Appendix 1 - HomeBirth Data

CERTIFICATE OF LIVE BIRTH WORKSHEET (Hawaii 2014)

LOCAL FILE NO. BIRTH NUMBER:

CHILD

1. CHILD'S NAME (First, Middle, Last, Suffix) | 2. TIME OF BIRTH (24 hr) | 3. SEX | 4. DATE OF BIRTH (Mo/Day/Yr)

5. FACILITY NAME (If not institution, give street and number) | 6. CITY, TOWN, OR LOCATION OF BIRTH | 7. COUNTY OF BIRTH

MOTHER

8a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix) | 8b. DATE OF BIRTH (Mo/Day/Yr)

8c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix) | 8d. BIRTHPLACE (State, Territory, or Foreign Country)

9a. RESIDENCE OF MOTHER-STATE | 9b. COUNTY | 9c. CITY, TOWN, OR LOCATION

9d. STREET AND NUMBER | 9e. APT. NO. | 9f. ZIP CODE | 9g. INSIDE CITY LIMITS? ☐ Yes ☐ No

FATHER

10a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix) | 10b. DATE OF BIRTH (Mo/Day/Yr) | 10c. BIRTHPLACE (State, Territory, or Foreign Country)

CERTIFIER

11. CERTIFIER'S NAME: _____

TITLE: ☐ MD ☐ DO ☐ HOSPITAL ADMIN. ☐ CNM/CM ☐ OTHER MIDWIFE ☐ OTHER (Specify)_____

12. DATE CERTIFIED _____ / _____ / _____ (MM / DD / YYYY)

13. DATE FILED BY REGISTRAR _____ / _____ / _____ (MM / DD / YYYY)

INFORMATION FOR ADMINSTRATIVE USE

MOTHER

14. MOTHER'S MAILING ADDRESS: ☐ Same as residence, or: State: City, Town, or Location:

Street & Number: Apartment No.: Zip Code:

19b. Publish Child's Name: Y/N ____

15. MOTHER MARRIED? (At birth, conception, or any time between) ☐ Yes ☐ No
IF NO, HAS PATERNITY ACKNOWLEDGEMENT BEEN SIGNED IN THE HOSPITAL? ☐ Yes ☐ No

16. SOCIAL SECURITY NUMBER REQUESTED FOR CHILD? ☐ Yes ☐ No

17. FACILITY ID. (NPI)

18. MOTHER'S SOCIAL SECURITY NUMBER | 19. FATHER'S SOCIAL SECURITY NUMBER:

INFORMATION FOR MEDICAL AND HEALTH PURPOSES ONLY

MOTHER

20. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)

- ☐ 8th grade or less
- ☐ 9th - 12th grade, no diploma
- ☐ High school graduate or GED completed
- ☐ Some college credit but no degree
- ☐ Associate degree (e.g., AA, AS)
- ☐ Bachelor's degree (e.g., BA, AB, BS)
- ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

21. MOTHER'S RACE Specify (Caucasian, Japanese, etc.)

_____

_____

_____

_____

_____

(Please spell out and list all races)

22. MOTHER OF HISPANIC ORIGIN? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina)

- ☐ No, not Spanish/Hispanic/Latina
- ☐ Yes, Mexican, Mexican American, Chicana
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latina

(Specify)_____

EMAIL ADDRESS

PHONE NUMBER

FATHER

23. FATHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)

- ☐ 8th grade or less
- ☐ 9th - 12th grade, no diploma
- ☐ High school graduate or GED completed
- ☐ Some college credit but no degree
- ☐ Associate degree (e.g., AA, AS)
- ☐ Bachelor's degree (e.g., BA, AB, BS)
- ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

24. FATHER'S RACE Specify (Caucasian, Japanese, etc.)

_____

_____

_____

_____

_____

(Please spell out and list all races)

25. FATHER OF HISPANIC ORIGIN? (Check the box that best describes whether the father is Spanish/Hispanic/Latina. Check the "No" box if father is not Spanish/Hispanic/Latina)

- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino

(Specify)_____

MOTHER'S NAME

MOTHER'S MEDICAL RECORD NO.

26. PLACE WHERE BIRTH OCCURRED (Check one)

- ☐ Hospital
- ☐ Freestanding birthing center
- ☐ Home Birth: Planned to deliver at home? ☐ Yes ☐ No
- ☐ Clinic ☐ Doctor's office
- ☐ Other (Specify)_____

27. ATTENDANT'S NAME, TITLE, AND NPI

NAME: _____ NPI: _____

TITLE: ☐ MD ☐ DO ☐ CNM/CM ☐ OTHER MIDWIFE ☐ OTHER (Specify)_____

28. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? ☐ Yes ☐ No
IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM:

_____

REV. 1/2014 DOH 2014

MOTHER

29a. DATE OF FIRST PRENATAL CARE VISIT
____ / ____ / ____ ☐ No Prenatal Care
MM DD YYYY

29b. DATE OF LAST PRENATAL CARE VISIT
____ / ____ / ____
MM DD YYYY

30. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY
____ (If none, enter "0".)

31. MOTHER'S HEIGHT
____ (feet/inches)

32. MOTHER'S PREPREGNANCY WEIGHT
____ (pounds)

33. MOTHER'S WEIGHT AT DELIVERY
____ (pounds)

34. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? ☐ Yes ☐ No

35. NUMBER OF PREVIOUS LIVE BIRTHS (Do not include this child)

35a. Now Living
Number____
☐ None

35b. Now Dead
Number____
☐ None

36. NUMBER OF OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies)

36a. Spontaneous or ectopic
Number ____
☐ None

36b. Induced
Number ____
☐ None

37. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY
For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. IF NONE, ENTER "0".
Average number of cigarettes or packs of cigarettes smoked per day.

	# of cigarettes		# of packs
Three Months Before Pregnancy	____	OR	____
First Three Months of Pregnancy	____	OR	____
Second Three Months of Pregnancy	____	OR	____
Third Trimester of Pregnancy	____	OR	____

38. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY
☐ Private Insurance
☐ Medicaid or Quest
☐ Self-pay
☐ Tricare or Military Insurance
☐ Other
(Specify) ____

35c. DATE OF LAST LIVE BIRTH
____ / ____ / ____
MM DD Y Y Y Y

36c. DATE OF LAST OTHER PREGNANCY OUTCOME
____ / ____ / ____
MM DD Y Y Y Y

39. DATE LAST NORMAL MENSES BEGAN
____ / ____ / ____
MM DD YYYY

40. MOTHER'S MEDICAL RECORD NUMBER

MEDICAL AND HEALTH INFORMATION

41. RISK FACTORS IN THIS PREGNANCY (Check all that apply)

Diabetes
☐ Prepregnancy (Diagnosis prior to this pregnancy)
☐ Gestational (Diagnosis in this pregnancy)

Hypertension
☐ Prepregnancy (Chronic)
☐ Gestational (PIH, preeclampsia)
☐ Eclampsia

☐ Previous preterm birth

☐ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)

☐ Pregnancy resulted from infertility treatment-If yes, check all that apply:
☐ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
☐ Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))

☐ Mother had a previous cesarean delivery
If yes, how many ____

☐ None of the above

42. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)
☐ Gonorrhea
☐ Syphilis
☐ Chlamydia
☐ Hepatitis B
☐ Hepatitis C
☐ None of the above

43. OBSTETRIC PROCEDURES (Check all that apply)
☐ Cervical cerclage
☐ Tocolysis

External cephalic version:
☐ Successful
☐ Failed

☐ None of the above

44. ONSET OF LABOR (Check all that apply)
☐ Premature Rupture of the Membranes (prolonged, >=12 hrs.)
☐ Precipitous Labor (<3 hrs.)
☐ Prolonged Labor (>= 20 hrs.)
☐ None of the above

45. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)
☐ Induction of labor
☐ Augmentation of labor
☐ Non-vertex presentation
☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
☐ Antibiotics received by the mother during labor
☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature >=38°C (100.4°F)
☐ Moderate/heavy meconium staining of the amniotic fluid
☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
☐ Epidural or spinal anesthesia during labor
☐ None of the above

46. METHOD OF DELIVERY
A. Was delivery with forceps attempted but unsuccessful?
☐ Yes ☐ No
B. Was delivery with vacuum extraction attempted but unsuccessful?
☐ Yes ☐ No
C. Fetal presentation at birth
☐ Cephalic
☐ Breech
☐ Other
D. Final route and method of delivery (Check one)
☐ Vaginal/Spontaneous
☐ Vaginal/Forceps
☐ Vaginal/Vacuum
☐ Cesarean
If cesarean, was a trial of labor attempted?
☐ Yes
☐ No

47. MATERNAL MORBIDITY (Check all that apply) (Complications associated with labor and delivery)
☐ Maternal transfusion
☐ Third or fourth degree perineal laceration
☐ Ruptured uterus
☐ Unplanned hysterectomy
☐ Admission to intensive care unit
☐ Unplanned operating room procedure following delivery
☐ None of the above

NEWBORN INFORMATION

NEWBORN

48. NEWBORN MEDICAL RECORD NUMBER

49. BIRTHWEIGHT (grams preferred, specify unit)
____
☐ grams ☐ lb/oz

50. OBSTETRIC ESTIMATE OF GESTATION:
____ (completed weeks)

51. APGAR SCORE:
Score at 5 minutes: ____
If 5 minute score is less than 6,
Score at 10 minutes: ____

52. PLURALITY - Single, Twin, Triplet, etc.
(Specify)____

53. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify)
____

54. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)
☐ Assisted ventilation required immediately following delivery
☐ Assisted ventilation required for more than six hours
☐ NICU admission
☐ Newborn given surfactant replacement therapy
☐ Antibiotics received by the newborn for suspected neonatal sepsis
☐ Seizure or serious neurologic dysfunction
☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)
☐ None of the above

55. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)
☐ Anencephaly
☐ Meningomyelocele/Spina bifida
☐ Cyanotic congenital heart disease
☐ Congenital diaphragmatic hernia
☐ Omphalocele
☐ Gastroschisis
☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
☐ Cleft Lip with or without Cleft Palate
☐ Cleft Palate alone
☐ Down Syndrome
☐ Karyotype confirmed
☐ Karyotype pending
☐ Suspected chromosomal disorder
☐ Karyotype confirmed
☐ Karyotype pending
☐ Hypospadias
☐ None of the anomalies listed above

56. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? ☐ Yes ☐ No
IF YES, NAME OF FACILITY INFANT TRANSFERRED TO:
____

57. IS INFANT LIVING AT TIME OF REPORT?
☐ Yes
☐ No
☐ Infant transferred, status unknown

58. IS THE INFANT BEING BREASTFED AT DISCHARGE?
☐ Yes ☐ No

MOTHER'S NAME

MOTHER'S MEDICAL RECORD NO.

Journal of Midwifery & Women's Health www.jmwh.org
Original Research

Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009

Melissa Cheyney, PhD, CPM, LDM, Marit Bovbjerg, PhD, MS, Courtney Everson, MA, Wendy Gordon, MPH, CPM, LM, Darcy Hannibal, PhD, Saraswathi Vedam, CNM, MSN, RM

Introduction: Between 2004 and 2010, the number of home births in the United States rose by 41%, increasing the need for accurate assessment of the safety of planned home birth. This study examines outcomes of planned home births in the United States between 2004 and 2009.

Methods: We calculated descriptive statistics for maternal demographics, antenatal risk profiles, procedures, and outcomes of planned home births in the Midwives Alliance of North American Statistics Project (MANA Stats) 2.0 data registry. Data were analyzed according to intended and actual place of birth.

Results: Among 16,924 women who planned home births at the onset of labor, 89.1% gave birth at home. The majority of intrapartum transfers were for failure to progress, and only 4.5% of the total sample required oxytocin augmentation and/or epidural analgesia. The rates of spontaneous vaginal birth, assisted vaginal birth, and cesarean were 93.6%, 1.2%, and 5.2%, respectively. Of the 1054 women who attempted a vaginal birth after cesarean, 87% were successful. Low Apgar scores (< 7) occurred in 1.5% of newborns. Postpartum maternal (1.5%) and neonatal (0.9%) transfers were infrequent. The majority (86%) of newborns were exclusively breastfeeding at 6 weeks of age. Excluding lethal anomalies, the intrapartum, early neonatal, and late neonatal mortality rates were 1.30, 0.41, and 0.35 per 1000, respectively.

Discussion: For this large cohort of women who planned midwife-led home births in the United States, outcomes are congruent with the best available data from population-based, observational studies that evaluated outcomes by intended place of birth and perinatal risk factors. Low-risk women in this cohort experienced high rates of physiologic birth and low rates of intervention without an increase in adverse outcomes.
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Keywords: birth place, home childbirth, midwife, midwifery, perinatal outcome, pregnancy outcomes

INTRODUCTION

In the United States, approximately 1% of all births occur in homes and birth centers, and these births are attended primarily by direct-entry midwives (DEMs), including certified professional midwives (CPMs).[1] Of the 1.18% of US births occurring outside of the hospital in 2010, approximately 66% (31,500) were home births. Although a small proportion of total births in the United States, home births are on the rise. After a steady decline between 1990 and 2004, home births increased by 41% between 2004 and 2010, up from 0.56% to 0.79%, with 10% of this increase occurring between 2009 and 2010.[1] By comparison, in Great Britain and the Netherlands 8% and 29% of women, respectively, give birth outside of an obstetric unit.[2,3]

Data on outcomes from planned home births in the United States have not been reported in the peer-reviewed literature since 2005,[4] when Johnson and Daviss described outcomes for 5418 home births attended by CPMs in 2000. In 2004, the Midwives Alliance of North American (MANA) division of research developed a Web-based data collection system (the MANA Statistics Project [MANA Stats]) for the purpose of collecting information on a large, multiyear, voluntary sample of midwife-led births occurring primarily at home and in birth centers within the United States.[5] This study describes outcomes from planned home births recorded in the MANA Stats database (version 2.0) from 2004 to 2009.

BACKGROUND

A complete understanding of the safety of planned home and birth center birth is difficult to achieve. To date, universal perinatal data are only available in the United States through birth certificates, which are unreliable with respect to information on the intended and the actual place of birth.[6–8] Until recently, high-quality data comparing outcomes by birth setting were not available because many published studies failed to reliably distinguish among intended and actual place of birth, type of attendant, and maternal risk profiles. Despite attempts to design a randomized controlled trial, sufficient numbers of women have not consented to be randomized according to birth site.[9]

In 2009, 3 well-designed, population-based cohort studies were published comparing planned home births to planned hospital births with professional midwives as attendants. In the first study, de Jonge and colleagues[10] used a national dataset (N = 529,688) of low-risk pregnancies in the Netherlands to compare perinatal mortality and morbidity outcomes for planned home (60.7%) and hospital births (30.8%) between 2000 and 2006. There were no significant differences in intrapartum death, neonatal death within 24 hours or 7 days

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Quick Points

- This study reports maternal and neonatal outcomes for women planning to give birth at home under midwife-led care, as recorded in the Midwives Alliance of North America Statistics Project dataset (version 2.0, birth years 2004-2009).
- Among 16,924 women planning a home birth at the onset of labor, 94% had a vaginal birth, and fewer than 5% required oxytocin augmentation or epidural analgesia.
- Eleven percent of women who went into labor intending to give birth at home transferred to the hospital during labor; failure to progress was the primary reason for intrapartum transfer.
- Nearly 1100 women attempted a vaginal birth after cesarean (VBAC) in this sample, with a total VBAC success rate of 87%.
- Rates of cesarean, low 5-minute Apgar score (< 7), intact perineum, breastfeeding, and intrapartum and early neonatal mortality for this sample are all consistent with reported outcomes from the best available population-based, observational studies of planned home births.

after birth, or rates of neonatal intensive care unit (NICU) admissions.

The second study, a prospective, 5-year (2000-2004) matched cohort study in British Columbia, compared outcomes for low-risk women in a midwife-attended planned home birth group (n = 2889), a physician-attended hospital birth group (n = 5331), and a midwife-attended planned hospital birth group (n = 4752).[11] In this intention-to-treat analysis, women in the planned home birth group had significantly fewer intrapartum interventions, including narcotic or epidural analgesia, augmentation or induction of labor, and assisted vaginal or caesarean birth—as well as significantly fewer adverse outcomes, including postpartum hemorrhage, and third- or fourth-degree lacerations. No significant differences were found between the home birth group and either comparison group with respect to the diagnosis of asphyxia at birth, seizures, need for assisted ventilation beyond the first 24 hours of life, or low 5-minute Apgar scores (< 7).

The third study analyzed data from the Ontario Ministry of Health Midwifery Program database to compare outcomes of all women planning home births between 2003 and 2006 (n = 6692) with a matched sample of women planning a hospital birth (n = 6692).[12] The primary outcome reported was a composite measure of perinatal and neonatal mortality or serious morbidity that included stillbirth or neonatal death at 0 to 27 days (excluding lethal anomalies), very low Apgar score (<4) at 5 minutes, neonatal resuscitation requiring both positive pressure ventilations and cardiac compressions, birth weight less than 2500 g, or admission to a neonatal or pediatric intensive care unit with a length of stay greater than 4 days. No differences were found between groups for perinatal and neonatal composite outcome measures (2.4% vs 2.8%; relative risk [RR] 0.84; 95% confidence interval [CI], 0.68-1.03). All measures of maternal morbidity were lower in the planned home birth group, as were rates for all obstetric interventions including cesarean (5.2% vs 8.1%; RR 0.64; 95% CI, 0.56-0.73).

Subsequently, in 2011 the Birthplace in England Collaborative Group reported findings from a prospective study of 64,538 births among low-risk women in England.[2,13] Investigators concluded that for healthy women, adverse maternal and newborn outcomes were extremely rare, regardless of birth setting. Planned home birth was associated with significantly fewer interventions, higher maternal satisfaction, and increased cost-effectiveness compared to birth in a hospital obstetric unit.[13] Most recently, Stapleton and colleagues[14] described outcomes from births attended by certified nurse-midwives (CNMs), licensed midwives (LMs), and CPMs that occurred in birth centers in the United States. These data were collected through the Uniform Data Set (UDS), a Web-based tool developed by the American Association of Birth Centers (AABC) for use in member centers. This National Birth Center Study II reported excellent outcomes and reduced interventions as a result of midwifery-led care in birth centers.

Olsen and Clausen,[15] in their 2012 Cochrane systematic review, suggest that while evidence from randomized controlled trials sufficiently powered to assess differences in perinatal mortality by birth site may never be available, the balance of evidence from large well-designed observational studies supports informed choice of birth place in jurisdictions where integrated maternity systems exist. However, some have suggested that these outcomes are not generalizable to the United States because there currently is no integrated maternity care system with clear communication between birth settings and across provider types.[16,17] Rising rates of home and birth center births, in the absence of a unified, national policy on choice and interprofessional collaboration across birth settings, are a major concern.[18] In addition, without established systems for universal maternity care data collection, it is difficult to evaluate the quality and safety of care across birth settings and by multiple provider types. The establishment of reliable and inclusive tools for US-based perinatal data collection has become a priority.

METHODS

Data Collection

Data were collected between 2004 and 2009 using the MANA Stats 2.0 Web-based data collection tool, which was developed by the MANA Division of Research in 2004 in accordance with the Agency for Healthcare Research and Quality guidelines.[19] Participation in the project was voluntary, with an estimated 20% to 30% of active CPMs and a substantially lower proportion of CNMs contributing.[5] Midwife participants obtained written informed consent from all clients at the onset of care, and only data from women who consented were included in the research dataset. More than 95% of women

consented to be included,[5] a high rate of participation that has been observed in other studies involving this population.[4,14] All analyses presented here were approved by the institutional review board at Oregon State University.

The MANA Stats 2.0 online form collected data on nearly 200 variables, including demographic characteristics of participating women and families; pregnancy history as well as general health and social histories; antepartum, intrapartum, neonatal, and postpartum events and procedures; and maternal and newborn outcomes. Data were also collected on antepartum, intrapartum, and postpartum maternal and neonatal transfers, as well as on intended and actual place of birth. The data collection design for MANA Stats includes preregistration, or prospective logging, of all clients at the start of care, before outcomes are known. Midwife contributors complete the Web-based form over the course of care through the 6-week postpartum visit, or the final visit if earlier. Data are stored on a secure server with encryption software congruent with privacy and security measures for protected health information, as defined by the United States Department of Health and Human Services.[20,21] Upon enrollment in the project, midwife contributors are provided with detailed instructions on the use of the online data collection tool; and data collection support team members, known as data doulas, provide e-mail and phone support to all contributors.

All courses of care reported here were submitted by midwives using the 2.0 form. These records were subjected to 3 postsubmission review processes, described in detail elsewhere.[5] All data forms indicating maternal, fetal, or newborn deaths also underwent detailed case review using a modified fetal-infant mortality review approach.[22,23] Analysis of pre- and postreviewed variables during quality testing evidenced near perfect agreement, suggesting that MANA Stats 2.0 data were entered with a high degree of accuracy by midwives.[5] Thus, any errors in the dataset are likely random rather than systematic. For a detailed analysis of the history, methodology, and validity of the MANA Stats 2.0 data collection tool, see Cheyney et al.[5]

Inclusion Criteria

The complete November 2004 through December 2009 MANA Stats 2.0 dataset (N = 24,848) includes records from all women receiving at least some prenatal care from contributor midwives. For the purposes of this analysis, we excluded women who transferred care to another provider prior to the onset of labor, women who at the onset of labor had a planned birth location other than home, and women who did not live in the United States. Thus, our final sample for this analysis consisted of all planned home births (N = 16,924).

Data Export and Analysis

All data from the 2.0 dataset were exported from the structured query language-based online data collection system as a comma-separated value (*.csv) file and then imported into SPSS Statistics[24] for analysis. Our main analyses, in keeping with the descriptive objective of this study, consisted of calculating basic frequencies, measures of central tendency, measures of variance, and confidence intervals as indicated.

Throughout the analyses, we were careful to limit the denominators to those women and newborns at risk for the outcome. For instance, for all demographic characteristics, obstetric history, and pregnancy complication data, as well as the intrapartum transfers, the denominator is women who went into labor intending to give birth at home. For most perinatal outcomes, the denominator is newborns—removing those no longer at risk. For instance, the denominator for low Apgar score (< 7) is liveborn newborns. There are 2 exceptions: neonatal transfers and postpartum transfers are reported among the entire sample of neonates/women, as well as among only those who gave birth at home, thus excluding intrapartum transfers. The second method is technically correct. Mother–newborn dyads transferred during the intrapartum period are not at risk of postpartum or neonatal transfer. However, because the reporting of these variables is not consistent in the literature,[14,25] we report both values to allow for comparison with as many other studies as possible. In addition, in keeping with standards for reporting results from observational studies,[26] we have included the actual denominators (ie, the theoretical denominator of women, or liveborn newborns, minus participants missing data for that variable) as well as 95% CIs, as relevant.

RESULTS

Contributing Midwives

Data were contributed by 432 different midwives, including CPMs/LMs/LDMs, CNMs/CMs, naturopathic midwives, unlicensed direct-entry midwives, and others (Table 1). The majority of births in the sample were attended by CPMs (79.2%).

Demographic Characteristics

The final sample included 16,924 women and 16,984 newborns (Figure 1). Complete demographic characteristics for the sample are reported in Table 2. Briefly, most women in this sample were white, college-educated, and married. Of note, greater than 6% of the sample was identified by their midwife as Amish or Mennonite. Although midwives in all states are eligible to contribute data to MANA Stats, the 2.0 home birth cohort comes disproportionately from the Western United States. Almost two-thirds of the women in this sample paid for midwifery care out-of-pocket, either because their insurance did not cover home birth, their midwife did not provide insurance billing, or because they were uninsured.

Antenatal Risk Status

Antenatal risk profiles of the women are presented in Table 2. Twenty-two percent of the sample was nulliparous, and 9.2% of multiparous women were grand multiparas (≥ 5 previous births after 20 weeks' gestation). Of the parous women, 8.0% had a history of previous cesarean. Most women began their pregnancies with a normal (18.5-25 kg/m^2) body mass index (BMI).

Very few of the pregnancies in our sample were complicated by maternal comorbidities, including hypertensive

Table 1. Midwife Credentials and Number of Births Attended for 16,984 Planned Home Births

Category	Number of Midwives With This Credential	Total Number of Births Attended by This Type of Midwife	Median (range) Number of Births Contributed by Individual Midwives of This Type During the Entire 62-month Study Period
CPM/LM/LDM	320	13,400	239 (4-880)
CNM/CM	44	1595	457 (108-800)
Both[a] CPM and CNM	16	1018	260 (7-721)
Neither[b]	52	971	287 (18-884)

Abbreviations: CM, certified midwife; CNM, certified nurse-midwife; CPM, certified professional midwife; LDM, licensed direct-entry midwife; LM, licensed midwife.
[a]These 16 practitioners held both a CPM and CNM credential.
[b]Neither a CPM, LM, LDM, CNM, and/or CM. This category includes direct-entry midwives without licensure or certification; "other" providers, which is a heterogeneous category containing students, naturopathic doctors, and doctors of osteopathy; and "missing," where the credential is unknown.

