



# ***THE HAWAI`I HOME BIRTH TASK FORCE***



*A Report  
to the Governor and the Legislature of the State of Hawai`i  
Per Act 32, Session Laws of Hawai`i, 2019*

*from the Hawai`i Home Birth Task Force*

*Administrative and clerical support by  
Hawai`i State Commission on the Status of Women  
Department of Human Services*

December 11, 2019

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## I. INTRODUCTION

The Hawai'i Home Birth Task Force (task force) was constituted pursuant to Act 32, Session Laws of Hawai'i, 2019 (Act 32), on April 30, 2019, and convened on July 8<sup>th</sup>, 2019. Act 32 specifies that the task force shall have no more than twelve members including the Director of Commerce and Consumer Affairs (DCCA), the Department of Health (DOH), the American College of Obstetricians and Gynecologists (ACOG), the Healthcare Association of Hawai'i (HAH), and representatives recommended by Hawai'i Home Birth Collective (HIHBC) that reflect the following groups, representing all counties: certified professional midwife; certified nurse midwife; home birth elder; traditional cultural birth attendant; and a member of the public that has used home birth services. The Hawai'i State Commission on the Status of Women was not a mandated task force member and provided only clerical support.

### **Task Force Members:**

- **Task Force Chair:** *Kristie Duarte, Public member who has used home birth services (O'ahu)*
- **Task Force Vice Chair:** *Tara Compehos, Public member, DEM/Traditional Midwife (Hawai'i)*
- *Lee Ann Teshima, Director's Designee, DCCA (O'ahu)*
- *Matthew Shim, DOH, Family Health Services Division (FHSD) (O'ahu)*
- *Chrystie Fujimoto / Eesha Bhattacharyya, ACOG (O'ahu)*
- *Kathleen Libao-Laygo, Healthcare Association of Hawai'i (HAH), Senior Director of Quality and Regulatory Affairs (O'ahu)*
- *Heather Milovina, Certified Nurse Midwife (Maui)*
- *Selena Green, Certified Professional Midwife (O'ahu)*
- *Mieko Aoki, Certified Professional Midwife (Kaua'i)*
- *Lori Kimata, Home Birth Elder (O'ahu)*
- *Ki'i Kaho'ohanohano, Traditional/Cultural Midwife, Hawaiian Healer/Birthkeeper (Maui)*
- *Rachel Curnel Struempf, Public member who has used home birth services, Direct-Entry Midwife/Traditional Midwife, Homebirth Elder (Hawai'i)*

## II. SCOPE AND METHODOLOGY

The Task Force worked diligently over five months to identify, discuss, and work toward consensus on the relevant issues. The task force reviewed Act 32 for its regulatory descriptions and researched issues as directed by Act 32. (See Appendix 7, Act 32, SLH 2019). Task force members volunteered as members and chairs for three working groups as follows:

- Data collection and reporting on home and hospital births
- Education and training of direct entry midwives

- Regulation of direct entry midwives

**Task Force Chairs and Workgroups Members:**

- **Task Force Chair:** *Kristie Duarte*
  - **Task Force Vice Chair:** *Tara Compehos*
1. **Data collection and reporting on home births:** *Chair Lori Kimata; Members: Matthew Shim, Kathleen Libao-Laygo, Heather Milovina, Selena Green, Chrystie Fujimoto, Rachel Curnel Struempf.*
  2. **Definitions, Education and training of direct entry midwives:** *Co-Chairs Lori Kimata & Selena Green; Members: Lee Ann Teshima, Ki'i Kaho'ohanohano, Tara Compehos, Rachel Curnel Struempf, Mieko Aoki.*
  3. **Regulation of direct entry midwives:** *CoChairs Rachel Curnel Struempf & Ki'i Kaho'ohanohano; Members: Lee Ann Teshima, Tara Compehos, Mieko Aoki, Matthew Shim, Kathleen Libao-Laygo.*

The task force took steps to democratize the drafting process above and beyond the requirements of law. The task force discussed allowing public access and public participation in task force meetings in the spirit of the State's "Sunshine laws," even though Act 32 exempted the task force from this requirement. The task force agreed to post meeting notices, agendas, approved minutes and drafts of the report on two websites: the Hawai'i State Commission on the Status of Women (HSCSW) and the Hawai'i Home Birth Collective (HIHBC). The task force further supported an opportunity for public members to comment on relevant matters during the last portion of the monthly meetings.

