CENTER *for* REPRODUCTIVE RIGHTS

Midwifery law reform in Hawai‘i

A case study highlighting challenges and opportunities for advocates of maternal health equity

October 2026



Image: Plaintiffs, their lawyers, and community members outside the Circuit Court on O‘ahu.

Executive Summary

In 2019, the Hawai‘i legislature passed a Midwifery Restriction bill, creating a licensure program for Certified Midwives and some Certified Professional Midwives, and restricting many other people from providing information, care, or advice to pregnant and birthing people. As a result, the midwives, doulas, and Native Hawaiian cultural practitioners that communities had come to rely on were unable to share their skills without risking civil and criminal penalties when the law took full effect in July 2023.

This change in the law disrupted networks of maternal care built by communities whose needs the mainstream health care system fails to address. It hit rural communities and families of color particularly hard. Pregnant people were deprived of access to trusted providers who, for years, had helped them to safely birth at home, often on ancestral lands, surrounded by the people and practices they chose. Midwives and students saw their futures and livelihoods evaporate. And those who were Native Hawaiian feared that, without the ability to continue practicing, learning, and teaching, their cultural traditions could be extinguished. To make matters worse, there was widespread confusion and disagreement about how the law should be interpreted.

In response to these alarming conditions, the Center for Reproductive Rights engaged in a multi-pronged strategy to reform Hawai‘i’s Midwifery Restriction Law, which included: (1) human rights advocacy and documentation; (2) litigation; and (3) legislative advocacy. Although this work centered on midwifery law, it aimed to protect families’ access to care. Rules about who may attend a birth determine whether pregnant people can give birth with the providers, in the places, and according to the practices they choose.

First, the Center conducted its own investigation and found evidence of rights violations. Under international law, access to reproductive health care, free from discrimination, is a human right. The Center supported the inclusion of Native

Hawaiian midwives in a delegation of advocates that traveled to Geneva to attend the United Nations Human Rights Committee's periodic review of the United States. After the midwives raised concerns about the Midwifery Restriction Law in Hawai'i, the Human Rights Committee became the second UN treaty monitoring body to recommend that the U.S. "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."

Second, the Center's factual research and investigation into the impact of the Midwifery Restriction Law also led the Center to explore domestic litigation. In 2024, the Center, the Native Hawaiian Legal Corporation, and the law firm Perkins Coie filed a lawsuit in Hawai'i state court on behalf of a racially diverse group of Plaintiffs that included midwives, midwifery students, Native Hawaiian cultural practitioners, and pregnant women. The lawsuit, *Kaho'ohanohano v. Hawai'i*, challenged the Midwifery Restriction Law as an unconstitutional violation of Native Hawaiians' rights to traditional and customary practices; individual rights to reproductive autonomy; and on the grounds that it was vague and overbroad.

During a week-long court hearing, Plaintiffs, witnesses, and experts testified about key facts, including adverse impacts of the Midwifery Restriction Law, the state's justifications for it, and Plaintiffs' efforts to comply with it. After the hearing, the court granted Plaintiffs a statewide, partial preliminary injunction. As a result, the state was prohibited from enforcing the law against individuals who practice, teach, and learn traditional Native Hawaiian maternal health practices.

Third, while the Center's litigation helped expose problems with the Midwifery Restriction Law, the Center's legislative advocacy encouraged a legislative fix that went beyond the court's ruling and provided relief to a wider range of affected individuals. Because the Midwifery Restriction Law was set to sunset in 2025, the Hawai'i legislature had an opportunity to revisit the law and address its shortcomings. Though the process was contentious, legislators ultimately passed a new bill that addressed many of the concerns raised in the lawsuit. On behalf of the Plaintiffs, the Center and co-counsel then negotiated a settlement with the state. The settlement ended the lawsuit and enhanced protections for midwives by promoting a clear, shared understanding of what the new law means and how it will be enforced.

As a result of this law reform process, pregnant people in Hawai'i have a wider range of care options than they did under the 2019 law. State law now (1) provides for licensure of Certified Professional Midwives from all training pathways (requiring a bridge certificate from some); (2) protects Native Hawaiian cultural practitioners; (3) does not criminalize unlicensed practice of midwifery; and (4) does not place excessive restrictions on doulas, childbirth educators, family members, and individuals in other, similar support roles.

A year after the midwifery law reform process ended in Hawai'i, the Center is reflecting on those events, documenting them, and sharing learnings with advocates and lawmakers across the country. Many of the issues and ideas debated in Hawai'i are not only relevant elsewhere, they are also increasingly urgent—global calls for protection and decriminalization of Indigenous midwifery are growing; exciting new initiatives aim to dramatically expand access to U.S. midwifery care; and the resiliency of our midwifery institutions and relationships continues to be tested. This case study and accompanying recommendations offer the Center's viewpoint on licensure policies and lawmaking practices likely to catalyze more equitable access to midwifery care. They are informed by recent experience and a commitment to human rights principles and

CENTER *for* REPRODUCTIVE RIGHTS

are intended to assist state and national leaders considering the implications of midwifery licensure laws.