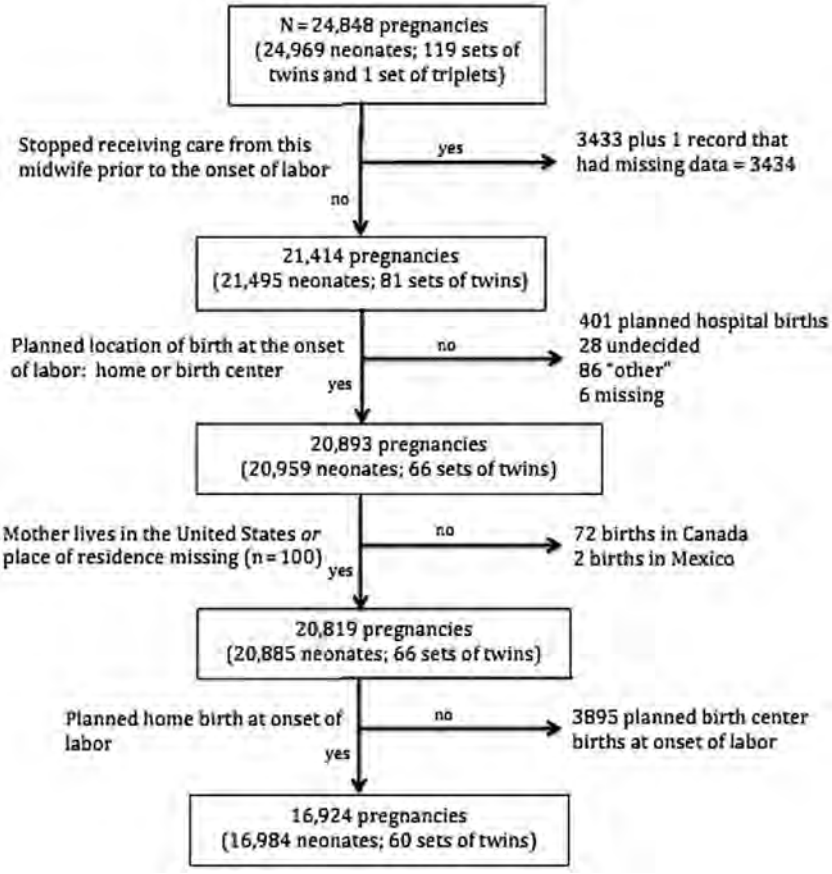

Figure 1. Sample Size Delimitation
Delimitation begins with all records entered into the Midwives Alliance of North America Statistics Project (MANA Stats) using the 2.0 data form (birth years 2004- 2009). Final analyses are limited to women who planned home birth at onset of labor (N = 16,924).

disorders, gestational diabetes mellitus (GDM), persistent anemia (defined as hematocrit <30 or hemoglobin <10 g/dL), or Rh sensitization. Because the 2.0 version form was not designed to collect data on collaborative care, it is impossible to determine exactly when these complications developed or how many women were co-managed with a physician. Of the 168 women with GDM, preeclampsia, eclampsia, or Rh sensitization, 74 had at least one prenatal visit with an obstetrician, and 47 had at least 3 prenatal visits with an obstetrician (an additional 33 women did not have data on obstetrician visits). In addition, of the 50 women with multiple gestations who had complete data on visits with other providers, 22 saw an obstetrician prenatally at least once, and 13 saw an obstetrician at least 3 times.

Mode of Birth

The spontaneous vaginal birth rate for the sample was 93.6%. The rate of vacuum or forceps-assisted vaginal birth was 1.2%. The overall cesarean rate was 5.2%, and most of these were primary cesareans (84.4%). Our sample included 1054 women with a history of cesarean, and these women had a vaginal

Table 2. Demographic Characteristics, Obstetric History, and Pregnancy Complications for 16,924 Women in the MANA Stats 2.0 Sample who Planned Home Births

Characteristics	
Race/Ethnicity,[a,b] n (%)	
White	15,614 (92.3)
Black	361 (2.1)
Latina	714 (4.2)
Asian/Pacific Islander	760 (4.5)
Native American	163 (1.0)
Other	145 (0.9)
Belongs to Amish, Mennonite, or other Plain church, n (%)	1098 (6.5)
Age at first prenatal visit, mean (SD), y	30.3 (5.3)
Education, n (%)	
High school graduate[c]	15,283 (92.4)
Completed ≥ 4 years of college[d]	8300 (58.0)
Marital status,[e] n (%)	
Married	14,961 (88.4)
Unmarried with a partner	1579 (9.3)
Single (includes separated, divorced)	331 (2.0)
Other	51 (0.3)
MANA region of residence,[f] n (%)	
Region 1: New England (CT, MA, ME, NH, RI, VT)	873 (5.2)
Region 2: North Atlantic (DC, DE, NJ, NY, MD, PA)	1992 (11.8)
Region 3: Southeast (AL, AR, FL, GA, LA, MS, NC, KY, SC, TN, VA, WV)	2054 (12.2)
Region 4: Midwest (IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, WI)	2646 (15.6)
Region 5: West (AZ, CO, ID, MT, NM, NV, OK, TX, UT, WY)	3949 (23.4)
Region 6: Pacific (AK, CA, HI, OR, WA)	5364 (31.8)
Method of payment,[g] n (%)	
Self-pay (does not necessarily mean uninsured)	10,888 (64.4)
Private insurance	4092 (24.2)
Government insurance (includes Medicaid, CHAMPUS)	1361 (8.0)
Other	576 (3.4)
Parity, n (%)	
Nulliparous	3773 (22.3)
Multiparous	13,150 (77.7)
Grand multiparous (≥ 5 pregnancies)[h]	1150 (9.2)
Trial of labor after cesarean[i]	1052 (8.0)
Normal BMI prepregnancy,[j] n (%)	11,144 (66.9)
Mother's pregravid BMI (kg/m^2),[k] median (IQR)	22.5 (20.6-25.7)
Complications/comorbid conditions affecting this pregnancy,[l] n (%)	
Chronic hypertension	59 (0.3)
Pregnancy-induced hypertension	243 (1.4)
Preeclampsia	29 (0.2)
Eclampsia	10 (0.1)
Gestational diabetes mellitus	132 (0.8)
Persistent anemia	146 (0.9)
Rh sensitization	41 (0.2)
Multiple gestation, n (%)	60 (0.4)
Breech presentation,[m] n (%)	222 (1.3)

Abbreviations: BMI, body mass index; CHAMPUS, Civilian Health and Medical Program of the Uniformed Services; IQR, interquartile range; MANA, Midwives Alliance of North America; SD, standard deviation.
[a]Midwife identified, categories are not mutually exclusive.
[b]Missing data for 14 women.
[c]Missing data for 390 women.
[d]Missing data for 970 women.
[e]Missing data for 2 women.
[f]Missing data for 46 women.
[g]Missing data for 7 women.
[h]Missing data for 606 women; percent calculated using multiparous women as the denominator.
[i]Missing data for 6 women.
[j]Missing data for 273 women.
[k]Missing data for 273 women.
[l]Missing data for one woman.
[m]Denominator is 16,984 neonates.

birth after cesarean (VBAC) success rate of 87.0%. Of the 915 successful VBACs, 94% were completed at home. A total of 222 newborns in a breech presentation were born vaginally (57.2%) or by cesarean (42.8%) (Table 3). Of the 127 breech neonates born vaginally, 92% were born at home.

Gestational Age and Birth Weight

Ninety-two percent of newborns were full-term, 2.5% were preterm, and 5.1% were postterm based on the midwife's clinical gestational age assessment following birth. The sample mean (SD) for live birth weight was 3651 g (488 g). The median birth weight was 3629 g (interquartile range, 3317 g-3969 g). Fewer than 1% of newborns were low birth weight (<2500 g), although almost one-quarter were macrosomic (> 4000 g) (Table 3).

Transfers

Intrapartum Transfers

Of the 16,924 women who began labor at home, 89.1% completed a home birth for an intrapartum transfer rate of 10.9%. Nulliparous women required transfer during labor 3 times as frequently as multiparous women (Table 4). The most common reason for transfer was failure to progress (n = 752, 40.7% of intrapartum transfers). Other reported reasons for

Table 3. Birth Outcomes for 16,984 Neonates with Planned Home Births in the MANA Stats 2.0 Sample

Outcome	n (%)
Mode of Birth[a]	
Spontaneous vaginal	15,876 (93.6)
Assisted vaginal (166 vacuum, 35 forceps)	201 (1.2)
Cesarean	887 (5.2)
If cesarean, was this birth a primary cesarean?[b]	
Yes	743 (84.4)
No	137 (15.6)
If this birth included a TOLAC, did mother have a vaginal birth?	
Yes	915 (87.0)
No	137 (13)
Breech presentation	
Vaginal birth	127 (57.2)
Cesarean	95 (42.8)
Gestational age of neonate[c]	
Preterm[d]	423 (2.5)
Postterm[e]	862 (5.1)
Birth weight[f]	
Low birth weight (<2500 g)	142 (0.8)
Macrosomic (> 4000g)	3817 (22.6)
5-minute Apgar score <7[g]	245 (1.5)
Any NICU admissions in the first 6 weeks[h]	479 (2.8)

Abbreviations: MANA, Midwives Alliance of North America; NICU, neonatal intensive care unit; TOLAC, trial of labor after cesarean.
[a]Missing data for 20 women.
[b]Missing data for 7 women.
[c]These data come from 2 questions on the 2.0 data entry form. The exact wording of the questions are: "Any clinical evidence that baby is preterm?" and "Any clinical evidence that baby is postterm?" Further instructions were not given to midwives.
[d]Missing data for 33 neonates.
[e]Missing data for 43 neonates.
[f]Missing data for 66 neonates.
[g]Missing data for 401 neonates.
[h]Missing data for 130 neonates.

Table 4. Intrapartum, Postpartum Maternal, and Neonatal Transfers with Key Outcomes Following Transfer[a]

Variable	n (%)	(95% CI)
Intrapartum transfer[b]	1850 (10.9)	(10.4-11.4)
Primiparous women (n = 3770)	864 (22.9)	(21.6-24.2)
Multiparous women (n = 13,143)	986 (7.5)	(7.0-8.0)
If intrapartum transfer		
Epidural analgesia[c]	1028 (56.1)	(53.8-58.4)
Oxytocin augmentation[d]	408 (22.0)	(20.1-23.9)
Vaginal birth[e]	984 (53.2)	(50.9-55.5)
5-minute Apgar score < 7[f]	69 (4.5)	(3.5-5.5)
NICU admission in the first 6 weeks[g]	167 (9.5)	(8.1-10.9)
Postpartum maternal transfer[h]	251 (1.5)	(1.3-1.7)
Neonatal transfer[i]	149 (0.9)	(0.7-1.1)
If neonatal transfer		
5-minute Apgar score < 7	66 (44.3)	(36.3-52.3)
NICU admission in the first 6 weeks[j]	109 (75.2)	(68.2-82.2)

Abbreviations: CI, confidence interval; NICU, neonatal intensive care unit.
[a]Denominators are 16,984 neonates or 16,924 mothers, unless otherwise indicated. Proportions are calculated for postpartum maternal and neonatal transfers using the entire sample (less missing) for the denominator, rather than limiting to mother/newborn dyads still at risk for transfer after birth, in order to be consistent with other literature in this field.
[b]Missing data for 11 women.
[c]Missing data for 18 women.
[d]Missing data for 1 woman.
[e]Missing data for 1 woman.
[f]Missing data for 329 women.
[g]Missing data for 93 women.
[h]Missing data for 91 women.
[i]Missing data for 128 newborns.
[j]Missing data for 4 neonates.

intrapartum transfer included desire for pain relief (n = 281, 15.2%), fetal distress or meconium (n = 185, 10.0%), malpresentation (n = 118, 6.4%), and maternal exhaustion (n = 98, 5.3%). When entering data, midwives could select more than one reason. Of the 1856 women who transferred to the hospital during labor, more than half gave birth vaginally (Table 4).

Postpartum Maternal Transfers

Postpartum maternal transfer occurred for 1.5% of women who went into labor intending to give birth at home and occurred for 1.7% of women who gave birth at home. Of the 251 women who were transferred after giving birth at home, 177 (70.5%) were transferred for complications related to hemorrhage and/or retained placenta, and 41 (16.3%) were transferred for a laceration repair. The remaining postpartum transfers were for a variety of reasons including abnormal maternal vital signs, hematoma, unassisted precipitous labor when parents called emergency medical services, or mother unable to void.

Neonatal Transfers

Neonatal transfer occurred for 0.9% (149/16,984) of all newborns whose mothers went into labor intending to give birth at home and occurred for 1.0% (149/15,134) of the newborns born at home. The majority of these 149 newborn transfers were for respiratory distress and/or Apgar scores below 7 (n = 116, 77.9%); an additional 9 newborns (6.0%) were transferred for evaluation of congenital anomalies.

Maternal Morbidity and Mortality

Of the 16,039 women who gave birth vaginally, 49.2% did so over an intact perineum; 1.4% had an episiotomy; 40.9% sustained a first- or second-degree perineal laceration; and 1.2% had a third- or fourth-degree perineal laceration. Labial lacerations or skin splits that did not require suturing occurred in 12.8% of the women, and 4.8% had more substantial labial lacerations that required suturing. Midwives could indicate more than one type or location of laceration. Of women who gave birth vaginally, 15.5% (n = 2426) lost greater than 500 mL of blood following birth, and 4.8% (n = 318) lost 1000 mL or greater. Of the women who lost greater than 500 mL of blood

after a vaginal birth, 51.4% were given oxytocin (n = 797), methergine (n = 132), or both (n = 317) to control bleeding.

There was one pregnancy-related maternal death in the sample. This multiparous mother had no antenatal or intrapartum risk factors. The newborn was born vaginally at home with Apgar scores of 8 and 9 at 5 and 10 minutes, respectively, and the postpartum course for mother and newborn was normal through the first 3 postpartum days. Death occurred at the mother's home on the third day postpartum in the afternoon, following a morning visit by the midwife during which all vital signs had been normal. A blood clot was found in the mother's heart during autopsy; the death was attributed to the pregnancy by the medical examiner.

Fetal and Neonatal Morbidity and Mortality

For all newborns in the sample (including those with congenital anomalies and regardless of actual location of birth), 1.5% (n = 245) had 5-minute Apgar scores below 7, and 0.6% (n = 97) had Apgar scores below 4. Of the 1850 newborns born in the hospital following an intrapartum transfer, 3.7% (n = 69) had a 5-minute Apgar score below 7. During the first 6 weeks postpartum, 479 (2.8%) newborns were admitted to the NICU (Tables 3 and 4).

The rate of intrapartum fetal death (occurring after the onset of labor, but prior to birth) was 1.30 per 1000. The rate of early neonatal death (death occurring after a live birth, but before 7 completed days of life) was 0.88 per 1000; and the rate of late neonatal death (death occurring at 7 to 27 completed days of life) was 0.41 per 1000. When lethal congenital anomaly-related deaths were excluded (n = 0 intrapartum, n = 8 early neonatal, n = 1 late neonatal), the rates of intrapartum death, early neonatal death, and late neonatal death were 1.30 per 1000 (n = 22), 0.41 per 1000 (n = 7), and 0.35 per 1000 (n = 6), respectively (Table 5).

Of the 22 fetuses who died after the onset of labor but prior to birth, 2 were attributed to intrauterine infections, 2 were attributed to placental abruption, 3 were attributed to cord accidents, 2 were attributed to complications from maternal GDM, one was attributed to meconium aspiration, one was attributed secondary to shoulder dystocia, one was attributed to preeclampsia-related complications, and one was attributed to autopsy-confirmed liver rupture and hypoxia. The causes of the remaining 9 intrapartum deaths were unknown. For the 7 newborns who died during the early neonatal period, 2 were secondary to cord accidents during birth (one with shoulder dystocia), and the remaining 5 were attributed to hypoxia or ischemia of unknown origin. Of the 6 newborns that died in the late neonatal period, 2 were secondary to cord accidents during birth, and the causes of the remaining 4 deaths were unknown.

When examining perinatal death rates among higher-risk women, the data suggest that compared to neonates born in vertex presentation, neonates born in breech presentations were at increased risk of intrapartum death (1.09/1000 vertex vs 13.51/1000 breech, $P < 0.01$), early neonatal death (0.36/1000 vertex vs 4.57/1000 breech, $P = 0.09$), and late neonatal death (0.30/1000 vertex vs 4.59/1000 breech, $P = 0.08$). In this sample, primiparous women were at increased risk of having an intrapartum fetal death compared to multiparous women (2.92/1000 primiparous vs 0.84/1000 multiparous, $P < 0.01$). Newborns born to primiparas were not, however, at increased risk of either early or late neonatal death. The same pattern was seen for multiparous women with a history of cesarean undergoing a trial of labor after cesarean (TOLAC): an increased risk of intrapartum fetal death, when compared to multiparous women with no prior cesarean (2.85/1000 TOLAC vs 0.66/1000 multiparas without a history of cesarean, $P = 0.05$; Table 5), but no increase in neonatal death. There was no evidence of increased risk of death among multiple births. When higher-risk women (those with multiple gestations, breech presentation, TOLAC, GDM, or preeclampsia) were removed from the sample, the intrapartum death rate was 0.85 per 1000 (95% CI, 0.39-1.31).

Breastfeeding

At 6 weeks postpartum, 97.7% (n = 16,338) of newborns were at least partially breastfed. Only 0.4% (n = 70) were never breastfed, and 86.0% (n = 14,344) were exclusively breastfed through at least 6 weeks postpartum.

DISCUSSION

In this large national sample of midwife-led, planned home births in the United States, the majority of women and newborns experienced excellent outcomes and very low rates of intervention relative to other national datasets of US women.[27–29] Rates of spontaneous vaginal birth, cesarean, low 5-minute Apgar score (<7), intact perineum, breastfeeding, and intrapartum and early neonatal mortality are all consistent with reported outcomes from the best available population-based observational studies of planned home and birth center births.[2,10–12,14,30] Rates of successful VBAC are higher than reported elsewhere (87% vs 60-80%),[31–33] with no significant increase in early or overall neonatal mortality. There is some evidence of increased intrapartum fetal death associated with TOLAC; however, the total number of events was too low for reliable analysis. Only 4.5% of the total MANA Stats sample required oxytocin augmentation and/or epidural analgesia, which is notably lower than rates of these interventions reported more broadly in the United States (26% for oxytocin augmentation and 67% for epidural analgesia).[27] Rates of operative vaginal birth and cesarean are also substantially lower than those reported for hospital-based US samples (1.2% vs 3.5% and 5.2% vs 32.8%, respectively).[27,29,34] Such reduced rates of obstetric procedures and interventions may result in significant cost savings and increased health benefits for low-risk women who give birth outside of the hospital.[13,35] In addition, fewer than 5% of the newborns born in the hospital after an intrapartum transfer had a 5-minute Apgar score below 7, and 2.1% had a score below 4, indicating relatively low morbidity even among the transferred subsample. These findings are consistent with outcomes reported in the National Birth Center Study II.[14]

The reported rate of postpartum hemorrhage (>500 mL for vaginal births) is higher in this sample relative to the rates reported by others (15.4% vs 1.4%-3.7%).[36–38] However, only 51.4% of women with postpartum hemorrhage received an antihemorrhagic agent. In addition, the frequency of

Table 5. Death Rates for the Entire Sample and for Selected Subgroups[a] Excluding Lethal Congenital Anomalies

	Intrapartum				Early Neonatal				Late Neonatal			
	Deaths	Denominator	Rate/1000 (95% CI)	*P* Value[b]	Deaths	Denominator	Rate/1000 (95% CI)	*P* Value[b]	Deaths	Denominator	Rate/1000 (95% CI)	*P* Value[b]
Overall	22	16,980	1.30 (0.75-1.84)		7	16,950	0.41 (0.11-0.72)		6	16,942	0.35 (0.07-0.64)	
Presentation												
Vertex	18	16,575	1.09 (0.58-1.59)	0.003	6	16,549	0.36 (0.07-0.65)	0.088	5	16,542	0.30 (0.04-0.57)	0.076
Breech	3	222	13.51 (0-28.70)		1	219	4.57 (0-13.50)		1	218	4.59 (0-13.56)	
Parity												
Multiparous	11	13,146	0.84 (0.34-1.33)	0.004	6	13,132	0.27 (0-0.79)	1.0	3	13,126	0.23 (0-0.49)	0.13
Primiparous	11	3773	2.92 (1.20-4.64)		1	3757	0.46 (0.09-0.82)		3	3755	0.80 (0-1.70)	
Trial of Labor After Cesarean[c]												
No	8	12,088	0.66 (0.20-1.12)	0.052	5	12,077	0.41 (0.05-0.78)	0.39	2	12,072	0.17 (0-0.40)	0.22
Yes	3	1052	2.85 (0-6.07)		1	1049	0.95 (0-2.82)		1	1048	0.95 (0-2.82)	
Multiple Gestation												
Singleton	21	16,914	1.24 (0.71-1.77)	0.14	7	16,831	0.42 (0.11-0.72)	–[d]	6	16,823	0.36 (0.07-0.64)	–
Twins	1	120	8.33 (0-24.6)		0	119	–		0	119	–	
Gestational Diabetes Mellitus												
No	20	16,787	1.19 (0.67-1.71)	0.013	7	16,759	0.42 (0.11-0.73)	–	6	16,751	0.36 (0.07-0.64)	–
Yes	2	132	15.15 (0-35.99)		0	130	–		0	130	–	
Preeclampsia												
No	21	16,880	1.24 (0.71-1.77)	0.037	7	16,862	0.42 (0.11-0.72)	–	6	16,854	0.36 (0.07-0.64)	–
Yes	1	29	34.48 (0-100.89)		0	27[e]	–		0	27	–	

Abbreviations: CI, confidence interval.
[a] There are 4 singleton pregnancies, 3 of which were breech presentations, for which all birth outcomes data are unavailable. These women began labor at home and then transferred to the hospital prior to birth. The midwives of record were contacted, and in each case the midwife did not accompany the mother, nor did the mother return to the midwife for postpartum care.
[b] Fisher's exact test.
[c] Among parous women only.
[d] Dashes indicate value cannot be calculated because there were no events in this subgroup.
[e] One newborn of a mother with preeclampsia died during the early neonatal period of a lethal congenital anomaly and was therefore excluded from all calculations for the neonatal period.

postpartum maternal transfer for excessive bleeding was low overall, suggesting that midwife contributors to MANA Stats did not deem all cases of blood loss greater than 500 mL to require pharmacologic intervention or transfer. We interpret these findings in 2 ways. First, we suspect that the MANA Stats rates for postpartum hemorrhage may be unreliable because they are dependent on visual estimation of blood loss, which has been shown to be highly inaccurate across provider types and birth setting.[39,40] Second, because active management of third stage is less frequent in this sample, and because so few of the women in MANA Stats had intravenous oxytocin administered at the time of birth, our findings call into question, as have other studies,[36,41–43] whether 500 mL is an appropriate benchmark for the diagnosis of postpartum hemorrhage in a physiologic birth population.

It is difficult to compare birth-related mortality statistics across studies; there are so few death outcomes that statistical power is quite low. This is not unexpected: The intrapartum, maternal, and neonatal death rates in high-resource countries are remarkably low overall. The lack of power is further compounded in studies of planned home and birth center births because cohorts from these birth locations are commonly comprised of relatively low-risk women, thus fewer deaths are expected. Furthermore, when examining the home and birth center birth literature to date, there is little consistency in the way that mortality data are defined and reported, and few authors provide confidence intervals or sufficient raw data to allow for comparison. Nonetheless, it is useful to compare death rates associated with planned home and birth center births, as reported across a variety of geographic settings (although confidence intervals around the rates are large) because any potential differences observed can serve to generate hypotheses for future work.