The report represents the culmination of valuable discussions and clarifications concerning the different types of midwives that serve Hawai'i's families, which focused on the importance of preserving and perpetuating different pathways for the benefit of women's birthing choices in Hawai'i. In addition, the report defines the currently exempt "birth attendant" category as two distinct types of midwives: Registered Traditional Community Midwives and Traditional Cultural Midwives. The report delineates common standards in education and training, accountability, disclosure requirements, regulating bodies, and methodology, which justify exempting them from state licensure on an ongoing basis. The recommended amendments or additions to Act 32 in this report are intended to bring the statute into alignment with its stated purpose.

The task force used data provided by the DOH and HIHBC as well as standards set by Midwives Alliance of North America (MANA), the North American Registry of Midwives (NARM), the World Health Organization (WHO) as standards for non-nurse midwives and traditional/cultural birth attendants. The task force also referenced the United Nations Declaration on the Rights of

Indigenous People (UNDRIP) to develop recommendations intended to assist the state in safeguarding access for consumers and ensuring accountability of midwives.

This report is a cumulative effort of task force members who represented their various private sector occupations and organizations, as well as public sector agencies whose roles and responsibilities are relevant to the regulated occupation. The task force recommendations may or may not reflect a specific member's stance, to the extent that their organizations will have appropriate time to reflect and respond to such recommendations during future Legislative Sessions. (See Appendix 6, Comments by Task Force Members and the Public).

### **III. ACKNOWLEDGMENTS**

The task force extends our gratitude and appreciation for the members who generously gave their time, expertise, personal expenses, and energy in meeting the legislative mandate to investigate issues relating to direct entry midwives and home births, including but not limited to data collection and reporting on home births, education and training of direct entry midwives, and regulation of direct entry midwives. The task force also thanks the administrative staff and volunteers of HSCSW and Representative Linda Ichiyama's staff who supported this work. HSCSW did not contribute to any substantive content of this report or inform the report's recommendations. The task force extends its gratitude to the DOH, FSD for supporting the task force's neighbor island members' travel expenses.

### **IV. TASK FORCE FINDINGS**

Each workgroup reported on and made recommendations on the following areas as presented:

- A. Data Collection by the Department of Health (DOH) and Hawai'i Home Birth Collective (HIHBC)
- B. Education and Training of Direct Entry Midwives
- C. Regulation of Direct Entry Midwives
- D. Training and Access to Emergency Drugs and Devices

All twelve task force members agree unanimously on the following findings:

Traditional midwives currently exist in Hawai'i, they define themselves as Traditional midwives and are in demand by the communities they serve. Traditional midwives are recognized and defined by Midwives Alliance of North America, and states such as Oregon and Canada formally recognize and perpetuate their practices by creating pathways other than licensure to allow Traditional midwives to continue to serve their communities.

Each woman has a right to choose where and with whom she gives birth.

**A. Data Collection by the Department of Health (DOH) and Hawai'i Home Birth Collective (HIHBC)**

In this section data was collected by the Department of Health (DOH) on hospital and planned home birth in Hawai'i and compared to data collected by Hawai'i Home Birth Collective (HIHBC) for 2017 and 2018 for the purposes of testing discrepancies and birth outcome comparisons. The taskforce found that the data from HIHBC showed the same or similar results to that of DOH. This current data collected in Hawai'i shows similar results to those of *Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009. (See Appendix 1, Home Birth Data)*

Data from DOH showed a total of 17,145 births in Hawai'i in 2017 and 16,649 in 2018. Home births made up 1.72% and 1.77 % of all births in Hawai'i, respectively. The infant transfer rate from home to hospital was 1.3% in 2017 and 2.3% in 2018.

Data from HIHBC showed similar results, with 302 (1.76%) home births reported in 2017 and 324 (1.94%) in 2018. The infant transfer rate to hospital documented by HIHBC was 1.3% in 2017 and 1.8% in 2018.

