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IN THE CIRCUIT COURT OF THE FIRST CIRCUIT

STATE OF HAWAI‘I

KI‘INANIOKALANI KAHO‘OHANOHANO; KIANA ROWLEY; A. EZINNE DAWSON; MAKALANI FRANCO-FRANCIS; KAWEHI KU‘AILANI; MORIAH SALADO; MOREA MENDOZA; EMILIE A.; and PI‘ILANI SCHNEIDER-FURUYA, on behalf of themselves, their students, and the pregnant and birthing people they care for, *Plaintiffs*, v. THE STATE OF HAWAI‘I; ANNE LOPEZ, in her official capacity as Attorney General of the State of Hawai‘i; DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS; and NADINE ANDO, in her official capacity as the Director of the Department of Commerce and Consumer Affairs, *Defendants*.	Civil NO. _______ (Declaratory Judgment) PLAINTIFFS’ COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF; SUMMONS

I do hereby certify that the foregoing is a full, true and correct copy of the official court record of the Courts of the State of Hawai`i.
Dated at: Honolulu, Hawai`i 27-FEB-2024, /s/ Lori Ann Okita, Clerk of the First Judicial Circuit, State of Hawai`i

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**Pro hac vice* petitions are forthcoming.

PRELIMINARY STATEMENT

1. The State of Hawai‘i unconstitutionally criminalizes skilled midwives, birth workers, and even family members for providing care and support to pregnant and birthing people.

2. In 2019, the State enacted the Midwifery Restriction Law (codified at Hawai‘i Revised Statues (HRS) § 457J), which defines midwifery in broad terms—essentially requiring anyone providing advice, information, or care during pregnancy, birth, and postpartum to have a state license. Nearly anyone without a proper license is subject to imprisonment, fines, and other legal penalties. Moreover, the Midwifery Restriction Law uses arbitrary and narrow criteria to determine who is eligible for a midwifery license, restricts who can call themself a “midwife,” and discriminates against residents of Hawai‘i.

3. The Law included a so-called “birth attendant” exemption that permitted the practice of “midwifery” without a state-issued license until July 1, 2023. Since the exemption expired, communities across Hawai’i have been reeling from irreparable harms.

4. The Midwifery Restriction Law is undermining reproductive autonomy, health, and the continuation of cultural practices at a time of crisis for maternal health equity. It cuts pregnant people off from care they need and desire, and its expansive reach ensnares their trusted midwives, doulas, lactation consultants, counselors, childbirth educators, cultural practitioners, extended family members, and friends. The Law violates rights of pregnant people, midwives, student midwives, and others supporting pregnant people guaranteed by Hawai‘i State Constitution.

5. Plaintiffs Ki‘inaniokalani Kaho‘ohanohano, Kiana Rowley, and A. Ezinne Dawson were recognized by their communities for years as trusted midwives before the Midwifery Restriction Law. As a result of the Law, they have been forced to make drastic changes, including to stop providing care, to stop teaching others, to change professional paths, and to stop working

with trusted collaborators, or risk criminal sanctions and other legal penalties.

6. Plaintiffs Kawehi Kuʻailani, Moriah Salado, Morea Mendoza, and Emilie A. are women whose reproductive autonomy the Law restricts. They are either currently pregnant and being denied access to their chosen midwife or have previously accessed care from a midwife who will not be legally permitted to assist them during future pregnancies.

7. Plaintiffs Kuʻailani, Makalani Franco-Francis, and Piʻilani Schneider-Furuya are Native Hawaiian student midwives whose training and life plans have been disrupted by the Midwifery Restriction Law. Their efforts to ensure that their communities will have trusted midwives and that their cultural traditions will endure are directly threatened now that the Midwifery Restriction Law criminalizes their mentors and/or devalues and dismisses their training.

8. Hawaiʻi, like the rest of the United States, is experiencing a crisis in maternal health. Poor maternal health outcomes are both preventable and far too prevalent, and women of color bear the brunt of these system failures. Native Hawaiian and Other Pacific Islander people have the highest rates of maternal mortality nationally, followed by Black and other Indigenous people. Hawaiʻi has a shortage of maternal health care providers and a limited number of facilities. For reasons related to geography, poverty, and systemic racial and ethnic inequities, many people struggle to access the health care they need. Some also find that the health care they ultimately receive during pregnancy and birth is discriminatory and disrespectful.

9. Poor maternal health outcomes are both a form and a symptom of discrimination. They expose complacency with gender inequality and systemic racism, and the unwillingness of those in positions of power to confront and repair a broken health care system that neglects and violates the rights of pregnant and birthing people. The solution to maternal health inequities is more reproductive autonomy, not less.

10. Decisions about pregnancy and birth are deeply personal and are often informed by an individual or community's history and culture. For many people, pregnancy and birth are experiences of great social, cultural, and spiritual significance, not just medical events. In the exercise of reproductive autonomy, pregnant people make their own decisions about where, how, and with whom they want to birth and access pregnancy-related care. They may choose the midwifery model of care because it recognizes birth as a natural physiological process and because it prioritizes respect for the pregnant person and their agency. And they may choose a particular midwife because they share mutual trust and cultural values with that practitioner. Midwives play a critical role in expanding access to health care, reducing unnecessary interventions, and strengthening cultural connections that empower pregnant people and their families.

11. Restrictive and discriminatory midwifery laws deny pregnant people knowledge and resources critical to their health and culture, perpetuating harmful legacies of control and coercion. The Midwifery Restriction Law follows a long line of legal interference with midwifery traditions and other cultural practices and threatens the fundamental human and constitutional rights of pregnant people, Native Hawaiians, and others.

12. United Nations Treaty Monitoring Bodies have urged the U.S. to take a different approach. In 2022, the Committee on the Elimination of Racial Discrimination recommended that the U.S. address "the limited availability of culturally sensitive and respectful maternal health care, including midwifery care for those with low incomes, those living in rural areas, people of African descent and indigenous communities"[1] and in 2023, the Human Rights Committee urged the U.S.

[1] Comm. on the Elimination of Racial Discrimination, Concluding Observations on the Combined Tenth to Twelfth Reps. of the U.S., ¶ 35, U.N. Doc. CERD/C/USA/CO/10-12 (Sept. 21, 2022), https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CERD%2FC%2FUSA%2FCO%2F10-12&Lang=en.

to “remove restrictive and discriminatory legal and practical barriers to midwifery care, including those affecting midwives in communities of people of African descent and Indigenous Peoples.”[2]

13. Against the backdrop of a state and national crisis in preventable maternal deaths disproportionately affecting Black and Native Hawaiian and Other Pacific Islander people, and increasing threats to reproductive autonomy and privacy, the Hawai‘i legislature chose to oppose the revitalization of community-based midwifery and to dismantle access to health care on which many families of color depend.

14. The Midwifery Restriction Law is causing great harm—to midwives, to people who want to grow their families, to student midwives, and others who want to play a supportive role in someone’s pregnancy, birth, or postpartum experience. It is also thwarting efforts in Hawai‘i to achieve the respectful, integrated, collaborative system of maternity care that residents need.

15. To address the harm the Midwifery Restriction Law is causing every day it is in effect, Plaintiffs ask this Court to declare the Law unconstitutional as to—and stop the threat of penalties against—traditional and apprenticeship-trained midwives and others who may fall within its expansive scope and do not meet its arbitrary and discriminatory requirements. The requested relief would restore the status quo that prevailed for decades. It would once again allow pregnant people to access, and midwives, student midwives, and other birth workers to provide safe, respectful, and culturally informed care without fear of criminalization.

[2] Comm. on Hum. Rts., Concluding Observations on the Fifth Periodic Rep. of the U.S., ¶ 27, U.N. Doc. CCPR/C/USA/CO/5 (Dec. 7, 2023), https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CCPR%2FC%2FUSA%2FCO%2F5&Lang=en.

PARTIES

16. Plaintiff KIʻINANIOKALANI KAHOʻOHANOHANO ("Kahoʻohanohano") is a Native Hawaiian whose ancestors were natives of the area which consists of the Hawaiian Islands prior to 1778. She is a Native Hawaiian cultural practitioner, midwife, and mentor based in rural Maui with over 20 years of experience. Kahoʻohanohano is one of the only midwives who has experience practicing as a midwife and a cultural practitioner who has knowledge of Native Hawaiian traditional and customary birthing practices. Prior to the Midwifery Restriction Law, Kahoʻohanohano practiced as a midwife, and continued to practice as an exempt "birth attendant" after it took effect. Since the exemption expired on July 1, 2023, she has turned away families seeking her care nearly every week. She sues on her own behalf, on behalf of her students, and on behalf of people who seek her care as a midwife.

17. Plaintiff KIANA ROWLEY ("Rowley") is an apprenticeship-trained midwife based in Maui and is currently a student in a certified nurse midwifery (CNM) program. Plaintiff Rowley previously worked as a registered nurse in a hospital labor and delivery unit but shifted careers after seeing the need for more community-based models of health care and the failure of the medical model to meet the needs of all families. Rowley practiced midwifery on Maui, including, after the Midwifery Restriction Law took effect, as an exempt "birth attendant." Although she is investing considerable resources to become a licensed CNM, she plans to practice midwifery alongside midwives who are not licensed and will risk criminal penalties for doing so. She sues on her own behalf and on behalf of people who seek her care as a midwife.

18. Plaintiff A. EZINNE DAWSON ("Dawson") is a certified professional midwife (CPM) and licensed midwife in Oʻahu who obtained her credential from the North American Registry of Midwives (NARM) through its apprenticeship-based training pathway, the Portfolio

Evaluation Process (PEP). She is one of only two licensed Black midwives in Hawaiʻi. She is a mentor for students who are pursuing that same pathway, but who will be ineligible for a Hawaiʻi State midwifery license, and risks criminal penalties for practicing midwifery alongside midwives and other birth workers who are not licensed. She sues on her own behalf, on behalf of her students, and on behalf of pregnant people who seek her care as a midwife.

19. Plaintiff MAKALANI FRANCO-FRANCIS ("Franco-Francis") is a Native Hawaiian doula and *haumāna* (student) midwife who has been training under Plaintiff Kahoʻohanohano since 2017. She is dedicated to training as a midwife because her own experiences with home birth were transformative, and she wants others to have that option. Franco-Francis's life, and vision for her future, have been profoundly shaped by this training pathway, and the anticipation of becoming a midwife, which is now thwarted by the Law. She sues on her own behalf and on behalf of people she expects to serve as a midwife.

20. Plaintiff KAWEHI KUʻAILANI ("Kuʻailani") is a Native Hawaiian mother who gave birth to two children at home in Maui, under the care of Plaintiff Kahoʻohanohano. After receiving midwifery care that both protected her health and met her cultural needs, she became a *haumāna* (student) midwife of Plaintiff Kahoʻohanohano. Plaintiff Kuʻailani is currently pregnant and wishes to birth at home in March 2024 with her chosen midwife. She sues on her own behalf and on behalf of people she expects to serve as a midwife.

