
Preserving an Ancient Practice:

# Traditional Home Birth in Hawai‘i

A Report to the Governor on the Traditional Practices Affected by SB 1033, SD2

**and request for VETO**

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# Introduction

Hānau (birth)is in many ways Hawai‘i’s most ancient tradition.

Nearly 100% of all births in the Kingdom of Hawai‘i prior to 1893 happened at home. And attending those births, from the most ancient Kanaka Maoli ancestors in the mists of time, to the plantation camps and villages of every ethnicity that arrived here, were midwives.

Kanaka Maoli pale keiki. Japanese sanba. Filipino partera. Each had a rich knowledge of of tradition, and how that tradition could be used, along with knowledge of health and the workings of the body, to safely bring forth the next generation.

Despite the medicalization of birth in 20th Century, some of these traditions survived.

This practical birth knowledge is important. It is also fragile, and in imminent danger of extermination — much is already gone.

The thing that makes birthing knowledge difficult to keep alive is that, to preserve it, it must be perpetuated through practice.

If SB 1033 passes into law, the only way to keep this knowledge alive will be to continue it underground, where these practices were prior to 1999.

Out-of-hospital birth is very much a matter of reproductive choice. And one thing we should all know about matters of reproductive freedom is that forcing practices underground does not stop them; it only endangers lives.

Birthing freedom is also a matter of human rights, indigenous rights, and civil liberty.

A better law is absolutely possible, and we have outlined a picture of what such a law would look like here. However, the only way to achieve this is to stop this terrible measure from moving forward, and start over.

Governor Ige, we urge you, on behalf of all of the midwives and other traditional birth attendants who helped to bring your ancestors into this world, and all of those continuing their legacy, wherever they mar be: VETO SB 1033 SD2 HD2.

We hope that this report, which was written with 100% volunteer labor, and is in itself an act of love, will help your understanding of this matter to grow. And we know that when it does, you will understand how important this protection really is.

Please veto SB 1033.
Mahalo nut loa for your attention to this very urgent matter.

Mahalo nui loa.

# Major Problems with SB 1033 at a Glance

- **Constitutionally protected practices are not protected.**

  - **Alleged protections for Indigenous Kanaka Maoli practices are purely speculative.** Papa Ola Lōkahi does not have the means to protect Kanaka midwifery at this time. While this could possibly be developed (subject to convening and agreement of kupuna), it has not been developed yet. Constitutional Protections must be *actual* (existig at all times), not *speculative* (possibly existing at some point in the future). Papa Ola Lōkahi also does not have the means to protect the central practice in question, which is hānau (birth), which requires assistance from traditional practitioners who are not Kanaka Maoli.
  - **Religious and spiritual practices are not protected at all, as required by the constitution.** Faith-based midwifery is a longstanding tradition practiced by many cultures and churches, as well as indigenous midwifery of many lands. These are deep-rooted traditions that are protected by the US Constitution, the Hawaii State Constitution, and federal law.

- **SB 1033 is DISCRIMINATORY as applied.**

  - **Hawai‘i-born midwives and students are excluded, as licensure is only available to CPMs.** **100%** of all CPMs eligible for licensure are from outside of Hawai‘i. There is NO equivalency pathway, as was recommended by the 2017 Audit. **100%** of local-born practitioners are made illegal in 2023. Some are made illegal in 2020. There is no feasible means for practitioners born and raised in Hawai‘i to achieve legitimacy and legality.
  - **All cultures and religions whose practices are made illegal in 2020 or 2023 are discriminated against** by this measure, which only benefits Caucasian CPMs from outside of Hawaii (as the 2 eligible POC CPMs are both traditional, and fighting the bill).
  - **“Fixing” a bad bill through a task force that needs to develop another bill to attempt to bring this one into compliance** (IF the legislature agrees) **is NOT a solution to discrimination.** Remedies through these means are again speculative — addressing the problem of discrimination needs to be done in the bill itself, because laws cannot be discriminatory for ANY length of time.
  - To be clear, there is nothing wrong with Caucasian midwives, who are represented in both CPM and traditional categories. There is a problem when ONLY Caucasian CPMs from the Continental US are legally able to fill the diverse needs of Hawai‘i’s local communities, and other practitioners, including elders of many cultures, are criminalized.

- **SB 1033 is special interest legislation,** and not compliant with the Regulatory Licensing Reform Act, which requires “all qualified members” of a profession” to have equivalent access. Only 10-13 members of a much larger profession are licensed, with no equivalency pathway.

- **Exempting the bodies in SB 1033 from the Sunshine Law is wrong,** and should not be allowed. Many of the problems in the measure are due to this law not being properly followed in the first place. Transparent, inclusive communication is needed, per the OIP.

## Major Problems with SB 1033 at a Glance (ctd)

- **SB 1033 Makes family assistance illegal.** Family members are illegal unless they are a "spouse, domestic partner, parent, sibling, or child". Grandparents, aunts, uncles, lanai family, cousins (all of whom play traditional attendant roles in many cultures) are all illegal.

- **SB 1033 harms the public.** It limits the availability of options. It creates dangerous birth conditions by driving legitimate practices underground. It interferes with women's reproductive choices. It artificially drives up costs. It reduces birth privacy, by overburdening scarce preceptors with the volume of student need that would be created.

- **SB 1033 is divisive,** and harms communication between midwives, as well as between midwives and hospital staff in the event of a hospital transport, by driving them underground.

- **SB 1033 attempts to fix something that is not broken.** The passage of this bill has been based on statements and testimony that is simply false, or only partially true (with very important pieces missing)! There has been NO actual evidence of abuse by any midwife.

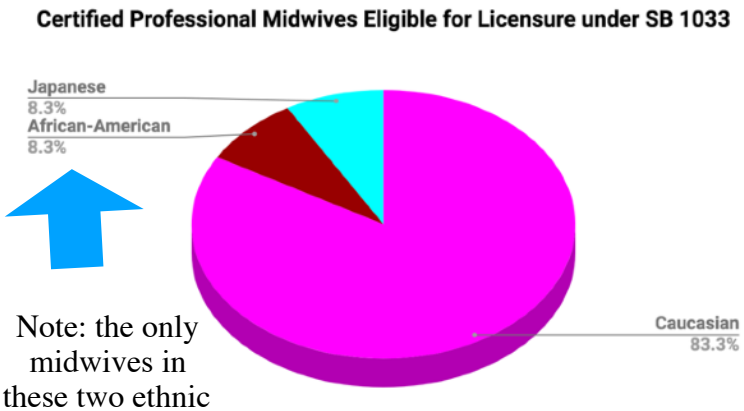
- **There is no evidence that it is needed.** "Horror stories" about alleged midwife error are continually debunked. A 2017 survey of home birth parents showed 94.6% satisfaction. There is zero actual evidence that this would be safer or beneficial for families.