The intrapartum fetal death rate among women planning a home birth in our sample was 1.3 per 1000 (95% CI, 0.75-1.84). This observed rate and CI are statistically congruent with rates reported by Johnson and Daviss[4] and Kennare et al[30] but are higher than the intrapartum death rates reported by de Jonge et al,[10] Hutton et al,[12] and Stapleton et al.[14] While the absolute risk[44] is still quite low, the relatively elevated intrapartum mortality rate in our sample may be partially a function of the higher risk profile of the MANA Stats sample relative to de Jonge et al,[10] Hutton et al,[12] and Stapleton et al[14] whose samples contain primarily low-risk, singleton, vertex births. When women who are at higher risk for adverse outcomes (ie, women with multiple gestations, breech presentation, TOLAC, GDM, or preeclampsia) are removed from our sample, the intrapartum death rate (0.85 per 1000; 95% CI, 0.39-1.31) is statistically congruent with rates reported by Hutton et al[12] and Stapleton et al,[14] although still higher than that reported by de Jonge et al.[10] It is also possible that the unique health care system found in the United States—and particularly the lack of integration across birth settings, combined with elevated rates of obstetric intervention—contributes to intrapartum mortality due to delays in timely transfer related to fear of reprisal and/or because some women with higher-risk pregnancies still choose home birth because there are fewer options that support normal physiologic birth available in their local hospitals.[18,30,45–48]

The early neonatal death rate in our home birth sample was 0.41 per 1000, which is statistically congruent with rates reported by de Jonge et al[10] and the Birthplace in England Collaborative Group.[2] Our combined early and late neonatal death rates, or total neonatal death rate, of 0.77 per 1000 is statistically congruent with the rate reported by Hutton et al.[12] Other studies of planned home or planned birth center birth either define neonatal mortality differently or do not define it at all, making comparisons difficult. In addition, some of the intrapartum fetal deaths, as well as some additional neonatal deaths, reported in MANA Stats may have been congenital anomaly-related. There were several incidences when the midwife or receiving physician suspected congenital defect based on visual assessment, but an autopsy or other testing was declined and no official cause of death was assigned. The number of unknown causes of death in our sample is also at least partially attributable to parents declining autopsies[49]; of the 35 intrapartum and neonatal deaths not attributed to congenital anomaly, only 6 received an autopsy.

Collectively, our findings are consistent with the body of literature that shows that for healthy, low-risk women, a planned home birth attended by a midwife can result in positive outcomes and benefits for both mother and newborn. However, the safety of home birth for higher-risk pregnancies, particularly with regard to breech presentation (5 fetal/neonatal deaths in 222 breech presentations), TOLAC (5 out of 1052), multiple gestation (one out of 120), and maternal pregnancy-induced comorbidities (GDM: 2 out of 131; preeclampsia: one out of 28) requires closer examination because the small number of events in any one subgroup limited the effective sample size to the point that multivariable analyses to explore these associations further were not possible. It is unclear whether the increased mortality associated with higher-risk women who plan home births is causally linked to birth setting or is simply consistent with the expected increase in rates of adverse outcomes associated with these complications.

Limitations

The main limitation of this study is that the sample is not population-based. There is currently no mandatory, reliable data collection system designed to capture and describe outcomes for all planned home births in the United States. We are also unable, for a number of reasons detailed elsewhere,[5] to quantify precisely what proportion of practicing midwives of various credentials contributed data to MANA Stats between 2004 and 2009. In addition, the data entered into the MANA Stats system come from medical records. Because medical records are kept primarily for patient care purposes with secondary uses for billing, research, and legal documentation, researchers using data derived from medical records must be cognizant of these limitations.[50–53] However, we expect that the outcomes reported here were likely to be recorded in the medical record with a reasonably high degree of accuracy because of their importance to clinical care. Furthermore, our pre-/postdata review analysis indicated that data were initially entered with a high degree of accuracy.[5] Finally, we cannot confirm with 100% certainty that participating midwives entered data from all of their clients. However, because the

MANA Stats system requires that clients be logged early in prenatal care, any such exclusions would have occurred prior to the outcome of the birth being known.[5]

CONCLUSION

Descriptive data from the first 6 years (2004-2009) of the MANA Statistics Project demonstrate that for this large, national cohort of women who planned home births under the care of a midwife, perinatal outcomes are congruent with the best available data from population-based observational studies that have evaluated outcomes by intended place of birth and by pregnancy risk profiles. Low-risk women in this sample experienced high rates of normal physiologic birth and very low rates of operative birth and interventions, with no concomitant increase in adverse events. Conclusions are less clear for higher-risk women. Given the low absolute number of events and the lack of a matched comparison group, we were unable to discern whether poorer outcomes among higher-risk women were associated with place of birth or related to risks inherent to their conditions.

Prospective cohort studies with matched comparison groups that utilize the large datasets collected by MANA Stats and AABC's UDS have the potential to address critical gaps in our understanding of birth settings and providers in the United States. We recommend that future research focus on 3 critical questions: 1) What place of birth is most likely to lead to optimal maternal and newborn health, given specific risk profiles and regionally available birth options? 2) What are the characteristics of midwife-led care that contribute to safe physiologic birth? and 3) Regardless of where a woman chooses to give birth, how can clinicians most effectively collaborate across birth settings and provider types to achieve the best possible outcomes for women and newborns?

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CONFLICT OF INTEREST

The authors have no conflicts of interest to disclose.

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Home births as safe as hospital births: International study suggests

Date: August 7, 2019

Source: McMaster University

Summary: The study examined the safety of place of birth by reporting on the risk of death at the time of birth or within the first four weeks, and found no clinically important or statistically different risk between home and hospital groups.

FULL STORY

A large international study led by McMaster University shows that low risk pregnant women who intend to give birth at home have no increased chance of the baby's perinatal or neonatal death compared to other low risk women who intend to give birth in a hospital.

The results have been published by *The Lancet*'s *EClinicalMedicine* journal.

"More women in well-resourced countries are choosing birth at home, but concerns have persisted about their safety," said Eileen Hutton, professor emeritus of obstetrics and gynecology at McMaster, founding director of the McMaster Midwifery Research Centre and first author of the paper. "This research clearly demonstrates the risk is no different when the birth is intended to be at home or in hospital."

The study examined the safety of place of birth by reporting on the risk of death at the time of birth or within the first four weeks, and found no clinically important or statistically different risk between home and hospital groups.

The study, which is the first systematic review and meta-analyses to use a previously published, peer-reviewed protocol for the research, used data from 21 studies published since 1990 comparing home and hospital birth outcomes in Sweden, New Zealand, England, Netherlands, Japan, Australia, Canada and the U.S. Outcomes from approximately 500,000 intended home births were compared to similar numbers of births intended to occur in hospital in these eight countries.

"Our research provides much needed information to policy makers, care providers and women and their families when planning for birth," said Hutton.

Story Source:

Materials provided by **McMaster University**. *Note: Content may be edited for style and length.*

Journal Reference:

1. Eileen K. Hutton, Angela Reitsma, Julia Simioni, Ginny Brunton, Karyn Kaufman. **Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses**. *EClinicalMedicine*, 2019; DOI: 10.1016/j.eclinm.2019.07.005

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Appendix 2 - Registered Traditional Community Midwife

Types of Midwives

About Midwives

In the United States there are several pathways to midwifery education and training. Most pathways result in midwifery certification and qualify the candidate for licensing in her/his state or municipality. Candidates seeking to become certified and licensed midwives can choose among several routes of entry into the profession using nurse-midwifery or direct-entry midwifery educational programs. The most common types of midwives are listed below including the three professional U.S. midwifery credentials, Certified Professional Midwives (CPM), Certified Nurse-Midwives (CNM), and Certified Midwives (CM).

Nurse Midwives

Certified Nurse-Midwife (CNM):

Certified Nurse-Midwives are trained in both nursing and midwifery. Their training is hospital-based, and the vast majority of CNMs practice in clinics and hospitals. Although their training

occurs in medical settings, the CNM/CM scope of practice allows them to provide care in any birth setting.

Direct-Entry Midwives:

Direct-entry midwives are trained to provide the Midwives Model of Care to healthy women and newborns primarily in out-of-hospital settings. They do not have nursing education as a prerequisite for midwifery education.

Certified Midwife (CM):

Certified Midwives are individuals who have or receive a background in a health related field other than nursing, then graduate from a masters level midwifery education program. They have similar training to CNMs, conform to the same standards as CNMs, but are not required to have the nursing component.

Certified Professional Midwife (CPM):

The vast majority of direct-entry midwives in the United States are Certified Professional Midwives. The CPM is the only midwifery credential that requires knowledge about and experience in out-of-hospital settings. Their education and clinical training focuses on providing midwifery model care in homes and freestanding birth centers. In some states, CPMs may also practice in clinics and doctors offices providing well-woman and maternity care.

Traditional Midwives

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.

MANA News

#MANA19 - Support Sustainable Midwifery Practices

Posted: 04/12/2019 - 12:28pm

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Nominations Open for 2020 Board Elections

Posted: 10/25/2018 - 2:22pm

ABOUT US

The Midwives Alliance of North America (MANA), established in 1982, is a professional membership organization that promotes excellence in midwifery practice, endorses diversity in educational backgrounds and practice styles, and is dedicated to unifying and strengthening the profession, thereby increasing access to quality health care and improving outcomes for women, babies, families, and communities.

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Standards and Qualifications for the Art and Practice of Midwifery

Revised at the Midwives Alliance Business Meeting
October 2, 2005

The midwife practices in accord with the MANA Standards and Quali cations for the Art and Practice of Midwifery and the MANA Statement of Values and Ethics, and demonstrates the clinical skills and judgments described in the MANA Core Competencies for Midwifery Practice.

1. *Skills*—Necessary skills of a practicing midwife include the ability to:
   - Provide continuity of care to the woman and her newborn during the maternity cycle. Care may continue throughout the woman's entire life cycle. The midwife recognizes that childbearing is a woman's experience and encourages the active involvement of
   - Identify, assess and provide care during the antepartal, intrapartal, postpartal, and newborn periods. She may also provide well woman and newborn care
   - review and practice
   - Deal with emergency situations appropriately
   - Use judgment, skill and intuition in competent assessment and response
2. *Appropriate equipment and treatment*—Midwives carry and maintain equipment to assess and provide care for the well-woman, the mother, the fetus, and the newborn; to maintain clean and/or aseptic technique; and to treat conditions including, but not limited to, hemorrhage, lacerations, and cardio-respiratory distress. This may include the use of non-pharmaceutical agents, pharmaceutical agents, and equipment for suturing and intravenous therapy.
3. *Records*—Midwives keep accurate records of care for each woman and newborn in their practice. Records

   Records shall be provided to the woman on request. The

   communications regarding women in her care.
4. *Data Collection*—It is highly recommended that midwives collect data for their practice on a regular basis and that this be done prospectively, following the protocol developed by the MANA Division of Research. Data collected by the midwife shall be used to inform and improve her practice.
5. *Compliance*—Midwives will inform and assist parents regarding public health requirements of the jurisdiction in which the midwifery service is provided.
6. *Medical Consultation, Collaboration, and Referral*—All midwives recognize that there are certain conditions for which medical consultations are advisable. The midwife shall make a reasonable attempt to assure that her client has access to consultation, collaboration, and/or referral to a medical care system when indicated.

7. *Screening*—Midwives respect the woman's right to self-determination. Midwives assess and inform each woman regarding her health and well-being relevant to the appropriateness of midwifery services. It is the right and responsibility of the midwife to refuse or discontinue services in certain circumstances. Appropriate referrals are made in the interest of the mother or baby's well-being or when the required or requested care is outside the midwife's personal scope of practice as described in her practice guidelines.

8. *Informed Choice*—Each midwife will present accurate information about herself and her services, including but not limited to:
   - Her education in midwifery
   - Her experience level in midwifery
   - Her practice guidelines
   -
   - The services she does and does not provide
   - Her expectations of the pregnant woman and the

   The midwife recognizes that the woman is the primary decision maker in all matters regarding her own health care and that of her infant.

   The midwife respects the woman's right to decline treatments or procedures and properly documents these choices. The midwife clearly states and documents when a woman's choices fall outside the midwife's practice guidelines.

9. *Continuing Education*—Midwives will update their knowledge and skills on a regular basis.

10. *Peer Review*—Midwifery practice includes an on-going process of case review with peers

11. *Practice Guidelines*—Each midwife will develop practice guidelines for her services that are in agreement with

    Practice of Midwifery, the MANA Statement of Values and Ethics, and the MANA Core Competencies for Midwifery Practice, in keeping with her level of expertise.

12. *Expanded scope of practice*—The midwife may expand her scope of practice beyond the MANA Core Competencies to incorporate new procedures that improve care for women and babies consistent with

    potential complications.

The following sources were utilized for reference

- Essential documents of the National Association of
- American College of Nurse-Midwives documents and standards for the Practice of Midwifery revised March 2003
- ICM membership and joint study on maternity; FIGO, WHO, etc. revised 1972
- New Mexico regulations for the practice of lay midwifery, revised 1982
- North West Coalition of Midwives Standards for Safety and Competency in Midwifery
- Varney, Helen, *Nurse-Midwifery* Pub., Boston, MA 1980

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Statement of Values and Ethics

Resources

- MANA Core Documents
- Position Papers
- Organizations & Coalitions
- Resources for Midwives

Ethics in Midwifery Guide Good Decision Making

The practice of midwifery is infused with values that guide the way midwives provide care to women, infants and families. Ethics is a necessary component of midwifery care and requires midwives to make ethical decision on a daily basis regardless of settings in which they provide services, such as clinics, homes, hospitals and birth centers.

The Midwives Alliance Statement of Values and Ethics was written and adopted by the MANA Board of Directors in 1997, and revised and adopted in August 2012.

MANA Statement of Values and Ethics

The Statement of Values and Ethics of the Midwives Alliance of North America (MANA) is a critical reflection of moral issues as they pertain to maternal and child health. It is intended to provide guidance for professional conduct in the practice of midwifery, as well as influence MANA's organizational policies, thereby promoting high quality care for childbearing families.

Statement of Values

Since what we value infuses and informs our ethical decisions and actions, the Midwives Alliance of North America affirms:

I. Woman As a Unique Individual:

> A. We value each woman as a strong, creative, unique individual with life-giving powers.
>
> B. We value each woman's right to a supportive caregiver appropriate to her needs and respectful of her belief system.
>
> C. We value a woman's right to access resources in order to achieve health, happiness and personal growth according to her needs, perceptions and goals.
>
> D. We value a woman as autonomous and competent to make decisions regarding all aspects of her life.

E. We value the empowerment of a woman during the processes of pregnancy, birth, breastfeeding, mother–infant attachment and parenting.

II. Mother and Baby as Whole:

A. We value the mother and her baby as an inseparable and interdependent whole and acknowledge that each woman and baby have parameters of well-being unique to themselves.

B. We value the physical, psychosocial and spiritual health, well-being and safety of every mother and baby.

C. We value the mother as the direct care provider for her unborn child.

D. We value the process of labor and birth as a rite of passage with mother and baby as equal participants.

E. We value the sentient and sensitive nature of the newborn and affirm every baby's right to a caring and loving birth without separation from mother and family.

F. We value breastfeeding as the ideal way to nourish and nurture the newborn.

III. The Nature of Birth:

A. We value the essential mystery of birth.

B. We value pregnancy and birth as natural, physiologic and holistic processes that technology will never supplant.

C. We value the integrity of a woman's body, the inherent rhythm of each woman's labor and the right of each mother and baby to be supported in their efforts to achieve a natural, spontaneous vaginal birth.

D. We value birth as a personal, intimate, internal, sexual and social experience to be shared in the environment and with the attendants a woman chooses.

E. We value the right of a woman and her partner to determine the most healing course of action when difficult situations arise.

F. We value the art of letting go and acknowledge death and loss as possible outcomes of pregnancy and birth.

IV. The Art of Midwifery:

A. We value our right to practice the art of midwifery, an ancient vocation of women.

B. We value multiple routes of midwifery education and the essential importance of apprenticeship training.

C. We value the wisdom of midwifery, an expertise that incorporates theoretical and embodied knowledge, clinical skills, deep listening, intuitive judgment, spiritual awareness and personal experience.

D. We value the art of nurturing the inherent normalcy of pregnancy and birth as expressions of wellness in a healthy woman.

E. We value continuity of care throughout the childbearing year.

F. We value birth with a midwife in any setting that a woman chooses.

G. We value homebirth with a midwife as a wise and safe choice for healthy families.

H. We value caring for a woman to the best of our ability without prejudice with regards to age, race, ethnicity, religion, education, culture, sexual orientation, gender identification, physical abilities or socioeconomic background.

I. We value the art of empowering women, supporting each to birth unhindered and confident in her natural abilities.

J. We value the acquisition and use of skills that identify and guide a complicated pregnancy or birth to move toward greater well-being and be brought to the most healing conclusion possible.

K. We value standing up for what we believe in the face of social pressure and political oppression.

V. Woman as Mother:

A. We value a mother's intuitive knowledge and innate ability to nurture herself, her unborn baby and her newborn baby.

B. We value the power and beauty of a woman's body as it grows in pregnancy and a woman's strength in labor and birth.

C. We value pregnancy and birth as processes that have lifelong impact on a woman's self-esteem, her health, her ability to nurture and her personal growth.

D. We value the capacity of partners, family and community to support a woman in all aspects of pregnancy, birth and mothering and to provide a safe environment for mother and baby.

VI. The Nature of Relationship:

A. We value an egalitarian relationship between a woman and her midwife.

B. We value the quality, integrity and uniqueness of our interactions, which inform our choices and decisions.

C. We value mutual trust, honesty and respect.

D. We value a woman's right to privacy, and we honor the confidentiality of all personal interactions and health records.

E. We value direct access to information that is readily understood by all.

F. We value personal responsibility and the right of a woman to make decisions regarding what she deems best for herself, her baby and her family, using both informed consent and informed refusal.

G. We value our relationship to a process that is larger than ourselves, recognizing that birth is something we can seek to learn from and to know, but cannot control.

H. We value humility and the recognition of our own limitations.

I. We value sharing information and understanding about birth experiences, skills and knowledge.

J. We value a supportive midwifery community as an essential place of learning.

K. We value diversity among midwives that broadens our collective resources and challenges us to work toward greater understanding.

L. We value collaboration between a midwife and other health-care practitioners as essential to providing a family with resources to make responsible and informed choices.

> M. We value the right and responsibility of both a midwife and a woman to discontinue care when insurmountable obstacles develop that compromise communication, mutual trust or joint decision making.
>
> N. We value the responsibility of a midwife to consult with other health-care practitioners when appropriate and refer or transfer care when necessary.

VII. Cultural Sensitivity, Competency and Humility

> A. We value cultural sensitivity, competency and humility as critical skills for the midwife to master in an increasingly multicultural society.
>
> B. We value cultural sensitivity—a midwife's awareness of and ability to honor differences between people and the cultural values of the women she serves.
>
> C. We value the importance of cultural competency in addressing the social and economic barriers to access to care for vulnerable, underserved and marginalized women, thereby improving maternal and infant health and the well-being of families.
>
> D. We value cultural humility as a lifelong process of self-reflection and self-critique in order to develop a respectful partnership with each woman.*
>
> *Section VII is derived from Melanie Tervalon and Jann Murray-Garcia, "Cultural Humility versus Cultural Competency: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education," Journal of Health Care for the Poor and Underserved 9 (May 1998): 117–25.

Statement of Ethics

Our values inform and inspire midwifery practice in our hearts and minds. Acting ethically is an expression of our values within the context of our individual, geographic, religious, cultural, ethnic, political, educational and personal backgrounds and in our relationships with others. As we seek to respond in the moment to each situation we face, we call upon ethical principles of human interaction as follows:

- Beneficence—to act so as to benefit others
- Nonmaleficence—to avoid causing harm
- Confidentiality—to honor others' privacy and keep personal interactions confidential
- Justice—to treat people respectfully and equitably
- Autonomy—to respect an individual's rights to self-determination and freedom to make decisions that affect his or her life.

The equality and mutuality of the relationship between midwife and client create a foundation uniquely suited to integrate these principles. As midwives, we seek to benefit women and babies in our care. Mutual trust and respect are critical to the success of a relationship that requires joint decision making at every level. Moral integrity, truthfulness and adequate information enable all participants to judge together the best course of action in varied situations.

Judgments are fundamentally based on awareness and understanding of ourselves and others. They grow out of our own sense of moral integrity, which is born within the heart of each individual. Becoming self-aware and increasing understanding are ongoing processes that must be nurtured as a function of personal and professional growth. MANA's affirmation of individual moral integrity and recognition of the complexity of life events bring us to an understanding that there cannot possibly be one right answer for all situations. Since the outcome of pregnancy is ultimately unknown and is always unknowable, it is inevitable that in certain circumstances our best decisions in the moment will lead to consequences we could not foresee.

We recognize the limitations of traditional codes of ethics that present a list of rules to be followed. Therefore, a midwife must develop a moral compass to guide practice in diverse situations that

arise from the uniqueness of pregnancy and birth as well as the relationship between midwives and birthing women. This approach affirms the mystery and potential for transformation present in every experience and fosters truly diverse practice. Midwifery care is woman-led care with informed choice and a clear set of values at its core. Decision making is a shared responsibility with the goals of healthy women and babies and of gentle, empowering births with a focus on individual and family needs and concerns. Ultimately, it is at the heart of midwifery practice to honor and respect the decisions women make about their pregnancies and births based on their knowledge and belief about what is best for themselves and their babies.

There are both individual and social implications to any decision-making process. Our decisions may be impacted by the oppressive rules and practices of a society that is often hostile to homebirth, midwives and midwifery clients. Our actual choices may be limited by the medical, legal, political, economic, cultural or social climate in which we function. The more our values conflict with those of the dominant culture, the greater the threat to the integrity of our own values, and the greater the risk that our actions may lead to professional repercussions or legal reprisal. In such conditions we may be unable to make peace with any course of action or may feel conflicted about a choice already made. The community of women, both midwives and those we serve, may provide a fruitful resource for continued moral support and guidance.

In summary, acting ethically requires us to define our values, respond to the communities of families, midwives and cultures in which we find ourselves, act in accord with our values to the best of our ability as the situation demands, and engage in ongoing self-examination, evaluation, peer review and professional growth. By carefully describing the multifaceted aspects of what we value and defining the elements of moral integrity and decision making, we have created a framework for ethical behavior in midwifery practice. We welcome an open and ongoing articulation of values and ethics and the evolution of this document.

Downloadable File: MANAStatementValuesEthicsColor.pdf

MANA News

#MANA19 - Support Sustainable Midwifery Practices

Posted: 04/12/2019 - 12:28pm

Call for Proposals 2019

Posted: 02/14/2019 - 2:53pm

Nominations Open for 2020 Board Elections

Posted: 10/25/2018 - 2:22pm

styles, and is dedicated to unifying and strengthening the profession, thereby increasing access to quality health care and improving outcomes for women, babies, families, and communities.

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Core Competencies for Basic Midwifery Practice

Adopted by the Midwives Alliance Board October 3, 1994

Revisions by committee, adopted by the Midwives Alliance Board August 4, 2011

Introduction

The Midwives Alliance of North America Core Competencies establish the essential knowledge, clinical skills and critical thinking necessary for entry-level midwifery practice. An entry-level mid-

The Competencies inform practicing midwives, student midwives, midwifery education programs, consumers, accreditation and certification agencies, state and federal legislators, licensing authorities, health policy makers and other health care professionals concerning the practice of midwifery. Individual midwives are responsible to the licensing authority and regulations of the jurisdiction within which they practice.

Midwives provide care to parturient women and their newborn babies in a variety of settings in accordance with the Midwives Model of Care™, which is based on the principle that pregnancy and birth are normal life processes.

The Midwives Model of Care™ includes:

- monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle;
- providing the mother with individualized education, counseling and prenatal care; continuous hands-on assistance during labor and delivery; and postpartum support;
- minimizing technological interventions;
- identifying and referring women who require obstetrical attention.

The application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma and cesarean section.

Note: The MANA Core Competencies were written during the early developmental phase of the Midwives Alliance of North America. The Board of Directors approved them in 1984. They were adopted by both NARM and MEAC as the education content for programs for CPMs Two years ago a task force was assembled to update and revise the original Core Competencies with representatives from MANA, NARM, MEAC, NACPM, and individuals who had been authors on the original document This resulted in a very thorough and intensive collaboration to update, revise, and invigorate this very important core document Thanks to the determination and passion of these partners and the skillful task force leadership of Pam Dyer Stewart and Justine Clegg, the revised Core Competencies for the Practice of Basic Midwifery were completed in Spring 2011 and approved by the MANA Board in July 2011 We present this incredible and inclusive document with pride and celebration of what it means to be a midwife

The scope of midwifery practice may be expanded beyond the Core Competencies outlined in this document to incorporate additional skills and procedures that improve care for women and their families.

The midwife provides care according to the following guiding principles of practice:

- Pregnancy and childbearing are natural physiologic life processes.
- Women have within themselves the innate biological wisdom to give birth.
- Physical, emotional, psychosocial and spiritual factors synergistically shape the health of individuals and affect the childbearing process.
- The childbearing experience and birth of a baby are personal, family and community events.
- The woman is the only direct care provider for herself and her unborn baby; thus the most important determinant of a healthy pregnancy is the mother herself.
- The parameters of "normal" vary widely, and each pregnancy, birth and baby is unique.