21. Plaintiff MORIAH SALADO ("Salado") is a Native Hawaiian mother living in Maui who received midwifery care from Plaintiff Kahoʻohanohano that both protected her health and met her cultural needs. Along with her partner (who is also Native Hawaiian), she wishes to grow her family and access her chosen midwife for her next pregnancy birth. She sues on her own behalf.

22. Plaintiff MOREA MENDOZA ("Mendoza") is a fourth generation Hawaiʻi resident of Filipino and Caucasian descent and a mother living in Maui who received midwifery care from Plaintiff Kahoʻohanohano that both protected her health and met her cultural needs. Along with her partner (who is Native Hawaiian), she wishes to grow her family and access her chosen midwife for her next pregnancy birth. She sues on her own behalf.

23. Plaintiff EMILIE A. ("Emilie") gave birth to her first child in February 2024. She and her partner (who is Native Hawaiian) wished to birth at home with a chosen midwife who could both protect her health and meet their cultural needs. Plaintiff Emilie is also a student in a CNM program. Although she is investing considerable resources to become a licensed CNM, she plans to practice midwifery alongside midwives who are not licensed but will be risking criminal penalties for doing so. She sues on her own behalf and on behalf of people she expects to serve as a midwife.

24. Plaintiff PIʻILANI SCHNEIDER-FURUYA ("Schneider-Furuya") is a Native Hawaiian doula and student midwife pursuing the apprenticeship-based path—the PEP—to earn her CPM credential and is an apprentice to Plaintiff Dawson. Although she is investing considerable resources to become a CPM, she will be ineligible for a Hawaiʻi State midwifery license under the Midwifery Restriction Law because she is pursuing this apprenticeship-based training path after January 1, 2020. She sues on her own behalf and on behalf of people she expects to serve as a midwife.

25. Defendant STATE OF HAWAIʻI (the "State") is responsible for the enforcement of Hawaiʻi law, including the Midwifery Restriction Law (codified at HRS § 457J) and the Uniform Professional and Vocation Licensing Act (codified at HRS § 436B).

26. Defendant ANNE LOPEZ is the Attorney General of the State of Hawaiʻi. As

Attorney General, Defendant Lopez has the authority to assess criminal penalties against midwives, including under HRS § 436B-27(b). Defendant Lopez is sued in her official capacity.

27. Defendant DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS ("DCCA") administers the midwifery licensing program, HRS § 457J, and enforces penalties under it, including assessing civil penalties under HRS § 457J-13.

28. Defendant NADINE ANDO is the Director of DCCA and in that capacity serves as the chief executive and administrative officer of DCCA. Defendant Ando is sued in her official capacity.

JURISDICTION AND VENUE

29. This court has jurisdiction over the claims in this action pursuant to HRS §§ 603-21.5 and 632-1, and Article 1, §§ 2, 3, 5, and 6; and Article XII, § 7 of the Hawai'i State Constitution.

30. Venue is proper in this court pursuant to HRS § 603-36 because the claims for relief arose within, and Defendants are domiciled in, this Circuit.

FACTUAL ALLEGATIONS

I. Maternal Health is in a State of Preventable Crisis in the United States and in Hawai'i.

31. Despite spending more money on maternity care than any other country, the United States' approach to health care is producing alarmingly poor maternal health outcomes. The U.S. already has the highest rates of maternal and infant mortality among wealthy countries and continues to see rising rates of maternal death and maternal morbidity (non-fatal health conditions caused or aggravated by pregnancy or childbirth that negatively affect the pregnant person's well-

being). The majority of pregnancy-related deaths are preventable.[3]

32. People of color and those living in poverty or in rural areas are more likely to suffer pregnancy-related deaths. Nationally, Black and Indigenous people are two to three times more likely to die of pregnancy-related causes than white people are,[4] and Native Hawaiians and other Pacific Islander people have the highest rates of all.[5]

33. Recent data from the Centers for Disease Control and Prevention show that Native Hawaiian and Other Pacific Islanders are 4.5 times more likely to experience pregnancy-related deaths than white people.[6]

34. Racial and ethnic disparities in maternal health outcomes are severe and pervasive in Hawai‘i as well. In Hawai‘i, 44 percent of the pregnancy-related deaths that occurred between 2015 and 2017 were among Native Hawaiian and Other Pacific Islander women, although they make up only 22 percent of all women in Hawai‘i.[7]

35. In Hawai‘i, and across the U.S., many people lack available, accessible, culturally

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[3] *Four in 5 pregnancy-related deaths in the U.S. are preventable*, Ctrs. for Disease Control & Prevention (Sept. 19, 2022), https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html; Susanna Trost et al., *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017-2019*, Ctrs. for Disease Control & Prevention (Sept. 19, 2022), https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html.

[4] Laura G. Fleszar et al., *Trends in State-Level Maternal Mortality by Racial and Ethnic Group in the United States*, JAMA 2023; 330(1):52 -61. doi:10.1001/jama.2023.9043, https://jamanetwork.com/journals/jama/article-abstract/2806661?appId=scweb.

[5] *Pregnancy Mortality Surveillance System: Pregnancy-Related Deaths by Race/Ethnicity*, Ctrs. for Disease Control & Prevention (Mar. 23, 2023), https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm.

[6] *Id*.

[7] Melanie Maykin & Stacy Pai-Jong Tsai, *Our Mothers Are Dying: The Current State of Maternal Mortality in Hawai‘i and the United States*, 79(10) Hawai‘i J. Health & Soc. Welfare 302 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7547177/.

acceptable, high-quality options for health care before, during, and after pregnancy. Instead, pregnant people must navigate an expensive, complex, and fragmented health care system that frequently segregates patients by poverty, location, and insurance status, and too often delivers inadequate, discriminatory, or undignified care.

A. Hawai'i Has a Shortage of Maternity Care Providers and Limited Facilities.

36. Hawai'i is negatively affected by the shortage of maternity care providers and reliance on a national health care system designed to fail the most vulnerable patients. As is, pregnant and birthing people in Hawai'i struggle to find available maternity care providers and access care at health clinics and hospitals. In a 2023 report to the legislature discussing its maternal mortality review activities, the State of Hawai'i Department of Health stated it would support strategies that would mitigate the complexity of the health care delivery system, including increasing online appointments outside traditional hours; allowing doulas; and making it easier for health professionals to conduct home visits and/or provide care through mobile clinic sites, especially in rural areas.[8]

37. Access to health care providers and facilities is especially challenging for people in rural areas. Extreme weather conditions, slow-moving and winding roads, and traffic from tourism are all barriers to reaching health care sites.[9]

38. There are no freestanding birth centers in Hawai'i and each island has, at most, only a handful of hospitals with a labor and delivery unit.

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[8] *Hawai'i Maternal Mortality Review Committee Report to the Thirty-Second Legislature*, Hawai'i State Dept. of Health, 20 (2023), https://www.capitol.hawaii.gov/sessions/session2023/bills/DC172_.PDF ["2023 HMMRC Report"].

[9] *Where You Live Matters: Maternity Care in Hawaii*, March of Dimes (2022), https://www.marchofdimes.org/peristats/assets/s3/reports/mcd/Maternity-Care-Report-Hawaii.pdf.

39. There are five hospitals on O‘ahu that provide labor and delivery services. All are located on the south side of the island. From the north shore, people may need to travel approximately an hour by car to reach one of these hospitals. In recent years, at least one O‘ahu hospital has been over capacity and referred maternity patients elsewhere.

40. Hospitals on O‘ahu also care for residents of other islands who have more complicated pregnancies or who experience complications after their pregnancy that require more complex care. A person on a neighbor island in need of more intensive medical care will be evacuated by helicopter to O‘ahu, referred to as an “evacuation birth.” Some people fly to O‘ahu to access care not offered at a hospital on their home island, including the opportunity to avoid a repeat cesarean surgery by attempting a vaginal birth after a cesarean surgery (VBAC). For pregnant people, going to O‘ahu means leaving their home and often their support system weeks before delivery, and paying for airfare and lodging—which may be financially, logistically, or emotionally impossible for some families.

41. The only hospital on Maui is approximately a two-to-three-hour drive from Hāna and Kīpahulu in east Maui, on a winding road often clogged with tourist traffic. Sometimes, pregnant people give birth on the side of the road, en route to the hospital.

42. In 2023, one of three obstetric practices on Maui stopped offering obstetric care, and the remaining practices are struggling to fill the gap. One of the remaining two practices only accepts certain types of insurance (typically, employer-sponsored insurance). The other practice serves people with a wider range of public and private insurance plans but requires patients to sign a document promising that they will not have a home birth. Some patients do not sign and forgo these services. Other patients who want to have a home birth sign the document because they have no other options for obtaining certain prenatal services. If those patients do not birth at the hospital,

the practice typically does not follow up—effectively dropping the patients. The practice also reportedly refuses to see such patients during subsequent pregnancies. Pregnant people often hide that they plan on having a home birth for fear of being dropped by the practice due to their home birth plans.

43. There is only one hospital on Molokaʻi. It treats people with low-risk births who have never had a cesarean surgery and has one labor and delivery room. The hospital has no operating room, does not perform cesarean surgeries, and does not offer epidurals.

44. There are no hospital labor and delivery services on Lānaʻi. Most pregnant people fly to Oʻahu in advance of their due date, sometimes without family or support systems and often at considerable financial expense.

45. There are two hospitals on Kauaʻi with labor and delivery rooms. Cesarean surgeries are performed at the hospitals, and individual providers determine the circumstances under which they permit vaginal births. There is a single highway that encircles most of the island, and both of the hospitals may be more than an hour drive from someone's home. Hanalei Bridge, the one route in and out of the island's north shore, closes often due to flash flooding. When the bridge closes, pregnant people cannot leave the area by car and may have limited or no access to maternity care. To avoid being isolated from their providers, pregnant people may leave their homes as early as a month before their due date, find a temporary place to stay, and incur additional expenses.

46. There are three hospitals on Hawaiʻi Island with labor and delivery units. They are located in three corners of the island—in Hilo, Kona, and Waimea—leaving vast swaths of the island hours away from hospital care. Physicians at all three hospitals perform cesarean surgeries, but patients are prohibited from having vaginal births after a cesarean surgery (VBAC) and must

fly to O‘ahu to access health care under certain circumstances.

47. The entire State is suffering a health care provider shortage, which is more pronounced in the rural areas of all the islands. Providers fly from O‘ahu to other islands to try to fill the gap. Turnover is also high, and providers often leave after a few years—leaving Hawai‘i residents with little opportunity to develop longstanding relationships with health care providers.