- **SB 1033 misses the elements that ARE needed,** such as education for the public, effective data collection, comprehensive problem-solving, and the building of better communication.

- **The public does not want SB 1033.**
  - Over **2000** people signed a petition against it.
  - Over **700** pages of opposing testimony were submitted
  - Major organizations have opposed it, such as
    - The Health Committee of the Democratic Party of Hawaii
    - Midwives Alliance of North America (MANA)
    - City Council of Maui
    - Pono Hawai'i Initiative

# Hawai‘i Midwives by Ethnicity

## ELIGIBLE UNDER SB 1033:




Note: the only midwives in these two ethnic categories are also traditional practitioners, and OPPOSE SB 1033

**Estimated Total: 13**

There are approximately 13 CPMs currently eligible for licensure in Hawaii.

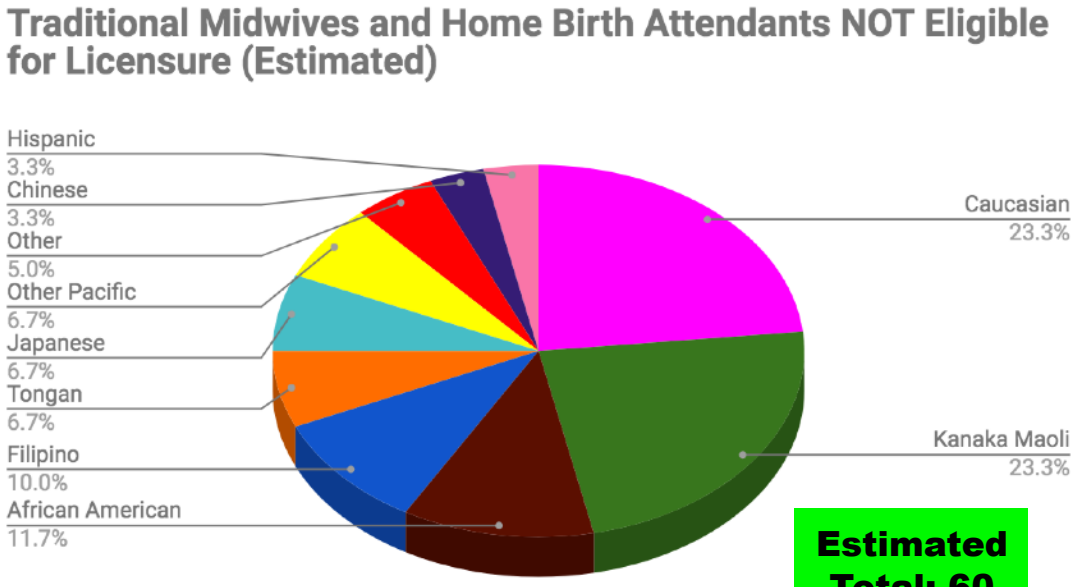
**100% of these are originally from outside of Hawai‘i.**

**There are no local-born CPMs in Hawai‘i.**

There is NO pathway that would allow any local-born person to achieve licensure prior to the 2023 “drop dead” date, after which all non-CPMs become illegal.

Most local midwives can **never** achieve CPM status, due to costs, continental location of schools, and time required away from Hawai‘i.

## INELIGIBLE (potentially criminalized) UNDER SB 1033:




**Estimated Total: 60**

Estimates for traditional midwives and student midwives serving all ethnic groups based on 22 meetings, 14 interviews, and community research. This does not include culture-specific midwives. The standard for criminalization being applied is: subject to $1000 fine and damages to reputation for non-compliance with requirements that the birth attendant is unable to meet within the timeframes in the measure, for cultural, spiritual, economic or logistic reasons.

# From Major Government Sources:

## Sunrise Analysis, 2017

Sunrise Analysis: Regulation of Certified Professional Midwives A Report to the Governor and the Legislature of the State of Hawai'i. Report No. 17-01 January 2017 http://files.hawaii.gov/auditor/Reports/2017/17-01.pdf

"**The proposed regulation of CPMs is flawed because it does not require licensure and benefits one group of midwives**." - p15

"**We expect that regulation of the practice of midwifery will likely reduce options for mothers interested in a midwife-assisted home birth**." - p.39

## Hawai'i Regulatory Licensing Reform Act

"**Evidence of abuses by providers of the service must be given great weight in determining whether regulation is desirable.**"

There have been **no proven cases** of abuse by midwives in Hawai'i.

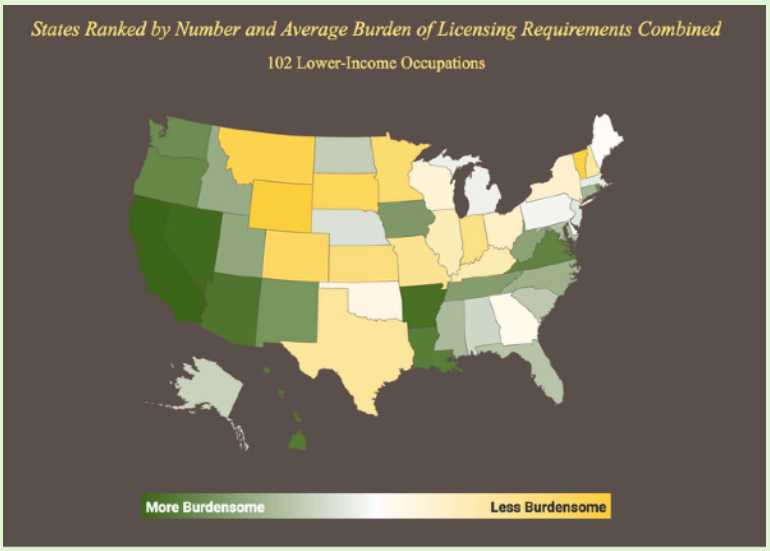
Virtually every example that has been brought forward in the course of SB 1033 testimony has been either examined through community process and found to be non-abusive (i.e. debunked) or possibly nonexistent, and based on rumor. Partial stories and hearsay have unfortunately caused reactions that have not been properly informed. These would not hold up in a court, and should not be used to create law.