**HAWAI'I DEPARTMENT OF HEALTH DATA**

	2017	2018
<b>Place of where birth occurred: hospital</b>	<b>17,145</b>	<b>16,649</b>
<b>Place where birth occurred: planned home</b>	<b>301 (1.72%)</b>	<b>302 (1.77%)</b>
<b>Infant transferred from home birth</b>	<b>4 (1.3%)</b>	<b>7 (2.3%)</b>

**HAWAI'I HOME BIRTH COLLECTIVE DATA**

Year	2017	2018
<b>Place where birth occurred: planned home</b>	<b>302 (1.76%)</b>	<b>324 (1.94%)</b>
<b>Infant transferred from home birth</b>	<b>4 (1.3%)</b>	<b>6 (1.8%)</b>

DOH data for fetal and infant morbidity from planned home birth indicate lower rates of resuscitation, assisted ventilation and NICU admission than planned hospital births.

Available data from vital records at DOH indicates that maternal and infant mortality rates for planned home births in Hawai'i in 2017 and 2018 were zero (0).

**ABNORMAL CONDITIONS OF NEWBORN IN HOSPITAL:**

	2017	2018
<b>Assisted Ventilation Following Delivery</b>	<b>885-6 = 879 (5.1%)</b>	<b>822-9 = 813 (4.9%)</b>
<b>Assisted Ventilation More than 6 hours</b>	<b>225-3 = 222 (1.3%)</b>	<b>176-3 = 173 (1.0%)</b>
<b>NICU Admission</b>	<b>1106-3 = 1103 (6.4%)</b>	<b>810-4 = 806 (4.8%)</b>

**ABNORMAL CONDITIONS OF NEWBORN IN PLANNED HOME BIRTHS:**

	2017	2018
<b>Assisted Ventilation Following Delivery</b>	<b>6 (2.0%)</b>	<b>9 (3.0%)</b>
<b>Assisted Ventilation More than 6 Hours</b>	<b>3 (1.0%)</b>	<b>3 (.99%)</b>
<b>NICU Admission</b>	<b>3 (1.0%)</b>	<b>4 (1.3%)</b>

The task force finds that there are areas where data from vital records is insufficient, specifically questions #26 and #28 of the "Certificate of Live Birth" worksheet (*See Appendix 1, Home Birth Data*). The task force also finds that the DOH collects its information on hospital and home births through the "Certificate of Live Birth" data from parents, and not from the hospitals or health care providers. The task force recommends further investigation on whether a change to the vital records statute should include additional data fields on the current DOH "Certificate of Live Birth" (2014) form. Additional data fields would be helpful in gathering information on:



- maternal transports from home births;
- reason for transport; and
- maternal/fetal/infant intrapartum and postpartum mortality outcomes.

In relation to data findings, consideration should be made for the large difference in numbers between hospital and home births (i.e. 17,145 compared to 301). The population of mothers who choose home birth are more commonly low risk with healthy pregnancies, whereas people of all risk levels give birth in hospitals.

Comparative data from both DOH and HIHBC clearly shows that home to hospital transfers with significant mortality or morbidity consequences for mother and/or infant are exceedingly rare and do not occur daily in Hawai'i hospitals (*See Appendix 1, Home Birth Data*). Given the data, suggestive comments such as the following are extremely misleading and lend consumers false impressions which can lead to harm:

The 2019 Journal of the Hawai'i House of Representatives reported floor comments that reflected a need for data transparency and longitudinal data reporting (*page 18*).

*“Each year we hear stories why regulation is so needed in Hawaii. We may not have hard stats or figures, but unfortunately, the stories about what is happening in our communities are getting worse and worse. The Hawaii Section of the American College of Obstetricians and Gynecologists made this bill a top priority because of the cases that they see every day in our hospitals...” (underline added)*

The task force recognizes the need to facilitate a safe environment for data to be shared without fear of persecution. The purpose of any data collection is to facilitate better data and therefore more understanding of home birth which can be used to build trust between the different types of birth practitioners.

The task force by consensus finds the following:

## **B. Education and Training of Direct Entry Midwives**

**Direct entry midwife is an umbrella term for people who attend births outside of hospital and who do not have a nursing degree.**

- **“Direct-Entry Midwife” (DEM):** is defined by Midwives Alliance of North America (MANA) as an independent practitioner educated in the discipline of midwifery through self-study, apprenticeship, a midwifery school, a college, or university-based program distinct from the discipline of nursing. A direct-entry midwife is trained to provide the

Midwives Model of Care to healthy women and newborns throughout the childbearing cycle primarily in out-of-hospital settings.<sup>1</sup>

The task force finds that DEM in Hawai'i can be classified into two groups: (1) those who hold certification and are best regulated through licensure, and (2) traditional midwives who can be best regulated through exemption.