B. Hawai‘i's Health Care System Fails to Ensure Respectful, Culturally Informed Care For All.

48. Even when individuals are able to reach health care facilities, the care they receive may not be appropriate for their needs. Birth interventions (e.g., epidural, Pitocin to induce labor, episiotomies, cesarean surgeries) are routine despite evidence that routine use of such interventions increases the risk of complications for birthing people and their babies.[10]

49. These interventions are common in Hawai‘i. For example, in 2022, more than 27% of births in Hawai‘i were by cesarean surgery. According to the World Health Organization, the ideal cesarean rate is between 10 and 15% of births and there is no evidence that mortality rates improve when the rate rises above 10%. The Hawai‘i State Department of Health warns: a cesarean "is the most common major surgery performed in the United States and results in higher costs, longer hospitalization, and increased risks of maternal morbidity compared to women who deliver vaginally."[11]

50. Sometimes, medical interventions are necessary. But when they are not, they can put an individual's life, health, and future reproductive plans at risk. People who deliver by

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[10] Judith A. Lothian, *Healthy Birth Practice #4: Avoid Interventions Unless They Are Medically Necessary*, 28(2) J. Perinatal Educ. 94 (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4235054/.

[11] *Cesarian Delivery Factsheet*, Hawai‘i State Dept. of Health/PRAMS (Oct. 2021), https://hhdw.org/wp-content/uploads/2023/07/Ceasarian-Delivery-Factsheet.pdf.

cesarean are highly likely to undergo a cesarean in subsequent pregnancies. In 2022, the rate of first time cesarean deliveries in Hawai‘i was 20.5 per 100 live births; the rate of repeat cesarean deliveries was 81.7 per 100 live births. The rate of vaginal birth after previous cesarean surgeries (VBAC) was just 18.3 per 100 live births.[12]

51. Mistreatment of patients in maternity care settings has also been normalized. Racism and sexism increase the risk of abuse and neglect in maternity care facilities. People birthing in hospital labor and delivery units are routinely treated as bodies from which babies will be extracted, rather than respected as the authority and ultimate decision-maker in the physiological process of birth. For pregnant people of color, the risks of objectification and violence are heightened.

52. Pregnancy and birth experiences too often include humiliation, verbal abuse, coercion, and threats. Pregnant, birthing, and postpartum patients may be restricted to a hospital bed during labor, forced to birth in a certain position or on a timeline preferred by the facility or provider, separated from a chosen companion, treated as a teaching aid for medical students, racially profiled for drug testing and referral to family policing authorities, forced into procedures, denied information and the opportunity to give or refuse consent, denied care and pain medication, and subjected to intimidation by police or hospital security guards for acts of self-advocacy.

53. Individuals and families in Hawai‘i have challenged specific health care system practices that fail to respect their religious and cultural traditions. For example, in 2005, the Hawai‘i State Department of Health issued a rule classifying placentas as infectious waste, and, as

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[12] *Delivery Method: Data for Hawaii*, March of Dimes (Jan. 2022), https://www.marchofdimes.org/peristats/data?reg=99&top=8&stop=86&lev=1&slev=4&obj=1&sreg=15; *Repeat Cesarean Deliveries: Hawaii*, 2015-2022, March of Dimes (Jan. 2022), https://www.marchofdimes.org/peristats/data?reg=15&top=8&stop=360&lev=1&slev=4&obj=1&sreg=15.

a result, hospitals denied two families their babies' *'iewe* (placenta). After legal action, the State enacted a law to better protect the birthing person's right to take their baby's *'iewe* home with them from the hospital. Nonetheless, reports of hospitals mistreating, misplacing, mistakenly destroying, or outright denying patients the ability to take their babies' *'iewe* home persist.

54. The lack of racial and ethnic diversity among health care providers contributes to mistreatment and discrimination. Physicians, nurses, and midwives of color are significantly underrepresented in the health care workforce, and many people never have an opportunity to be cared for by someone who shares their racial, ethnic, or cultural background.

55. Among the recommendations offered by the Hawai'i State Department of Health to combat maternal mortality is a commitment to providing "implicit bias training to increase the cultural competency/humility of the clinical workforce, focusing on the important context of the maternal health disparities observed by public health and other health professionals in their work." The trainings "emphasize historical influences that have contributed to deep rooted social inequities, discrimination, and biases that impact the health and well-being of Native Hawaiians and Pacific Islanders."[13]

II. Reproductive Autonomy Includes Personal Decisions About Where and With Whom to Birth and Access Pregnancy Care.

56. Pregnancy and childbirth should be safe, healthy, and supported experiences, free from discrimination and preventable health harms. For many people, including Plaintiffs, experiences with pregnancy and childbirth carry deeply personal social, cultural, and spiritual significance and are not singularly or primarily medical events. Hawai'i's State Auditor has recognized the variety of factors that can impact a person's decision about where and with whom

[13] 2023 HMMRC Report at 20.

to birth, and that "birthing choice is a central issue in terms of women's empowerment, reproductive freedom, cultural perpetuation, and self-determination."[14]

57. For some people, giving birth in a hospital with a physician or midwife is the preferred and safest option. For others, including Plaintiffs, birthing in community settings with a midwife is a way to ensure they experience birth in a place that is comfortable and safe, and allows them to incorporate family members, loved ones, and cultural or religious practices more easily. For people who have experienced traumatic births in facility-based birth settings, planning a birth at home or in a birth center with a trusted midwife may also help heal or mitigate trauma.

58. There is broad consensus, including among medical organizations, that pregnant people "have the right to make informed decisions about their care, including decisions about their choice of care provider and place of birth."[15] For example, the American College of Obstetricians & Gynecologists (ACOG)—the largest organization of obstetricians and gynecologists in the country—states that, in the obstetric setting, a pregnant person is "the appropriate decision maker" for themself and "for the fetus that she is carrying."[16]

59. As the National Academies of Science, Engineering, and Medicine—a non-governmental entity established by Congress to provide independent, objective analysis of the nation's complex challenges—have concluded, all pregnancies and all birth settings come with

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[14] *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), Office of the Auditor at 12 (Jan. 2017), https://files.hawaii.gov/auditor/Reports/2017/17-01.pdf

[15] *Birth Settings in America Outcomes, Quality, Access, and Choice*, Nat'l Acads. of Sci., Eng'g, & Med. at 3-5 (2020) ["*Birth Settings in America*"], https://www.ncbi.nlm.nih.gov/books/NBK553600/pdf/Bookshelf_NBK553600.pdf

[16] *Committee Opinion No. 390: Ethical Decision Making in Obstetrics and Gynecology*, Amer. Coll. of Obstet. & Gynecol. (Dec. 2007, reaffirmed 2019), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2007/12/ethical-decision-making-in-obstetrics-and-gynecology.

risks and benefits that the pregnant or birthing person must have the opportunity to learn about and weigh for themselves. Pregnant and birthing people "may conceive of, tolerate, or understand risk differently from their health care providers or may simply have competing priorities and values (e.g., control, respect, faith) that they prioritize over and above medical risks."[17]

III. Midwives are Critical to Meeting the Maternal Health Needs of People in Hawaiʻi, and Have a Unique Role in Strengthening Cultural Connections and Empowering Families.

60. Midwives provide skilled, compassionate care for people during pregnancy, birth, and postpartum. The midwifery model of care approaches birth as a natural process, rather than a pathology, and respects the pregnant person's right to make informed, autonomous decisions.

61. Low-risk pregnant people who plan a home or birth center birth with a midwife, compared to those who choose hospital birth, have lower rates of intervention (including cesarean surgeries, induced or augmented labor, and episiotomy) and lower rates of intervention-related mortality (including infection, postpartum hemorrhage, and tearing).[18] They are also more likely to describe their birth experiences as joyful and positive.

62. Over time, midwives have developed different methods for passing down knowledge and preparing new midwives to care for pregnant people. Some midwives acquire and apply their midwifery skills in community settings, such as birth centers or people's homes. These midwives do not typically train in or work at hospitals, and their training does not require a nursing degree. They include midwives who may self-identify or be referred to as "direct entry midwives (DEM)," "lay midwives," or "traditional midwives," and who train with experienced midwives and do not earn a formal credential. It also includes CPMs, who may earn that credential after a

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[17] *Birth Settings in America* at 4.

[18] *Id.* at 6.

formal education program or apprenticeship training.

63. *Pale keiki* or *hoʻohānau* are terms referring to Native Hawaiian traditional and customary birthing and child-rearing practices, comprised of religious/spiritual and medicinal/practical elements, and include activities now commonly referred to as midwifery.

64. *Hānau* (childbirth), is an active process controlled by the person giving birth. It is the pregnant person's *kuleana* (responsibility) to choose the proper location for the birth and the proper attendants.[19] This *kuleana* helps to prepare a pregnant person for birth and also helps pregnant people, families, and communities to reclaim and perpetuate sacred and cultural practices.

65. Some of the practical and spiritual aspects of *pale keiki* are found in other Native Hawaiian traditional and customary practices. For instance, the medicines used in *pale keiki* exist in the repertoire of *kahuna lāʻau lapaʻau* (traditional medicinal healers) and *lomilomi* (traditional bodywork) practices. *Pale keiki* also involves engaging in the practice of *hoʻoponopono* (traditional conflict resolution) as a part of the spiritual cleansing process. These practical and spiritual aspects of *pale keiki* consist of Native Hawaiian practices that were established prior to November 25, 1892.

66. Religious and methodological aspects are an important distinguishing element of *pale keiki*. Certain *akua* (gods), *pule* (prayers), and *oli* (chants) are associated specifically with child birthing, coupled with specific *lomilomi* (traditional bodywork) techniques and *lāʻau lapaʻau* (traditional medicines). These religious and methodological aspects of *pale keiki* also consist of Native Hawaiian practices that were established prior to November 25, 1892.

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[19] *See Preserving and Ancient Practice: Traditional Home Birth in Hawaiʻi: A Report to the Governor on the Traditional Practices Affected by SB 1033, SD2 and request for VETO*, Hoʻopae Pono Peace Project at 10, https://docs.wixstatic.com/ugd/5ff77e_da67ead1acb441538a948757410b958f.pdf?index=true.

67. Aided by the adults in a birthing person's *ʻohana* (family), a *pale keiki* or *kahuna hoʻohānau* performed duties similar to those expected of a Western obstetrician and/or midwife.

68. Knowledge, traditions, and customs relating to pregnancy, birth, and child care are passed down from generation to generation. *Moʻolelo* (historical narratives) suggest that training and certification for *pale keiki* existed in Hawaiʻi prior to western contact in 1778. *Moʻolelo* (historical narratives) also reference specific training areas and sacred sites dedicated to birthing. Midwives trained as *pale keiki* can offer pregnant people a connection to Native Hawaiian birthing practices by educating families about and guiding them through the *oli* (chants), *pule* (prayers), and ceremony surrounding birth. These midwives also support families to *hānau* (birth) at home, on a family's *ʻāina kūpuna* (ancestral lands), which, for many is itself a critical reconnection to the land and to their ancestors.