"**Regulation must not unreasonably restrict entry into professions and vocations by all qualified persons**"

SB 1033 violates the Hawaii Licensing Reform Act by creating a singular pathway that cannot be reasonably achieved by anyone but a CPM trained outside of Hawai'i. There are many skilled pathways recognized elsewhere that are ignored by SB 1033.

**"Regulation must be avoided if it will artificially increase the cost of goods and services to consumers, except in cases where this cost is exceeded by the potential danger to the consumer."**

Since there is no danger to consumers, and since many midwives typically do 24 or fewer births per year, the costs passed to consumers is tremendous.




Studies have shown that regulatory licensing does NOT increase safety.; Hawai'i is amongst the most burdened. Dick Carpenter, Lisa Knepper, Kyle Sweetland, Jennifer McDonald, "License to Work: A National Study of Burdens from Occupational Licensing, 2nd Edition," Institute for Justice (2017).

# What a Good Bill Would Look Like

*Real solutions are absolutely possible.*
*Here is what a good bill SHOULD look like.*

## Sample Measure Outline

(based on proposals by Hawaii Midwifery Council, Midwives Alliance, Ho'opae Pono, and others)

**RESPECTFUL PREAMBLE**
Keys: factually accurate, fair to all cultures and practices

**LICENSURE for CPMS + EQUIVALENCY PATHWAY**
for experienced midwives who are able to show competency
Keys: compliant w/Licensing Reform Act, constitutional, reasonable, affordable

**PROTECTION for TRADITIONAL PRACTITIONERS**
Mothers (as hānau practictioners), Indigenous Birth Attendants, TBAs of ALL cultures
Keys: constitutional, human rights protected, NO RESTRICTIONS on ancient practices until TASK FORCE develops framework

**TASK FORCE**
to develop comprehensive solutions PRIOR TO REGULATION
Keys: culturally appropriate, inclusive, historically sensitive, multiculturally competent

(concept originally proposed by Josh Green in 2014)

Create **OVERSIGHT BODY** appropriate for Traditional Healers
Keys: culturally appropriate, effective, fair, self-regulatory

Develop **STRATEGIES** to
Improve Communication
Build Trust, Consensus
Address Safety Concerns
Gather Real Data
Keys: culturally appropriate, effective, comprehensive

**IMPORTANT:**
Good legislation **CANNOT** be created through the Task Force included in SB 1033, because it:

- makes constitutional rights dependent on FUTURE legislation, which may not pass (speculative),
- does not address key legal issues, such as Equivalency (required by Regulatory Licensing Reform Act
- Is exempt from Sunshine Law (incompatible with public trust)

**SPECULATIVE PROTECTIONS** of **CONSTITUTIONAL RIGHTS** are **INVALID. Constitutional Rights MUST** have **ACTUAL PROTECTIONS** at all times.

## Elements of a GOOD BILL:

- Provides LICENSURE for CPMs
- Provides affordable licensure **EQUIVALENCY** pathway for non-CPMs who can prove equivalent training and skills (required by law)
- Provides real **PROTECTION** for all Traditional Practitioners (required)
- Provides realistic means to develop community **ACCOUNTABILITY** and effective means to competently **ADDRESS PROBLEMS** if any arise
- Provides **EDUCATION** to the public about different types of midwifery, risks and benefits to each.
- Increases **COMMUNICATION** between all midwives and MDs (especially ER Doctors, in the event of a transport), as well as DOH, insurance companies, etc.
- Is based on **EVIDENCE** and **DATA**
- Meets **REQUIREMENTS** of the **CONSTITUTION**, along with **HUMAN RIGHTS** laws, the License Reform Act, and other applicable laws.

*Legend:*

● SD 1033 fulfills this

● SB1033 does **NOT** fulfill this

**The requirement for CPM status in SB 1033 is discriminatory.** This is largely because MEAC-accredited schooling is prohibitively expensive and distant for Hawai'i midwives, the majority of whom are low-income healers, many with small children. These midwives are also already integral parts of their communities, and uprooting them so that they can receive training that many already have equivalency for is wrong.

*Licensure under SB 1033 requires CPM status, which is **not achievable for most local people from Hawai'i**.*

*CPM status involves graduation from a MEAC (Midwifery Education Accreditation Council) school (**$10,000** min), Apprenticeships of at least 60 births with a CPM preceptor (which realistically means **travel for unpaid work**), and **$2500** on top of tuition for Certification. Licensure cost (**$1000**/yr) is on top of all of this.*

## The Facts about MEAC Schooling:

- There are **11** Total MEAC-Accredited Schools
- Tuition ranges from **$10,000-$90,000**
- Most programs are **2-3 years** with some outliers
- Seven schools offer distance learning, 4 do not.
- Of the seven distance learning programs, three require regular travel to the learning site, and one is currently on probationary status, leaving only **3 schools that do not require regular travel or relocation** from Hawaii.

These are:

National College of Midwifery Taos, NM Approx **$10,500 2-5 yrs** full time
Midwives College of Utah Approx **$45,000 4-6 years** full time
Southwest Wisconsin Technical College Approx: **$10,130 2-5 yrs** w 3 preceptors w/contracts, must be on 24/7 call, near zero absences

- Tuition does not include travel expense, books or the cost of CPM certification itself which is an additional **$2500.**
- Preceptors vary in training charges. Some do not charge, and others do. This is an additional expense. It is unlikely that students would have a choice, due to rarity and geographic considerations.

**Midwifery is not a high-profit "Profession." Community midwives can't afford this.**

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*A note on apprenticeship:*

In Hawaii, across all islands, there are only a handful of approved NARM preceptors. Anyone who attends any of the schools listed below will have to attend approximately **60 births** under the supervision of an approved preceptor **REGARDLESS OF HOW MANY BIRTHS THEY HAVE ALREADY ATTENDED**. The homebirth rate in Hawaii is low. It may take 2 or three years for an approved preceptor to attend 60 births and any apprentices they choose to take on will have to share this number of births between them. It follows that **anyone who seeks to achieve CPM and thus Hawaii State Licensure by attending one of the MEAC accredited schools will probably have to leave the State in order to fulfill the clinical requirements involved.** The added cost of this should be factored in when considering even the distance learning options on this list.