Acknowledgements: The Center for Reproductive Rights uses the power of the law to advance reproductive rights as fundamental human rights around the world. We are grateful to our courageous clients who fought for their reproductive autonomy and trusted us to be part of that effort. We are also deeply appreciative of our skilled co-counsel at Perkins Coie, and at the Native Hawaiian Legal Corporation—whose unmatched expertise in protecting Native Hawaiian identity and culture through law was essential to the success of *Kahoʻohanohano v. Hawaiʻi*. We continue to be inspired by the many families and advocates who so generously shared their knowledge and time with us. While we hope that this publication honors all our collaborators, we note that the views expressed here belong to the Center for Reproductive Rights and do not necessarily reflect the position of any other individual or organization. Additionally, this publication focuses on issues and events that the Center was directly involved with—other aspects of this history can only be told by others.

Table of Contents

Introduction 4

Background on midwifery in the United States 4

The 2019 Midwifery Restriction Law is enacted 4

The Center's investigation finds evidence of rights violations 7

The Center and advocates engage in human rights advocacy before the United Nations 7

The Hawaiʻi Attorney General issues a letter confirming community fears 7

Kahoʻohanohano v. Hawaiʻi: The Center sues Hawaiʻi, challenging the 2019 Midwifery Restriction Law 8

The Hawaiʻi Legislature passes a new midwifery licensure bill in 2025 13

The Center reaches a settlement, solidifying protections for midwives 15

Hawaiʻi's current midwifery law (HRS § 457J): 16

Conclusion 16

Looking ahead: recommendations for maternal health advocates and lawmakers interested in midwifery licensure 16

What lawmakers should know about the US MERA statement on the "Licensure of Certified Professional Midwives (CPM)" 21

Introduction

The Center for Reproductive Rights (the Center) engaged with Hawai'i's midwifery law reform process in multiple ways between 2023 and 2025, including through advocacy at the United Nations, state legislative advocacy, and litigation in state court. In this resource, the Center provides a case study of those law and policy developments, highlighting lessons that advocates and lawmakers interested in expanding midwifery access can draw from. It is a tool for better understanding the potential consequences of decisions to create or modify midwifery licensure frameworks, not an argument against licensure. At the end of this resource, the Center's recommendations to advocates and lawmakers encourage an approach to midwifery licensure that responds to the conditions their constituents actually live in, addresses inequities, and prioritizes the needs and autonomy of the pregnant person. Finally, the Center argues that adopting such an approach will require lawmakers to avoid reliance on a 2015 joint policy position that is adversely impacting the midwifery workforce (the US MERA statement on the Licensure of Certified Professional Midwives) and, instead, seek out guidance better adapted for the current moment.

Background on midwifery in the United States

Before the first hospitals and medical schools were ever built, communities had midwives. Midwives were familiar with the physiological process of pregnancy and birth, knowledgeable about local plant medicines and cultural factors that might impact the experience and trusted to guide community members through an important phase of life. Today, midwives remain critical facilitators of maternal and community health. In many countries, midwives are the primary providers of maternity care.[1] According to the World Health Organization, further expanding midwifery models of care—which emphasize informed choice, communication, and non-invasive techniques—is key to saving lives and ensuring respectful care around the globe.[2]

In the U.S., however, midwifery is still recovering from a century of neglect and marginalization. During the early 1900's, male physicians who sought to bring birth into hospitals and under their control viewed community midwives as competitors and problems.[3] Midwives became targets of discriminatory campaigns and regulatory efforts aimed at discrediting or eliminating them.[4] Midwives of color faced particularly harsh stigmatization.[5] Against this hostile backdrop, some midwives sought to professionalize midwifery by establishing a variety of formal training pathways and national credentials.

Restrictive state laws and a lack of integration, investment, and inclusion continue to hold U.S. midwifery back. All too often, pregnant people want midwives but can't access them; experienced and aspiring midwives want to practice but are limited or prevented from doing so; and lawmakers who wish to create a more enabling environment for midwifery care must decipher a complex web of credentials, acronyms, and conflicting guidance from maternal health stakeholders. These were the dynamics in Hawai'i when an effort to impose new licensure requirements on midwives threatened care that Native Hawaiian and other under-resourced communities valued and depended on—ultimately necessitating legal challenges and a revised law.

The 2019 Midwifery Restriction Law is enacted

In 2019, the Hawai'i state legislature passed legislation ("the Midwifery Restriction Law"), imposing new requirements on individuals practicing midwifery.[6] For the first time in twenty years, the law, codified at HRS 457J, regulated midwives who were not nurses.[7] Proponents of the Midwifery Restriction Law celebrated it as progress towards health, safety, and the professionalization of midwifery.[8] However, after hearing from affected community members, the Center and other civil and human

rights advocates found the law's adverse impacts on pregnant people, Native Hawaiian midwives, and midwifery students unjustified—and in some instances, unconstitutional.