69. For pregnant people whose own family may no longer hold the knowledge of the ceremonial and sacred aspects of birth, a midwife trained in Native Hawaiian traditional and customary birthing practices can be an invaluable, culturally informed health care provider.

IV. Restrictive Midwifery Laws Impede Access to Care and Threaten Cultural Traditions.

70. Unlike many other wealthy nations where midwives provide maternal health care for most people, the medical model of pregnancy care and birth has become the dominant and default model in the United States. Most births—98.4%—occur in hospitals and are predominantly managed by physician surgeons.[20]

71. This was not always the case. In Hawaiʻi, efforts targeting midwifery began in the 1930s when the Territorial Board of Health sought to end the practice of midwifery by encouraging

[20] *Birth Settings in America* at 18.

pregnant people to birth in hospitals with physicians. The Territorial Board of Health also required midwives to register with the government in 1931. These efforts followed other colonialist suppression of Native Hawaiian practices, including the banning of Hawaiian healing practices in 1905. By 1941, the Territorial Government made it illegal to practice midwifery without a license, and restricted licensure to nurse-midwives. In 1973, as a result of a growing Native Hawaiian rights movement, Native Hawaiian healers were again permitted to practice lawfully, but midwifery laws remained the same: practicing midwifery without a license was a misdemeanor, and only nurse-midwives were eligible for licensure.

72. In 1998, the midwifery licensure requirement was repealed. Nurse-midwives were placed under the purview of the Board of Nursing as advanced practice registered nurses. The State no longer required a license to practice midwifery or restricted the practice of midwifery to nurse-midwives only, effectively decriminalizing midwifery provided by traditional and apprenticeship-trained midwives.

73. Midwives who had been practicing despite the threat of penalties began to openly practice and train others. With freedom to revitalize Native Hawaiian healing practices around pregnancy and birth, a new generation of traditional and apprenticeship-trained midwives emerged.

74. However, decades of colonial suppression of traditional and cultural practitioners and their knowledge posed barriers to revitalization. Multiple sources of knowledge and experience were critical to rebuilding a community of culturally informed midwives. After the 1998 legal change, experienced midwives who were not Native Hawaiian taught others the skills they had acquired over the previous decades, often underground. *Kūpuna* (elders) who held cultural knowledge surrounding pregnancy and birth, but who did not practice midwifery, also

shared their knowledge with aspiring midwives.

75. For the next 25 years, Native Hawaiian midwives and midwives of other cultural backgrounds worked through apprenticeship-based models of training and education to rebuild safe and sustainable networks of culturally competent pregnancy and birth support throughout Hawai‘i, particularly in rural areas and communities of color.

V. Hawai‘i Enacted the Midwifery Restriction Law.

76. In 2019, after two decades without restrictive midwifery regulation, Hawai‘i enacted the Midwifery Restriction Law, which imposed new requirements on midwives to obtain a Hawai‘i State midwifery license.

77. The Midwifery Restriction Law acknowledged that “mothers and families seek out alternatives to hospital births and they find significant value in community or home birth services.” The Law claimed it would “continue to allow a woman to choose where and with whom she gives birth” and that “practicing midwifery according to [the Law] does not impede one’s ability to incorporate or provide cultural practices.” S.B. 1033, S.D. 2, H.D. 2, 30th Leg., Reg. Sess. (2019), § 1 (2019 Hawai‘i Act 32). These statements have not held true.

78. The legislature did not cite to any adverse incident involving an unlicensed midwife before excluding existing practitioners.

A. The Midwifery Restriction Law Uses Narrow and Arbitrary Criteria for Licensure That Exclude Some of the State’s Skilled Midwives and Disadvantage Hawai‘i Residents.

79. The Midwifery Restriction Law created the “Midwives Licensing Program,” which requires that all persons obtain a state-issued license from the Department of Commerce and Consumer Affairs (DCCA) to practice midwifery or use the title “midwife.” HRS §§ 457J-3, 457J- 5.

80. The Law broadly defines midwifery as

> the provision of one or more of the following services:
> (1) Assessment, monitoring, and care during pregnancy, labor, childbirth, postpartum 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.

HRS § 457J-2.

81. To obtain a license from the State, the Law requires an applicant to provide proof of certification as a "certified midwife" (CM) or "certified professional midwife." HRS § 457J-8(3). CNMs are also licensed by the State, but through the Board of Nursing rather than the Midwifery Licensing Program established by the Midwifery Restriction Law. *See* HRS § 457J-6(a)(1).

82. CNMs and CMs obtain midwifery skills through higher education and clinical training in hospitals. Some CNMs and CMs ultimately practice in community settings, like birth centers and homes, but most attend births in hospitals. Both CNMs and CMs are certified by the American Midwifery Certification Board (AMCB), a private, non-governmental entity. To complete their education, CNMs and CMs must complete clinical rotations under registered preceptors (an experienced practitioner under whom an apprentice trains). For students who do not live near registered preceptors, clinical rotations can prove difficult and costly, often involving travel and time away from family.

83. Certified professional midwives, or CPMs, are certified by the North American Registry of Midwives (NARM), a private, non-governmental body. All CPMs must pass the NARM exam. They may qualify to sit for the exam after apprenticing with a qualified midwife (the Portfolio Evaluation Process or PEP) or graduating from a midwifery program accredited by the Midwifery Education Accreditation Council (MEAC).

84. Under the Midwifery Restriction Law, only some CPMs are eligible for a Hawaiʻi State midwifery license. HRS § 457J-8.

85. CPMs who earn their certification after completing a MEAC program are eligible for a Hawaiʻi State midwifery license. *Id.*

86. Midwives who obtained their CPM certification through the apprenticeship-based path (the Portfolio Evaluation Process, or PEP) are only eligible for a Hawaiʻi State midwifery license if they obtained certification as a CPM before January 1, 2020, or maintained licensure in another state that does not require completing a MEAC-accredited program. The Law also requires that, to obtain a Hawaiʻi State midwifery license, these CPMs must also obtain a Midwifery Bridge Certificate from NARM, which requires CPMs to complete 50 hours of continuing education in certain topics. HRS § 457J-8.

87. The legislative history does not indicate why CPMs credentialed through apprenticeship training after January 1, 2020 are not eligible for a Hawaiʻi State midwifery license unless they have also completed a MEAC program.

88. There are only eight MEAC accredited programs in the U.S. and none are located in Hawaiʻi. Students must either relocate to the continental U.S. or complete online distance learning. Tuition, whether for an in-person, remote, or hybrid program, is thousands of dollars annually. Programs can take approximately 3 years to complete, and sometimes longer for students not attending full time. Attending an in-person or hybrid program that requires some on-campus presence means leaving one's home and community, or relocating with family, and raising funds for out-of-state travel and lodging expenses.

89. Four MEAC-accredited schools offer fully remote programs. Fully remote programs also require stable internet connections, which can be especially challenging for people

in rural areas.

90. There are limited preceptors in Hawai‘i who meet the requirements to be a registered preceptor with NARM. MEAC schools may have their own additional requirements for preceptors. The lack of available preceptors can create untenable delays for students working to complete their education and obtain the necessary experience to become licensed providers. Students may also be forced to relocate to find available preceptors. Delays create financial challenges, including having to pay for additional semesters of a midwifery education program. Such challenges are compounded by the fact that students are generally not paid as midwives in training, and many are pursuing part-time or full-time paid work to support themselves while completing their midwifery training.

91. CPMs who hold state licensure in another state that does not completing a MEAC program for licensure in that state are eligible for a Hawai‘i State midwifery license. HRS § 457J-8(4)(B). Accordingly, some midwives who move to Hawai‘i are eligible for a Hawai‘i State midwifery license even if they have not completed the educational requirements the Midwifery Restriction Law imposes on residents of Hawai‘i.

92. On information and belief, none of the 29 midwives listed as licensed by the State under the Midwifery Restriction Law identify as Native Hawaiian. Many obtained their training before moving to Hawai‘i.

93. On information and belief, several of the 29 midwives licensed under the Midwifery Restriction Law do not currently practice midwifery in, or even reside in, Hawai‘i.

B. The Midwifery Restriction Law’s Exemptions and Purported Protections Are Not Sufficient.

94. The Midwifery Restriction Law contains a limited exemption for “birth attendants” and vague language about the rights of Native Hawaiian cultural practitioners.

1. The Time Limited and Expired Birth Attendant Exemption.

95. When the Midwifery Restriction Law was enacted in 2019, it permitted practitioners referred to as "birth attendants" to practice midwifery without a state-issued license until July 1, 2023, and subject to certain limitations. HRS § 457J-6.

96. The Law stated that, before the exemption expired, "the legislature intends to enact statutes that will incorporate all birth practitioners and allow them to practice to the fullest extent under law." According to the legislature, the three-year period between the time the licensure requirement took effect in 2020 and the expiration of the birth attendant exemption in 2023 provided time to better define those practitioners who were practicing midwifery as exempt "birth attendants" and to develop common standards, accountability measures, and disclosure requirements. S.B. 1033, S.D. 2, H.D. 2, 30th Leg., Reg. Sess. (2019), § 1 (2019 Hawai'i Act 32).

97. Every year since the Midwifery Restriction Law was enacted, the legislature has considered proposals to amend the Law to extend an exemption from State licensure and to provide a path to State licensure for CPMs credentialed through the apprenticeship-based training path (the Portfolio Evaluation Process or PEP) after January 1, 2020.

98. The legislature has enacted no further statutes to incorporate all birth practitioners, and although the "birth attendant" exemption expired on July 1, 2023, the Exempt Birth Attendant Disclosure Form remains on DCCA's website.

2. Purported Protection for Native Hawaiian Practices.

99. The Midwifery Restriction Law also references protections for Native Hawaiian traditional and customary practices, but the extent to which *pale keiki* or Native Hawaiian midwives who engage in Native Hawaiian traditional and customary practices related to birthing are covered is not clear. The Law states that it does not "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 Lōkahi." HRS § 457J-6(b). It also states that it does not "limit, alter, or otherwise adversely impact the practice of traditional Native Hawaiian healing pursuant to the Constitution of the State of Hawaii." *Id.*

100. Despite the Law's references to Papa Ola Lōkahi and the state constitution as sources of protection for Native Hawaiian healing practices, clear and affirmative protections for Native Hawaiian traditional and customary birthing and child-rearing practices have not materialized.

101. Papa Ola Lōkahi is a non-profit, non-governmental, Native Hawaiian health organization whose mission is to improve the health and well-being of Native Hawaiians. Papa Ola Lōkahi can convene *kūpuna* councils (traditional healing councils of elders) that, in turn, can recognize and protect Indigenous practitioners who are not licensed. Although the existing *kūpuna* councils have expertise in Native Hawaiian healing practices that may overlap with midwifery care, none has expertise specific to *pale keiki* practices and they have thus far declined to recognize midwives who are *pale keiki*.

