> See *id.*

<sup>330</sup> See *Midwives*, MED. BD. OF CAL., [https://www.mbc.ca.gov/Licensees/Midwives/Midwives\\_Practice\\_Act.aspx](https://www.mbc.ca.gov/Licensees/Midwives/Midwives_Practice_Act.aspx) (last visited Mar. 25, 2022).

<sup>331</sup> CAL. BIRTH CTR., <https://calbirthcenter.com/about/> (last visited Mar. 25, 2022).

<sup>332</sup> *Id.*

<sup>333</sup> *Meet the Staff*, SANTA BARBARA MIDWIFERY & BIRTH CTR., <http://sbbirthcenter.org/meet-the-staff> (last visited Mar. 24, 2022).

to strengthen women's bonds to family and community."<sup>334</sup> CWI's future focus is to develop a culturally centered reproductive wellness and birth center by creating a physical space for education and healing for Native American women.<sup>335</sup> Accordingly, CWI has created the White Shell Woman Homebirth Services,<sup>336</sup> and Corn Mother Easy Access Women's Health Clinic,<sup>337</sup> both of which provide culturally centered services for Native American women that incorporate traditional teachings and plant medicine knowledge throughout their pregnancy and birth.<sup>338</sup>

A birth center in Hawai'i is vital for the choice of women in Hawai'i because it would allow them to give birth with whom they want and how they want. A birth center would also allow Native Hawaiian women to incorporate more culture and tradition into their birth. There must be steps taken to ensure that traditional birthing practices are preserved, and HAR § 11-93 should be amended to provide Native Hawaiians the opportunity to draw on their "cultural strengths to renew indigenous birth knowledge and healing through holistic approaches and community empowerment," as the Native Americans have been able to work towards.<sup>339</sup>

## VI. CONCLUSION

The regulation of midwifery creates barriers for midwives who have taken the apprenticeship pathway to becoming a midwife, and with fewer midwives practicing, the ability to have a home birth is impacted. Regulation of midwifery has adverse consequences for traditional indigenous birthing practices because it constrains the ability of traditional

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<sup>334</sup> *Who We Are*, CHANGING WOMAN INITIATIVE [CWI], <http://www.changingwomaninitiative.com/about.html> (last visited Mar. 24, 2022).

<sup>335</sup> *Id.*

<sup>336</sup> *See White Shell Woman Homebirth Services*, CWI, <http://www.changingwomaninitiative.com/white-shell-woman-homebirth-services.html> (last visited Mar. 25, 2022). "The challenge that CWI has undertaken is to address these known health care delivery gaps for Native American women in New Mexico through the creation of culturally centered home birth services that would integrate traditional teachings and plant medicine knowledge." *Id.* Services provided include: prenatal care, birth services, nutrition consultation and access to healthy produce, lactation assessment, postpartum care up to six weeks, prenatal, birth, postpartum plant medicine making, and traditional medicine referrals. *Id.*

<sup>337</sup> *See Corn Mother Easy Access Women's Health Clinic*, CWI, <http://www.changingwomaninitiative.com/corn-mother-easy-access-womens-clinic.html> (last visited Mar. 25, 2022). "Changing Woman Initiative offers easy access care to Native American/Alaska Native Indigenous women from the surrounding Santa Fe area(s)." *Id.* Services include: pap smears, STD/STI screening and treatment, birth control education, pregnancy testing, prenatal care, postpartum care, referrals, plant medicine education, traditional medicine and healing, and breast-feeding support. *Id.*

<sup>338</sup> *See id.*; *White Shell Woman Homebirth Services*, CWI, *supra* note 336.

<sup>339</sup> *See Corn Mother Easy Access Women's Health Clinic*, CWI, *supra* note 337.

practitioners to become midwives and limits access of midwives, which affects the ability of a woman to birth at home. Act 32 has negatively impinged on midwifery in Hawai‘i, leading to consequences for Native Hawaiian mothers who desire a home birth or the incorporation of traditional birth practices. The Act makes it so that there are less midwives able to provide services unless they are licensed or working towards being licensed, and traditional midwives who have become midwives by apprenticeship, are ineligible for licensure. Any decrease in midwives is a detriment to traditional birthing practices because that means that there will be less traditional midwives to assist with home births and the incorporation of traditional birth practices. The Act is also imposed without any means of providing a pathway for licensure in Hawai‘i, making it more difficult for individuals from and living in Hawai‘i to achieve licensure.

Traditional Native Hawaiian practices, like those incorporated at birth, are adversely impacted by legislation in Hawai‘i, making it harder for Native Hawaiians to perpetuate and continue their practices. Act 32 was implemented without the forward-thinking necessary to keep Native Hawaiian practices in birth, alive. The Hawai‘i State legislature must introduce and pass other legislation supporting cultural incorporation and choice in birth, allow for the opening of birth centers, and provide a pathway to licensure to ensure that traditional Native Hawaiian practices are perpetuated. The State must support and allow for the opportunity for a child to be born with the full incorporation of his or her Native Hawaiian culture, no matter the method, place, or people. Each birth is the opportunity to continue and perpetuate the Native Hawaiian culture, an opportunity which Native Hawaiian women and children are entitled and deserve.