In consideration thereof:

- Midwives work in partnership with women and their chosen support community throughout the caregiving relationship.
- Midwives respect and support the dignity, rights and responsibilities of the women they serve.
- Midwives are committed to addressing disparities in maternal and child health care status and outcomes.
- Midwives work as autonomous practitioners, although they collaborate with other health care and social service providers when necessary.
- Midwives work to optimize the well-being of mothers and their developing babies as the foundation of caregiving.
- Midwives recognize the empowerment inherent in the childbearing experience and strive to support women to make informed decisions and take responsibility for their own and their baby's well-being.
- Midwives integrate clinical or hands-on evaluation, theoretical knowledge, intuitive assessment, spiritual awareness and informed consent and refusal as essential components of effective decision making.
- Midwives strive to ensure optimal birth for each woman and baby and provide guidance, education and support to facilitate the spontaneous processes of pregnancy, labor and birth, lactation and mother–baby attachment, using appropriate intervention as needed.
- Midwives value continuity of care throughout the childbearing cycle and strive to maintain such continuity.
- Midwives are committed to sharing their knowledge and experience through such avenues as peer review, preceptorship, mentoring and participation in MANA's statistics collection program.

MANA Core Competencies

Academic knowledge provides the theoretical foundation for understanding the scope of health during the childbearing year in order to distinguish deviations from healthy functioning.

Clinical skills refer to the hands-on assessment of the woman's physical health, observation of her psychosocial well-being and skilled listening. The midwife views health holistically, uses critical thinking to evaluate clinical applies intuition as authoritative knowledge, maintains an integrated understanding of the whole picture and, with the woman, and creates a plan of care based on conscious analysis of challenges and goals.

I. General Knowledge and Skills

The midwife's knowledge and skills include but are not limited to:

A. communication, counseling and education before pregnancy and during the childbearing year;

B. human anatomy and physiology, especially as relevant to childbearing;

C. human sexuality;

D. various therapeutic health care modalities for treating body, mind and spirit;

E. community health care, wellness and social service resources;

F. nutritional needs of the mother and baby during the childbearing year;

G. diversity awareness and competency as it relates to childbearing.

The midwife maintains professional standards of practice including but not limited to:

A. principles of informed consent and refusal and shared decision making;
B. and application to best practices;
C. documentation of care throughout the childbearing cycle;
D. ethical considerations relevant to reproductive health;
E. cultural sensitivity and competency;
F. use of common medical terms;
G. implementation of individualized plans for woman-centered midwifery care that support the relationship between the mother, the baby and their larger support community;
H. judicious use of technology;
I. self-assessment and acknowledgement of personal and professional limitations.

II. Care During Pregnancy

The midwife provides care, support and information to women throughout pregnancy and determines the need for consultation, referral or transfer of care as appropriate. The midwife has knowledge and skills to provide care that include but are not limited to:

A. baby well-being throughout the process of pregnancy;
B. education and counseling during the childbearing cycle;
C. or supportive measures to enhance client well-being during pregnancy;
D. nutritional requirements of pregnant women and methods of nutritional assessment and counseling;
E. emotional, psychosocial and sexual variations that may occur during pregnancy;
F. environmental and occupational hazards for pregnant women;
G. methods of diagnosing pregnancy;
H. the growth and development of the unborn baby;
I. genetic factors that may indicate the need for counseling, testing or referral;
J. screening methods and diagnostic tests used during pregnancy;
K. anatomy, physiology and evaluation of the soft and bony structures of the pelvis;
L. palpation skills for evaluation of the baby and the uterus;
M. the causes, assessment and treatment of the common discomforts of pregnancy;
N. of various infections, disease conditions and other problems that may affect pregnancy;
O. management and care of the Rh-negative woman;
P. counseling to the woman and her family to plan for a safe, appropriate place for birth.

III. Care During Labor, Birth and Immediately Thereafter

The midwife provides care, support and information to women throughout labor, birth and the hours immediately thereafter. The midwife determines the need for consultation, referral or transfer of care as appropriate. The midwife has knowledge and skills to provide care that include but are not limited to:

A. the processes of labor and birth;
B. parameters and methods, including relevant health history, for evaluating the well-being of mother and baby during labor, birth and immediately thereafter;
C. assessment of the birthing environment to assure that it is clean, safe and supportive and that appropriate equipment and supplies are on hand;
D. maternal emotional responses and their impact during labor, birth and immediately thereafter;
E. comfort and support measures during labor, birth and immediately thereafter;

F. fetal and maternal anatomy and their interrelationship as relevant to assessing the baby's position and the progress of labor;

G. techniques to assist and support the spontaneous vaginal birth of the baby and placenta;

H.

and immediately thereafter;

I. maternal rest and sleep as appropriate during the process of labor, birth and immediately thereafter;

J. treatment for variations that can occur during the course of labor, birth and immediately thereafter, including prevention and treatment of maternal hemorrhage;

K. emergency measures and transport for critical problems arising during labor, birth or immediately thereafter;

L. appropriate support for the newborn's natural

hours following birth, including practices to enhance mother–baby attachment and family bonding;

M. current biotechnical interventions and technologies that may be commonly used in a medical setting;

N. care and repair of the perineum and surrounding tissues;

O. third-stage management, including assessment of the placenta, membranes and umbilical cord;

P. breastfeeding and lactation;

Q.

implementation of preventive or supportive measures to enhance client well-being during labor, birth, the immediate postpartum and breastfeeding.

IV. Postpartum Care

The midwife provides care, support and information to women throughout the postpartum period and determines the need for consultation, referral or transfer of care as appropriate. The midwife has knowledge and skills to provide care that include but are not limited to:

A. anatomy and physiology of the mother;

B. lactation support and appropriate breast care including treatments for problems with nursing;

C. support of maternal well-being and mother–baby attachment;

D. treatment for maternal discomforts;

E. emotional, psychosocial, mental and sexual variations;

F. maternal nutritional needs during the postpartum period and lactation;

G. current treatments for problems such as postpartum depression and mental illness;

H. grief counseling and support when necessary;

I. family-planning methods, as the individual woman desires.

V. Newborn Care

The midwife provides care to the newborn during the postpartum period, as well as support and information to parents regarding newborn care and informed decision making, and determines the need for consultation, referral or transfer of care as appropriate. The midwife's assessment, care and shared information include but are not limited to:

A. anatomy, physiology and support of the newborn's

B. newborn wellness, including relevant historical data and gestational age;

C. nutritional needs of the newborn;

D.

E. laws and regulations regarding prophylactic biotechnical treatments and screening tests commonly used during the neonatal period;

F. neonatal problems and abnormalities, including referral as appropriate;

G. newborn growth, development, behavior, nutrition, feeding and care;

H. immunizations, circumcision and safety needs of the newborn.

VI. Women's Health Care and Family Planning

The midwife provides care, support and information to women regarding their reproductive health and determines the need for consultation or referral by using a foundation of knowledge and skills that include but are not limited to:

A. reproductive health care across the lifespan;

B. evaluation of the woman's well-being, including relevant health history;

C. anatomy and physiology of the female reproductive system and breasts;

D. family planning and methods of contraception;

E. decision making regarding timing of pregnancies and resources for counseling and referral;

F. preconception and interconceptual care;

G. well-woman gynecology as authorized by jurisdictional regulations.

VII. Professional, Legal and Other Aspects of Midwifery Care

The midwife assumes responsibility for practicing in accordance with the principles and competencies outlined in this document. The midwife uses a foundation of theoretical knowledge, clinical assessment, critical-thinking skills and shared decision making that are based on:

A. MANA's Essential Documents concerning the art and practice of midwifery,

B. the purpose and goals of MANA and local (state or provincial) midwifery associations,

C. principles and practice of data collection as relevant to midwifery practice,

D. ongoing education,

E. midwifery practice and application as appropriate,

F. jurisdictional laws and regulations governing the practice of midwifery,

G. basic knowledge of community maternal and child health care delivery systems,

H. skills in entrepreneurship and midwifery business management.

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The Midwives Model of Care

About Midwives

- What is a Midwife
- Midwives & the Law
- Midwifery Education
- Homebirth and Community Midwifery

The Model of Care Matters

Social scientists who are experts in women's health, reproduction, and maternity care have identified characteristics that define models of maternity care. In 1979 sociologist Barbara Katz-Rothman was the first to define the difference between the medical model and midwifery model of care. In 1992, medical anthropologist Robbie Davis-Floyd described the technocratic and holistic models of birth. Others have provided further clarification. Each model is different in terms of scientific, humanistic, economic and outcome efficiencies and deficiencies, as well as effect on providers and recipients of these models of care. What is important to note when reviewing models of maternity care is that each model relies on different skills, tools, language, underlying beliefs, interventions, and power relationships between patients and providers.

Midwives Model of Care™ Is Woman-Centered

The Midwives Model of Care™ is a fundamentally different approach to pregnancy and childbirth than contemporary obstetrics. Midwifery care is uniquely nurturing, hands-on care before, during, and after birth. Midwives are health care professionals specializing in pregnancy and childbirth who develop a trusting relationship with their clients, which results in confident, supported labor and birth. While there are different types of midwives practicing in various settings, all midwives are trained to provide comprehensive prenatal care and education, guide labor and birth, address complications, and care for newborns. The Midwives Model of Care™ is based on the fact that pregnancy and birth are normal life events. The Midwives Model of Care includes:

- monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle
- providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support
- minimizing technological interventions and
- identifying and referring women who require obstetrical attention.

The application of this model has been proven to reduce to incidence of birth injury, trauma, and cesarean section.

Midwifery Model of Care Works Well in Any Setting

The midwifery model of care, whether practiced in clinics, private homes, hospitals or birth centers, has at its core the characteristics of being with women, listening to women, and sharing knowledge and decision-making with women. The goal of the midwifery model of care is to support women and their families in the process of birthing their babies safely, unhindered and with confidence. Every woman deserves access to the high quality, safe, personalized, attentive, affordable, and respectful care of a midwife.Women Receive Personalized Care with a Midwife

Midwives Have Excellent Outcomes

Across our planet, eighty percent of people alive today have been born with midwives. In many of the industrialized countries of the world, midwives attend approximately 70% of all births. The countries with the lowest mortality and morbidity rates for mothers and infants are those in which midwifery is a valued and integral pillar of the maternity care system. The midwifery model is a low-tech, high-caring model that produces excellent outcomes not only for low risk women, but for vulnerable and at-risk women as well.

The Midwives Alliance is committed to advocating for women's access to a full-range of birth options. If you are a legislator, hospital administrator or health insurance policymaker, MANA can show you how the Midwives Model of Care ™ can benefit your constituents and your community.

MANA News

Call for Proposals 2019

#MANA19 - Support Sustainable Midwifery Practices

Posted: 04/12/2019 - 12:28pm

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ABOUT US

The Midwives Alliance of North America (MANA), established in 1982, is a professional membership organization that promotes excellence in midwifery practice, endorses diversity in educational backgrounds and practice styles, and is dedicated to unifying and strengthening the profession, thereby increasing access to quality health care and improving outcomes for women, babies, families, and communities.

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Entry Level (PEP) Applicants

Photo: Lynsey Stone

Life as a CPM

A Certified Professional Midwife (CPM) is a knowledgeable, skilled and professional independent midwifery practitioner who has met the standards for certification set by the North American Registry of Midwives (NARM) and is qualified to provide the Midwives Model of Care. The CPM is the only midwifery credential that requires knowledge about and experience in out-of-hospital settings.

Most CPMs own or work in private home or birth center based practices throughout the United States. Providing continuous care for women throughout their childbearing cycle, CPMs generally carry a relatively low client load (averaging 3-6 births per month) which allows for more personalized and comprehensive care than typical obstetrical practices. The scope of practice of the CPM is derived from the NARM Job Analysis, state laws and regulations, and individual practice guidelines developed by each midwife according to her skills and knowledge.

Based on the MANA Core Competencies, the guiding principles of the practice of CPMs are to work with women to promote a healthy pregnancy, and provide education to help her make informed decisions about her own care. In partnership with their clients they carefully monitor the progress of the pregnancy, labor, birth, and postpartum period and recommend appropriate management if complications arise, collaborating with other healthcare providers when necessary. The key

elements of this education, monitoring, and decision making process are based on Evidence-Based Practice refers to a thoughtful integration of the best available evidence, coupled with clinical expertise. As such it enables midwives and their clients to address healthcare questions with an evaluative and qualitative approach. Evidence based decisions flow from a process that includes the assessment of current and past research, clinical guidelines, and other information resources in order to determine the best course of care.Evidenced-Based Practice and Informed Consent refers to the rights of healthcare consumers to be fully informed about testing or treatment options so that they can then make an educated "choice" among those options.Informed Consent.

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How to Become a CPM — Entry Level

The Certified Professional Midwife was developed to provide competency-based certification for midwives who are primarily apprentice-trained in out of hospital birth. The CPM credential allows multiple routes of entry to the profession in order to encourage innovation in education, adaptability to evolving best practices of the profession, diversity in the pool of credentialed midwives and broad accessibility to the profession.The competency-based model for certification assures well-educated, skilled and competent providers.

Aspiring Midwives can:

- Apprentice with a qualified midwife, completing an Entry-Level Portfolio Evaluation Process (PEP).
- Attend a midwifery program or school.
- If the school is accredited by MEAC, graduation qualifies you for the NARM written exam. (See Student or Graduate of a MEAC Accredited Program page for more information)
- If the school or program is not MEAC accredited, you must complete the Entry-Level Portfolio Evaluation Program.

Registered Preceptor Requirements

NARM Policy states that a preceptor for a NARM PEP applicant must meet requirements for supervising CPM candidates and have current, approved registration through NARM. The NARM Registered Preceptor must be credentialed as a Certified Professional Midwife (CPM), Certified Nurse Midwife (CNM), Certified Midwife (CM); or s/he must be a licensed practitioner legally recognized by a [...]

Read more »

NARM's Portfolio Evaluation Process (PEP) is an educational evaluation process that includes verification of knowledge and skills by qualified preceptors. Completion of this process qualifies applicants to sit for the NARM skills and written examinations.

Candidates applying for certification through NARM's Portfolio Evaluation Process (PEP) will undergo a 3-step process:

STEP 1: Verification of Experience and Skills.

I. Fulfill the General Education Requirements (described in the Candidate Information Booklet).

II. Document the fulfillment of these requirements on the appropriate NARM application forms.
   A. Phase 1: Births as an Observer
      10 births in any setting, in any capacity (observer, doula, family member, friend, beginning apprentice).

   B. Phase 2: Clinicals as Assistant Under Supervision
      20 births, 25 prenatals (including 3 initial exams), 20 newborn exams, 10 postpartum visits as an assistant under the supervision of a qualified preceptor.

   C. Phase 3: Clinicals as Primary Under Supervision
      20 births, 75 prenatals (including 20 initial prenatals), 20 newborn exams, and 40 postpartum exams as a primary midwife under supervision. Continuity of Care births are required in this phase. CPR and NRP are submitted with this phase. The verification of Knowledge and Skills (Form 201a) will be submitted with this phase and may have been signed during Phase 2 or 3.

III. Provide verification from the preceptor(s) that you have achieved proficiency on each area listed on the Skills, Knowledge and Abilities Essential for Competent Practice Verification Form.

IV. Provide an affidavit from the preceptor(s) asserting that you have developed and utilize:
   A. Practice guidelines;

   B. An emergency care form;

   C. Informed disclosure (given at initiation of care); and

   D. An informed consent document used for shared decision making during care.

V. Provide three professional letters of reference.

VI. Submit completed Second Verification of Skills form.

Upon fulfillment of the above requirements you will be sent a Letter of Completion of NARM's Portfolio Evaluation Process, which will qualify you to sit for the NARM Examination.

STEP 2: Application for Certification Examination.

I. Submit the CPM Application Form (400) and your Letter of Completion of NARM's PEP Program to register for the exam.

Upon approval of your application materials, you will be receive a letter of intent from the Testing Department to register for the NARM Examination.

STEP 3: Phase 4

I. Five Additional Births as Primary Under Supervision

After you pass the NARM Examination and have submitted all other required documentation, you will receive your Certified Professional Midwife (CPM) Certificate.

Recertification is required every three years.

DOWNLOAD: Candidate Information Booklet (CIB)

The Candidate Information Booklet (CIB) is a comprehensive guide to all aspects of the certification process. It is recommended that all candidates have a copy of the CIB as they move through the process of documentation of experience, knowledge and skills.
The CIB also contains information on the NARM Skills and Written Exams, including test specifications and textbook lists. A paper copy can be ordered through the applications department or you can simply download an electronic copy.

Download the CIB pdf file

Order Paper Version of the CIB and/or the full CPM Application

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Getting Clinical Experience

The CPM credential requires that all candidates demonstrate a mastery of critical clinical components of midwifery care. The experience that leads to this proficiency can take many forms. For Entry-Level candidates seeking certification through the Portfolio Evaluation Process (PEP), NARM relies on experienced preceptors who validate the knowledge and skills acquired by their apprentices. Similar to a medical intern or resident, a midwifery apprentice is exposed to a variety of experiences that affirm didactic knowledge. NARM encourages aspiring midwives to establish solid and lasting apprenticeships with Registered Preceptors who can provide the best examples for professional practice.

Preceptor Information:

- Preceptor Registration and Information
- NARM Policy on Preceptor/Apprentice Relationships
- Guidelines for Verifying Clinical Experience
- Quarterly Evaluations
- Clinical Experience Form (to assist the student with record-keeping, not to be submitted to NARM)

- Revoked Preceptors

Resources:

- Networking Opportunities
- Professional Organizations
- State Info

Entry Level Application Information

The NARM Application Packet contains forms for documentation of experience, knowledge and skills, along with detailed instructions on how to fill out each form. All Entry Level Pep candidates must submit a completed application to the Applications Department in order to be eligible for the Written Exam.

NARM will continue to accept documentation on the older forms for clinicals obtained prior to September 1, 2012. Applicants who submit those forms are still required to submit the additional skills/clinicals on the current Form 111. For example, if you have Active Participants births on the old Form 111, prenatals, postpartums, etc will still need to be submitted on the new form.

Download all Entry Level Application Forms in pdf format here

Order Paper Version of the CIB and/or the full CPM Application

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Testing Information

The NARM Examination is now computer-based and the test is given year-round. Candidates will schedule their preferred test date directly with the testing company once their application process has been completed to the stage of testing.
Read more »

Entry Level FAQ

Very few applicants make it through the process without needing to ask a few questions. We have complied some of the more frequently asked questions (and answers!) for you here. If you don't find your question's answer here, you can contact us at applications@narm.org Are online CPR courses accepted by NARM? No. While we understand […]

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NARM Phone and Fax Number

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Appendix 3 - Traditional Cultural Midwife

Appendix 3- Traditional Cultural Midwife

Traditional Cultural Midwife is defined by Na Pua O Haumea 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.

*The definition of Traditional Cultural Midwife has been adapted (with permission) from the National Aboriginal Council of Midwives definition for aboriginal midwives in Canada.

UN Declaration on the Rights of Indigenous Peoples (UNDRIP):

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, Adopted by the General Assembly 61/295 in September 2007. As written, Act 32 violates these rights.

UN Declaration on the Rights of Indigenous Peoples (UNDRIP)
Article 8
1. Indigenous peoples and individuals have the right not to be subjected to forced assimilation or destruction of their culture.
2. States shall provide effective mechanisms for prevention of, and redress for:
(a) Any action which has the aim or effect of depriving them of their integrity as distinct peoples, or of their cultural values or ethnic identities;
(b) Any action which has the aim or effect of dispossessing them of their lands, territories or resources;
(c) Any form of forced population transfer which has the aim or effect of violating or undermining any of their rights;
(d) Any form of forced assimilation or integration;
(e) Any form of propaganda designed to promote or incite racial or ethnic discrimination directed against them.

Article 22
1. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities in the implementation of this Declaration.
2. States shall take measures, in conjunction with indigenous peoples, to ensure that indigenous women and children enjoy the full protection and guarantees against all forms of violence and discrimination.

Article 23
Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.
Article 24
1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.
2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

https://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf

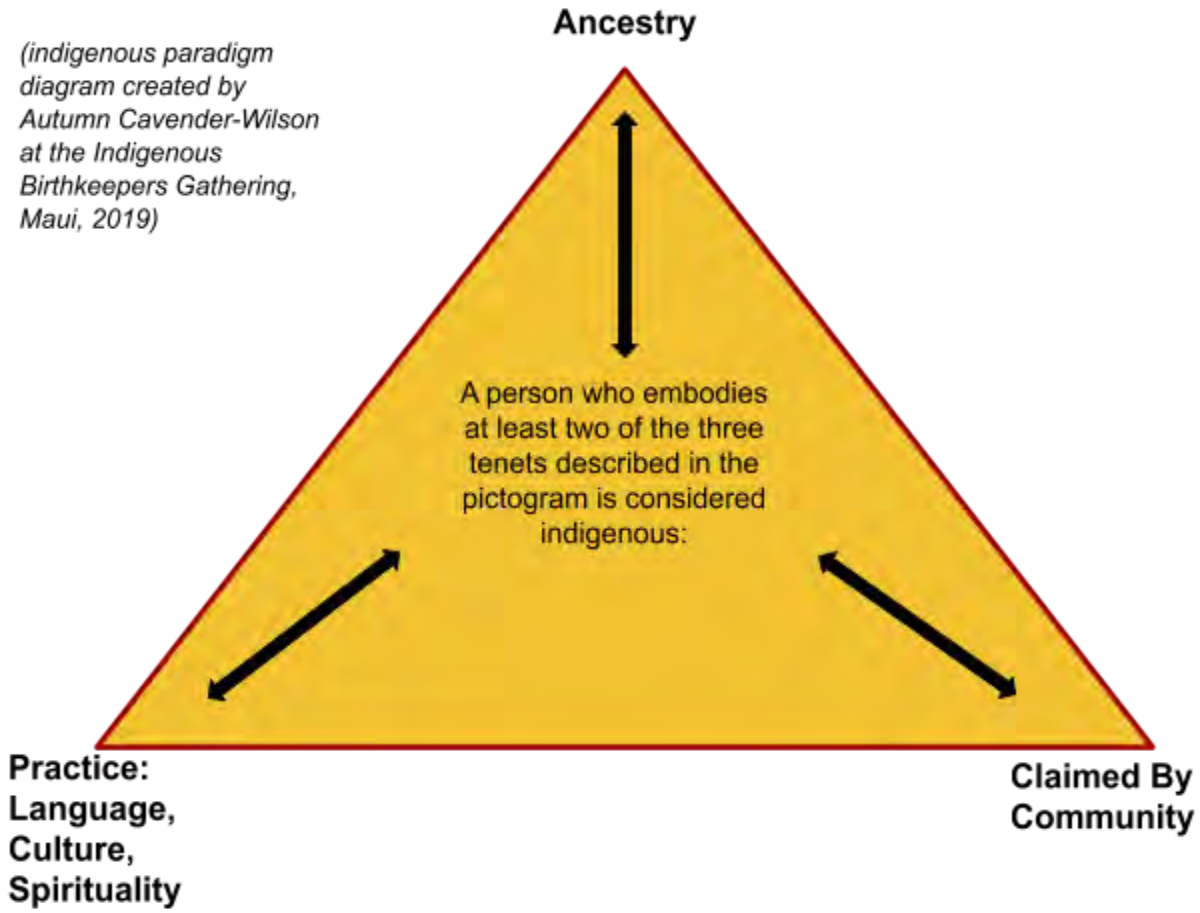
Traditional Cultural Midwives should be *exempt* from licensure because:

1. The pathway to licensure under Act 32 is based upon a set of values, beliefs and practices which come from the dominant western culture which has colonized them. Article 8 of the UN Declaration on the Rights of Indigenous Peoples (UNDRIP) states that they are specifically *protected from forced assimilation*. Act 32 forces indigenous midwives to assimilate in order to get licensed.
2. In addition, Article 8 provides *protection from destruction of culture*. Requiring Indigenous Traditional midwives to attain licensure forces them to learn, practice and perpetuate the culture of western midwifery instead of the midwifery of their people. This leads to a loss of traditional knowledge and skills which is *destruction of culture*. History shows that a widespread lapse of practice quickly leads to ancient knowledge slipping into obscurity.

> "Research shows that a strong determinant of a community's overall health is their ability to be self-determined and to reclaim and practice their cultural ways. Indigenous midwifery is crucial to this reclamation. It is the right of Indigenous midwives and communities to reclaim birth."

"Na Pua O Haumea" is the advisory council which provides guidance and accountability for traditional cultural midwives as well as the communities they serve. They support and promote the perpetuation of traditional childbirth practices in those communities while overseeing accountability for those who practice under the Traditional Cultural Midwives exemption.

Na Pua O Haumea uses the criteria in the diagram below to verify claims to indigeneity:



Upon request from Na Pua O Haumea, Traditional Cultural Midwives are expected to provide the following in order to substantiate their claim to indigeneity:

Lineage: Documentation demonstrating that the individual's practice of midwifery has been directly received through a spiritual and/or cultural lineage

Resume/biography of relevant experience and training in spiritual/cultural practices.