102. Efforts to convene a new council of *kūpuna* that could recognize *pale keiki* practitioners have also been unsuccessful. For example, on July 31, 2023, Papa Ola Lōkahi denied the application of Ea Hānau Cultural Council, a council of birth-knowledgeable *kūpuna* (elders) convened in an effort to protect Indigenous midwifery and *pale keiki* practices. Papa Ola Lōkahi stated it was denying recognition to the council because the proposed council was not "attached" to a federally qualified health center or federal "look alike," as current Papa Ola Lōkahi rules require. Papa Ola Lōkahi also stated "Act 153 defines Traditional Healing" and "specifically states "'Traditional Hawaiian <u>healing</u> practices shall refer to "lāʻau lapaʻau, lāʻau kāhea, lomilomi, and

hoʻoponopono.'" Papa Ola Lōkahi's letter appears to be referring to S.B. 1285, S.D. 2, H.D. 1, 23rd Leg., Reg. Sess. (2005), § 2 (2005 Hawaiʻi Act 153), which defines "Traditional Hawaiian healing practices as lāʻau lapaʻau, lāʻau kāhea, lomilomi, and hoʻoponopono, and similar practices historically performed by traditional native Hawaiian healers."[21] The denial letter quoted only the four specified practices—and not including *pale keiki* practices—suggesting that no council *could* be recognized.

103. Clear protections for Native Hawaiian midwives practicing Native Hawaiian traditional and customary birthing practices are necessary, and HRS § 457J does not provide that protection.

104. Midwives and pregnant people of other racial and ethnic groups, and with other cultures and traditions, are also negatively impacted by the Midwifery Restriction Law. Following decades of efforts to eradicate Native Hawaiian traditional healing practices that left few Native Hawaiian midwives in the State, Plaintiffs and others developed collaborative systems of caring for pregnant people as part of multi-ethnic communities. The Midwifery Restriction Law breaks up those networks, undermining essential care for pregnant people and families.

C. Practicing Midwifery Without a License Carries Criminal Sanctions and Other Legal Penalties.

105. Individuals who run afoul of the Midwifery Restriction Law, HRS § 457J, face penalties under that law and the Uniform Professional and Vocational Licensing Act, a pre-existing law codified at HRS § 436B.

106. Practicing midwifery without a license carries criminal penalties of up to one (1) year's imprisonment and a criminal fine not exceeding $2,000, HRS § 436B-27(b) (with each day

[21] This language does not appear in current statutes; it amends an introductory section of an earlier Act.

being a separate offense); civil fines of up to $1,000 per offense (with each day being a separate offense), HRS § 457J-13; *see also* HRS § 436B-26.5 (civil fines); and denial of future licensure, HRS §§ 457J-12, 436B-19. Individuals may also be liable for civil damages if DCCA sues to enjoin their unlicensed practice of midwifery. HRS § 436B-27.

107. Individuals who use the title "midwife" but do not hold a state license to practice midwifery risk $1,000 in fines for each day they hold themselves out as a midwife. HRS §§ 457J-5, J-13. Additionally, individuals "engaging in false, fraudulent, or deceptive advertising, or making untruthful or improbable statements"—for example, holding themselves out as "midwives"—may result in denial of a future license. HRS §§ 457J-12, 436B-19.

108. Licensed providers, including licensed midwives who work with unlicensed midwives, may face liability for "aiding and abetting" unlicensed midwifery, which carries substantial civil fines. HRS § 436B-27(a). "Aiding and abetting" unlicensed midwifery or "employing, utilizing, or attempting to employ or utilize" an unlicensed midwife may also result in denial, suspension, or revocation of a license. HRS §§ 457J-12, 436B-19.

D. The Attorney General Has Confirmed the Breadth and Severity of Penalties Under the Midwifery Restriction Law.

109. On January 17, 2024, the Department of the Attorney General responded to several questions about the Midwifery Restriction Law. The Attorney General confirmed that exempt birth attendants "are not legally allowed to continue practicing past July 1, 2023," the date the exemption expired. Attorney General Letter at 1.

110. The Attorney General also confirmed that the "provision of any one service, or one service in combination with another service included in the definition of midwifery, constitutes the practice of midwifery for which a license is required." *Id*. at 3. This includes care and support provided by doulas, lactation consultants, counselors, and cultural or religious practitioners to the

extent it overlaps with any part of the definition of "midwifery." The Midwifery Restriction Law further bars "grandparents, aunties, uncles, cousins, or broader hānai family" from engaging in what the Law broadly defines as "midwifery" unless they have a license to do so. *Id*. at 3.[22]

111. As to "religious and cultural practitioners," the Attorney General stated that the Midwifery Restriction Law "seems to allow traditional healing practices of prenatal, maternal, and child care so long as those practices are recognized by a council of kūpuna convened by Papa Ola Lōkahi." *Id*. at 4.

112. Although the Midwifery Restriction Law "allows the practice of Native Hawaiian healing pursuant to the Constitution of the State of Hawaii," the Attorney General commented that "the specific Native Hawaiian healing practice protected by the State Constitution is not identified." *Id*. at 4. Further, although "a licensed midwife can certainly include cultural practices, it is unclear what, if any, cultural practices are exempted from midwifery licensure." *Id*.

113. Finally, the Attorney General confirmed that HRS § 436B-27(b), which imposes criminal penalties for practice without a license, applies to "any person who engages in any of the activities included in the definition of midwifery for which a license is required and fails to obtain such a license, or advertises or represents that the person is licensed to engage in midwifery," unless otherwise exempt. *Id*. at 4-5.

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[22] *Hānai* is defined as fostered or adopted, as well as to raise and feed. Traditionally, this form of adoption was done at infancy, as opposed to adult "hoʻokama" adoptions that also occurred in ancient times. Presently, *hānai* has become a local Hawaiʻi colloquialism to refer to a person's "chosen family," as is the case here. The Supreme Court of the Kingdom of Hawaiʻi first addressed *hānai* in *In re Estate of Nakuapa*, 3 Hawaiʻi 400 (Haw. Kingdom 1872) which focused on traditional *hānai* relationships.

VI. The Midwifery Restriction Law is Causing Significant Harm and Confusion, Undermining Maternal Health Care in Hawai‘i.

114. The Midwifery Restriction Law is creating confusion and fear of criminal sanction for midwives, pregnant people, and those who support them. It has already prevented midwives from providing care, denied pregnant people access to trusted practitioners, interrupted training for student midwives and the dissemination of endangered cultural knowledge, and undermined collaboration between various actors in the health care system. These harms are ongoing.

A. The Midwifery Restriction Law Puts Experienced Midwives at Risk of Criminal Penalties for Using Their Skills to Serve Their Community.

115. The Midwifery Restriction Law criminalizes a growing community of midwives whose considerable efforts to restore midwifery traditions in Hawai‘i have been legal for the last two decades. Although nothing about their experience, skills, or their community’s needs diminished during those decades, on July 1, 2023, midwives including Plaintiffs Kaho‘ohanohano and Rowley, who have served as midwives for years and have been training others, are now constrained by the threat of criminal sanctions.

116. Plaintiff Kaho‘ohanohano’s approach to midwifery is based on preventive and proactive care. For Kaho‘ohanohano, pregnancy is not a sickness, and *hānau* (birth) does not always need to be a medical event. *Hānau* (birth) is a sacred ceremony, a rite of passage that can help families reconnect with the practices of their ancestors. As a midwife, Kaho‘ohanohano offers guidance to families seeking to conceive, and cares for them through the prenatal, labor, birth, and postpartum periods. She assesses and monitors their health, provides guidance about signs and symptoms to look out for, and supervises labor and delivery.

117. The foundation of Kaho‘ohanohano’s midwifery practice is her training as a cultural practitioner. For pregnant people seeking a connection to Native Hawaiian traditional and customary birthing practices, Kaho‘ohanohano offers that connection, educating families about

and guiding them through these practices. Kahoʻohanohano uses her knowledge of *lāʻau lapaʻau* (traditional medicines) to advise pregnant people about traditional foods and plants that they can use to promote health. She offers *lomilomi* (traditional bodywork) to pregnant people, and practices *hoʻoponopono* (traditional conflict resolution) to counsel families throughout pregnancy and postpartum. Kahoʻohanohano's care also supports families to *hānau* (birth) at home, on their family's *ʻāina kūpuna* (ancestral lands).

118. Kahoʻohanohano is one of the only midwives who travels to rural and remote areas on Maui, including in rural East Maui (Hāna and Kīpahulu), and on Molokaʻi. When Kahoʻohanohano travels to them, the pregnant person gets the attention and care that she needs, in her own home, and without having to drive several hours to the hospital. At any time that Kahoʻohanohano believes a pregnant person needs a different level of care or a different type of health care provider, she offers that advice, explains why, and will often continue to support them in other ways.

119. For all of these reasons, families seek out Kahoʻohanohano to support them throughout pregnancy, to birth on their ʻ*āina kūpuna* (ancestral lands), and to heal from different forms of trauma, including abuse and mistreatment during prior pregnancies or births.

120. Along with Plaintiff Kahoʻohanohano, Plaintiff Rowley is one of the only midwives who travels to rural areas in Maui County, enabling pregnant people to experience the family-based births they seek and to which they would not otherwise have access. Most of the families she served as a midwife were born and raised in Hawaiʻi; many are Native Hawaiian, others are Filipino, Japanese, white, or multiracial. They often had multiple reasons for wanting to birth at home. For many, home felt safest. Some experienced, or anticipated, disrespectful or coercive treatment in hospital settings and were wary of being treated as just another number in an

impersonal system. Birthing at home was also a way to reclaim sovereignty over their body, and to reconnect with familial and cultural traditions.

121. Before the Midwifery Restriction Law took effect in 2019, Kahoʻohanohano and Rowley typically acted as midwives attending one to three births per month, and supported others through prenatal or postpartum care throughout the year. Kahoʻohanohano and Rowley continued to practice midwifery as exempt "birth attendants" after the Law took effect, continuing to attend one to three births per month.

122. Around December 2022, in light of the impending expiration of the "birth attendant" exemption, Kahoʻohanohano and Rowley began turning families away. Although it was months before the "birth attendant" exemption would expire, they could not commit to attending births as midwives for pregnant people with due dates after July 1, 2023 for fear of liability under the new law. Since the expiration of the exemption, the Law has regularly forced Kahoʻohanohano to turn pregnant people and families away.

123. In some cases, a pregnant person will still reach out in distress, and may even delay making that call for fear of putting Kahoʻohanohano at legal risk. When a pregnant person calls in need of urgent help, Kahoʻohanohano is forced to decide whether to risk using her skills to help avert an adverse outcome.