# What is a Traditional Midwife?

The spectrum of midwifery largely exists between two major axis points: Traditional and Clinical.

Most midwifery practices exist somewhere along this spectrum.

| TRADITIONAL MIDWIFERY | CLINICAL MIDWIFERY |
|---|---|
| • Requires traditional mentorship from elders, hands-on work known in community and to elders | • Requires formal (school) training, documented hours of hands-on practice with recognized preceptor |
| • Utilizes ancient techniques, herbs, traditional cultural practices, etc. | • Utilizes certain medical devices, techniques, drugs - IV, O2, pitocin injections, etc. along with herbs, etc. |
| • Validity through recognition by elders, community | • Validity through certification, recognition by established professional bodies |
| • Emphasizes ancient techniques, culture, ancient traditional knowledge | • Emphasizes modern techniques, research, updated knowledge |
| • Essentially a cultural, spiritual practice | • Essentially a professional practice |
| • Mandates are primarily cultural, spiritual, based on mandates of training lineage | • Mandates are primarily legal, professional, based on training and law |
| • Exchange based on traditional principles (can involve money, gifts, trade, or no compensation, depending on tradition) | • Exchange based on fair business model, often involves some gratis services |

**It must be emphasized that this is a spectrum, and not a dichotomy.** Most actual practices exist at some point along this continuum, with many variations that work for that particular midwife. Safety is best assured when midwives practice according to their own cultural and professional mandates, skills, and community needs.

Here is the recognized MANA definition of Traditional Midwifery:

**Traditional Midwifery**

"In addition, there are midwives who—for religious, personal, and philosophical reasons—choose not to become certified or licensed. Typically they are called traditional midwives. They 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 at all; or that women have a right to choose qualified care providers regardless of their legal status."

– Midwives Alliance of North America (MANA), "Types of Midwives" https://mana.org/about-midwives/types-of-midwife

# Traditional Midwifery: Indigenous Roots

The roots of all midwifery — and obstetric practice, for that matter — are in the indigenous cultures they have come from. Birthing knowledge, along with food lore, farming methods, herbal medicines, and other practices, are being recognized worldwide as crucial to sustainability and human survival and diversity.

These practices are threatened and fragile. They are being extinguished with urbanization and medicalization. To continue into the future, they must be **practiced**. Furthermore, that practice must be directed by healers themselves, and not by external forces, because their healing power lies in their veracity, which is easily lost through interference.

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) and the Universal Declaration on Human Rights (UDHR) both recognize cultural practices, including health practices, as a fundamental right. Protection of these practices must be actual, and without lapse.

The revival of indigenous midwifery is improving health outcomes worldwide. From Africa to Standing Rock, midwifery traditions are making a comeback, and achieving excellent results. Alignment with this cultural revival would benefit the State of Hawai‘i greatly.

# Kānaka Maoli Hānau and Midwifery: Overview

As in any ancient culture, birth is Hawai‘i’s **oldest** cultural practice. Before Kapi‘olani Maternity home opened in 1890, the entire population was born outside of a hospital setting. Midwives have always been an important part of this picture.

> **“Midwives placed a gourd at the head of a woman in difficult labour, with a request for ancestral help in delivering the child.”**
>
> -“The Bitter Gourd,” Handy and Pukui, 1958

**Ancient Kanaka Maoli Midwifery**

While specialty kahuna attended the births of the highest chiefs, and might intervene for complications, most Kanaka births, since ancient times, were generally attended by immediate family and/or traditional community midwives, who used knowledge passed through generations. As *hānau* is traditionally seen as an active process controlled by the wahine giving birth (as opposed to a passive process in which emphasis is on “delivery” by professionals, in American thought) along with the direction of the child him/herself and ancestral “messages”, part of the mother’s *kuleana* (responsibility/right) is choosing the proper location for her baby’s birth, and the proper attendants, based upon her personal understanding of what is needed and *pono*.

**Midwifery Remains Important.** This continued through the early 20th Century, and in many cases, through the present day. Much of this was cultural. Only six babies were born in Kapi‘olani Home in the first year it opened (1890), as Native Hawaiian women remained suspicious of doctors and institutions. * In some rural areas, there is still no realistic access to hospital facilities, and while many will stay in or near a hospital for days or weeks to give birth, others simply follow their community traditions of birthing at home. In some of these areas, trained midwives still serve their communities, some of them learning their skills from early youth, and receiving many years of knowledge transmission and experience from kupuna, and sometimes haole or other immigrant midwives.

> **“Almost EVERY birth in the Hawaiian Kingdom was outside of a hospital. That is a lot of knowledge to lose!”**
>
> -Anonymous kupuna, O‘ahu

**Most of this has been done underground.** Forced medicalization, licensure and persecution of healers (see Timeline), along with perceptions of discrimination and mistreatment for birth choices has led to deep wariness and secrecy. Rural families commonly report births as “accidental”, and omit midwife information (note: family-attended births may be more common than midwife-attended births in some areas, where midwives are only called in as needed). This approach has indeed kept the practices from being wiped out, according to families interviewed, but may limit the ability to transmit medical information in the event of an emergency.

**Revitalization of Tradition.** Since 1999, with the advent of decriminalization of midwifery practices in Hawai‘i, a new generation of Kanaka Maoli mothers revitalizing hānau traditions, and in many cases becoming student midwives themselves, has arisen. Through them, hope has been rekindled for traditional Kanaka Maoli birthing practices to achieve even broader revitalization, even in urban areas.


An Advanced Skills Training, 2017


Donlin AL. *When all the Kahuna are Gone: Evaluating Hawai‘i's Traditional Hawaiian Healers' Law*. Asian-Pacific Law & Policy J. 2010

*Hawaiian Gazette*. February 10, 1891

Pukui, Mary K., E.W. Haertig, and Catherine A. Lee. *Nānā i ke Kumu: Look to the Source*. Vol. 1,1972

Pukui, Mary K. *Hawaiian Beliefs and Customs* during *Birth, Infancy and Childhood*. Honolulu: Bishop Museum Occasional Paper XVI, No. 17, 1942.

“The Bitter Gourd.” In Handy, E. S. Craighill (Edward Smith Craighill), and Mary Kawena Pukui. 1972. “Polynesian Family System In Ka-’U, Hawai'I.” Rutland, Vt.: C. E. Tuttle Co.