Ten notarized letters from members of the community they serve, attesting to the individual's service to the community. Seven of these should be directly from families that the individual has served under the direct supervision of an exempt midwife preceptor; three of these letters can come from organizations or community members who are familiar with the services provided to the community by the individual.

Na Pua O Haumea consists of seven volunteer members who have been selected for their cultural and midwifery knowledge as well as their respect in the community. They work in conjunction with indigenous and cultural midwives from Alaska, Canada and The United States to protect the integrity of Traditional Cultural Midwifery in Hawaii.

National Aboriginal Council of Midwives (NACM)

Position Statement on Evacuation for Birth

The National Aboriginal Council of Midwives (NACM) strongly condemns the routine and blanket evacuation of pregnant people for birth and demands the return of birthing services to all Indigenous communities. It is unacceptable that people must leave their communities and travel to large and usually southern centres to access maternity care services.1
NACM strongly advocates for the return of birth to all Indigenous, remote, and rural communities in Canada. It is vital that Indigenous Peoples are surrounded with all the love and support possible, which includes their families, community members, and the land.2 Giving birth in community is safe; communities under the care of a community midwifery program with careful risk screening can have better health outcomes than communities which have a blanket evacuation policy.3
NACM recognizes that some people will need to leave their community to give birth. However, the routine and blanket evacuation for all births is one factor that contributes to poorer birth outcomes for Indigenous Peoples. Evacuation for birth exposes Indigenous Peoples to the

systemic bias, racism, and trauma that is part of Canadian health care systems and continues the trauma of colonization.4,5,6

NACM affirms that Indigenous Peoples have an inherent right to birth in our communities and on the land. As Indigenous midwives, it is our right and responsibility to revitalize Indigenous birth ceremonies, knowledges, and languages to counter Canada's colonial path of purposeful and aggressive erasure of our Peoples. We actively assert our inherent rights as Indigenous Peoples and as Indigenous midwives.

NACM strongly asserts Indigenous midwives are key to the restoration of community birth. We are visibly present and engaged in health care systems across the country and provide clinically excellent care to our community members. We advocate for reproductive care that builds strong Indigenous families and communities and develops relationality. We work towards respectful, inclusive, and reciprocal relationships with Indigenous families, Indigenous care providers, and other health care providers so that Indigenous Peoples, families, and communities can achieve optimum health and wellness.

RECOMMENDATIONS

1. NACM calls for the immediate return of reproductive care and birth to Indigenous lands and communities as quickly and safely as possible. Having a trained and qualified professional provide reproductive care in the community creates better health outcomes.

2. NACM calls on all levels of government, health care organizations, and educational institutions to engage and provide equitable funds to Indigenous midwives. Increasing the number of Indigenous midwives and midwifery-led practices will bring birth back to as many communities as possible.

3. NACM calls on all Midwifery Education Programs (MEP) to establish and recognize Indigenous core competencies for Indigenous students and educators for the development of community-based education programs for Indigenous midwives.

4. NACM calls on national, provincial, and territorial midwifery associations and colleges to continue their support of expanding Indigenous midwifery in their jurisdictions.

5. NACM recognizes that some people will need to leave their community to give birth and that, with optimal support, communities will self-determine their individual needs and readiness. In the interim period of restoration of community birthing services, NACM supports Indigenous midwives who engage with medical referral centres and advocates for the recognition of barriers to equitable health services and systemic changes needed to achieve optimum health and wellness.

NACM calls for immediate actions to create the following conditions for evacuated families:

- Establish and maintain communication links between caregivers in the home community and referral centre;

- Create linkages to a complete range of support services in the referral centres including legal, financial, spiritual, informational and system navigation, advocacy, education, and counselling;

- Establish medical housing facilities in the referral centres that are safe, comfortable, culturally reflective, and can accommodate family needs. Complete support services must be accessible at or through the housing facility in a variety of Indigenous languages;

- Provide an assigned companion in the referral centres available to each person and family to provide information and emotional and physical support during the period of transition to parenthood. An ideal companion is an Indigenous doula;

- Provide financial support for hardship incurred by travelling for birth, such as childcare expenses, family visitation in cases of extended absence, and escort costs, including employment compensation, meals, transportation, and communication costs. Breastfeeding babies and young children or children with special needs must have funded accommodation and travel;

- Maintain the client as an active participant in planning for place of birth, primary caregiver, and travel arrangements. This includes scheduling travel according to individual postpartum needs and adjustments, such as prioritizing the establishment and support of breastfeeding and

- Ensure the referral centre staff who care for evacuated parents and families are trained in cultural safety, evacuation procedures, and know the services available to evacuated clients and their families.

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4. Kornelsen, J., Kotaska, A., Waterfall, P., Willie, L., & Wilson, D. (2010). The geography of belonging: The experience of birthing at home for First Nations women. *Health & Place, 16(*4), 638-645.

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6. Olson, R. (2013). *Relocating childbirth: The politics of birth place and Aboriginal midwifery in Manitoba, Canada* (Unpublished doctoral dissertation). University of Sussex, Brighton, U.K.

ADDITIONAL RESOURCES

Darling, L., Lawford, K., Wilson, K., Kryzanauskas, M., & Bourgeault, I. (2018). Distance from homebirth to emergency obstetrical services and neonatal outcomes: A cohort study. *Journal of Midwifery & Women's Health, 64*(2), 170-178. doi: 10.1111/jmwh.12896

Grzybowski, S., Stoll, K., & Kornelsen, J. (2011). Distance matters: A population-based study examining access to maternity services for rural women. *BMC Health Services Research, 11*(1), 147.

Lawford, K.M., Giles, A.R., & Bourgeault, I.L. (2018). Canada's evacuation policy for pregnant First Nations women: Resignation, resilience, and resistance. *Women and Birth 31*(6), 479-488. doi: 10.1016/j.wombi.2018.01.009

Lawford, K., & Giles, A.R. (2012). Marginalization and coercion: Canada's evacuation policy for pregnant First Nations women who live on reserves in rural and remote regions. *Pimatisiwin, 10*(3), 327-340.

NACM resource: *Indigenous Midwifery Knowledge and Skills: A Framework of Competencies*

General Areas of Competence, Skills, Sub-Skills, Knowledge, and Abilities

General Area of Competence A: Provide Culturally Safe Care

General Area of Competence B: Support Rites of Passage

General Area of Competence C: Communicate

General Area of Competence D: Develop the Profession

General Area of Competence E: Support Indigenous Health and Well-Being

General Area of Competence F: Manage Prenatal Care

General Area of Competence G:Manage Labour and Delivery

General Area of Competence H:Provide Postpartum Care

General Area of Competence I: Provide Newborn Care

https://indigenousmidwifery.ca/wp-content/uploads/2019/07/NACM_CompetencyFramework_2019.pdf

Midwives Alliance of North America:

MANA Statement of Values and Ethics
The Statement of Values and Ethics of the Midwives Alliance of North America (MANA) is a critical reflection of moral issues as they pertain to maternal and child health. It is intended to provide guidance for professional conduct in the practice of midwifery, as well as influence MANA's organizational policies, thereby promoting high quality care for childbearing families.

Statement of Values
Since what we value infuses and informs our ethical decisions and actions, the Midwives Alliance of North America affirms:

I. Woman As a Unique Individual:

A. We value each woman as a strong, creative, unique individual with life-giving powers.

B. We value each woman's right to a supportive caregiver appropriate to her needs and respectful of her belief system.

C. We value a woman's right to access resources in order to achieve health, happiness and personal growth according to her needs, perceptions and goals.

D. We value a woman as autonomous and competent to make decisions regarding all aspects of her life.

E. We value the empowerment of a woman during the processes of pregnancy, birth, breastfeeding, mother–infant attachment and parenting.

II. Mother and Baby as Whole:

A. We value the mother and her baby as an inseparable and interdependent whole and acknowledge that each woman and baby have parameters of well-being unique to themselves.

B. We value the physical, psychosocial and spiritual health, well-being and safety of every mother and baby.

C. We value the mother as the direct care provider for her unborn child.

D. We value the process of labor and birth as a rite of passage with mother and baby as equal participants.

E. We value the sentient and sensitive nature of the newborn and affirm every baby's right to a caring and loving birth without separation from mother and family.

F. We value breastfeeding as the ideal way to nourish and nurture the newborn.

III. The Nature of Birth:

A. We value the essential mystery of birth.

B. We value pregnancy and birth as natural, physiologic and holistic processes that technology will never supplant.

C. We value the integrity of a woman's body, the inherent rhythm of each woman's labor and the right of each mother and baby to be supported in their efforts to achieve a natural, spontaneous vaginal birth.

D. We value birth as a personal, intimate, internal, sexual and social experience to be shared in the environment and with the attendants a woman chooses.

E. We value the right of a woman and her partner to determine the most healing course of action when difficult situations arise.

F. We value the art of letting go and acknowledge death and loss as possible outcomes of pregnancy and birth.

IV. The Art of Midwifery:

A. We value our right to practice the art of midwifery, an ancient vocation of women.

B. We value multiple routes of midwifery education and the essential importance of apprenticeship training.

C. We value the wisdom of midwifery, an expertise that incorporates theoretical and embodied knowledge, clinical skills, deep listening, intuitive judgment, spiritual awareness and personal experience.

D. We value the art of nurturing the inherent normalcy of pregnancy and birth as expressions of wellness in a healthy woman.

E. We value continuity of care throughout the childbearing year.

F. We value birth with a midwife in any setting that a woman chooses.

G. We value homebirth with a midwife as a wise and safe choice for healthy families.

H. We value caring for a woman to the best of our ability without prejudice with regards to age, race, ethnicity, religion, education, culture, sexual orientation, gender identification, physical abilities or socioeconomic background.

I. We value the art of empowering women, supporting each to birth unhindered and confident in her natural abilities.

J. We value the acquisition and use of skills that identify and guide a complicated pregnancy or birth to move toward greater well-being and be brought to the most healing conclusion possible.

K. We value standing up for what we believe in the face of social pressure and political oppression.

V. Woman as Mother:

A. We value a mother's intuitive knowledge and innate ability to nurture herself, her unborn baby and her newborn baby.

B. We value the power and beauty of a woman's body as it grows in pregnancy and a woman's strength in labor and birth.

C. We value pregnancy and birth as processes that have lifelong impact on a woman's self-esteem, her health, her ability to nurture and her personal growth.

D. We value the capacity of partners, family and community to support a woman in all aspects of pregnancy, birth and mothering and to provide a safe environment for mother and baby.

VI. The Nature of Relationship:

A. We value an egalitarian relationship between a woman and her midwife.

B. We value the quality, integrity and uniqueness of our interactions, which inform our choices and decisions.

C. We value mutual trust, honesty and respect.

D. We value a woman's right to privacy, and we honor the confidentiality of all personal interactions and health records.

E. We value direct access to information that is readily understood by all.

F. We value personal responsibility and the right of a woman to make decisions regarding what she deems best for herself, her baby and her family, using both informed consent and informed refusal.

G. We value our relationship to a process that is larger than ourselves, recognizing that birth is something we can seek to learn from and to know, but cannot control.

H. We value humility and the recognition of our own limitations.

I. We value sharing information and understanding about birth experiences, skills and knowledge.

J. We value a supportive midwifery community as an essential place of learning.

K. We value diversity among midwives that broadens our collective resources and challenges us to work toward greater understanding.

L. We value collaboration between a midwife and other health-care practitioners as essential to providing a family with resources to make responsible and informed choices.

M. We value the right and responsibility of both a midwife and a woman to discontinue care when insurmountable obstacles develop that compromise communication, mutual trust or joint decision making.

N. We value the responsibility of a midwife to consult with other health-care practitioners when appropriate and refer or transfer care when necessary.

VII. Cultural Sensitivity, Competency and Humility

A. We value cultural sensitivity, competency and humility as critical skills for the midwife to master in an increasingly multicultural society.

B. We value cultural sensitivity—a midwife's awareness of and ability to honor differences between people and the cultural values of the women she serves.

C. We value the importance of cultural competency in addressing the social and economic barriers to access to care for vulnerable, underserved and marginalized women, thereby improving maternal and infant health and the well-being of families.

D. We value cultural humility as a lifelong process of self-reflection and self-critique in order to develop a respectful partnership with each woman.*

*Section VII is derived from Melanie Tervalon and Jann Murray-Garcia, "Cultural Humility versus Cultural Competency: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education," Journal of Health Care for the Poor and Underserved 9 (May 1998): 117–25.

Statement of Ethics

Our values inform and inspire midwifery practice in our hearts and minds. Acting ethically is an expression of our values within the context of our individual, geographic, religious, cultural, ethnic, political, educational and personal backgrounds and in our relationships with others. As we seek to respond in the moment to each situation we face, we call upon ethical principles of human interaction as follows:

- Beneficence—to act so as to benefit others
- Nonmaleficence—to avoid causing harm
- Confidentiality—to honor others' privacy and keep personal interactions confidential
- Justice—to treat people respectfully and equitably
- Autonomy—to respect an individual's rights to self-determination and freedom to make decisions that affect his or her life.

The equality and mutuality of the relationship between midwife and client create a foundation uniquely suited to integrate these principles. As midwives, we seek to benefit women and babies in our care. Mutual trust and respect are critical to the success of a relationship that requires joint decision making at every level. Moral integrity, truthfulness and adequate information enable all participants to judge together the best course of action in varied situations.

Judgments are fundamentally based on awareness and understanding of ourselves and others. They grow out of our own sense of moral integrity, which is born within the heart of each individual. Becoming self-aware and increasing understanding are ongoing processes that must be nurtured as a function of personal and professional growth. MANA's affirmation of individual moral integrity and recognition of the complexity of life events bring us to an understanding that there cannot possibly be one right answer for all situations. Since the outcome of pregnancy is ultimately unknown and is always unknowable, it is inevitable that in certain circumstances our best decisions in the moment will lead to consequences we could not foresee.

We recognize the limitations of traditional codes of ethics that present a list of rules to be followed. Therefore, a midwife must develop a moral compass to guide practice in diverse situations that arise from the uniqueness of pregnancy and birth as well as the relationship between midwives and birthing women. This approach affirms the mystery and potential for transformation present in every experience and fosters truly diverse practice. Midwifery care is woman-led care with informed choice and a clear set of values at its core. Decision making is a shared responsibility with the goals of healthy women and babies and of gentle, empowering

births with a focus on individual and family needs and concerns. Ultimately, it is at the heart of midwifery practice to honor and respect the decisions women make about their pregnancies and births based on their knowledge and belief about what is best for themselves and their babies.

There are both individual and social implications to any decision-making process. Our decisions may be impacted by the oppressive rules and practices of a society that is often hostile to homebirth, midwives and midwifery clients. Our actual choices may be limited by the medical, legal, political, economic, cultural or social climate in which we function. The more our values conflict with those of the dominant culture, the greater the threat to the integrity of our own values, and the greater the risk that our actions may lead to professional repercussions or legal reprisal. In such conditions we may be unable to make peace with any course of action or may feel conflicted about a choice already made. The community of women, both midwives and those we serve, may provide a fruitful resource for continued moral support and guidance.

In summary, acting ethically requires us to define our values, respond to the communities of families, midwives and cultures in which we find ourselves, act in accord with our values to the best of our ability as the situation demands, and engage in ongoing self-examination, evaluation, peer review and professional growth. By carefully describing the multifaceted aspects of what we value and defining the elements of moral integrity and decision making, we have created a framework for ethical behavior in midwifery practice. We welcome an open and ongoing articulation of values and ethics and the evolution of this document.

Midwives Model of Care™ Is Woman-Centered

The Midwives Model of Care™ is a fundamentally different approach to pregnancy and childbirth than contemporary obstetrics. Midwifery care is uniquely nurturing, hands-on care before, during, and after birth. Midwives are health care professionals specializing in pregnancy and childbirth who develop a trusting relationship with their clients, which results in confident, supported labor and birth. While there are different types of midwives practicing in various settings, all midwives are trained to provide comprehensive prenatal care and education, guide labor and birth, address complications, and care for newborns. The Midwives Model of Care™ is based on the fact that pregnancy and birth are normal life events. The Midwives Model of Care includes:

- monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle
- providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support
- minimizing technological interventions and
- identifying and referring women who require obstetrical attention.

The application of this model has been proven to reduce to incidence of birth injury, trauma, and cesarean section.

Improved Outcomes for Aboriginal Mothers/Infants with Aboriginal Midwife Exemption:

Remote midwifery in Nunavik, Québec, Canada: outcomes of perinatal care for the Inuulitsivik health centre, 2000-2007.Van Wagner V1, Osepchook C, Harney E, Crosbie C, Tulugak M.

Midwifery Education Program, Ryerson University, Toronto, Ontario, Canada.

Abstract

BACKGROUND:

The Inuulitsivik midwifery service is a community-based, Inuit-led initiative serving the Hudson coast of the Nunavik region of northern Québec. This study of outcomes for the Inuulitsivik birth centers, aims to improve understanding of maternity services in remote communities.

METHODS:

We used a retrospective review of perinatal outcome data collected at each birth at the Inuulitsivik birth centers to examine outcomes for 1,372 labors and 1,382 babies from 2000 to 2007. Data were incomplete for some indicators, particularly for transfers to Montreal.

RESULTS:

Findings revealed low rates of intervention with safe outcomes in this young, largely multiparous "all risk" Inuit population. Ninety-seven percent of births were documented as spontaneous vaginal deliveries, and 85 percent of births were attended by midwives. Eighty-six percent of the labors occurred in Nunavik, whereas 13.7 percent occurred outside Nunavik. The preterm birth rate was found to be 10.6 percent. Postpartum hemorrhage was documented in 15.4 percent of women; of these cases, 6.9 percent had blood loss greater than 1,000 mL. Four fetal deaths (2.9 per 1,000) and five neonatal deaths (< 3.6 per 1,000) were documented. Nine percent (9%) of births involved urgent transfers of mother or baby. The most common reasons for medical evacuation were preterm labor and preeclampsia, and preterm birth was the most common reason for urgent neonatal transfer.

CONCLUSIONS:

The success of the Innulitsivik midwifery service rests on the knowledge and skills of the Inuit midwives, and support of an interprofessional health team. Our study points to the potential for safe, culturally competent local care in remote communities without cesarean section capacity. Our findings support recommendations for integration of midwifery services and Aboriginal midwifery education programs in remote communities.

Reclaiming Birth, Health, and Community: Midwifery in the Inuit Villages of Nunavik, Canada

VickiVan WagnerRMBrendaEpooJulieNastapokaEvelynHarneyBA, SM

Journal of Midwifery & Women's Health
Volume 52, Issue 4, July–August 2007, Pages 384-391

This article describes the Inuulitsivik midwifery service and education program, an internationally recognized approach to returning childbirth to the remote Hudson coast communities of Nunavik, the Inuit region of Quebec, Canada. The service is seen as a model of community-based education of Aboriginal midwives, integrating both traditional and modern approaches to care and education. Developed in response to criticisms of the policy of evacuating women from the region in order to give birth in hospitals in southern Canada, the midwifery service is integrally linked to community development, cultural revival, and healing from the impacts of colonization. The midwifery-led collaborative model of care involves effective teamwork between midwives, physicians, and nurses working in the remote villages and at the regional and tertiary referral centers. Evaluative research has shown improved outcomes for this approach to returning birth to remote communities, and this article reports on recent data. Despite regional recognition and wide acknowledgement of their success in developing and sustaining a model for remote maternity care and aboriginal education for the past 20 years, the Nunavik midwives have not achieved formal recognition of their graduates under the Quebec Midwifery Act.

https://www.sciencedirect.com/science/article/pii/S1526952307001122?via%3Dihub

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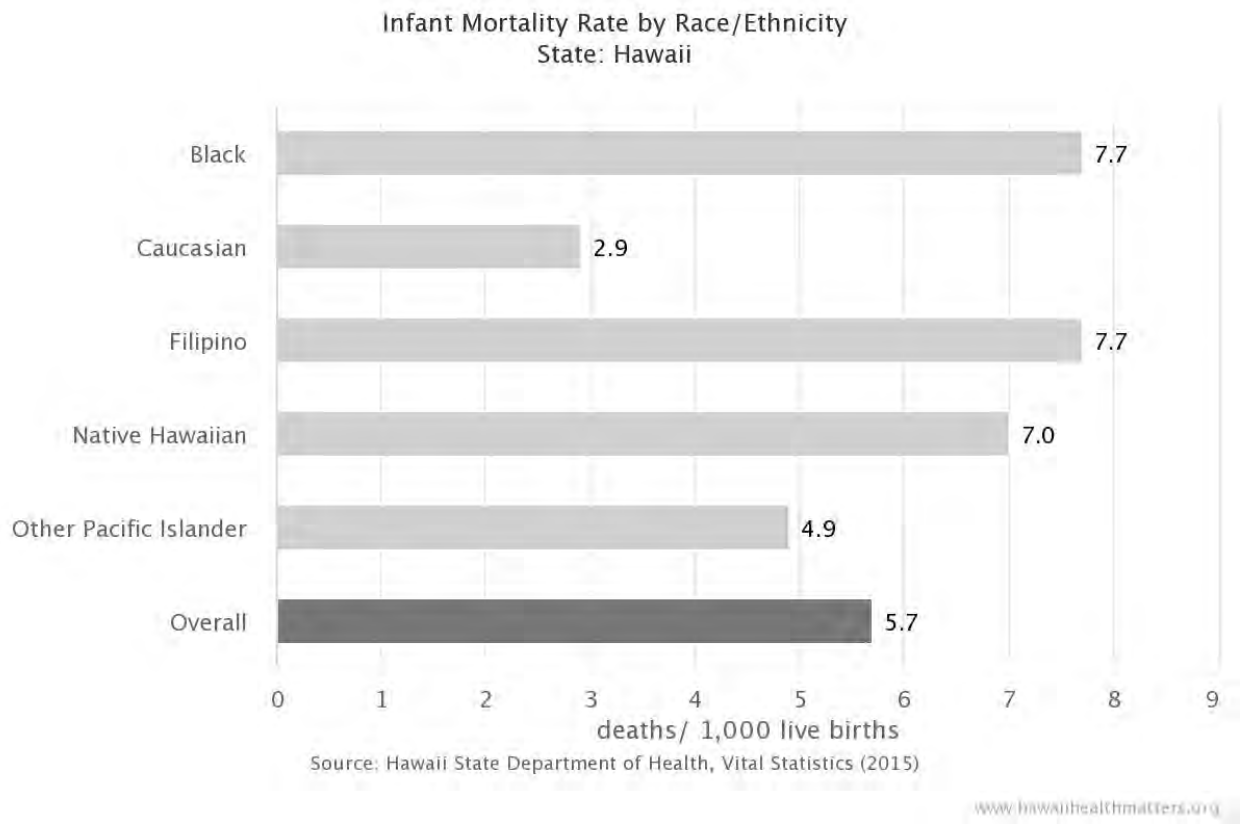
While the modern medical system may be working for the most privileged portion of our population it is not working for the indigenous, impoverished and disenfranchised. Native Hawaiian infant mortality rates are 22.81% higher than the statewide average and more than double that of caucasian infant mortality rates. African American and Filipino infant mortality rates are even higher than those of Hawaiians.



https://apps.who.int/iris/bitstream/handle/10665/112697/WHO_RHR_14.13_eng.pdf;jsessionid=47E9CC4C193F63CAC04F2FEA4F50758F?sequence=1

http://www.hawaiihealthmatters.org/indicators/index/view?indicatorId=1259&localeId=14

https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm

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United Nations Permanent Forum on Indigenous Issues:

Understanding the term “indigenous”

Considering the diversity of indigenous peoples, an official definition of “indigenous” has not been adopted by any UN-system body. Instead the system has developed a modern understanding of this term based on the following:

- Self- identification as indigenous peoples at the individual level and accepted by the community as their member.
- Historical continuity with pre-colonial and/or pre-settler societies
- Strong link to territories and surrounding natural resources
- Distinct social, economic or political systems
- Distinct language, culture and beliefs
- Form non-dominant groups of society
- Resolve to maintain and reproduce their ancestral environments and systems as distinctive peoples and communities.

A question of identity

- According to the UN the most fruitful approach is to identify, rather than define indigenous peoples. This is based on the fundamental criterion of self-identification as underlined in a number of human rights documents.

https://www.un.org/esa/socdev/unpfii/documents/5session_factsheet1.pdf

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Additional Resources:

https://midwiferytoday.com/mt-articles/traditional-midwives-are-midwives/

https://drive.google.com/file/d/0B67ejH46ELQ_UE43RXUxRG1Qak5DSFpJUk9MZE9jSmJwanBV/view?usp=sharing

Appendix 4 - Training and Access to Emergency Drugs and Devices

Appendix 4: Training and access to emergency drugs and devices.