B. The Midwifery Restriction Law Deprives Pregnant People of Their Rights to Reproductive Autonomy and Undermines Their Health.

124. The Midwifery Restriction Law does not protect the health and lives of pregnant and birthing people and their families, and in fact, endangers them.

125. Pregnant people and their families are confronting the reality that they must birth under circumstances that they do not want or would not choose because midwives like Kahoʻohanohano and Rowley cannot act as their midwife. Because of the Midwifery Restriction

Law, families that want a home birth are forced to either hire a practitioner they would not otherwise choose, or birth without the assistance of a skilled practitioner.

126. The Midwifery Restriction Law leaves individuals who decide to birth at home with fewer options since they must now choose a midwife from a limited number of licensed practitioners who may not have the skills and experience to support them in their birth choices. For instance, CNMs and physicians are not required to have training or experience in supervising home birth, yet the Law does not prohibit them from doing so. Instead, the Law bars those practitioners (certain CPMs and apprenticeship-trained traditional midwives) more likely to have experience supervising labor and delivery at home from doing so.

127. The Law exacerbates the maternity care provider shortage by barring midwives who had been serving rural areas and providing culturally informed care. Among the remaining providers, pregnant people may not be able to obtain the care they seek.

128. For example, Plaintiff Kuʻailani gave birth to her two daughters at home, assisted by midwives, including Kahoʻohanohano, and supported by her closest friends and family. She is pregnant with her third daughter and due March 2024. The care Kuʻailani received from Kahoʻohanohano during her prior pregnancies and births was transformative for Kuʻailani and her family. Under Kahoʻohanohano's guidance and care, Kuʻailani and her family reconnected with Native Hawaiian traditional and customary birthing practices of *pale keiki*, which brought them closer together as an *ʻohana* (family).

129. Because of the Midwifery Restriction Law, Kuʻailani has not been able to receive prenatal care from Kahoʻohanohano as she did during her previous pregnancies. The Law has also made it difficult for Kuʻailani to plan, and she is uncertain where she will give birth or with whom. She wants to birth again in the safety of her home, surrounded by her family and friends, and

supported by Kaho‘ohanohano as her midwife. But the Law threatens Kaho‘ohanohano with criminal sanctions and other legal penalties if she attends Ku‘ailani’s birth as a midwife.

130. Plaintiff Emilie, who gave birth in February 2024, experienced the limited access to maternity care on Maui and the even more limited access to the culturally informed care she and her Native Hawaiian partner wanted. She has been unable to access care from a traditional midwife who could guide her and her partner through the physiological changes of pregnancy and Native Hawaiian practices around pregnancy and birth.

131. Plaintiffs Mendoza and Salado and their partners want to grow their families and have started preparing to be pregnant again. Both selected Kaho‘ohanohano as their midwife during prior pregnancies because of her years of experience as a midwife and cultural practitioner, and her knowledge of Native Hawaiian traditional and customary birthing practices. Each received holistic, culturally informed care from her—care that was markedly different from the care they received from other maternity care providers. Both Mendoza and Salado want Kaho‘ohanohano as their midwife again, but neither want her to risk criminal sanctions and other legal penalties for them. Without Kaho‘ohanoohano as their midwife, Mendoza and Salado cannot access their preferred choice of maternity care provider.

132. The ongoing maternity care shortage on Maui further narrows options for Mendoza and Salado. In the context of inadequate access to health care on the island, the Midwifery Restriction Law fails to prioritize Mendoza’s health, safety, or autonomy. And the Law takes away Salado’s chosen midwife while providing her few alternatives to get the care she needs.

C. The Midwifery Restriction Law Derails Student Midwives Pursuing Apprenticeship-Based Pathways.

133. The Midwifery Restriction Law upends the training of student midwives who learn in community settings under experienced midwives and are not seeking a formal credential or

expecting to become licensed. It also derails training for students who earn their CPM credential through apprenticeship training and are ineligible for a Hawai‘i State midwifery license, despite sitting for and passing the same exam as their counterparts who complete a MEAC education program.

134. The Midwifery Restriction Law discriminates in favor of those who follow a certain path (a MEAC education) that is inaccessible and unaffordable for many Hawai‘i residents. It also provides a legal preference for midwives from out of state who did not train in local communities, are less likely to be culturally aligned with the people they serve, and may be temporary residents.

135. Plaintiff Kaho‘ohanohano is committed to growing a community of skilled, culturally informed midwives, which her community desperately needs. She has taught classes about culturally informed midwifery care, which encompassed training in the midwifery model of care and Native Hawaiian traditions and customary practices around pregnancy and birth.

136. Kaho‘ohanohano had multiple midwife apprentices seek her out because of her experience as a midwife and as a cultural practitioner. Plaintiff Franco-Francis began training with her because her own experiences with home birth were transformative and she wanted others to have that option. Plaintiff Ku‘ailani began apprenticing with Kaho‘ohanohano to continue her own family lineage of healers and midwives. Kaho‘ohanohano's apprentices train as she did: they listen, observe, assist, and gradually begin to practice alongside their teacher. As a result of Kaho‘ohanohano's efforts, the small community of midwives on Maui, including Plaintiffs Franco-Francis and Ku‘ailani, was growing.

137. The Midwifery Restriction Law is disrupting the midwifery training of Kaho‘ohanohano's apprentices, including Franco-Francis and Ku‘ailani. Kaho‘ohanohano has not reconvened her class or continued training apprentice midwives despite continued interest from

students, some of whom do not have other means to obtain that knowledge and training. Because Kahoʻohanohano cannot practice midwifery without threat of criminal sanctions and other legal penalties, student midwives cannot apprentice with her. Without the opportunity to train apprentices, Kahoʻohanohano, Franco-Francis and Kuʻailani's community will continue to suffer a sustained maternity care provider shortage.

138. Plaintiff Dawson, a CPM and licensed midwife in Hawaiʻi, is a preceptor for aspiring midwives who want to provide holistic, patient-centered midwifery care. Dawson is committed to supporting and mentoring student midwives of color who are trying to diversify the midwifery profession, center patient autonomy, and improve maternal health outcomes.

139. Plaintiff Schneider-Furuya is pursuing a CPM through apprenticeship training and is one of Dawson's students. Some of Dawson's other apprentices are pursuing MEAC programs to earn their CPM. Several have decided not to complete, or are considering not completing, the program due to the financial strain it is causing, and because preceptors are difficult to find.

140. Schneider-Furuya chose apprenticeship-based midwifery training because it was the best way for her to gain knowledge and skills as a midwife. It also offered her more flexibility to continue working at a restaurant to earn a living; she is not paid as a student midwife and enrolling in a MEAC school is expensive. Additionally, Schneider-Furuya has already made substantial progress toward meeting the requirements for her CPM and would largely have to begin again if she enrolled in a MEAC program. Because Schneider-Furuya is pursuing an apprenticeship-based training pathway to earn her CPM, and chose to pursue that pathway after 2020, she will not be eligible a Hawaiʻi State midwifery license.

D. The Midwifery Restriction Law Threatens to Extinguish Native Hawaiian Birthing Practices and Traditions of Community Care.

141. Because the Midwifery Restriction Law prevents those with critical cultural

knowledge from training apprentices, it endangers Native Hawaiian traditional and customary birthing practices.

142. For Franco-Francis and Kuʻailani, Kahoʻohanohano is one of the few remaining midwives in Hawaiʻi who holds knowledge of Native Hawaiian traditional and customary birthing practices and is the person who can provide the training that they want and need to become midwives themselves. Because the Law prevents Kahoʻohanohano from practicing midwifery without risking criminal sanctions and other legal penalties, Kahoʻohanohano cannot transfer the *ʻike* (knowledge) she had been sharing in the context of this hands-on training.

143. Franco-Francis is aware there are midwifery schools on the continental U.S. that are recognized by the Law but believes the *ʻike* (knowledge) and skills she needs are in her community. Franco-Francis does not believe the pathway to State licensure required by the Law will prepare her best to serve her community. Nor does Franco-Francis believe that the state of Hawaiʻi should mandate—as the only legal option—programs that do not align with her cultural knowledge and values.

144. The Midwifery Restriction Law disrupts Kuʻailani's own training, and threatens to deprive future generations of the midwifery skills and cultural knowledge that Kahoʻohanohano holds. Kuʻailani's daughters now understand that practicing traditional ceremonies and rituals while pregnant, eating traditional foods, and birthing at home are important aspects of their Native Hawaiian culture and identity. Kuʻailani wants her third daughter to have the same experience as her sisters who were both born at home, surrounded by their family's love and culture, and for all three of them to have culturally informed options for maternity care when they are older.

145. As a Native Hawaiian woman, aspiring midwife, and hula practitioner, Plaintiff Schneider-Furuya also wants to learn midwifery skills in the context of Native Hawaiian traditional

and customary practices surrounding pregnancy and birth. Few *kumu* (teachers) hold this culturally informed knowledge. For Schneider-Furuya, learning the traditional and customary practices around pregnancy and birth is an expression of her cultural identity. Schneider-Furuya recognizes that *pale keiki* practices, like her language and her hula practice, have been threatened by colonization and patriarchy and must be intentionally reclaimed. It is by building, using, and sharing this *ike* (knowledge) that Schneider-Furuya fulfills her *kuleana* (responsibility) to her community, and to prior and future generations.

E. The Midwifery Restriction Law Sows Confusion and Fear, Threatening Efforts to Grow and Sustain an Integrated, Collaborative Maternity Care System.

146. The Midwifery Restriction Law threatens a wide range of people who provide support, information, and care during pregnancy and birth, and undermines the development of collaborative relationships that are necessary to prioritize the health, safety, and well-being of pregnant people and families.

147. The Law's broad definition of "midwifery" encompasses many activities commonly performed by friends, extended family members, and a spectrum of "birth workers" that provide support to people during the perinatal period, including doulas, lactation consultants, counselors, childbirth educators, midwife assistants, and community health workers. As a result, many people must now guess at how much support they can provide a pregnant person before they may risk penalties. For example, as trained doulas, Plaintiffs Franco-Francis and Schneider-Furuya, "provide advice and information regarding the progress of childbirth and care for newborns and infants." According to the Midwifery Restriction Law, they may need a midwifery license to do so.

148. The prohibition on using the title "midwife" leads practitioners and pregnant people to tie themselves in knots to avoid the legal consequences the Law puts on a widely used and

understood term. It also contributes to the misimpression that individuals can avoid liability for practicing what law defines as "midwifery" so long as they call it something else.

149. Proponents of the Midwifery Restriction Law contributed to the confusion by making assurances that Plaintiffs' practices specifically are unaffected by the new law. Their words conflict directly with the text of the Midwifery Restriction Law, the Attorney General's letter, and the experience of midwives, apprentice midwives, and pregnant people.