- 1) **Certified Midwives and Certified Professional Midwives** hold certification and are best regulated through licensure.
  - a) **Certified Midwife (CM)** is defined by Act 32 as a person who holds a current and valid certification as a certified midwife from the American Midwifery Certification Board (AMCB), or any successor organization.

The task force finds that to date, only a few states have recognized the CM credential: New York, New Jersey, Delaware, Maine, Missouri, and Rhode Island. There are currently no certified midwives in Hawai'i, and no schools offering the CM credential within Hawai'i. The task force finds that licensure is a good method of regulating CMs, but because there are currently no CMs in the state, and the credential is difficult for Hawai'i residents to access at this time, the regulation of the CM does not address the goals of Act 32.

- b) **Certified Professional Midwife (CPM)** is defined by Act 32 as a person who holds a current and valid national certification as a Certified Professional Midwife from the North American Registry of Midwives (NARM), or any successor organization.

NARM offers two distinct pathways for individuals to obtain the CPM credential. They can either 1) graduate from a Midwifery Education Accreditation Commission (MEAC) accredited school, or 2) complete an apprenticeship with a qualified midwife preceptor and the Entry-Level Portfolio Evaluation Process (PEP). Both educational pathways require passing of the NARM written exam in addition to all other requirements.

The task force finds limited opportunity for the MEAC, PEP and NARM licensure pathway. Under Act 32, only those CPM students who have attended a MEAC accredited school are eligible to apply for licensure after the end of the current year (2019). In addition, there are no MEAC accredited midwifery education programs in Hawai'i for the CPM student. There are only nine MEAC accredited midwifery programs in the United States, and only six of those offer a distance learning program. CPM students are only allowed to sit for the NARM exam **after** they have completed either the MEAC or PEP process. If the CPM student cannot complete either process, then they are not allowed to take the test.

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<sup>1</sup> Midwives Alliance of North America, *Resources*, <https://mana.org/resources/become-a-midwife>, Date last visited Nov. 25, 2019.

The task force finds that there are currently fewer than ten NARM approved preceptors across all the Hawaiian islands. Student midwives are required to attend at least 55 births under the supervision of a midwife preceptor. The Hawai'i home birth rate is low, averaging less than 2% of all births annually (approximately 300 per year). Limiting approved preceptors to those ten NARM approved preceptors creates an apprenticeship bottleneck which further limits the student midwife's access to required education.

Concerns have been raised around cost and access barriers to education required for certification and ultimate licensure in Hawai'i. The task force finds that a combination of amendments within Act 32 which will be clearly explained in the "Task Force Recommendations" section of this report, as well as exemptions from licensure will open up educational options and pathways to licensure, including the PEP educational pathway and/or allow all direct entry midwives to practice to the fullest extent under the law.

**2) Traditional Midwives: Registered Traditional Community Midwife and Traditional Cultural Midwife can be best regulated through exemption.**

Per Act 32, "This Act also exempted a separate category of birth attendants for a three-year period, to allow this community to define themselves and develop common standards, accountability measures, and disclosure requirements. By the end of the three-year period, the legislature intends to enact statutes that will incorporate all birth practitioners and allow them to practice to the fullest extent under the law."

After months of focused discussion, the task force has elected to define these exempt "birth attendants" pursuant to Act 32 as the: a) Registered Traditional Community Midwife and b) Traditional Cultural Midwife. Traditional midwives are the oldest type of midwife and are recognized nationally and internationally by Midwifery Education Accreditation Commission (MEAC) and Midwifery Alliance of North America (MANA). In Hawai'i the task force finds that Traditional Midwives can be best defined, and their standards and scope of practice clearly developed when categorized into two types:

**a) Registered Traditional Community Midwife**

Registered Traditional Community Midwife means a midwife who is registered with the Hawai'i Home Birth Collective who, for religious, personal, and/or philosophical reasons chooses not to become certified or licensed. (*See Appendices 2 & 5, Registered Traditional Community Midwife & Hawai'i Home Birth Collective Forms*)

The 2017 Sunrise Analysis Report on Certified Professional Midwives found:

**"Licensure is the most stringent form of regulation; it restricts a profession so that it may become illegal for individuals to provide specific services without a license. For that reason, licensure should be used only as a last resort. Registration is a less stringent, rigorous form of regulation that typically requires professionals to provide their names and addresses to a**

**designated agency.... Registration is appropriate where the threat to life, health, safety, and economic well-being is low.** “2017 Sunrise Analysis Report No.17-01, pg. 34, Jan. 2017.