The role of oxygen in neonatal resuscitation

Approximately 10% of newborns require some assistance to begin breathing at birth. Less than 1% require extensive resuscitation measures,[4] such as cardiac compressions and medications. Although most newly born infants successfully transition from intrauterine to extrauterine life without special help, because of the large total number of births, a significant number will require some degree of resuscitation.[3]

Newly born infants who do not require resuscitation can be generally identified upon delivery by rapidly assessing the answers to the following 3 questions:

- Term gestation?
- Good tone?
- Breathing or crying?

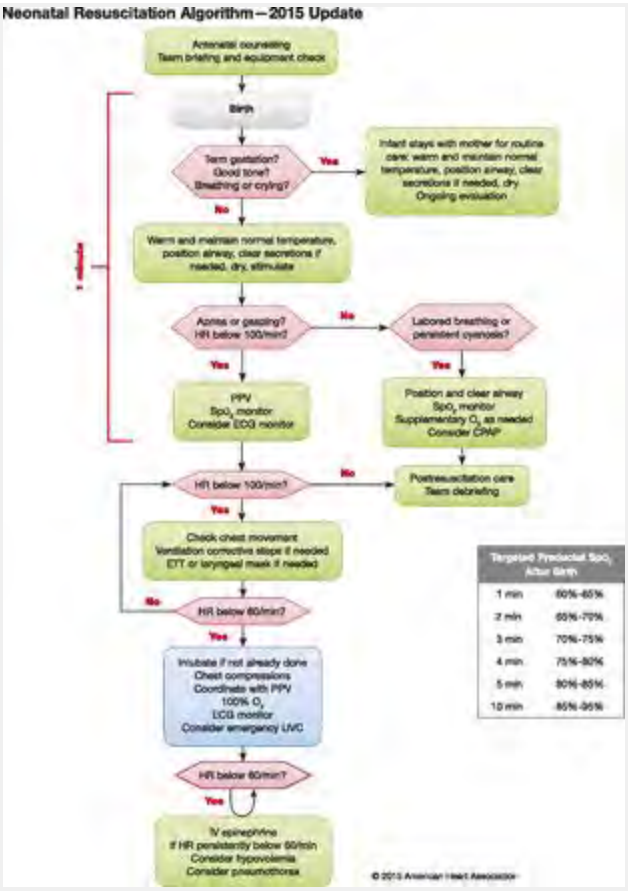
If the answer to all 3 questions is "yes," the newly born infant may stay with the mother for routine care. Routine care means the infant is dried, placed skin to skin with the mother, and covered with dry linen to maintain a normal temperature. Observation of breathing, activity, and color must be ongoing.

If the answer to any of these assessment questions is "no," the infant should be moved to a radiant warmer to receive 1 or more of the following 4 actions in sequence:

A. Initial steps in stabilization (warm and maintain normal temperature, position, clear secretions only if copious and/or obstructing the airway, dry, stimulate)
B. Ventilate and oxygenate
C. Initiate chest compressions
D. Administer epinephrine and/or volume

Approximately 60 seconds ("the Golden Minute") are allotted for completing the initial steps, reevaluating, and beginning ventilation if required (**Figure 1**). Although the 60-second mark is not precisely defined by science, it is important to avoid unnecessary delay in initiation of ventilation, because this is *the* most important step for successful resuscitation of the newly born who has not responded to the initial steps. The decision to progress beyond the initial steps is determined by simultaneous assessment of 2 vital characteristics: respirations (apnea, gasping, or labored or unlabored breathing) and heart rate (less than 100/min). Methods to accurately assess the heart rate will be discussed in detail in the section on Assessment of Heart Rate. Once positive-pressure ventilation (PPV) or supplementary oxygen administration is started, assessment should consist of simultaneous evaluation of 3 vital characteristics: heart rate, respirations, and oxygen saturation, as determined by pulse oximetry and discussed under Assessment of Oxygen Need and

Administration of Oxygen. The most sensitive indicator of a successful response to each step is an increase in heart rate.[3]



https://pediatrics.aappublications.org/content/136/Supplement_2/S196

https://www.aap.org/en-us/continuing-medical-education/life-support/NRP/Pages/About-NRP.aspx

WHO Recommendations for the prevention of PPH

(1) "The use of uterotonics for the prevention of PPH during the third stage of labour is recommended for all births. (Strong recommendation, moderate-quality evidence)"

1. "Oxytocin (10 IU, IV/IM) is the recommended uterotonic drug for the prevention of PPH. (Strong recommendation, moderate-quality evidence)"
2. "In settings where oxytocin is unavailable, the use of other injectable uterotonics (if appropriate ergometrine/methylergometrine or the fixed drug combination of oxytocin and ergometrine) or oral misoprostol (600 µg) is recommended. (Strong recommendation, moderate quality evidence)"
3. "In settings where skilled birth attendants are not present and oxytocin is unavailable, the administration of misoprostol (600 µg PO) by community health care workers and lay health workers is recommended."

WHO recommendations for the prevention and treatment of postpartum haemorrhage

http://apps.who.int/iris/bitstream/10665/75411/1/9789241548502_eng.pd

Recommendations for the prevention of neonatal ophthalmia

Neonatal ophthalmia is defined as conjunctivitis that occurs within the first four weeks of life (2). It is a relatively common illness, occurring in 1% to 12% of newborn infants. Antibiotics used in the prevention of gonococcal ophthalmia (tetracycline and erythromycin) may be more effective than silver nitrate and they are considered to be acceptable alternatives (2,11–14). Tetracycline is more active than erythromycin in vitro against sensitive isolates of *N gonorrhoeae*. The estimated failure rate of tetracycline prophylaxis is 0.012%, while that of erythromycin is 0.005% (9). Other agents may also be effective in prophylaxis. The use of these agents may also provide some benefit in the prevention of ophthalmia due to other organisms. As well, the Canadian Paediatric Society supports routine prenatal screening for *N gonorrhoeae* and *Chlamydia trachomatis*, and the treatment of identified infections during pregnancy.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2795679/

The use of erythromycin eye ointment in newborns has its roots in the late 1800s. Back then, about 10% of newborns born in hospitals across Europe developed an illness called ophthalmia neonatorum. This illness caused blindness in 3% of affected infants (Schaller & Klauss, 2001).

https://evidencebasedbirth.com/is-erythromycin-eye-ointment-always-necessary-for-newborns/

Vitamin K in the Newborn Period

Failure to receive vitamin K after birth significantly increases the risk of vitamin K dependent bleeding (VKDB). VKDB has been classified as early (<24 hours of age), classical (days 1-7) and late (> 1 week and < 6 months of age). Late VKDB is usually characterized by intracranial bleeding and carries a high risk of negative neurodevelopmental impact. The risk for late VKDB is 81 times greater among infants not receiving vitamin K intramuscularly compared to those receiving this treatment.

(4) Vitamin K per the American Academy of Pediactrics; https://www.aappublications.org/news/2018/07/27/vitamin-k-in-the-newborn-period-how-important-is-it-pediatrics-7-27-18

Antibiotics during Labor

Clinicians give antibiotics to women who are at increased risk of having a baby who will develop GBS disease. The antibiotics help protect babies from infection, but only if given during labor. Doctors cannot give antibiotics before labor begins because the bacteria can grow back quickly.

Clinicians give the antibiotic by IV (through the vein). Clinicians most commonly prescribe a type of antibiotic called beta-lactams, which includes penicillin and ampicillin.

https://www.cdc.gov/groupbstrep/about/prevention.html

Use of Intravenous Fluids in the Treatment of Postpartum Hemorrhage

Most common causes of postpartum blood loss:
Uterine atony Tone 70%
Episiotomy, tears Trauma 20%
Retained placenta Tissue 10%

Primary coagulopathy Thrombin <1%

From a transfusion requirement perspective, among women who fit the basic diagnostic criteria for PPH there are generally 3 groups:

◦ Mild PPH • May require fluid resuscitation but generally respond to first line pharmacological treatment

• Do not require blood products.

https://www.ucc.ie/en/media/research/nationalperinatalepidemiologycentre/npecstudyday2016/PPH_Transfusion_Strategies_NPEC_2017.pdf

ACOG Practice Bulletin No. 181: Management of Alloimmunization During Pregnancy

Rho (D) immune globulin per ACOG;

In the United States, a recommendation for the administration of anti-D immune globulin was introduced in the 1970s. The current practice of administering a single antenatal dose of 300 micrograms of anti-D immunoglobulin at 28 weeks of gestation followed by a second dose after birth when newborn Rh D typing has identified the infant as Rh positive. A single dose given to susceptible Rh D-negative women within 72 hours of delivery reduced the rate of Rh D alloimmunization by 80–90%.

https://www.ncbi.nlm.nih.gov/m/pubmed/16880320/

https://journals.lww.com/greenjournal/FullText/2017/08000/Practice_Bulletin_No__181__Prevention_of_Rh_D.54.aspx

2019 Minnesota Statutes

147D.09 LIMITATIONS OF PRACTICE FOR TRADITIONAL MIDWIVES.

(a) A licensed traditional midwife shall not prescribe, dispense, or administer prescription drugs, except as permitted under paragraph (b).

(b) A licensed traditional midwife may administer vitamin K either orally or through intramuscular injection, maternal RhoGAM treatment, postpartum antihemorrhagic drugs

under emergency situations, local anesthetic, oxygen, and a prophylactic eye agent to the newborn infant.

(c) A licensed traditional midwife shall not perform any operative or surgical procedures except for suture repair of first- or second-degree perineal lacerations.
https://www.revisor.mn.gov/statutes/cite/147D.09

Oregon continuing education requirements for direct entry midwives:

Eight and a half (8.5) continuing education hours for subsequent renewal - Legend Drugs and Devices

Must complete eight and a half hours of legend drugs and devices CE every two (2) years. CE components for subsequent renewals must

For the current CE requirements, please see OAR 332-020-0010.

https://secure.sos.state.or.us/oard/viewSingleRule.action;JSESSIONID_OARD=Wbep834d_BIf6N6xTk9Zfj9n5vRGJIyIQ5K5Z_ORuc6pm62yofNl!2024649768?ruleVrsnRsn=51787

https://www.oregon.gov/OHA/PH/HLO/Pages/Board-Direct-Entry-Midwifery-Education.aspx

HiHBC Elder/Experienced Midwife Application

Please document the fulfillment of the requirements on the following HiHBC forms.

Primary Midwife for a minimum of 15 years with a minimum of the last 5 years in Hawaii (These births must have occurred in the US)

75 out of hospital births with at least 10 having occurred in the last 2 years
300 Prenatal visits with at least 50 different women
50 newborn exams
75 Postpartum visits

Additional Documentation to complete your application:
Individualized Practice Guidelines
Informed Consent Document
Hospital Transport Form
Current CPR
Approved NRP Certification
4 professional letters of reference; 3 from prior midwifery clients and 1 from midwives or physicians whom Have knowledge of your experience, skill level, and good character

Please fill out and submit the form below to register.

Name:

Last First

Email Address: Phone:

Mailing Address

Street Address:	Address line 2:
City:	State:
Zip Code:	County:

Date of Birth:	High School Graduate or Equivalent:
Social Security # or State ID #	Degree of Vocational/technical certificate, please specify:

Midwife Birth Log for Elder/Experience Midwife

(75 req.)

Registering Midwife Name:

Birth #	Client # or Code	Date of Birth	# of Prenatals (300 req)	# of Newborn Exams (50 req)	# of Postpartum Exams (75 req)
1.					
2.					
3.					
4.					
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72.					
73.					
74.					
75.					
TOTAL:					

Additional Documentation to complete your application:

- ☐ Individualized Practice Guidelines
- ☐ Informed Consent Document
- ☐ Hospital Transport Form
- ☐ Current CPR
- ☐ Approved NRP Certification
- ☐ Professional Character Letter Reference
- ☐ Professional Character Letter Reference
- ☐ Professional Character Letter Reference
- ☐ Professional Character Letter Reference

HiHBC Registered Midwife application for use of limited medications:
Please attach documentation of specified CEU classes.

Applicant:

_____ _____
Last **First**

_____
Email Address:

_____
Phone:

_____
Mailing Address:

_____
Address line 2:

_____ _____ _____ _____
City: **State:** **Zip Code:** **County:**

_____ _____ _____
Date of Birth **HiHBC Registration number** **Social Security / State ID number**

To maintain authorization for the use of State approved Legend Drugs this form must be completed. Please attach proof of a minimum of eight and a half hours of CEUs relating to the use of legend drugs and devices in midwifery. This must be renewed every three (3) years.

CEU must include the following:
2 hours in Pharmacology;
1.5 hours in administering of medications through injection;
1 hour in advanced treatment of shock;
3 hours in intravenous therapy; and
3 hours in suturing.

HiHBC Registered Community Based Midwife Application

Please document the fulfillment of the requirements on the following HiHBC forms.

Observer

10 Births in any setting, in any capacity (observer, doula, family member, friend, beginning apprentice)

Assistant Under Supervision

20 births
25 prenatals (including 3 initial exams)
20 newborn exams
10 postpartum visits

Primary Under Supervision

25 births
75 prenatals (including 20 initial prenatals)
20 newborn exams
40 postpartum exams

Additional Documentation:

Provide verification from your preceptor(s) that proficiency has been achieved in each area listed on the appropriate HiHBC form. In the event that a preceptor is unable to verify the applicants proficiency, the applicant must provide a notarized affidavit attesting to these special circumstances, as well as 3 additional professional letters of reference that can verify these circumstances.

If your Preceptor is unable to verify your log documentation, please provide the following 5 Letters:
Notarized Preceptor Letter
Notarized Applicant Letter
Professional Letter of Reference
Professional Letter of Reference
Professional Letter of Reference

Additional Documentation to complete your application:
Individualized Practice Guidelines
Informed Consent Document
Hospital Transport Form
Current CPR
Approved NRP Certification
Professional Character Letter Reference
Professional Character Letter Reference
Professional Character Letter Reference

Applications that are incomplete or unable to be verified will not be guaranteed registration and will be evaluated on a case by case basis. Upon verification of the completed application, new members will receive a welcome letter from HiHBC with a registration number, and certificate.

Please fill out and submit the form below to register.

Name:

Last First

Email Address: Phone:

Mailing Address

Street Address:	Address line 2:
City:	State:
Zip Code:	County:

Date of Birth:	High School Graduate or Equivalent:
Social Security # or State ID #	Degree of Vocational/technical certificate, please specify:

PRECEPTOR (S) INFORMATION:

	First/Last Name	**ID#**	**Signature**	**Initials**
1.				
2.				
3.				

Births as an Observer Log (10 req.)

Registering Midwife Name:

Birth #	Client # or Code	Date of Birth	Location Of Birth	Role in Birth
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Midwife Birth Log for Assistant under Supervision

Assistant Under Supervision (20 req.)

Registering Midwife Name:

Birth #	Client # or Code	Date of Birth	Attended Birth Y/N	# of Prenatals (25 req)	# of Newborn Exams (20 req)	# of Postpartum Visits (10 req)	Preceptor ID	Preceptor Initials
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								
16.								
17.								
18.								
19.								
20.								
TOTALS:								

Midwife Birth Log for Primary under Supervision

Primary Under Supervision (25 req.)

Registering Midwife Name:

Birth #	Client # or Code	Date of Birth	Attended Birth Y/N	# of Prenatals (75 req)	# of Newborn Exams (20 req)	# of Postpartum Exams (40 req)	Preceptor ID	Preceptor Initials
1.								
2.								
3.								
4.								
5.								
6.								
7.								
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10.								
11.								
12.								
13.								
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15.								
16.								
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18.								
19.								
20.								
TOTALS:								

Additional Documentation to complete your application:

- ☐ Individualized Practice Guidelines
- ☐ Informed Consent Document
- ☐ Hospital Transport Form
- ☐ Current CPR
- ☐ Approved NRP Certification
- ☐ Professional Character Letter Reference ☐ Professional Character Letter Reference ☐ Professional Character Letter Reference

Additional Documentation

If your Preceptor is unable to verify your log documentation, please provide the following 5 Letters:

- ☐ Notarized Preceptor Letter
- ☐ Notarized Applicant Letter
- ☐ Professional Letter of Reference ☐ Professional Letter of Reference ☐ Professional Letter of Reference

Appendix 6 - Comments by Task Force Members and the Public

RE: HiHBC response to Hawaii Home Birth Task Force Report

Dear Ms. Duarte,

HiHBC represents the majority of home birth midwives in Hawai'i. We are thankful we had the opportunity to work on the report for the Hawai'i Home Birth Task Force regarding Act 32 with the other concerned task force members.

Act 32 clearly mandates this community of "birth attendants" DEFINE THEMSELVES and develop common standards, accountability measures, and disclosure requirements" (Act 32 Part I Section 1). In the four short months of meetings HiHBC has seen "this community" accomplish all of what it was asked to do in this section and clearly outline this in the task force report.

How to incorporate themselves into a "statute that will incorporate ALL birth practitioners and allow them to practice to the fullest extent under the law" has been more challenging, primarily due to opposition from ACOG and DCCA to fulfill what is mandated ("define themselves... and incorporate ALL birth practitioners and allow them to practice to the fullest extent under the law"). Once again, the statute clearly states this community is to DEFINE THEMSELVES, not be defined by others.

We are confused as to why ACOG or DCCA feel they have the right to tell this community who they are and how they should practice and insists on filing separate appendices, for example. This community is self determined and knows clearly who they are. The Task Force Report speaks for itself, as the statute requires.

We are however optimistic because we did have a unanimous decision from all task force members to continue working on this complex issue together. We look forward to finding consensus and fulfillment of what Act 32 mandated, and anticipate producing a second report before the dissolution of the task force to fulfill the purpose of this act.

We sincerely appreciate your hard work as Chair.

Mahalo,

HiHBC Board of Directors

Dear Kristie Duarte
Home Birth Task Force Chair and Public Member

I am reaching out as a member of the community in regards to the Home Birth Task Force Committee Report and Findings.

As many legislators know, this law was extremely controversial and passed despite the mass majority of the public being in opposition to it. Upon looking at the data collection performed by both HIHBC and the department of health birth certificate information, it appears we do not have a public health crisis when it comes to home birth in Hawaii. Our diverse group of home birth midwives are having safer outcomes than the hospitals, despite the lack of licensing and regulation.

With these numbers revealed, I would like to express my deepest gratitude for Act 32 for creating the opportunity to allow non-CM and non-CPM midwives to define themselves and find pathways for exemption of licensure. The public supports an alternative to licensure for non-CM/CPM midwives for a variety of reasons and just as every family has the right to a licensed medical midwife, they also have a right to a traditional midwife without fear of persecution of their chosen provider. It is crucial for the legislative body to understand that even if they personally would not choose a home birth, it is not the State's responsibility to choose or limit the choice for someone else.

I am in agreement for continued data collection. The suggestion of updating birth certificate forms for more accurate collection is an important step in understanding the numbers we are looking at.

I agree that registration through HIHBC is an appropriate alternative to licensure for non-CM/CPM midwives for accountability purposes.

I agree that the title "midwife" is too broad for the medical community to claim, and the suggestion of using licensed or unlicensed midwife is more accurate and transparent for the public to understand.

I agree with the addition of the PEP process for CPMs and removing the deadline date for the bridge certificate. It is the only way for Hawaii's student midwives to obtain a CPM certificate locally.

With great appreciation and respect,

Jaymie Lewis
Home Birth Mother of Two

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

Ho‘opae Pono Peace Project
Laulani Teale, MPH,
Tara Compehos, Caterina DeSiato, PhD
eapono.org
nativepeace@gmail.com

CONTENTS

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.

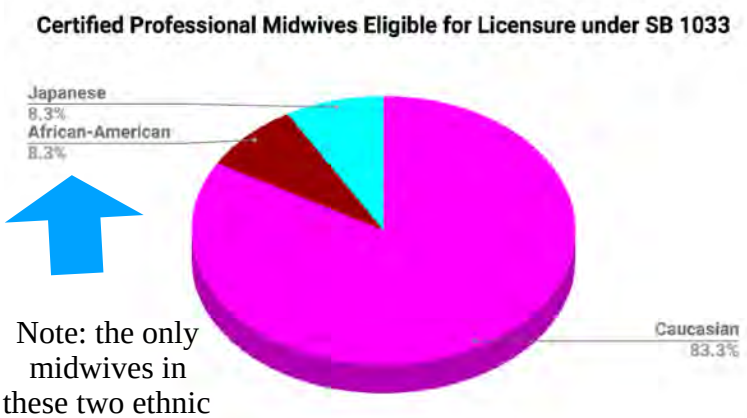
- **There is no evidence that it is needed.** "Horror stories" about alleged midwife error are continually debunked. A 2017 survey of home birth parents showed 94.6% satisfaction. There is zero actual evidence that this would be safer or beneficial for families.

- **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.

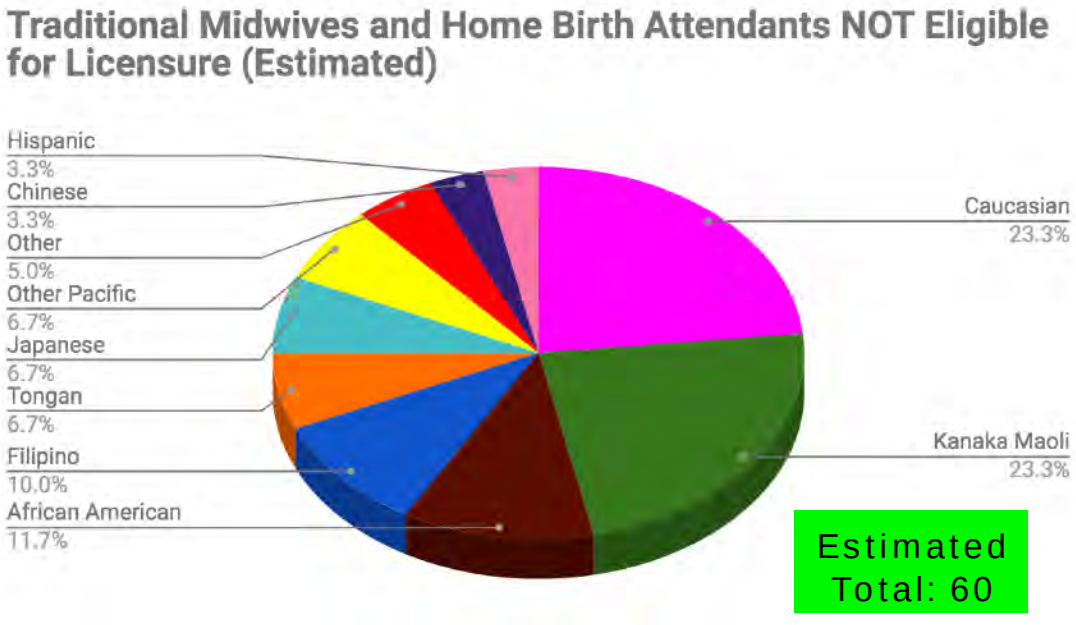
100% of these are originally from outside of Hawai‘i.

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.

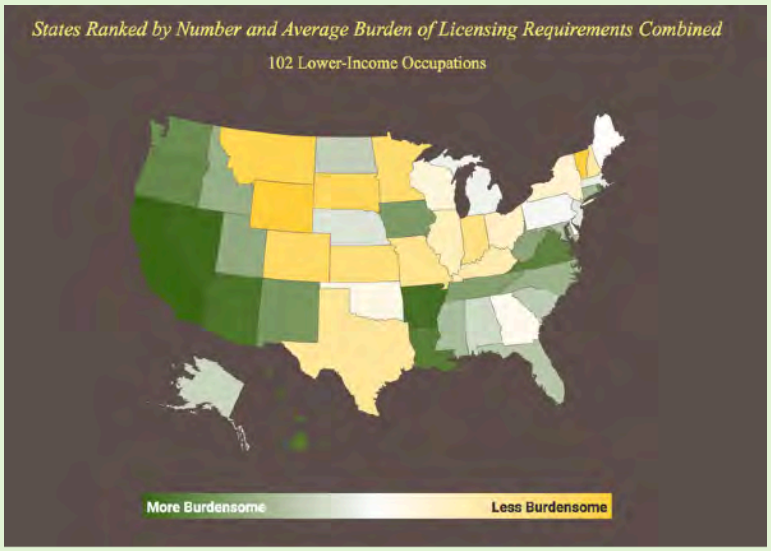
Virtually every example that has been brought forward in the course of SB 1033 testimony has been either examined through community process and found to be non-abusive (i.e. debunked) or possibly nonexistent, and based on rumor. Partial stories and hearsay have unfortunately caused reactions that have 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.

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.

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.