Wikipedia, *Kapi‘olani Medical Center for Women and Children* https://en.wikipedia.org/wiki/Kapiolani_Medical_Center_for_Women_and_Children

Smith, Helen Wong. Transition from Traditional to Western Medicine in Hawai'i (Part 2). *Western Legislative Impacts on Traditional Medical Practices*. Hawaii Journal of Medicine & Public Health . May 2016, Vol. 75 Issue 5, p148-150.

# Why Kānaka Maoli Practices are NOT Protected in SB 1033

SB 1033 claims to protect Kānaka Maoli birthing practices by placing them under Papa Ola Lōkahi's Kupuna Council System. The trouble is that:

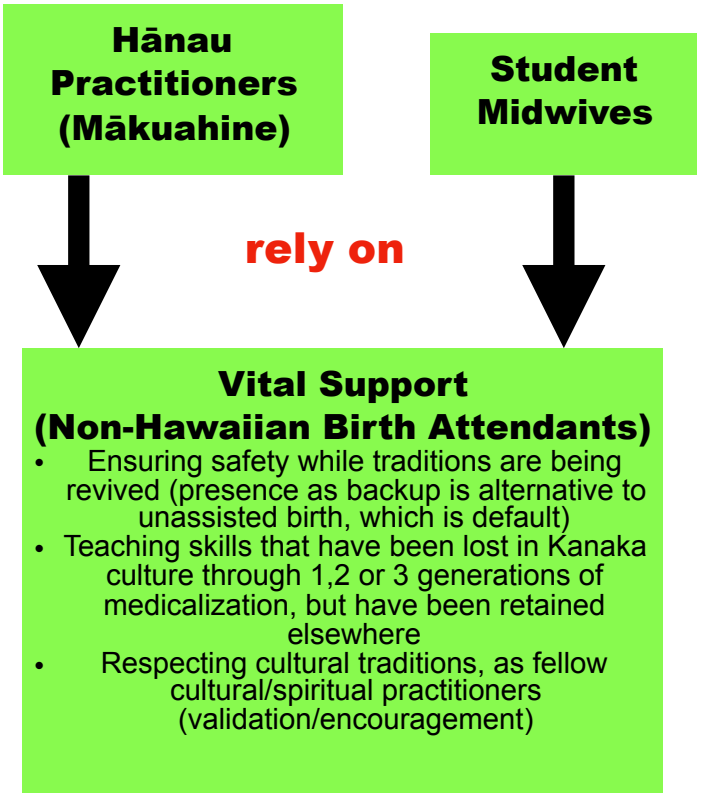
1) this is not guaranteed protection, as it is up to the kupuna, and not the legislature to recognize **(SPECULATIVE)**, and

2) the primary practice being revitalized is **HĀNAU** (birth), and not midwifery. Practitioners of Hānau (Hawaiian mothers revitalizing ancestral traditions) rely on midwives and other birth attendants who are not Kanaka Maoli by blood or practice. They also rely on the ability of these birth attendants to attend other births in the community, including those that are not Kānaka Maoli.

The 1998 Kahuna Statement is at the foundation of Papa Ola Lōkahi's Healer Recognition system. This statement was very clear: it is inappropriate for the State of Hawai'i to ascertain licensure matters relating to Hawaiian Healing Practices.

**Kahuna Statement 1998**
(excerpt)

(1) THAT WE ARE ONLY INSTRUMENTS IN THE HEALING PROCESS AND THAT THE TRUE SOURCE OF HEALING COMES FROM THE ALMIGHTY, KNOWN AS AKUA, 'IO, OR GOD. IT IS THIS SOURCE THAT GIVES US OUR CALLING TO PRACTICE;
(2) THAT **THE LEGISLATURE OF THE STATE OF HAWAI`I IS NOT KNOWLEDGEABLE IN THE HEALING TRADITIONS OF THE HAWAIIAN PEOPLE**; AND
(3) THAT WHILE WE ARE GRATEFUL THAT THE LEGISLATURE HAS PASSED S.B. 1946, THE **BLOOD QUANTUM, LICENSURE, AND CERTIFICATION ISSUES RAISED IN THE LEGISLATION ARE INAPPROPRIATE AND CULTURALLY UNACCEPTABLE FOR GOVERNMENT TO ASCERTAIN.** THESE ARE THE KULEANA OF THE HAWAIIAN COMMUNITY ITSELF THROUGH KUPUNA WHO ARE PERPETUATING THESE PRACTICES.




**"IF TRADITIONAL PRACTITIONERS of ALL CULTURES are not protected, Kanaka Maoli practices would suffer greatly."**
- Kanaka Maoli Medicine Kupuna

# Immigrants to Hawai'i:Traditional Birth and Midwifery

As settlers from other lands arrived to work the plantations, they brought with them their own birth and midwifery traditions. There were Chinese, Portuguese, and eventually Filipino, Japanese, Okinawan and other cultural midwives. Like Kānaka Maoli, these communities did not see birth as a medical emergency or event, but as a natural part of life needing minimal intervention.

**1900s**: "Hundreds of Japanese midwives, or *sanba,* immigrated to the United States in the early twentieth century at a time when the nation grappled with concerns about both the 'Japanese problem' and the 'midwife problem.'"
- Smith, *Japanese-American Midwives,* 2005

Control of immigrant midwives was intrinsically linked to control of plantation workers themselves. Along with harsh educational assimilation programs, the Territory of Hawaii actively sought to medicalize birthing practices amongst the immigrant population. Between 1910 and 1920, Territorial obstetricians sought to eliminate midwifery entirely, but were met with opposition. In 1931, in concert with its clampdown on medical kahuna (see Timeline), the Territorial Board of Health required registration of midwives. By 1937 it had hired a midwife overseer, Alice Young, a Chinese nurse-midwife who inspected midwife bags, supervised births, and attempted to ease tensions between the midwives and government, as restrictions imposed by the Territorial Board of Health continued to increase. In 1941, the Territory made it illegal to practice midwifery without a license, and began to restrict its licensure to nurse-midwives, which became official in 1976. This nearly exterminated immigrant traditional midwifery, and drove its remaining practices underground, where very little was known about them. The rules under Sections 321-13 to 321-15 had essentially become obsolete, and sunset in 1989, re-emerging as Hawaii's existing CNM licensure, which did not address traditional births.