The task force finds that HIHBC is committed to creating a structure of accountability and transparency for midwives who cannot or do not obtain state licensure. Registration with Hawai'i Home Birth Collective (HIHBC) is an appropriate way to regulate the Registered Traditional Community Midwife. (See Appendices 2 & 5, *Registered Traditional Community Midwife & Hawai'i Home Birth Collective Forms*)

Pursuant to Act 32, the taskforce has determined that common standards in education/training and accountability for the Registered Traditional Community Midwife should adhere to the following national and global standards and organizations:

- Midwives Alliance of North America (MANA)
- MANA Routes of Entry into Midwifery and Definitions
- MANA Standards and Qualifications for the Art and Practice of Midwifery
- MANA statement of Values and Ethics
- MANA Core Competencies for Midwifery practice
- Follows the MANA midwifery model of care
- North American Registry of Midwives (NARM) Standard in clinical experience  
(See Appendix 2, *Registered Traditional Community Midwife*)

**b) Traditional Cultural Midwife**

Act 32 states that, “The legislature also notes that practicing midwifery according to this Act does not impede one's ability to incorporate or provide cultural practices.”

The rights of Indigenous People to practice their cultural traditions and choose their own caregivers is protected by the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), adopted by the General Assembly 61/295 in September 2007. In addition to Kanaka Maoli, who are indigenous to Hawai'i, there are people of many cultures indigenous to other lands, whose rights to continue their birthing traditions in Hawai'i should also be protected. Cultural and spiritual rights are protected by the United Nations Declaration on Human Rights (UDHR), the United States Constitution, the Hawai'i State Constitution, and many other laws and human rights instruments.

It is therefore our recommendation that the Hawai'i State Legislature protect these traditions by exemption from the regulatory requirements of Act 32, which is the only realistic way to avoid impeding cultural practices as referenced in the Act.

Due to the widespread adoption of modern medical birth in the last century, all ancient cultural out-of-hospital birthing arts are both fragile and threatened with extinction. They cannot be

modified by external forces, including regulation, without damage. As traditionally-trained attendants are critical for the safe continuation of ancient out-of-hospital practices in a cultural context, the task force finds that exemption of these traditionally-trained attendants is necessary, and aligned with the spirit of “not impeding” cultural practices expressed in Act 32. The task force finds that Hawai‘i is home to many groups of indigenous people who have specific cultural birth practices. The task force finds that it is imperative for the Hawai‘i State Legislature to protect these practices, along with birthing practices of spiritual traditions, through exemption from regulation.

Hawai‘i is rich in a wide diversity of spiritual birth traditions, some of which overlap with or are indistinct from cultural practices, and some of which are not. The ability to practice these spiritual traditions as a part of childbirth, with a practitioner of the mother’s choice in attendance, is a right of all women. Such a choice realistically exists only if practitioners trained within that spiritual tradition can legally practice. Therefore, this task force finds that midwives trained within a spiritual tradition should be exempt from regulation as well.

Traditional Cultural Midwife is defined by Hawai‘i Na Pua O Haumea (a cultural healers’ alliance with expertise in birthing traditions throughout Hawai‘i) as an autonomous birth attendant who has acquired the skills to care for pregnant people, babies, and their families throughout pregnancy, birth, and postpartum through a spiritual and/or cultural lineage and who provides care to indigenous persons or members of an indigenous community in accordance with the United Nations Declaration on the Rights of Indigenous People, and/or to individuals or members of a community which subscribe to a congruent set of spiritual and/or cultural beliefs or practices. *(See Appendix 3, Traditional Cultural Midwife)*

Pursuant to Act 32, the task force finds that the common standards in education/training, and accountability for the Traditional Cultural Midwife adhere to the national and global standards of the following organizations:

- United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)
- United Nations (UN) Universal Declaration of Human Rights and related Instruments
- National Aboriginal Council of Midwives (NACM)
- Midwives Alliance of North America (MANA) definition of Traditional Midwife

*(See Appendix 3, Traditional Cultural Midwife)*

### C. Regulation of Direct Entry Midwives

**Use of the word midwife:** The task force finds that only a licensed individual may claim that they are “licensed,” or use the title “licensed midwife”. However, the task force also finds that the term “midwife” is used by all direct-entry midwives regardless of their educational pathway or licensure status. Utah and Oregon have set the precedent for licensed midwives as well as an exempt category of midwives to call themselves “midwife.” It is thereby recommended that instead of turning the term “midwife” into an occupational title, both licensed **and** exempt midwives may continue to use “midwife” as an informal term.