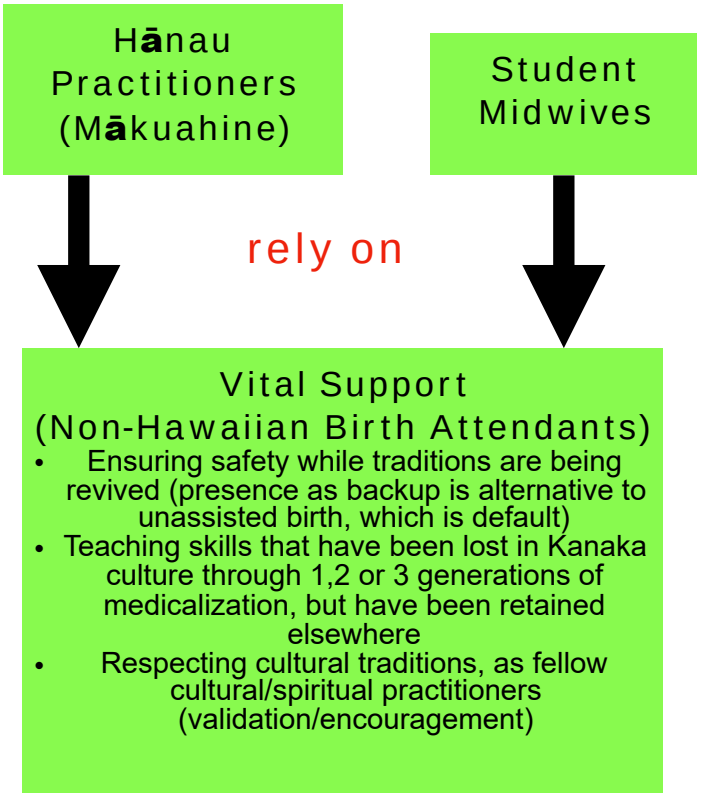
The 1998 Kahuna Statement is at the foundation of Papa Ola Lōkahi's Healer Recognition system. This statement was very clear: it is inappropriate for the State of Hawai'i to ascertain licensure matters relating to Hawaiian Healing Practices.

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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Li, Ling-Ai . *Life Is for a Long Time: A Chinese-Hawaiian Memoir*. New York: Hastings House, 1972.
Monroe, Shafia. *Sacred Birth Place*. Black Midwives and Healers Review, Fall 2012 pp 5-6.
Smith, Susan L. *Japanese American Midwives: Culture, Community, and Health Politics*, 1880-1950. University of Illinois Press, 2005.
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.

Sources:

Chun, Malcolm Naea. *Must We Wait in Despair: The 1867 Report of the `Ahahui La`au Lapa`au of Wailuku, Maui on Native Hawaiian Health.* Honolulu: First People's Productions, 1994.
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
Papa Ola Lōkahi. CHRONOLOGY OF EVENTS RELATING TO TRADITIONAL HAWAIIAN HEALING PRACTICES SINCE 1985.
Pukui, Mary K., E.W. Haertig, and Catherine A. Lee. *Nānā i ke Kumu: Look to the Source.* Vol. 1,1972
Testimony on SB 1033 SD2 HD1 Before the Committee on Finance of the House of Representatives, State of Hawaii, March 29,

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.

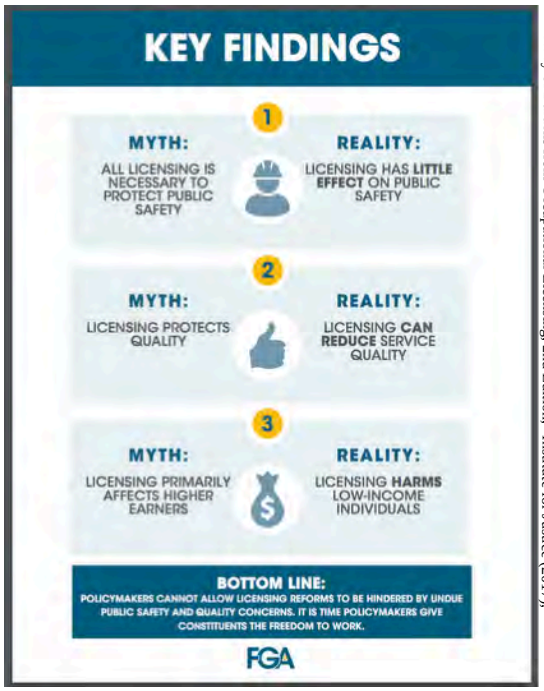
In a 2017 survey of Hawai‘i home birth families, nearly 36% were found to live in areas that were at least 45 minutes from the nearest hospital; in some cases, hours. There are too few CPMs to serve this population. Outlawing traditional midwives puts some families in the position where their only legal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

McDonald, Kerry. *Arresting Homebirth Midwives Just Reduces Women's Birth Choices* The Foundation for Economic Education, March 05, 2019
DeVries, R. G., & DeVries, R. G. (1996). *Making midwives legal: Childbirth, medicine, and the law*. Columbus: Ohio State University Press.
Henderson J, Gao H, Redshaw M. Experiencing maternity care: the care received and perceptions of women from different ethnic groups. BMC Pregnancy Childbirth. 2013 Oct 22;13:196 https://www.ncbi.nlm.nih.gov/pubmed/24148317 Brown, Marilyn and Margaret Bloom. Colonialism and Carceral Motherhood: Native Hawaiian Families Under Corrections and Child Welfare Control. Feminist Criminology. Volume: 4 issue: 2, April 1, 2009 page(s): 151-169 *Scientific Evidence Underlying the American College of Obstetricians and Gynecologists' Practice Bulletins* Kallianidis, A. F., Schutte, J. M., van Roosmalen, J., & van den Akker, T. (2018) Wagner, M. (2006). *Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First.* Berkeley; Los Angeles; London: University of California Press. Retrieved from http://www.jstor.org/stable/10.1525/j.ctt1pp0zn

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.

Bergström, S., & Goodburn, E. (2001). The role of traditional birth attendants in the reduction of maternal mortality. *Studies in HSO&P*, 17, pp. 77-95. Retrieved from http://dspace.itg.be/bitstream/handle/10390/2654/2001shsop0077.pdf

Cheyney, M., Bovbjerg, M., Everson, C., Gordon, W., Hannibal, D., & Vedam, S. (2014). Outcomes of care for 16,924 planned home births in the United States: the Midwives Alliance of North America Statistics Project, 2004 to 2009. *Journal of Midwifery & Women's Health*, *59*(1), 17–27. https://doi.org/10.1111/jmwh.12172

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Kallianidis, A. F., Schutte, J. M., van Roosmalen, J., & van den Akker, T. (2018). Maternal mortality after cesarean section in the Netherlands. *European Journal of Obstetrics and Gynecology and Reproductive Biology*, *229*, 148–152. https://doi.org/10.1016/j.ejogrb.2018.08.586

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Wagner, M. (2006). Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First. Berkley; Los Angeles; London: University of California Press. Retrieved from http://www.jstor.org/stable/10.1525/j.ctt1pp0zn

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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Please VETO SB 1033 SD2 HD2!
Mahalo!

Aloha Kakou,

We, as representatives of traditional cultural and spiritual birthing practices in Hawai‘i, would like to offer the following comments to the Report to the Governor and the Legislature by the Hawaii Home Birth Task Force under Act 32.

We deeply appreciate the work of all who participated in this process. This Task Force brought together many extremely different viewpoints, and laid a foundation for important communication in the future. Everyone who participated in its work did so with diligence, sincerity and aloha. We thank everyone for their tremendous efforts.

There is still much work to be done. We as traditional practitioners do not feel that our practices are adequately protected. In truth, Act 32 represents persecution of our ways, which have come from our ancestors, and belong to our daughters and granddaughters. These fragile ancient practices require the protection of all of the midwives of the entire community, all of whom have an important role in perpetuating and revitalizing ancient cultural practices that were nearly decimated by the modernization of medical birth in the past century.

A’ohe pau ka ‘ike i ka hālau ho‘okahi

This well-known ‘ōlelo no‘eau tells us that not all knowledge is taught in one school. In the context of midwifery regulation it is important to remember that there are many kinds of intelligence and many ways of knowing. Creating one pathway to licensure without exemption criminalizes those who perpetuate the other kinds of knowledge. Hawai‘i is heading towards a dynamic and innovative future of economic and cultural abundance. Creating legislation which threatens to make some kinds of knowledge extinct counters that progress. The more diversity in knowledge the more resilient a community is.

We appreciate the inclusion of indigenous peoples of all origins in the Task Force's recommendations for exemption from Act 32. The practices of Kanaka Maoli, the indigenous people of Hawai‘i, are complemented by the continued traditional practices of other cultures and spiritual practices. Samoan birthing practices, Filipino birthing practices, European birthing traditions, African-American birthing traditions, and the practices of many spiritual and religious birthing ways have all helped to support the revitalization of Kanaka birthing ways; likewise, the host Kanaka Maoli culture provides an important connection to land and history that has been crucial for the rights of traditional practices of all lands to flourish. Harm to any part of this network of tradition is harm to all of it.

We strongly recommend that the legislature take the recommendation to exempt traditional practitioners of all cultures and spiritual traditions to heart, and act accordingly.

We would like to note that the other recommendations also affect traditional cultural practices. Access to reasonable training pathways of all kinds is crucial in completing the full spectrum of

traditional practices, which range from strictly ancient to contemporary. The revitalization and perpetuation of cultures depends upon the health of this entire spectrum.

While there are parts of this report that we would very much like to see strengthened in real protection of our traditions and our rights, we stand by the hard-earned consensus represented here. We are disappointed that the constituencies of some member agencies opposed the findings of the Task Force. This was rather shocking, after all of the work that was put into building consensus at the table. From this, we take the lesson that greater communication is essential going forward.

In response to those who repeatedly thwart the collaboration process we offer this variation on the ʻōlelo noʻeau above:

A'ohe pau ka ʻike i kāu hālau

It tells us that not all knowledge is taught in YOUR school. We are living in a time of global de-colonization and Hawaiʻi is on the forefront. Believing that the only valuable knowledge is that which is taught at your school is the definition of colonization, an archaic mentality of the last century. Tolerance, flexibility and understanding are the only ways for us to evolve forward and keep up with the times we are living in.

In summary, we support the recommendations provided to exempt and protect all traditional birthing practices of all kinds, in accordance with the rights articulated in the Universal Declaration of Human Rights (UDHR) and the United Nations Declaration on the rights of indigenous peoples (UNDRIP).

Me ke aloha ʻaia

Halau O Haumea
Na Pua O Haumea
Hale Hoʻolana Island Inspired Therapies
Kaʻū Womenʻs Health Collective
Wahine Hoʻopaʻa
Ka Pā Ehu O Waiola
Nawahineakauhiakama

To: Ms. Kristie Duarte, Chair and Public Member, Hawai`i Home Birth Task Force
From: Midwife Mieko Aoki, CPM, Kaua`i, Member, Hawai`i Home Birth Task Force
Date: December 6, 2019

Re: Homebirth Midwife/CPM response to Hawaii Home Birth Task Force Recommendations

Dear Ms. Duarte,

Thank you for the opportunity to provide comments on the proposed amendments to Act 32. Regulating Direct Entry Midwives (DEM) is an important topic to me as I am a DEM who has gone through the process of becoming a Certified Professional Midwife (CPM). I support the amendments recommended by the Hawai`i home birth task force as it is based on how best DEMs can practice and function transparently.

Homebirth Midwife recommendations on home birth ethics & care are based on direct experience & evidence and are not simple opinions, such may be from distinct medical organizations. Homebirth Midwives have and offer their experience, expertise, skills, time and love to:

- mindfully assist in physiological labor and with truly minimal interventions at birth
- attend to maternal, newborn and family needs
- support the mother in emotional, mental, physical, spiritual realms
- be present for individual maternal & newborn care with ample time and compassion
- nurture the relationship between mother and midwife
- build a trusting bond between mother, family and midwife
- listen to maternal & midwife's instincts and intuitions
- full access and transparency to informed consent (responsibility)
- educate in nutrition, any health conditions and decision making (accountability)
- heal their traumatic hospital birth experiences and bullying obstetrical care (treatable conditions gone lethal, unprepared for emergency, etc.)
- heal their unnecessary traumatic cesarean birth experiences (home birth after cesarean)
- heal their abandoned postpartum period (postpartum care for mother and newborn)

Homebirth Midwives attend to the mother in supportive birthing positions, private location of choice and when it is time to birth. Home has always been the place of birth since the beginning of time and is the safest feeling for most mothers to birth at. ACOG's belief that hospitals are safest is a matter of inexperienced opinion (class C) in home birth and is not based on evidence-based research.

There is a private contract between mother and midwife where an agreement is made in conscious comprehensive conversation to begin the relationship. It is the mother's responsibility to ask questions and to inquire about anything of the Homebirth Midwife of their choice. It is the

Homebirth Midwife's responsibility to respond and to disclose any information that is being sought. This type of relationship is vital to the well-being of the mother and child, and is primarily built on trust, transparency and accountability.

Homebirth Midwives come in all shapes, forms, colors and sizes. Our path to becoming a Homebirth Midwife are variable and unique. Apprenticeship paths are powerful and rooted in direct home birth life experience. Academic programs are rich in science & research and also participates in an apprenticeship. There is traditions in many midwives practices and that is to be honored and upheld independently. Culture is rooted in many generations and signifies identity, customs, rituals, beliefs in midwifery practices and is to be honored and respected. Western medical education is also available for nurse-midwives who have options to attend home births after training in hospitals. The various routes and times in each Homebirth Midwives education is nonetheless equally profound and all can be perpetuated.

The public, primarily Home Birthing mothers who have had obstetrical/hospital care, have repeatedly made comments that they detest, despise, dislike, shudder at, feel aversion to obstetrical care and protocolized care given at the hospital. Some opinions of obstetricians have been that they had to "fix" a homebirth transfer to the hospital. Homebirth Midwives evidence has been that we had to "fix" the long-term trauma induced by obstetrical care and hospital policies.

Recommendations for ACOG and HAH are to focus on reducing the rapid rise in US maternal mortality rates that rank 24th in the developed nations in 2015 (10.3 in 1991, 23.8 in 2014, 26.4 in 2015 of deaths per 100,000 live births), rather than restricting consumers' choice under the guise of safety by limiting availability of Homebirth Midwives through restrictive licensure. And two-thirds of these deaths were considered preventable! The US is the only developed nation that increased in maternal mortality with the most expensive healthcare system. https://www.npr.org/2017/05/12/528098789/u-s-has-the-worst-rate-of-maternal-deaths-in-the-developed-world

Recommendations for ACOG and HAH to reconsider protocols that promote to sacrifice the freedom of consumers to make an informed choice by protecting hospital and medical industry or obstetricians. Is it in the consumer's interest if you sacrifice their freedom of choice in the intention of keeping them safe?

Recommendation for obstetricians is to attend normal physiological undisturbed labor & birth at home before providing any recommendations for home birth midwives.

Recommendation for HAH:
1. Push contracted health plans to create strong incentives for health care providers to charge a single "bundled" price for the entire episode of maternity care. Since C-sections cost more than

vaginal deliveries, a bundled payment would give providers an incentive to avoid unnecessary Cesarean births.

2. Demand that health plans require participating hospitals to follow best evidence-based practices.
https://hbr.org/2019/06/the-rising-u-s-maternal-mortality-rate-demands-action-from-employers

Home birth Midwife Mieko Aoki, CPM supports the Hawai`i Home Birth Task Force recommendations and advises the legislature to strongly adhere to these recommendations.

Thank you for your dedication and commitment to the Task Force and for your leadership as Task Force Chair.

Sincerely,

Mieko Aoki, CPM
Home Birth Midwife, Kaua`i

DAVID Y. IGE
GOVERNOR

JOSH GREEN
LIEUTENANT GOVERNOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
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CATHERINE P. AWAKUNI COLÓN
DIRECTOR

JO ANN M. UCHIDA TAKEUCHI
DEPUTY DIRECTOR

October 11, 2019

Dear Task Force Members:

Thank you for allowing the Department of Commerce and Consumer Affairs to comment on the proposed amendments to Act 32, SLH 2019, Relating to the Licensure of Midwives, from the Midwives Task Force.

Ahlani Quiogue and Lee Ann Teshima have kept us apprised of the discussions during the Task Force meetings and we are grateful to be involved and appreciate the transparent discussion of the issues being raised.

As a regulatory agency, our mission is to uphold fairness and public confidence in the marketplace, promote sound consumer practices and increase knowledge, opportunity, and justice in our community. Consumer protection is a priority that we must consider. This translates to establishing the minimum qualifications for education and training to ensure that qualified individuals may practice their profession safely.

Consequently, we have reviewed and discussed the proposals from the Task Force and although we may not agree and are unable to support some of the recommendations, we are able to support other recommendations made by the Task Force.

Again, I'd like to thank you for your time and efforts in participation on this Task Force and look forward to our continued collaboration to ensure that women have the right to choose their birthing experience and that the birthing experience they choose is provided by qualified individuals.

Mahalo nui loa,

Catherine P. Awakuni Colón
Director
Department of Commerce and Consumer Affairs

DAVID Y. IGE
GOVERNOR OF HAWAII

BRUCE S. ANDERSON, Ph.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

In reply, please refer to:
File:

October 29, 2019

Ms. Kristie Duarte
Chair & Public Member, Hawaii Home Birth Task Force
Hawaii State Commission on the Status of Women
Department of Human Services
235 S. Beretania Street, Room 407
Honolulu, Hawaii 96813

Dear Ms. Duarte:

Subject: Proposed amendments from the Hawaii Home Birth Task Force regarding Act 32, SLH 2019

Thank you for the opportunity to provide comments on the proposed amendments to Act 32, SLH 2019, Relating to the Licensure of Midwives, from the Hawaii Home Birth Task Force.

The issues concerning direct entry midwives and home births are important topics related to the Department of Health's Strategic Goal of Investing in Healthy Babies and Families. We often work with and support diverse community partners to address public health issues from different perspectives. One of our community partners, the Hawaii Maternal and Infant Health Collaborative (HMIHC), has a diverse membership of public and private partners committed to improving birth outcomes and reducing infant mortality. Although the Department of Health supports the HMIHC both fiscally and logistically, the Hawaii Maternal and Infant Health Collaborative's opinions, positions, and views do not represent Department of Health policy priorities.

The Department of Commerce and Consumer Affairs (DCCA) Professional and Vocational Licensing Division (PVL) is responsible for implementing the licensing regulations for 48 different professions and vocations and provides guidance for proper implementation of the licensing laws and administrative rules for the 48 licensing areas.

The Department of Health (DOH) respectfully defers to the position of the DCCA on the recommendations from the Hawaii Home Birth Task Force.

Thank you for your dedication and commitment to the Task Force and for your leadership as Task Force Chair. We appreciate the Task Force's efforts to investigate issues relating to direct entry midwives and home births.

Sincerely,

BRUCE S. ANDERSON, Ph.D.
Director of Health

c: Catherine Awakuni Colon, Director, Department of Commerce and Consumer Affairs
Danette Wong Tomiyasu, M.B.A. Deputy Director, Health Resources Administration
Family Health Services Division
Office of Planning Policy and Program Development

HAH
Healthcare Association
of Hawaii

TO: Hawaii Home Birth Task Force

FROM: Kathleen Libao-Laygo, RN
Senior Director, Quality & Regulatory Affairs
Healthcare Association of Hawaii (HAH)
707 Richards St, PH 2
Honolulu, HI 96813

DATE: October 25, 2019

SUBJECT: HAH Response to Hawaii Home Birth Task Force Recommendations

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Dear Task Force Members:

The Healthcare Association of Hawaii (HAH), established in 1939, serves as the leading voice of healthcare on behalf of 170 member organizations who represent almost every aspect of the healthcare continuum in Hawaii. Members include, but are not limited to, acute care hospitals, pharmacies, emergency medical services, skilled nursing facilities, home health agencies, hospices, assisted living facilities, and durable medical equipment suppliers. In addition to providing access to appropriate, affordable, high quality care to all of Hawaii's residents, our members contribute significantly to Hawaii's economy by employing over 20,000 people statewide.

Our vision is: A healthy Hawaii where every resident of every age has convenient access to appropriate, affordable, high quality care, and where healthcare providers are reimbursed adequately to deliver that care. As the unifying voice of Hawaii's healthcare providers and an authoritative and respected leader in shaping healthcare policy Hawaii, the Healthcare Association of Hawaii works with committed partners and stakeholders to lead the movement toward achieving an equitable, sustainable Hawaii healthcare system driven to improve quality, efficiency and effectiveness for the patients and communities who entrust their care to us.

Given our vision, I want to thank you for the opportunity to allow me to gather information from our members in order to provide an appropriate response that is reflective of their collective input. Below is a summary of HAH responses:

Regarding the task force's proposal for using the title of midwife that is not in congruence with Act 32, the majority of HAH members responded with disagreement (non-support).

Regarding the task force's proposal to amend the Advisory Committee established by Act 32 by including three (3) licensed midwives who are Certified Professional Midwives (CPMs) which work exclusively in the community; including two (2) members of the public who have been consumers of home birth services; removing the Certified Nurse Midwife (CNM) and replacing that individual with a community-based home birth attendant; and including one (1) traditional cultural midwife, the majority of HAH members responded by deferring to the position taken by the Department of Commerce and Consumer Affairs (DCCA). DCCA's position states that by adding a representative for each type of exempted individual to participate on an advisory committee to oversee and implement a chapter for which they are exempt is unreasonable, and DCCA would oppose such an amendment.

Regarding the Task Force's proposal to remove the requirement that student midwives be currently enrolled in a midwifery educational program and replace with those training under the direct supervision of a qualified licensed or exempt midwife preceptor, the majority of HAH members deferred to DCCA's position. DCCA recommends retaining language which includes those currently enrolled in a midwifery educational program and inserting language which allows those who are training and under the direct supervision of one of the exemptions in Act 32. This language would allow both a student training for national certification as a midwife and a student training under an exempted individual to be recognized as exempt.

Regarding the Task Force's proposal to create a "midwife assistant" who operates under the supervision of a qualified or exempt midwife, the majority of HAH members deferred to DCCA's position, and DCCA would not be able to support this amendment.

Regarding the Task Force's proposal to amend Act 32 to allow the use of legend drugs or devices by exempt individuals who are registered with the Hawaii Home Birth Collective (HiHBC), and who have self-reported education in pharmacology, administration of injected medication, and treatment of shock, granting limited access to obtain, store and administer a specific list of medications (specifically the use of uterotonics for prevention of postpartum hemorrhage during the third state of labor, including Oxytocin, ergometrine/ methylergometrine, oral misoprostol, and oxygen to be used by community health care workers and lay health workers in an emergency situation), the majority of HAH members defer to DCCA's position on this.

Regarding the Task Force's proposal to allow exempt birth attendants who are registered with the HiHBC and have self-reported CEUs, to purchase store, and administer specific non-controlled legend drugs or devices that are used in pregnancy, birth, postpartum care, newborn care, or resuscitation during the practice of midwifery (specifically, oxygen per neonatal resuscitation guidelines; neonatal eye prophylaxis per American Academy of Pediatrics; Anti-hemorrhagic agents and devices for postpartum per WHO guidelines; Vitamin K per the American Academy of Pediatrics; Group beta streptococcus prophylaxis antibiotics per guidelines by the CDC; IV fluids for blood loss, and Rho (D) immune globulin per ACOG; Epinephrine for neonatal resuscitation guidelines and treatment of anaphylactic reaction;

amino amide local anesthetic without epinephrine; Mebendazole; Magnesium sulfate; and Calcium gluconate), the majority of HAH members defer to DCCA's position on this.

Regarding the Task Force's proposal to establish a minimum requirement of self-reported continuing education units to the HiHBC for exempt birth attendants for "suturing, pharmacology, and phlebotomy," as a qualifier for the administration of certain prescriptions drugs, the majority of HAH members defer to DCCA's position on this.

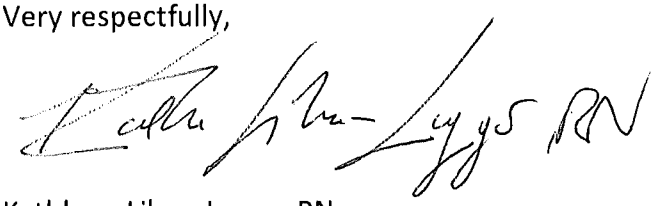
Regarding the Task Force's proposal to require the use of the Hawaii Home Birth Collective Hospital Transport Form, the majority of HAH members defer to DCCA's position, which states that this amendment is unnecessary as there is nothing in law prohibiting the use of the HIHNC transport form.

The Healthcare Association of Hawaii does suggest that members of the Home Birth Task Force, specifically those registered with the Hawaii Home Birth Collective, may find it beneficial to have formal, open communication with the statewide emergency medical services (EMS) to help identify and discuss potential opportunities for improvement regarding the necessity of emergency transportation and treatment following an intended home birth. HAH is willing to invite the key stakeholders and convene such a meeting opportunity.