150. Holding a license does not end the confusion or threat of penalties. For example, as a licensed midwife, Dawson risks penalties for working with unlicensed midwives who previously could practice midwifery as exempt "birth attendants." Many of the families Dawson cares for are Black; others are Native Hawaiian, Latino, or other racial or ethnic minority backgrounds. Dawson is an especially critical resource for Black mothers on O'ahu who find safety and support in her care, including many who belong to military families. They often do not have extended family in Hawai'i and face challenges finding a community of care and support during pregnancy and parenthood. The holistic care Dawson provides would not be possible without the dedicated and collaborative community of midwives with whom she trained and practices. Some of the midwives who lawfully trained Dawson before the Midwifery Restriction Law are now licensed under it, while others are not eligible.

151. Plaintiff Rowley has taken significant steps to comply with the state's midwifery licensure laws and faces the threat of penalties nonetheless. After the Midwifery Restriction Law passed, Plaintiff Rowley applied to, and enrolled in, an online CNM program because she believes that becoming a CNM will ensure that she can continue to provide midwifery care to pregnant people. The CNM program is expensive, and traveling to neighbor islands for clinical rotations adds additional cost and requires time away from her family. Rowley's decision to pursue a CNM

has not alleviated her concerns about the punitive aspects of the Law, her community's increasingly limited access to care, or her children's future. After the Midwifery Restriction Law passed, an anonymous complaint was filed with DCCA against Rowley for identifying herself as a midwife on an outdated online profile. Although DCCA ultimately dismissed the complaint, Rowley was terrified about the penalties she could face for allegedly violating the Midwifery Restriction Law by referring to herself as a midwife—a title that her community came to associate with her.

152. Rowley fears the threat of penalties for "aiding and abetting" unlicensed activity will interfere with her ability to practice as the CNM she believes her community needs—one who can practice alongside midwives like Plaintiff Kahoʻohanohano who do not hold a state license. For Rowley, the Midwifery Restriction Law further fragments an already broken system and thwarts collective efforts to grow and sustain a collaborative, integrated maternity care system.

153. The Midwifery Restriction Law further undermines cooperation and communication between maternity care providers by deterring unlicensed midwives like Kahoʻohanohano and Rowley from accompanying a pregnant person to the hospital during a transfer of care, since hospital staff are now empowered to report midwives for unlicensed and unlawful practice.

F. The 2023 Maui Wildfires Have Exacerbated Hawaiʻi's Maternal Health Crisis and Add Urgency to Plaintiffs' Claims for Relief.

154. In response to the August 8, 2023 wildfire that swept through Lahaina, Maui, Plaintiffs Kahoʻohanohano and Rowley have been organizing and participating in the "Healer's Hui" in Honokōwai Beach Park. Kahoʻohanohano and Rowley have been helping to distribute supplies and information to families, and Kahoʻohanohano confronts uncertainty about offering traditional healing practices like *lomilomi* (traditional bodywork) free to pregnant people on Maui.

155. In the midst of trauma and crisis, when it is apparent that her midwifery skills are also urgently needed, Kahoʻohanohano has had to consider the Midwifery Restriction Law and guess at how much support for pregnant people the State might consider too much. Grieving the loss of her own loved ones and the devastation to her community, Kahoʻohanohano wonders, "Why do we need permission to help our people and get them what they need?"

156. As pandemics, climate disasters, and other emergencies strain health and hospital systems and displace families, pregnant people continue to need safe places to birth and access pregnancy-related care. Rather than address that reality, the Midwifery Restriction Law threatens skilled practitioners with fines and criminal penalties if they share the skills that their communities need.

CLAIMS FOR RELIEF

COUNT I: VIOLATION OF FUNDAMENTAL RIGHTS TO REPRODUCTIVE AUTONOMY

157. Plaintiffs hereby reallege and incorporate by reference all the above allegations.

158. Multiple and reinforcing provisions of the Hawaiʻi State Constitution guarantee the people of Hawaiʻi the fundamental rights to reproductive autonomy, which encompasses an individual's right to make decisions about pregnancy and childbirth, including where and with whom to access pregnancy care and birth.

159. Article I, § 6 of the Hawaiʻi State Constitution guarantees "the right to privacy," which "shall not be infringed without the showing of a compelling state interest," and obligates the legislature to "take affirmative steps to implement" the right. The right to privacy encompasses the right to "personal decisions relating to marriage, procreation, contraception, family relationships, and child rearing." *State v. Mallan*, 86 Hawaiʻi 440, 444, 950 P.2d 178, 182 (1998) (quoting *State v. Mueller,* 66 Haw. 616, 627, 617 P.2d 1351, 1359 (1983)).

160. Article I, § 6 makes explicit and supplements other guarantees under the Hawai'i State Constitution, such as article I, § 2 which guarantees "all persons" their "inherent and inalienable rights," including "the enjoyment of life, liberty and the pursuit of happiness" and article I, § 5, which provides "[n]o person shall be deprived of life, liberty or property without due process of law." The rights to life and liberty include the right of "bodily autonomy [] and self-determination." *State v. Abella*, 145 Hawai'i 541, 553, 454 P.3d 483, 494 (2019). The right to liberty also includes the fundamental right to "bodily integrity." *State v. Kotis*, 91 Hawai'i 319, 335, 984 P.2d 78, 94 (1999).

161. Article I, § 3, which provides that "[e]quality of rights under the law shall not be denied or abridged by the State on account of sex," further protects the rights of pregnant and birthing people and guarantees that individuals do not lose their rights to reproductive autonomy when they become pregnant.

162. The most rigorous court review, strict scrutiny, applies to infringements of these fundamental rights. *E.g.*, Art. 1 § 6 (right to privacy "shall not be infringed without the showing of a compelling state interest"); *Mallan*, 86 Hawai'i at 451, 981 P.2d at 189.

163. HRS § 457J denies Plaintiffs' their fundamental reproductive autonomy rights to make decisions about pregnancy and birth, including from whom to access pregnancy support and care, and where and with whom to birth.

COUNT II:
VIOLATION OF EQUAL RIGHTS

164. Plaintiffs hereby reallege and incorporate by reference all the above allegations.

165. Article I, § 3 of the Hawai'i State Constitution provides that "[e]quality of rights under the law shall not be denied or abridged by the State on account of sex." Article I, § 3 also guarantees that "[n]o person shall be . . . denied the equal protection of the laws, nor be denied the

enjoyment of the person's civil rights or be discriminated against in the exercise thereof because of race, religion, sex or ancestry."

166. HRS § 457J violates equal protection in numerous ways. It discriminates based on sex and is based on and perpetuates sex-based stereotypes, including that Plaintiffs, women, and pregnant people need paternalistic State intervention to control their decisions about pregnancy and birth.

167. HRS § 457J also discriminates among midwives without adequate justification. For example, individuals who practiced midwifery as exempt "birth attendants" before July 1, 2023 are similarly situated to—and in some instances are the same people as—midwives for whom it is now a crime to practice midwifery. Apprenticeship-trained CPMs who earn their CPM today are similarly situated to CPMs who earned their credential before January 1, 2020; the former are not eligible for a Hawai'i State midwifery license and the latter are. Apprenticeship-trained CPMs who earn their CPM after training in Hawai'i are similarly situated to CPMs who earn their credential via apprenticeship training in a state that does not require a MEAC education for state licensure; the former are not eligible for licensure and the latter are.

168. HRS § 457J further discriminates among other birth workers without adequate justification. For example, the State does not require "community health workers" to hold a license but appears to require community health workers who practice any aspect of what the Law defines as "midwifery" to be licensed.

COUNT III:
VIOLATION OF RIGHTS OF MIDWIVES AND BIRTH WORKERS TO PRACTICE

169. Plaintiffs hereby reallege and incorporate by reference all the above allegations.

170. Article I, § 2 of the Hawai'i State Constitution guarantees "all persons" their "inherent and inalienable rights," including the enjoyment of life, liberty and the pursuit of

happiness." Article I, § 5 guarantees that "[n]o person shall be deprived of life, liberty or property without due process of law." These liberty rights include the "right to pursue one's chosen profession free from unreasonable government interference." *Minton v. Quintal*, 131 Hawaiʻi 167, 186, 317 P.3d 1, 20 (2013).

171. HRS § 457J violates with the rights of midwives and other birth workers, including Plaintiffs, who do not meet the requirements of the Midwifery Restriction Law to practice "midwifery" as defined in HRS § 457J-2.

COUNT IV: VIOLATION OF RIGHTS TO FREEDOM OF SPEECH AND EXPRESSION

172. Plaintiffs hereby reallege and incorporate by reference all the above allegations.

173. Article I, § 4 of the Hawaiʻi State Constitution provides "[n]o law shall be enacted . . . abridging the freedom of speech."

174. HRS § 457J violates Plaintiffs' rights to free speech and expression, including by restricting who can call themselves a "midwife" and who can provide "advice and information" about the "progress of childbirth and care for newborns and infants" to individuals who meet the requirements of the Midwifery Restriction Law. The State has no adequate justification for penalizing Plaintiffs for using the term "midwife" by which they are known in their community. Nor does it have any adequate justification for prohibiting midwives—or doulas, childbirth educators, lactation consultants, counselors, and extended family members—who do not hold a specific state license from communicating advice and information about pregnancy, childbirth, and newborn care.

COUNT V: VIOLATION OF AFFIRMATIVE DUTY TO PROTECT NATIVE HAWAIIAN TRADITIONAL AND CUSTOMARY PRACTICES

175. Plaintiffs hereby reallege and incorporate by reference all the above allegations.

176. HRS § 1-1 provides "The common law of England, as ascertained by English and American decisions, is to be declared the common law of the State of Hawaii in all cases, except as otherwise expressly provided by the Constitution or laws of the United States, or by the laws of the State, or fixed by Hawaii judicial precedent, <u>or established by Hawaiian usage</u>[.]" (emphasis added)

177. Article XII, § 7 of the Hawaiʻi Constitution provides "The State reaffirms and <u>shall protect all rights customarily and traditionally exercised</u> for subsistence, <u>cultural</u> and religious *purposes* and possessed by tenants who are descendants of native Hawaiians who inhabited the Hawaiian Islands prior to 1778, subject to the right of the State to regulate such rights." (emphasis added).

178. HRS § 457J fails to reasonably protect the rights of Native Hawaiian practitioners, such as Plaintiff Kahoʻohanohano, to engage in Native Hawaiian traditional and customary *pale keiki* practices as guaranteed under article XII, § 7 of the Hawaiʻi State Constitution.

179. As recently affirmed by the Hawaiʻi Supreme Court, "Native Hawaiian traditional and customary rights do not exist at the sufferance of the State and its agencies. These rights must be protected and indeed, the State and its agencies have a constitutional obligation to do so." *Flores-Case ʻOhana v. Univ. of Hawaiʻi*, 153 Hawaiʻi 76, 88, 526, P.3d 601, 613 (2023).