The task force reached unanimous agreement that traditional midwives do exist in Hawai‘i, and are in demand in the community, and that other states recognize them as exempt midwives and have created pathways for them to continue to practice without licensure.

### D. Training and Access to Emergency Drugs and Devices

The task force finds that in some remote areas of Hawai‘i, home to hospital transport can take two hours or more. The eighth step in the 10 Steps of the International Mother Baby Childbirth Initiative is to:

Provide access to evidence-based skilled emergency treatment for life-threatening complications. Ensure that all maternal and newborn healthcare providers have adequate and ongoing training in emergency skills for appropriate and timely treatment of mothers and their newborns.  
*(See Appendix 4, Training and Access to Emergency Drugs and Devices)*

Task force discussion on this topic showed agreement that all people who give birth have the right to emergency treatment. The majority of task force members support allowing DEM with proof of training the use of limited basic formulary medications. Some task force members advocate for access to the following list of drugs and devices while others feel that only items numbers 1) and 2) on the list are necessary.

1. Antihemorrhagic medications recommended based on the following World Health Organization guidelines:

Oxytocin (10 IU, IV/IM) is the recommended uterotonic drug recommended for the prevention of postpartum hemorrhage ALL births. In settings where skilled birth attendants are not present, the administration by community health care workers and lay health workers is recommended. *(See Appendix 4, Training and Access to Emergency Drugs and Devices)*

2. Oxygen necessary for proper execution of neonatal resuscitation per American Academy of Pediatrics guidelines.

3. Intravenous fluids to stabilize a laboring or recently delivered person while awaiting EMS for transport.
4. Rho (D) immune globulin to protect those with negative blood types from sensitization per ACOG and NIH guidelines.
5. Neonatal eye prophylaxis to prevent injury to the eyesight of newborns per the guidelines set by the American Academy of Pediatrics.
6. Injectable Vitamin K to prevent bleeding disorders in the newborn per the guidelines set by the American Academy of Pediatrics.
7. Local anesthetic without epinephrine for use during repair of simple perineal lacerations.

*(See Appendix 4, Training and Access to Emergency Drugs and Devices)*

Utah, Oregon, Minnesota and Canada have developed educational programs for midwives which offer a minimum of eight and a half hours of legend drugs and devices continuing education every three (3) years, including the following:

- 2 hours: in Pharmacology for midwives;
- 1.5 hours: the administration of medications through injection;
- 1 hour: in advanced treatment of shock;
- 3 hours: in intravenous therapy; and
- 3 hours: in suturing.

*(See Appendix 4, Training and Access to Emergency Drugs and Devices)*

Due to Hawaii's unique geography and isolated rural communities, the task force finds that it would be beneficial to the safety of home birth consumers in Hawai'i to provide these trainings to both licensed and exempt midwives. The task force recommends further investigation into how to implement a program offering these courses and providing access to limited legend drugs and devices to DEMs because they are an important lifeline to laboring women in geographically isolated communities. Some options to house a program discussed by the task force include: Hawai'i Home Birth Collective, American College of Obstetricians and Gynecologists, Hawai'i community colleges or adult education programs.

## **V. TASK FORCE RECOMMENDATIONS**

All twelve task force members recommend unanimously that:

- That the task force continue to meet at least until June 30, 2020.

- That Healthcare Association of Hawai'i convenes meetings with EMS, hospital receiving staff/physicians and task force representatives to build relationships and identify opportunities to improve transports from home birth to hospital.
- That the task force convenes a meeting with Papa Ola Lokahi and the home birth community to work out issues and build bridges of education and understanding.
- That the task force representatives meet with ACOG members for the purpose of information sharing, prevention of misconceptions and promotion of transparency.