Photo: Midwife Elsie Masao Tsuchiyama holding a baby. Honolulu, ca. 1950. Courtesy of Bernice Pauahi Bishop Museum

**WWII**: "The child was born at night and delivered by a "*partera*" the Ilocano word for "midwife, usually an old woman experienced in child delivery, in the house of Apo Gimmo that was lit by a simple lamp consisting of a piece of rag soak in a bottle of kerosene while tracer bullets flew above the roof of the house lighting the night sky while other gunfire erupted in the distance. There was no formal medical assistance or use of western medicine during the birthing process as was the common childbirth practice of the day even before the start of the War. "- Romel Dela Cruz *The Last Sakadas of Pa'auilo*. Hamakua Times, 2013

After decriminalization in 1999, non-nurse midwifery began to rise again amongst settlers, as it was re-emerging amongst Kanaka Maoli. Post-plantation immigrants, including neighboring Polynesians, Micronesians, and settlers from other States and countries, brought with them their birthing traditions. Birth Centers, and other options available outside of Hawai'i, were proposed, and consciousness of the worldwide revival of birthing traditions grew. Strong relationships were formed between traditional midwives, and tensions arose as legislation — every version of which essentially outlawed traditional practices — was proposed.

**Modern Birth Center**: "We see every race, ethnicity, culture, religion, and women who identify as lesbian and bisexual…(This is) a safe and loving space for women to give birth, and the opportunity to give families another option when the hospital or home isn't what they want. "
- Selena Green, CPM/Traditional African American Midwife


Dela Cruz, Romel. The Last Sakadas of Pa'auilo: How Our Family Came To Hawaii On A Bicycle. Hamakua Times, January 2, 2013.
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SUNSET EVALUATION REPORT REGULATION OF MIDWIVES: A Report to the Governor and the Legislature of the State of Hawaii Submitted by Legislative Auditor of the State of HawaII Honolulu, Hawaii Report No. 89-21 December 1989

## Forced Medicalization and Persecution of Kahuna Healers - Timeline

**1820: Missionaries arrive and immediately ban traditional healing.** "Section 1034: Sorcery - Penalty. Any person who shall attempt the cure of another by the practice of sorcery, witchcraft…or other superstitious or deceitful methods, shall be fined in a sum not less than one hundred dollars or be imprisoned not to exceed six months at hard labor.'

**1865: Extermination through Licensure:** "Increasing Western influence on such cultural practices triggered inconsistent laws for over a century. (This) set up an obstacle for all legitimate practitioners, requiring them to go through a licensing process to practice. There is no record of the government issuing licenses to kahuna at this time."

**June 1, 1868: Kingdom Law recognizing healers.** "a motion to allow traditional Hawaiian practitioners to practice passed. One legislator argued: *Hawaiians were all dying under the influence of foreign medicine. If a man died under a native doctor, the doctor would probably be taken up for murder. No one could deny that natives had died at the Queen's Hospital*."

**1890s: Anti-healer fervor in buildup to Overthrow.** As the monarchy sought to restore traditions, fervor grew amongst U.S. settlers in the attack of "dangerous" healing and spirituality. From an 1891 article: *"Kahunadom must be discredited, and then it may die out. It cannot be stamped by force unless it was possible to convict a dozen or so of kahunas of manslaughter."*

**1893: Outlawing of kahuna and healing practices.** All kahuna practices were banned following the takeover by the Committee of Safety and ensuing Provisional Government and Republic. Many healers were actively persecuted. Practices continued in secrecy.

**1919: Territory of Hawai'i authorizes Hawaiian Medicine Board to issue licenses** to Hawaiian herbalists. This required a written exam, with tests including the latin names for plants used, before a primarily Caucasian examination board. Hawaiian healers could not pass this exam. The Board was dismantled as obsolete in 1965.

**1998: Act 162 temporarily exempted Native Hawaiian practitioners from state licensure,** to give time to structure parameters. These were developed through subsequent legislation. Under the administration of Papa Ola Lokahi, kupuna councils recognizing specific practices (currently limited to Laau Lapaau, Lomilomi, Hooponopono and eventually, Laau Kahea) could apply for recognition through Papa Ola Lokahi. Councils would keep records and resolve any problems arising with their individual practitioners. This has worked well. It must be noted, however, that midwifery is not included amongst the practices recognized, and that the original Kahuna Statement at the foundation of the Council system stands against legislative dictation of recognition.

**2019: SB 1033 SD2, HD2 passes House and Senate.** This measure, if enacted, would again repress or outlaw traditional Kanaka Maoli healing practices. The most significant practice affected would be the practice of hānau (birth) itself, which, according to tradition, is practiced by each wahine in the manner she deems appropriate, with assistants chosen by her specifically. Practices of Pale Keiki (midwifery) would also be forced underground, westernized, or exterminated.

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## Spiritual Birth & Midwifery Practices

Another important area of traditional midwifery is in faith-based midwifery practices. These may be associated with a church or faith, or they may be individual spiritual practices. Hawai‘i has Christian, Muslim and Rastafarian practitioners, along with others. Many are highly skilled, as well as strong in their faith.

Indigenous practices, in and of themselves, are also often faith-based, as indigenous cultural practice connotes spiritual bonds, ancestral obligations, and direction that should be respected.

**SB 1033 does not adequately respect faith-based practices, which are constitutionally protected.**

**Examples:**

• The consent release listed in Section 6(5)C, requiring a signed consent form, violates some religious practices, which forbid State interference in a spiritual process. Many spiritual healers view their relationship with those they assist as a divinely mandated. While they follow principles of health and safety, these are determined by a righteous relationship, or pono. Following State mandates that may not be Pono violates their rights to practice their religion without interference. The separation of Church and State should go both ways.

• Birthing itself is a spiritual process for many parents practicing faith-based birth. If faith-based midwives are made illegal in 2023, they would be forced to be unassisted in order to practice the spiritual practice of birthing in a faith-based setting. This is dangerous, and imposing secular practices (or no assistance) on to faith-based birthing practices violates the freedom of religion for the parents.