180. The regulation of Native Hawaiian traditional and customary *pale keiki* practices set forth in HRS § 457J impermissibly regulates *pale keiki* traditional and customary practices out of existence. *See Pub. Access Shoreline Haw. v. Haw. Cnty. Plan. Commʻn (PASH)*, 79 Hawaiʻi 425, 451, 90 P.2d 1246, 1272 (1995). "[T]he Stateʻs authority to regulate Native Hawaiian rights, although substantial, is not unfettered." *Flores-Case ʻOhana*, 153 Hawaiʻi at 82, 526 P.3d at 607.

COUNT VI:
VOID FOR VAGUENESS

181. Plaintiffs hereby reallege and incorporate by reference all the above allegations.

182. Article I, § 5 of the Hawaiʻi State Constitution guarantees that "[n]o person shall be deprived of life, liberty or property without due process of law." A criminal statute is unconstitutionally vague and violates the right of due process if it does not define the criminal offense with sufficient definiteness that ordinary people can understand what conduct is prohibited and in a manner that does not encourage arbitrary and discriminatory enforcement. *State v. Beltran*, 116 Hawaiʻi 146, 151, 172 P.3d 458, 463 (2007). Statutes that reach fundamental rights and other constitutionally protected conduct are subject to the most searching constitutional scrutiny. *State v. Pacquing*, 139 Hawaiʻi 302, 314, 389 P.3d 897, 909 (2016).

183. HRS § 457J contains numerous vague terms, beginning with the definition of "Midwifery," which means providing "[a]ssessment, monitoring, and care during pregnancy, labor, childbirth, postpartum and interconception periods, and for newborns;" "supervising" labor and childbirth; or providing "advice and information" about the "progress of childbirth and care for newborns and infants." HRS § 457J-2. The definition does not provide adequate notice to Plaintiffs and other individuals who support pregnant people about the line between permissible and prohibited conduct.

184. HRS § 457J invites arbitrary and discriminatory enforcement against a wide range of individuals and practitioners, including Plaintiffs, who support pregnant people. Midwives, doulas, childbirth educators, lactation consultants, counselors, community health workers, friends, Native Hawaiian cultural practitioners, and extended family support pregnant people by engaging in aspects of what the Law defines as "midwifery" without the required license.

185. The vagueness in HRS § 457J implicates constitutional rights including Plaintiffs'

rights to reproductive autonomy; right to practice "midwifery" as defined in HRS § 457J-2, and to do so without arbitrary discrimination; rights to engage in Native Hawaiian traditional and customary practices protected by the Hawai'i State Constitution; and rights to free speech and expression guaranteed by the Hawai'i State Constitution.

186. HRS § 457J is void for vagueness because it is internally inconsistent and incomprehensible to a person of ordinary intelligence; fails to establish clear standards on the types of care and advice individuals can provide without risking the Law's criminal sanctions and other legal penalties; and invites arbitrary and discriminatory enforcement.

COUNT VII:
UNCONSTITUTIONALLY OVERBROAD

187. Plaintiffs hereby reallege and incorporate by reference all the above allegations.

188. Article I, § 5 of the Hawai'i State Constitution guarantees that "[n]o person shall be deprived of life, liberty or property without due process of law." A law is unconstitutionally overbroad and violates rights to due process if it "sweep[s] so broadly that constitutionally protected conduct as well as unprotected conduct is included in its proscriptions." *State v. Kaneakua*, 61 Haw. 136, 143, 597 P.2d 590, 612 (1979); *see also Beltran*, 116 Hawai'i at 146, 151, 172 P.3d at 463. Such a law is unconstitutional when its terms can "conceivably" lead to substantial unconstitutional applications to protected conduct, as seen by analyzing the scope of prohibited conduct. *See Beltran*, 116 Hawai'i at 152, 172 P.3d at 464.

189. HRS § 457J's overbroad restrictions govern Plaintiffs' and others' protected speech, including by expansively prohibiting the use of the word "midwife" and the "provision of advice and information" about the "progress of childbirth and care for newborns and infants" by individuals licensed as midwives.

190. HRS § 457J overbroad restrictions also intrude on Plaintiffs' and others'

fundamental rights to reproductive autonomy to access pregnancy care from and to birth with a trusted midwife of their choice, and to seek care from a broad swath of birth workers, friends, and extended family.

191. HRS § 457J overbroad restrictions also interfere with Plaintiffs' and others' constitutionally protected right to practice what HRS § 457J defines as "midwifery" and to do so without arbitrary discrimination.

192. HRS § 457J's unconstitutionally overbroad language risks the State breaching its affirmative duty under article XII, § 7 of the Hawai'i State Constitution to protect all Native Hawaiian traditional and customary rights and practices.

193. The tenuous nature and present condition of Native Hawaiian traditional and customary birthing practices and the extreme nature of the regulative language in HRS § 457J risks these practices being regulated out of existence in contravention of long held court precedent. *See PASH*, 79 Hawai'i at 451, 903 P.2d at 1272.

194. The broad sweep of the Law is chilling the exercise of constitutional rights by Plaintiffs, pregnant people, midwives, and others who support and care for pregnant people.

<u>**REQUEST FOR RELIEF**</u>

WHEREFORE, Plaintiffs respectfully request that the Court:

1. Issue a declaratory judgment that HRS §§ 457J and 436B are unconstitutional as applied to and unenforceable against individuals practicing midwifery (as defined in HRS § 457J-2) who do not hold a State license under the Midwifery Restriction Law;

2. Issue a declaratory judgment that the January 1, 2020 deadline to obtain the certified professional midwife credential via the apprenticeship-based training pathway in HRS § 457J(4)(B) is unconstitutional and unenforceable against candidates who are otherwise eligible for a Hawai'i State midwifery license;

3. Issue a declaratory judgment that Defendant State of Hawaiʻi violated Plaintiff Kahoʻohanohanoʻs rights under Article XII, § 7 of the Hawaiʻi State Constitution and HRS § 1-1;

4. Issue a preliminary injunction prohibiting Defendants, their agents, employees, appointees, or successors, and all persons in active concert or participation with them, from enforcing, threatening to enforce, or otherwise applying the penalties under HRS §§ 457J and 436B against individuals practicing midwifery (as defined in HRS § 457J-2) who do not hold a license under the Midwifery Restriction Law, or from enforcing, threatening to enforce or otherwise applying the January 1, 2020 deadline to obtain the certified professional midwife credential via the apprenticeship-based training pathway against applicants who are otherwise eligible for a Hawaiʻi State midwifery license;

5. Issue a permanent injunction prohibiting Defendants, their agents, employees, appointees, or successors, and all persons in active concert or participation with them, from enforcing, threatening to enforce, or otherwise applying the penalties under HRS §§ 457J and 436B against individuals practicing midwifery (as defined in HRS § 457J-2) who do not hold a State license under the Midwifery Restriction Law, or from enforcing, threatening to enforce or otherwise applying the January 1, 2020 deadline to obtain the certified professional midwife credential via the apprenticeship-based training pathway in HRS § 457J(4)(B) against applicants who are otherwise eligible for a Hawaiʻi State midwifery license;

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6. Award reasonable attorney's fees, costs, and other expenditures incurred as a result of bringing this action, pursuant to any applicable law; and

7. Grant further relief as the Court shall deem just and proper.

Respectfully submitted,

DATED: February 27, 2024

PERKINS COIE LLP

By *s/ Javier Garcia*
Javier Garcia

Attorney for Plaintiffs, KI'INANIOKALANI KAHO'OHANOHANO, KIANA ROWLEY, A. EZINNE DAWSON, MAKALANI FRANCO-FRANCIS, KAWEHI KU'AILANI, MORIAH SALADO, MOREA MENDOZA, EMILIE A., and PI'ILANI SCHNEIDER-FURUYA

STATE OF HAWAIʻI CIRCUIT COURT OF THE FIRST CIRCUIT	**SUMMONS** TO ANSWER CIVIL COMPLAINT	CASE NUMBER

PLAINTIFF VS.	DEFENDANT(S)
KIʻINANIOKALANI KAHOʻOHANOHANO; KIANA ROWLEY; A. EZINNE DAWSON; MAKALANI FRANCO-FRANCIS; KAWEHI KUʻAILANI; MORIAH SALADO; MOREA MENDOZA; EMILIE A.; and PIʻILANI SCHNEIDER-FURUYA, on behalf of themselves, their students, and the pregnant and birthing people they care for	THE STATE OF HAWAIʻI; ANNE LOPEZ, in her official capacity as Attorney General of the State of Hawaiʻi; DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS; and NADINE ANDO, in her official capacity as the Director of the Department of Commerce and Consumer Affairs

PLAINTIFF'S NAME & ADDRESS, TEL. NO.

PERKINS COIE LLP, Javier F. Garcia,11543, 1888 Century Park East, Suite 1700, Los Angeles, CA 90067, (310) 788-3293

TO THE ABOVE-NAMED DEFENDANT(S)

You are hereby summoned and required to file with the court and serve upon

Attorney for Plaintiffs:
Javier Garcia, (11543), PERKINS COIE LLP,1888 Century Park East, Suite 1700, Los Angeles, CA 90067

____ ,

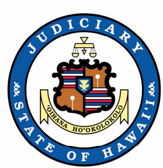
plaintiff's attorney, whose address is stated above, an answer to the complaint which is herewith served upon you, within 20 days after service of this summons upon you, exclusive of the date of service. If you fail to do so, judgment by default will be taken against you for the relief demanded in the complaint.

THIS SUMMONS SHALL NOT BE PERSONALLY DELIVERED BETWEEN 10:00 P.M. AND 6:00 A.M. ON PREMISES NOT OPEN TO THE GENERAL PUBLIC, UNLESS A JUDGE OF THE ABOVE-ENTITLED COURT PERMITS, IN WRITING ON THIS SUMMONS, PERSONAL DELIVERY DURING THOSE HOURS.

A FAILURE TO OBEY THIS SUMMONS MAY RESULT IN AN ENTRY OF DEFAULT AND DEFAULT JUDGMENT AGAINST THE DISOBEYING PERSON OR PARTY.

The original document is filed in the Judiciary's electronic case management system which is accessible via eCourt Kokua at: http:/www.courts.state.hi.us

Effective Date of 28-Oct-2019
Signed by: /s/ Patsy Nakamoto
Clerk, 1st Circuit, State of Hawaiʻi



In accordance with the Americans with Disabilities Act, and other applicable state and federal laws, if you require a reasonable accommodation for a disability, please contact the ADA Coordinator at the Circuit Court Administration Office on OAHU- Phone No. 808-539-4400, TTY 808-539-4853, FAX 539-4402, at least ten (10) working days prior to your hearing or appointment date.