HAH membership deferred to the DCCA's position on many of the Task Force's proposals, as the DCCA is the official Hawaii state's legal governing authority on professional licensure, and HAH is respectful of its purview.

Thank you.

Very respectfully,



Kathleen Libao-Laygo, RN

American College of Obstetricians and Gynecologists
District VIII, Hawai'i (Guam & American Samoa) Section

TO: Ms. Kristie Duarte
Chair and Public Member, Hawai'i Home Birth Task Force

DATE: November 4, 2019

FROM: Hawai'i Section, ACOG
Dr. Chrystie Fujimoto, FACOG, Chair
Dr. Eesha Bhattacharyya, FACOG, Member

Re: ACOG Response to Hawaii Home Birth Task Force Recommendations

Dear Ms. Duarte:

The Hawai'i Section of the American College of Obstetricians and Gynecologists (HI ACOG) represents more than 200 obstetrician/gynecologist physicians in our state. We thank you for the opportunity to participate in and provide comments on the report from the Hawai'i Home Birth Task Force regarding Act 32. We appreciate the shared concerns of other task force members regarding the safety of birth in Hawai'i while still supporting a woman's choice.

The College believes that hospitals and accredited birth centers are the safest settings for birth, and each woman has the right to make a medically informed decision about delivery. We believe that women should be informed that several factors are critical to reducing perinatal mortality and achieving favorable home birth outcomes. These factors include the appropriate selection of candidates for home birth; the availability of a certified nurse–midwife, certified midwife or midwife whose education and licensure meet International Confederation of Midwives' (ICM) Global Standards for Midwifery Education, or physician practicing obstetrics within an integrated and regulated health system; ready access to consultation; and access to safe and timely transport to a hospital. The Committee on Obstetric Practice considers fetal malpresentation, multiple gestation, or prior cesarean delivery to be an absolute contraindication to planned home birth.

https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co697.pdf?dmc=1&ts=20191105T0635572563

In April 2015, ACOG endorsed the ICM education and training standards and strongly advocates the ICM criteria as a baseline for midwife licensure in the United States. The ICM definitions are accepted throughout the world across 6 regions, by over 130 member organizations and by all U.S. midwifery professional organizations. Women in every state should be guaranteed care that meets these important minimum standards. Hawai'i should uphold the standards of midwifery care expected by women in other nations around the world. Unfortunately, the Task Force Proposal for the education and training of "direct-entry midwives" does not adhere to the ICM standards.

- ICM's baseline midwifery education standards include:
  - curriculum is a minimum of 40% theory and 50% practice
  - minimum length of direct-entry education is 3 years
  - minimum length of post-nursing education is 18 months
  - faculty is formally prepared to teach

- time limited certification
- certifying body should not simultaneously define/validate education and develop/administer exam
- defined continued education requirements
- periodic external review of education program effectiveness

In addition, the North American Registry of Midwives (NARM) Portfolio Evaluation Process (PEP) does not meet international standards as the apprenticeship programs lack accreditation. ACOG does support the **"bridge certificate"** program as a grandmothering in pathway for certified professional midwife applicants who have been credentialed prior to January 1, 2020 through non-accredited apprenticeship programs. ACOG supports requiring all midwife providers certifying on or after January 1, 2020 to have completed an accredited education that meets ICM education and training standards.

https://www.acog.org/About-ACOG/News-Room/Statements/2015/ACOG-Endorses-the-International-Confederation-of-Midwives-Standards-for-Midwifery-Education

https://www.acog.org/-/media/Statements-of-Policy/Public/82MidwiferyCollege2014AMENDED3reaffirmed2017-Jul-21.pdf?dmc=1&ts=20191105T0627477866

https://www.acog.org/-/media/Departments/State-Legislative-Activities/2017CPMLicensureLaws-EducationStandards.pdf?dmc=1&ts=20191105T0608246437

https://www.internationalmidwives.org/assets/files/general-files/2018/04/icm-standards-guidelines_ammended2013.pdf

Hawai'i ACOG advocates for implementation of the ICM standards to ensure all women have access to safe, qualified, highly skilled providers in all settings.

Sincerely,

Chrystie K. Fujimoto, MD, FACOG
ACOG Hawai'i Section Chair

To: Kristie Duarte, Hawaii Home Birth Task Force

From: The Hawaii Affiliate of the American College of Nurse-Midwives (HAA).

Date: October 25, 2019

Re: Task Force Report. HAA is on record in whole-hearted support of families′ choices for safe, high quality care, home birth, and the midwifery model of care. In consultation with the State Government Affairs Consultant of the American College of Nurse-Midwives, HAA opposes the Hawaii Home Birth Task Force's Recommendation VI. A., to remove the International Confederation of Midwives and US MERA language, definitions, and standards from Act 32. Consequently, HAA cannot support the additional recommendations of the Task Force. We recognize the lack of midwifery education and midwife preceptors as a contributing factor to limiting access to care. We hope that future initiatives focus on this issue.

Additional comment: HAA notes that the opinions of the certified nurse-midwife who served on the Task Force are her own, and they are not in alignment with the official position of HAA. HAA only learned about the Task Force meetings and this report 4 days before final comments on the draft were due. HAA would have willingly sent a CNM representative actively involved in homebirth practice to join the Task Force, since HAA represents the perspectives of CNMs who provide home birth care in Hawaii. We are committed to excellence in midwifery and believe that the people of Hawaii should have access to pregnancy and birth care that is safe and satisfying at home, in birth centers or hospitals.

Colleen Bass, CNM, President

Carmen Linhares, CNM, Vice-President

Celeste Chavez, CNM Treasurer

Jenny Foster, CNM (ret.), Secretary, *pro tem*

Emily Simpson, CNM, Policy Chair

EXECUTIVE CHAMBERS
HONOLULU

DAVID Y. IGE
GOVERNOR

April 30, 2019 **GOV. MSG. NO. 1133**

The Honorable Ronald D. Kouchi,
President
and Members of the Senate
Thirtieth State Legislature
State Capitol, Room 409
Honolulu, Hawai'i 96813

The Honorable Scott K. Saiki,
Speaker and Members of the
House of Representatives
Thirtieth State Legislature
State Capitol, Room 431
Honolulu, Hawai'i 96813

Dear President Kouchi, Speaker Saiki, and Members of the Legislature:

This is to inform you that on April 30, 2019, the following bill was signed into law:

SB1033 SD2 HD2 RELATING TO THE LICENSURE OF MIDWIVES.
ACT 032(19)

Sincerely,

DAVID Y. IGE
Governor, State of Hawai'i

Approved by the Governor
on APR 30 2019
THE SENATE
THIRTIETH LEGISLATURE, 2019
STATE OF HAWAII

ACT 032
S.B. NO. 1033 S.D. 2 H.D. 2

A BILL FOR AN ACT

RELATING TO THE LICENSURE OF MIDWIVES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

PART I

SECTION 1. As determined by Senate Concurrent Resolution No. 64, S.D.1 (1998), subsequent Auditor's Report No. 99-14 (1999), House Concurrent Resolution No. 65, H.D.1 (2016), and the subsequent Auditor's Report No. 17-01 (2017), the legislature finds that it is necessary to establish a mandatory regulatory process for the midwifery profession.

Hawaii regulated midwifery starting with registration in 1931, which progressed into certification and then licensure. However, the regulation of midwifery was repealed in 1998 when nurse-midwives were placed under the purview of the board of nursing. Since 1998, there has been a lapse in regulation, yet individuals in the community have continued to practice midwifery and offer birth services to the public.

The legislature finds that mothers and families seek out alternatives to hospital births and they find significant value in community or home birth services. These services are

currently provided by individuals identifying themselves as traditional or cultural practitioners, midwives, certified professional midwives, lay midwives, direct entry midwives, birth keepers, or birth attendants. This Act will continue to allow a woman to choose where and with whom she gives birth.

The legislature further finds that the profession of midwifery has continued to evolve since the lapse in regulation. Common definitions, training, and competency standards for the practice of midwifery have developed on both a global and national level. However, not all practitioners easily fit into these definitions, categories, and standards. Hawaii currently has many individuals offering birth services under different titles and at varying levels of competency and training.

The legislature further finds the term "midwife" connotes an expectation of a minimum level of care by consumers and the community. The Hawaii regulatory licensing reform act requires the State to regulate professions or vocations where the health, safety, or welfare of the consumer may be jeopardized by the nature of the service offered by the provider. The practice of midwifery meets these criteria, and, therefore, must be regulated by the State.

The purpose of this Act is to resolve the lapse in regulation of midwifery and to regulate midwives engaged in the practice of midwifery by establishing licensure and regulatory requirements under the department of commerce and consumer affairs. This Act also exempts 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. The legislature also notes that practicing midwifery according to this Act does not impede one's ability to incorporate or provide cultural practices.

SECTION 2. The Hawaii Revised Statutes is amended by adding a new chapter to be appropriately designated and to read as follows:

"**CHAPTER**

MIDWIVES

§ -1 **Findings and purpose.** The legislature finds that:

(1) Midwives offer maternity and newborn care from the antepartum period through the intrapartum period to the postpartum period;

(2) The improper practice of midwifery poses a significant risk of harm to the mother or newborn, and may result in death; and

(3) The regulation of the practice of midwifery is reasonably necessary to protect the health, safety, and welfare of mothers and their newborns.

§ -2 **Definitions.** As used in this chapter:

"Accreditation Commission for Midwifery Education" means the United States Department of Education-recognized commission that provides accreditation and pre-accreditation of certificates, post-baccalaureates, graduate degrees, and pre-certificate programs in nurse-midwifery and midwifery.

"American Midwifery Certification Board" means the national certifying body for certified nurse-midwife candidates and certified midwife candidates who have received their graduate level education in programs accredited by the Accreditation Commission for Midwifery Education.

"Certified midwife" means a person who holds a current and valid national certification as a certified midwife from the American Midwifery Certification Board, or any successor organization.

"Certified professional midwife" means 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.

"Client" means a person under the care of a licensed midwife, as well as the person's fetus and newborn child.

"Department" means the department of commerce and consumer affairs.

"Director" means the director of commerce and consumer affairs.

"Interconception" means care provided to mothers between pregnancies to improve health outcomes for women, newborns, and children.

"International Confederation of Midwives" means the accredited nongovernmental organization and representative of midwives and midwifery to organizations worldwide to achieve common goals in the care of mothers and newborns.

"Midwife" means a person licensed under this chapter.

"Midwifery" means the provision of one or more of the following services:

(1) 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;

(2) Supervising the conduct of labor and childbirth; and

(3) Provision of advice and information regarding the progress of childbirth and care for newborns and infants.

"Midwifery Education Accreditation Council" means the independent, nonprofit organization recognized by the United States Department of Education as an accrediting agency of direct-entry midwifery institutions and programs.

"North American Registry of Midwives" means the organization that sets national standards for the certified professional midwife credential.

"Postpartum" means the period of time immediately after and up to eight weeks following the birth of the baby.

"Qualified midwife preceptor" means a licensed and experienced midwife, or other maternal health professional licensed in the State, who participates in the clinical education of individuals enrolled in a midwifery education program accredited by the Midwifery Education Accreditation Council or Accreditation Commission For Midwifery Education and who meets the criteria for midwife preceptors set forth by the applicable organization.

§ -3 **Midwives licensing program.** There is established a midwives licensing program within the department to be administered by the director.

§ -4 **Powers and duties of the director.** In addition to any other powers and duties authorized by law, the director shall have the power and duties to:

(1) Grant permission to a person to use the title of "midwife" or "licensed midwife" and engage in the practice of midwifery in this State pursuant to this chapter and the rules adopted pursuant thereto;

(2) Adopt, amend, or repeal rules pursuant to chapter 91 to carry out the purposes of this chapter;

(3) Administer, coordinate, and enforce this chapter and rules adopted pursuant thereto;

(4) Discipline a licensee for any cause described by this chapter or for any violation of rules or refuse to license a person for failure to meet the licensing requirements or for any cause that would be grounds for disciplining a licensee;

(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) Three midwives who are certified professional midwives or certified midwives;

(B) Two members of the public; and

(C) A certified nurse midwife; and

(6) Add, remove, or otherwise modify the authorized non-controlled legend drugs and legend devices listed in -11 by rule under chapter 91.

§ -5 **License required.** (a) 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, abbreviations, or insignia indicating or implying that the person is a licensed midwife without a valid license issued pursuant to this chapter.

(b) Nothing in this section shall preclude a person holding a national certification as a midwife from identifying the person as holding such certification, so long as the person is not practicing midwifery or professing to be authorized to practice midwifery in the State unless that person is licensed in accordance with this chapter.

§ -6 **Exemptions.** (a) A person may practice midwifery without a license to practice midwifery if the person is:

(1) A certified nurse-midwife holding a valid license under chapter 457;

(2) Licensed and performing work within the scope of practice or duties of the person's profession that overlaps with the practice of midwifery;

(3) A student midwife who is currently enrolled in a midwifery educational program under the direct supervision of a qualified midwife preceptor;

(4) A person rendering aid in an emergency where no fee for the service is contemplated, charged, or received; or

(5) A person acting as a birth attendant on or before July 1, 2023, who:

(A) Does not use legend drugs or devices, the use of which requires a license under the laws of the State;

(B) Does not advertise that the person is a licensed midwife;

(C) Discloses to each client verbally and in writing on a form adopted by the department, which shall be received and executed by the person under the birth attendant's care at the time care is first initiated:

(i) That the person does not possess a professional license issued by the State to

provide health or maternity care to women or infants;

(ii) That the person's education and qualifications have not been reviewed by the State;

(iii) The person's education and training;

(iv) That the person is not authorized to acquire, carry, administer, or direct others to administer legend drugs;

(v) Any judgment, award, disciplinary sanction, order, or other determination that adjudges or finds that the person has committed misconduct or is criminally or civilly liable for conduct relating to midwifery by a licensing or regulatory authority, territory, state, or any other jurisdiction; and

(vi) A plan for transporting the client to the nearest hospital if a problem arises during the client's care; and

(D) Maintains a copy of the form required by subparagraph (C) for at least ten years and makes the form available for inspection upon request by the department.

(b) 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.

(c) Nothing in this chapter shall prohibit a person from administering care to a person's spouse, domestic partner, parent, sibling, or child.

§ -7 Fees. (a) Each applicant shall pay a licensing fee upon application for an initial license or renewal of a license. Fees collected pursuant to this section or by rule adopted under this section shall be nonrefundable.

(b) Pursuant to section 26-9(l), the director may establish fees to restore a license, penalty fees, and any other fees required for the administration of this chapter by rule.

(c) All fees collected pursuant to this chapter shall be deposited by the director to the credit of the compliance resolution fund established pursuant to section 26-9(o).

(d) Fees assessed pursuant to this chapter shall be used to defray costs incurred by the department in implementing this chapter.

(e) The director may assess fees as provided in this chapter and section 26-9 and, notwithstanding any other law to the contrary, may change the amount of the fees required by this section at any time without regard to chapter 91, if the director:

(1) Holds at least one public hearing to discuss and take testimony on the proposed fee change; and

(2) Provides public notice at least thirty days prior to the date of the public hearing.

§ -8 Application for license as a midwife. To obtain a license under this chapter, the applicant shall provide:

(1) An application for licensure;

(2) The required fees;

(3) Proof of current, unencumbered certification as a:

(A) Certified professional midwife; or

(B) Certified midwife;

(4) For certified professional midwives, proof of a successful completion of a formal midwifery education and training program that is either:

(A) An educational program or pathway accredited by the Midwifery Education Accreditation Council; or

(B) 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;

(5) If applicable, evidence of any licenses held or once held in other jurisdictions indicating the status of the license and documenting any disciplinary proceedings pending or taken by any jurisdiction;

(6) Information regarding any conviction of any crime which has not been annulled or expunged; and

(7) Any other information the department may require to investigate the applicant's qualifications for licensure.

§ -9 **Issuance of license.** The director may issue a license to any person who meets all licensure requirements and pays the appropriate fees.

§ -10 **Renewals.** Every license issued under this chapter shall be renewed triennially on or before June 30, with the first renewal deadline occurring on June 30, 2023. Failure to renew a license shall result in a forfeiture of the license. Licenses which have been so forfeited may be restored within one year of the expiration date upon payment of renewal and penalty fees. Failure to restore a forfeited license within one year of the date of its expiration shall result in the automatic termination of the license. Relicensure after termination shall require the person to apply as a new applicant and again satisfy all licensing requirements in place at the time of the new application.

§ -11 **Authority to purchase and administer certain legend drugs and devices.** (a) A midwife licensed under this chapter may purchase and administer non-controlled legend drugs

and devices that are used in pregnancy, birth, postpartum care, newborn care, or resuscitation, and that are deemed integral to providing care to the public by the department.

(b) Legend drugs authorized under subsection (a) are limited for:

(1) Neonatal use to prophylactic ophthalmic medications, vitamin K, epinephrine for neonatal resuscitation per neonatal resuscitation guidelines, and oxygen; and

(2) Maternal use to antibiotics for Group B Streptococcal antibiotic prophylaxis per guidelines adopted by the Centers for Disease Control and Prevention, postpartum antihemorrhagics, Rho(D) immune globulin, epinephrine for anaphylactic reaction to an administered medication, intravenous fluids, amino amide local anesthetic, and oxygen.

(c) Legend devices authorized under subsection (a) are limited to devices for:

(1) Injection of medications;

(2) The administration of intravenous fluids;

(3) Adult and infant resuscitation;

(4) Rupturing amniotic membranes;

(5) Repairing vaginal tears; and

(6) Postpartum hemorrhage.

(d) A pharmacist who dispenses drugs and devices to a midwife as authorized by this section and in conformity with chapter 461 is not liable for any adverse reactions caused by the midwife's administration of legend drugs and devices.

§ -12 Grounds for refusal to grant, renew, reinstate, or restore licenses and for revocation, suspension, denial, or condition of licenses. In addition to any other acts or conditions provided by law, the director may refuse to grant, renew, reinstate, or restore, or may deny, revoke, suspend, or condition in any manner, any license for any one or more of the following acts or conditions on the part of the licensee or the applicant thereof:

(1) Failing to meet or maintain the conditions and requirements necessary to qualify for the granting of a license;

(2) Failing to notify the department in writing that the licensee's certification as a certified professional midwife or as a certified midwife is no longer current

or unencumbered within thirty days of the change in status;

(3) Engaging in false, fraudulent, or deceptive advertising, or making untruthful or improbable statements;

(4) Being addicted to, dependent on, or a habitual user of a narcotic, barbiturate, amphetamine, hallucinogen, opium, or cocaine, or other drugs or derivatives of a similar nature;

(5) Practicing as a licensed midwife while impaired by alcohol, drugs, physical disability, or mental instability;

(6) Procuring a license through fraud, misrepresentation, or deceit;

(7) Aiding and abetting an unlicensed person to directly or indirectly perform activities requiring a license;

(8) Engaging in professional misconduct as defined by the program in accordance with its own rules, incompetence, gross negligence, or manifest incapacity in the practice of midwifery;

(9) Failing to maintain a record or history of competency, trustworthiness, fair dealing, and financial integrity;

(10) Engaging in conduct or practice contrary to recognized standards of ethics for the practice of midwifery;

(11) Violating any condition or limitation upon which a conditional license was issued;

(12) Engaging in business under a past or present license issued pursuant to this chapter, in a manner causing injury to one or more members of the public;

(13) Failing to comply, observe, or adhere to any law in a manner such that the director deems the applicant or licensee to be an unfit or improper person to hold a license;

(14) Having a revocation, suspension, or other disciplinary action by a territory, or by another state or federal agency against a licensee or applicant for any reason provided by the licensing laws or this section;

(15) Having a criminal conviction, whether by nolo contendere or otherwise, of a penal crime directly

related to the qualifications, functions, or duties of a licensed midwife;

(16) Failing to report in writing to the director any disciplinary decision issued against the licensee or the applicant in another jurisdiction within thirty days of the disciplinary decision;

(17) Employing, utilizing, or attempting to employ or utilize at any time any person not licensed under this chapter where licensure is required;

(18) Violating this chapter, any other applicable licensing laws, or any rule or order of the director; or

(19) Using or removing without authorization controlled substances or drugs, including diverting or attempting to divert drugs or controlled substances for unauthorized use.

§ -13 **Penalties.** Any person who violates this chapter or rules adopted pursuant thereto shall be subject to a fine of not more than $1,000 for each separate offense. For purposes of this section, each day of violation shall constitute a separate offense."

SECTION 3. Section 26H-4, Hawaii Revised Statutes, is amended to read as follows:

"**§26H-4 Repeal dates for newly enacted professional and vocational regulatory programs.** (a) Any professional or vocational regulatory program enacted after January 1, 1994, and listed in this section shall be repealed as specified in this section. The auditor shall perform an evaluation of the program, pursuant to section 26H-5, prior to its repeal date.

(b) Chapter 465D (behavior analysts) shall be repealed on June 30, 2021.

(c) Chapter 466L (appraisal management companies) shall be repealed on June 30, 2023.

(d) Chapter (midwives) shall be repealed on June 30, 2025."

SECTION 4. The department of commerce and consumer affairs may appoint an executive officer and a secretary, without regard to chapter 76, Hawaii Revised Statutes, to assist with the activities of the midwives licensing program.

SECTION 5. The department of commerce and consumer affairs may adopt interim rules to carry out the purposes of this Act

without regard to chapters 91 or 201M, Hawaii Revised Statutes; provided that:

(1) The department shall hold at least one public hearing prior to the adoption of interim rules; and

(2) The interim rules shall be effective for no more than one year after their adoption.

SECTION 6. There is appropriated out of the general revenues of the State of Hawaii the sum of $146,000 or so much thereof as may be necessary for fiscal year 2019-2020 to be deposited into the compliance resolution fund.

SECTION 7. There is appropriated out of the compliance resolution fund the sum of $146,000 or so much thereof as may be necessary for fiscal year 2019-2020 and $73,000 or so much thereof as may be necessary for fiscal year 2020-2021 to implement the licensure of midwives as required by this Act.

The sums appropriated shall be expended by the department of commerce and consumer affairs for the purposes of this Act.

PART II

SECTION 8. (a) There is established a home birth task force under the Hawaii state commission on the status of women.

(b) The task force shall consist of no more than twelve members and shall include:

(1) The director of commerce and consumer affairs, or the director's designee;

(2) The director of health, or the director's designee;

(3) A representative from the Hawaii section of the American College of Obstetricians and Gynecologists;

(4) A representative of the Healthcare Association of Hawaii; and

(5) Members recommended by the Hawaii Home Birth Collective that represent the following stakeholder groups: certified nurse midwife; certified professional midwife; home birth elder; traditional or cultural birth attendant; and a member of the public that has used home birth services.

(c) The task force shall include representation from all counties. The task force may recommend additional members with appropriate expertise, to be approved by the chairperson.

(d) The task force shall elect a chairperson from among the members of the task force.

(e) The task force shall investigate issues relating to direct entry midwives and home births. The investigation shall include but not be limited to the following:

(1) Data collection and reporting on home births;

(2) Education and training of direct entry midwives; and

(3) Regulation of direct entry midwives.

(f) The members of the task force shall serve without compensation. No member of the task force shall be made subject to section 84-17, Hawaii Revised Statutes, solely because of that member's participation on the task force. The task force shall be exempt from part I, chapter 92, Hawaii Revised Statutes.

(g) The Hawaii state commission on the status of women shall provide administrative and clerical support required by the task force.

(h) The task force shall submit a report of its findings and recommendations, including any proposed legislation, to the legislature no later than twenty days prior to the convening of the regular session of 2020.

(i) The home birth task force shall dissolve on June 30, 2020.

PART III

SECTION 9. If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, the invalidity does not affect other provisions or applications of the Act that can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

SECTION 10. This Act does not affect rights and duties that matured, penalties that were incurred, and proceedings that were begun before its effective date.

SECTION 11. New statutory material is underscored.

SECTION 12. This Act shall take effect upon its approval; provided that sections 6 and 7 shall take effect on July 1, 2019.

APPROVED this 30 day of APR, 2019

GOVERNOR OF THE STATE OF HAWAII

SB No. 1033, SD 2, HD 2

THE HOUSE OF REPRESENTATIVES OF THE

STATE OF HAWAII

Date: April 9, 2019
Honolulu, Hawaii

We hereby certify that the above-referenced Bill on this day passed Third Reading in the House of Representatives of the Thirtieth Legislature of the State of Hawaii, Regular Session of 2019.

Scott K. Saiki
Speaker
House of Representatives

Brian L. Takeshita
Chief Clerk
House of Representatives

THE SENATE OF THE STATE OF HAWAI'I

Date: April 12, 2019
Honolulu, Hawaii 96813

We hereby certify that the foregoing Bill this day passed Final Reading in the Senate of the Thirtieth Legislature of the State of Hawai'i, Regular Session of 2019.

President of the Senate

Clerk of the Senate