## Traditional Birth Stories

### *Carrying On Traditions*

“I was born with only my parents and only my dad and I was present when my youngest brother was born.The choice should be what the mother is comfortable with.
And just like having a child is a personal choice it is and always should be our right to choose how and where we wish to give birth... Besides sometimes people can't make it to the hospital on time.”
- Indira, O‘ahu (from Pohnpei)

“My Tutu's, my grandmother and her sister were midwives in the villages from Kaupo to Hana before the dispensary was built. After 2 hospital births, i chose to have my last 2 children at home.”
- Noelani, Kaua‘i

# Myths and Facts

## 1. MYTH: SB 1033 would make home birth safer.

## FACT: SB 1033 is dangerous, and does not address actual safety.

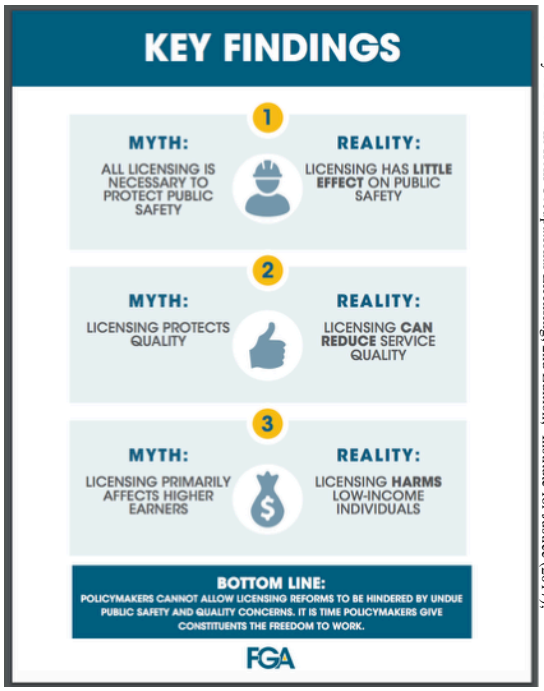
In a 2017 survey of Hawai'i home birth families, nearly 36% were found to live in areas that were at least 45 minutes from the nearest hospital; in some cases, hours. There are too few CPMs to serve this population. Outlawing traditional midwives puts some families in the position where their only legal option is an unassisted birth.

SB 1033 creates dangerous transport scenarios with poor communication. When problems arise in a home birth that require medical assistance, two crucial variables make the biggest difference in outcome:

1. **Timing of transport**, and
2. **Communication.**

Both of these are harmed by SB 1033, by forcing the majority of practitioners underground with no feasible recourse to legality.

**The climate of fear created by a state of illegality has been shown to be harmful to labor itself.** In addition, **it is known to delay transport decisions**. It should be noted that the final say in when to transport to a hospital is the decision of the *mother*, not the midwife. Mothers may delay transport due to bad experiences with hospitals or fear of repercussions. Fear of trauma, discrimination or unwarranted child removal is increased amongst ethnic groups, such as Kanaka Maoli and African-Americans, who have experienced actual systemic prejudice in their communities. Birthing with an illegal traditional midwife could increase that fear significantly, resulting in avoidance of medical services and delay of transport.




Studies have shown that regulatory licensure does NOT increase safety. Dick Carpenter, Lisa Knepper, Kyle Sweetland, Jennifer McDonald, "License to Work: A National Study of Burdens from Occupational Licensing, 2nd Edition," Institute for Justice (2017).

If a midwife is illegal, she cannot accompany the mother to the hospital, due to fear this might increase systemic danger to the parents and the likelihood of a child welfare accusation. She cannot provide medical records, birth information, or the story of what happened. The mother is unlikely to disclose information that she may fear might be used against her or her midwife. This creates a gaping chasm at a critical point in a medical crisis.

**It has been historically proven that forcing a reproductive choice underground is <u>never</u> a safe thing to do**. SB 1033 does exactly this. By making traditional practices illegal, it widens the communication gap between them and medical professionals, and between families and doctors as well.

Furthermore, SB 1033 does not address actual safety. There is no evidence that licensure of midwives increases safety for mothers and babies anywhere; in fact, there is evidence that **safety is decreased overall where licensure has been mandated.**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## 2. MYTH: Home birth is dangerous; hospitals are safe.

## FACT: They are about the same. However, rates of unnecessary interventions and obstetric violence are higher in planned hospital births, and successful vaginal delivery rates are highest at home.

Planned home birth with the possibility to a transport to the hospital if needed are as safe as planned hospital births, or more. As shown by a recent review of international studies, out-of-hospital birth safety increases with the increase of communication with a referral network of obstetric care when needed. SB 1033, however, actually cuts all communication, depriving both the non-medical birthing system and the medical one from their reciprocal containment of respective risks (medical emergency on one hand, and unnecessary or abusive interventions on the other).

Home birth and hospital births have similar morbidity rates but for different reasons. Home births have the highest rates of uncomplicated birth and the lowest rates of medical interventions, which leads to lower negative outcomes initiated by such interventions. For instance, in the US the rate of cesarean sections among US hospital births in 2006 was 30.2%, against the evidence-based approach presented by the WHO which suggests that hospital births should not have a c-section rate over 10-15%, while the rate of cesarean sections among home births in 2004-2009 was even lower, that is 5.2%. If we consider high-resource settings like the Netherlands, where maternal mortality after cesarean section is 3 times higher than after vaginal birth, we can understand the importance of lowering the risk of unnecessary medical interventions.

The rates of obstetric violence, that is, abuses perpetrated by OB/GYN personnel, that women face during hospital births are also high. Among survey respondents in the Listening to Mothers Study III (n=2400), 30% of black and Hispanic primiparous women and 21% of white women who delivered in hospitals in the United States reported that they sometimes or always felt "treated poorly because of a difference of opinion with [their] caregivers about the right care for [herself or her] baby". In the same study, 25% of women who had experienced an induction of labor or a cesarean section felt pressured to accept those interventions, 59% of women who received episiotomies did not give consent at all, and 63% of women experiencing a primary Cesarean section and 47% of women who had a repeat C-Section reported that the provider made the "final decision" about whether they would receive cesarean surgery.