#### **A. Data Collection Recommendations**

- The Hawai'i State Legislature rely on verifiable collected data rather than anecdotal opinions when making important legislative decisions. *(See Appendix 1, Home Birth Data)*
- Continued home birth data collection by DOH and HIHBC for the purpose of building trust and increased understanding. The task force recognizes the need to facilitate a safe environment for data to be shared without fear of persecution.
- DOH Vital Records consider additional fields to obtain data regarding maternal transports from home births, reasons for transport and any maternal/fetal/infant intrapartum and postpartum mortality outcomes.
- Further research be conducted regarding causes and/or contributing factors for fetal/infant mortality and morbidity relating to transports from an intended home birth;
- Further research be conducted regarding the increase in the use of hospital procedures which may contribute to maternal/fetal/infant morbidity and mortality.

***The task force by consensus also recommends the following. Consensus means the numerical majority of 12 mandated task force members, but does not mean that all members agreed:***

#### **B. Education and Training of Direct Entry Midwives**

In the area of education and training of direct entry midwives, the task force finds that concerns regarding lack of access to the certification required to attain licensure can be addressed by making the following amendments to Act 32:

- "For Certified Professional Midwives, proof of a successful completion of a midwifery education and training program that is either:
  1. An educational program or pathway accredited by the Midwifery Education Accreditation Council; or
  2. A midwifery bridge certificate issued by the North American Registry of Midwives for Certified Professional Midwife applicants who either



obtained certification (~~before January 1, 2020~~) through a non-accredited pathway, or who have maintained licensure in a state that does not require accredited education.”

- The majority of the task force members recommend changing the definition of “qualified midwife preceptor” to read: “means an (~~licensed~~) exempt or licensed and experienced midwife, or other maternal health professional licensed in the State, who participates in the clinical education of **midwives**. Repeal date for exempt category of birth attendants of July 1, 2023 be changed to June 30, 2025 in alignment with the repeal date of Act 32.
- The task force recommends the current exemption for student midwives be changed to:  
“Student midwife” who is studying midwifery through self-study, apprenticeship, or enrollment in a midwifery education program under the direct supervision of a midwife preceptor.

#### **C. Birth Attendant Defined Pursuant Act 32**

- Act 32 exempts birth attendants from licensure for a three-year period, to allow this community to define themselves and develop common standards, accountability measures and disclosure requirements. The Registered Traditional Community Midwife and the Traditional Cultural Midwife are these exempt birth attendants. Based on the findings in data, precedence, national and global education and training, the majority of the task force recommends replacing “birth attendants” with “traditional midwives” and that the exemption date of July 1, 2023 be extended to match the repeal date of Act 32 of, June 30, 2025.

#### **D. Traditional Midwife Recommendation**

- The majority of the task force recommends exemption from licensing requirements for Traditional Midwives in accordance with United Nations Declaration on the Rights of Indigenous People (UNDRIP) and United Nations Universal Declaration of Human Rights (UDHR). Exemptions for traditional midwives exist in Maine, Oregon, Utah, Washington, Ontario and Quebec. (*See Appendix 3, Traditional Cultural Midwife and Appendices 2 & 5, Registered Traditional Community Midwife & Hawai'i Home Birth Collective Forms*).

#### **E. Training and Access to Emergency Drugs**

- The task force recommends further discussion and investigation into providing education for and allowing access to the following legend drugs and devices for all midwives/birth attendants who are exempt under subsection -6 Exemptions, of Act 32 in order to “Provide access to evidence-based skilled emergency

treatment for life-threatening complications.” (see Appendix 4, Training and Access to Emergency Drugs and Devices)

- Antihemorrhagic medications recommended based on The WHO guidelines which state:

**Oxytocin (10 IU, IV/IM) is the recommended uterotonic drug recommended for the prevention of postpartum hemorrhage ALL births. In settings where skilled birth attendants are not present, the administration by community health care workers and lay health workers is recommended.** (see Appendix 4, Training and Access to Emergency Drugs and Devices)

- Oxygen necessary for proper execution of neonatal resuscitation per American Academy of Pediatrics guidelines. (see Appendix 4, Training and Access to Emergency Drugs and Devices)
- Intravenous fluids to stabilize a laboring or recently delivered person while awaiting EMS for transport.
- Rho (D) immune globulin to protect those with negative blood types from sensitization per ACOG and NIH guidelines. (see Appendix 4, Training and Access to Emergency Drugs and Devices)
- Neonatal eye prophylaxis to prevent injury to the eyesight of newborns per the guidelines set by the American Academy of Pediatrics. (see Appendix 4, Training and Access to Emergency Drugs and Devices)
- Injectable Vitamin K to prevent bleeding disorders in the newborn per the guidelines set by the American Academy of Pediatrics. (see Appendix 4, Training and Access to Emergency Drugs and Devices)
- Local anesthetic without epinephrine for use during repair of simple perineal lacerations. (see Appendix 4, Training and Access to Emergency Drugs and Devices)