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## 3. MYTH: Many Hawaii midwives lack rigorous training

**i.e. "Self trained" and "haven't had a formal education or done apprenticeships"**

(Star Bulletin, 4/15/19)

## FACT: There is NO evidence of any untrained midwife in Hawai'i.

Non-CPM midwives in Hawai'i have an estimated average of **1.5 years of formal schooling or equivalent[1], 2.5 years of hands-on apprenticeship, and 7 years of experience attending births.** While this varies widely, **NO** Hawai'i midwives (using the title "midwife") were found to have less than 1 year of schooling or equivalent, 1 year of hands-on apprenticeship, and 3 years attending births. Midwifery training - both traditional and clinical - is intensive and

rigorous.
Hawai‘i’s midwifery community is small. With the exception of culture-specific traditional midwives whose practices exist deep within specific communities, the vast majority of midwives and birth workers are known to one another. Out of 45 midwives, students, doulas, cultural experts and home birth parents questioned (ranging from clinical to very traditional)[2], none had ever met or heard of a person in Hawai‘i representing themselves as a midwife who was “self-trained” or had not done some form of intensive apprenticeship prior to attending births without supervision. “Formal education” was variable: about 70% had heard of someone practicing without this, which is consistent with the intensive cultural training required of indigenous healers and other known equivalencies.
Two people on islands other than O‘ahu said that they had heard “rumors” of people reportedly calling themselves “midwives” with no known credentials; however, these were said to have quickly left Hawai‘i, without having done any births, to the knowledge of those interviewed.

## 4. MYTH: Hawaii Midwives had licenses revoked elsewhere

## FACT: No midwife in Hawai‘i has had a license revoked or suspended.

Revoked licenses are listed on the NARM website: https://narm.org/accountability/revocation-of-certification/.
No Hawai‘i midwives appear (out of only 6 since 2000) .
No State licenses have been revoked. This is one of many examples of false rumors used in SB 1033 promotion.

## 5. MYTH: SB 1033 Stops “dangerous” midwives.

## FACT: “Dangerous” midwives* are not stopped, but legitimate ones are.

It should be noted that **SB 1033 would not stop anyone who was actually problematic.** Because no public education is provided, because *the fines for infractions are the same as the cost for annual licensure*, and because midwives have always been able to operate underground through periods of illegality, this would not stop an actual charlatan at all.

Fortunately, there is no evidence that charlatan midwives have existed in Hawai‘i in our time.

**“The ‘dangerous midwife‘ has long been a convenient fictional figure of misogyny and societal control all over the world. She goes back to the witch hunts of the Inquisition. and is akin to the construed “welfare queen” of modern political yarns. Exaggeration and invention follows her everywhere.”**

**The only midwives potentially stopped by this are those who are so law-abiding that they will shut down rather than break the law, while everyone else goes underground.**

Are *those* the midwives the State of Hawai‘i really wants to shut down?

* If they exist at all, as their existence in Hawai‘i has NOT been proven.
[1] Equivalency may consist of formal or informal but intensive training with master practitioners, study with multiple elders, or other means of equivalency recognized by the culture in question and the community of midwifery
[2] Interviews conducted May 2014 to April 2019, consisting of 45 participants; 3 CPMs 5 non-CPM midwives, 12 Student Midwives, former student midwives, or Doulas; 7 traditional elders, 2 naturopaths, and 16 home birth parents not represented in other categories.
See: Horsley, Ritta Jo, and Richard A. Horsley. “On the Trail of the ‘Witches:" Wise Women, Midwives and the European Witch Hunts.” *Women in German Yearbook*, vol. 3, 1987, pp. 1–28

## 6. MYTH: SB 1033 is based on community input.

## FACT: The community was NOT consulted in creating this measure.

## SB 1033 was created through a flawed and discriminatory process:

*Note: There is no record of this process, which did not follow Chapter 91 rules. This is the best we can ascertain what happened:*

1 **Midwives Alliance of Hawai‘i** (MAH), representing pro-licensure CPMs/ CNMs, requested licensure.
2. DOH convened a “**Hawaii Maternal and Infant Health Collaborative**” to create legislation. The collaborative consisted of medical, government and clinical professionals (no traditional practitioners, families or other community).

3. A "Midwifery Working Group" was created by the "Collaborative." Participants were ACOG, the Chair of DCCA, the ACNM, the MIH Collaborative, Hawaii Pacific Health, DOH, Healthcare Association of Hawaii, HMSA, Hawaii State Center for Nursing, and MAH (no traditional practitioners, families or other community were included).

4. In 2017 and 2018 this "working group" held several private meetings and one public meeting. These were not made known to the community.

5. in December 2018, a single discussion was held in which some community members were invited to attend. They were given no actual input or time for discussion. There was a request to work on building comprehensive solutions, but this was not done, except for a small "problem solving" gesture in the last five minutes of the meeting. An extension of time was requested for this, but the meeting ended five minutes later, and no further time was scheduled. This was the **only** known participation of any community member outside of the all-medical/clinical "Working Group". In other words, the entire process lacked community participation and input **entirely**. Much of the birth/midwifery community was shocked that this had been taking place without their knowledge.

5. **It was widely and incorrectly told to legislators that a Working Group inclusive of community voices had helped to create this measure.** The birth community and some legislators asserted that SB 1033 needed more community discussion, and that rather than impose a restrictive law prematurely without community input, comprehensive solutions should be developed. However, t**his was rejected by legislators, under the incorrect assertion that there had already been a community Working Group process.** The legislature was essentially lied to in order to create special interest legislation.

## 7. MYTH: SB 1033 is needed because a better bill is not possible.
## FACT: A better bill is not only possible, but necessary.

It should be noted that creating a better bill through the process in SB 1033 will not work.

If SB 1033 passes into law, protest and litigation are likely, as these would be the only way to address the Constitutional violations and discrimination inherent in the measure. These processes, though necessary for the protection of basic human rights, civil rights, reproductive rights and cultural rights in the case of such deep injustice, would make it very difficult to simultaneously work on legislative efforts to remedy the disaster that SB 1033 created, especially as these efforts are clearly unlikely to succeed, as there would be no motivation on the part of the regulatory interests within the legislature, as evidenced by the swift passage of this bill itself, to protect these rights at all.

The truth is that there has never been an opportunity to work together. Since 2014, our community has been embattled over terrible legislation, leaving us no opportunity to focus on the creation of real solutions.

Fortunately, several legislators have now recognized this measure for what it is, and have offered to introduce an effective bill (see p.6) in the next session. This would be supported by the Commission on the Status of Women, and many other prominent voices. However, these legislators too recognize that these efforts would be likely to be futile if SB 1033 passes into law, as we would be starting from an extreme deficit.

The ONLY way to achieve true safety for out-of-hospital births in Hawai'i is a VETO on SB 1033.

Mahalo nui loa.

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