## VI. ADDITIONAL RECOMMENDATIONS

***The task force by consensus recommends the following. Consensus means the numerical majority of 12 mandated task force members, but does not mean that all members agreed.***

- A. The International Confederation of Midwives, and US MERA language, definitions, and standards should **not** be used for the purpose of regulating, defining, or establishing the scope of practice for direct entry midwives in Act 32.
- B. Removing the word “midwife” from Act 32, subsection -5 License required: Beginning July 1, 2020, except as provided in this chapter, no person shall engage in the practice of midwifery, or use the title “~~midwife~~”, “licensed midwife” or the abbreviation “L.M.”, or any other words, letters, or insignia indicating or implying that the person is a licensed midwife without a valid license issued pursuant to this chapter. The task force reached unanimous agreement that traditional midwives do exist in Hawai‘i, and are in demand in the community, and that other states recognize them as exempt midwives and have created pathways for them to continue to practice without licensure.
- C. The Advisory Committee of Midwives as enacted in Act 32, number (5), subsection -4 Powers and duties of the director, also include representatives from: Registered Traditional Community Midwives (RCM), and Traditional Cultural Midwives (TCM). The task force proposes amending the current language as follows:
- (5) Appoint an advisory committee to assist with the implementation of this chapter and the rules adopted pursuant thereto. The advisory committee shall consist of the following:
- (a) Four licensed midwives who are: 2 Certified Professional Midwives and 2 certified midwives and who work exclusively in the community birth setting; if there are not enough midwives available from one category (either CPM or CM), the positions can be filled from the other category.
- (b) Two members of the public who have been consumers of home birth within the state of Hawai‘i;
- ~~(c) a certified nurse midwife~~
- (c) One traditional Hawaiian healer as defined in Act 32.
- (d) One traditional midwife who works exclusively in the community birth setting.
- D. Addition of the following definition; **“Traditional Midwife”** means an autonomous birth attendant who has acquired the skills to care for pregnant people, babies, and their families throughout pregnancy, birth, and postpartum through a spiritual and/or cultural lineage, and/ or who provides care to indigenous persons or members of an indigenous community in accordance with the United Nations Declaration on the Rights of Indigenous People, and/ or who, for religious, personal, and/or philosophical reasons chooses not to become certified or licensed.
- E. Addition of the following definition; **“Midwives Model of Care”** means monitoring the physical, psychological, and social well-being of a birthing parent throughout the childbearing cycle, providing them with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support; minimizing technological interventions; and referring birthing persons who require obstetrical attention

- F. Replace the definition of the word “Midwife” under subsection -2 Definitions, of Act 32 with: **“Licensed Midwife”** means a person licensed under this chapter.
- G. The task force dissolution date of June 30, 2020, be extended to June 30, 2021 to allow for adequate consideration of on-going issues relating to regulating direct entry midwives and home birth as assigned in part II, section 8 of Act 32.

## VII. CONCLUSION

In summary, this report reflects the discussion of a task force of diverse stakeholders with a shared interest in safe access to birth for all women in Hawai'i, especially rural women and those who wish to adhere to traditional practices of care. Hawai'i should make a commitment that all women, especially those in geographically isolated, rural areas without licensed practitioners, have access to safe, skilled assistance during childbirth. Further, to honor and perpetuate the unique cultural diversity of Hawai'i, the state should commit to allow for culturally sensitive, traditional and customary-rooted birth practices for women of all ethno-national backgrounds.

## **APPENDICES**

Appendix 1 – Homebirth Data

Appendix 2 – Registered Traditional Community Midwife

Appendix 3 – Traditional Cultural Midwife

Appendix 4 – Training and Access to Emergency Drugs and Devices

Appendix 5 – Hawai`i Home Birth Collective Forms for Midwife Registration

Appendix 6 – Comments by Task Force Members and the Public

Appendix 7 – Act 32, SLH 2019