Definitions

The Midwifery Restriction Law contained a broad definition of midwifery, encompassing nearly anyone providing care, information, or advice to individuals experiencing pregnancy, birth, or postpartum. Under the Midwifery Restriction Law, individuals engaged in this conduct were required to obtain a midwifery license issued by the state, with few exceptions.[9]

The law defined 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 (2019).

Eligibility requirements

While expansive in its reach, the Midwifery Restriction Law imposed narrow eligibility requirements on those seeking a state midwifery license. It required proof of a certified midwife (CM) or certified professional midwife (CPM) credential, but made some midwives ineligible based on when or how they earned it.[10] Midwives who had earned their CPM credential by attending schools accredited by the Midwifery Education Accreditation Council (MEAC) were eligible for licensure, while those who earned the same credential after apprenticing with a qualified midwife (the Portfolio Evaluation Process) and passing the same exam were only eligible if they had done so before 2020.[11] The Midwifery Restriction Law also made CPMs who obtain a midwifery license in another state (with or without completion of a MEAC accredited program) eligible, thereby creating more restrictive educational requirements for Hawai'i's own residents than the ones it imposed on midwives who move to Hawaii from other states.[12]

Penalties

The Midwifery Restriction Law created a risk of civil and criminal penalties for individuals accused of *practicing midwifery* without a license. It set out civil fines of up to $1,000 per offense (with each day being a separate offense)[13]; and denial of future licensure.[14] It also stated that individuals could be liable for civil damages if the Department of Commerce and Consumer Affairs (the government agency tasked with administering the "midwives licensing program") sued to enjoin their unlicensed practice of midwifery.[15] Additionally, individuals who *used the title "midwife"* but did not have a Hawaii midwifery license could be punished with $1,000 in fines for each day they held themselves out as a midwife.[16] They could also be denied licensure in the future.[17]

Like many states, Hawaii also has a general law related to occupational licensure that penalizes people who practice licensed professions without the required license. As a result, the Midwifery Restriction Law and this pre-existing law interacted, adding to the consequences of unlicensed midwifery practice. Individuals who ran afoul of the Midwifery Restriction Law would also face penalties under the Uniform Professional and Vocational Licensing Act, codified at HRS § 436B. Under the Uniform Professional and Vocational Licensing Act, practicing midwifery without a license carried criminal penalties of up to one (1) year's imprisonment and a criminal fine not exceeding

$2,000 (with each day being a separate offense).[18] It also included civil penalties such as fines and denial of future licensure, as well as liability for licensed providers, including licensed midwives who work with unlicensed midwives, for "aiding and abetting" unlicensed midwifery.[19]

Exemptions

The Midwifery Restriction Law's exemptions and purported protections were insufficient to balance the restrictions created by its broad "midwifery" definition and narrow eligibility requirements.

Other licensed professionals

While the Midwifery Restriction Law included exemptions for certified nurse midwives and other professionals who are licensed by the state of Hawaii under other statutes, it did not exempt individuals fulfilling many other roles that do not (and should not) require state licensure. For example, doulas, childbirth educators, and lactation counselors all provide some form of information, care, and advice during the perinatal period, yet were not exempt from the requirement to obtain a midwifery license.

Family members

The Midwifery Restriction Law did not "prohibit a person from administering care to a person's spouse, domestic partner, parent, sibling, or child" but this still left extended family members who provide care, information, or advice (such as "aunties" and grandmothers) at risk.

Native Hawaiian rights

The Midwifery Restriction Law required traditional Native Hawaiian midwives to comply with an unworkable process. The Law stated that it did 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."[20] It also stated that it did not "limit, alter, or otherwise adversely impact the practice of traditional Native Hawaiian healing pursuant to the Constitution of the State of Hawaii."[21]

This language implied that, if Native Hawaiian midwives are recognized by a *kūpuna* council (traditional healing council of elders) convened by the federally funded non-profit organization Papa Ola Lōkahi, they could be exempt from the requirement to obtain a midwifery license when engaging in traditional practices that come within the law's definition of "midwifery." This requirement, however, was based on a misunderstanding of *kūpuna* councils and the role of Papa Ola Lōkahi. While Papa Ola Lōkahi does many important things to promote Native Hawaiian health, it was not positioned to convene *kūpuna* councils that recognize *pale keiki* or *hoʻohānau* (traditional and customary birthing and child-rearing practices comprised of religious/spiritual and medicinal/practical elements, and including activities now commonly referred to as midwifery).

The "birth attendant" exemption

The Midwifery Restriction Law did not immediately change the status quo in Hawaiʻi because it contained a three year "birth attendant" exemption that allowed those who could not obtain a license to practice without one, subject to certain limitations, until July 1, 2023.[22] The bill 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.[23]

During those three years, midwives and birth workers who were not eligible for licensure under the Midwifery Restriction Law tried to work with decision-makers in the state to create a legal framework that addressed their practices. As time passed and bills stalled in the legislature, friction surrounding the midwifery law grew.[24]

The Center's investigation finds evidence of rights violations

In 2023, as expiration of the birth attendant exemption approached and no additional laws had been passed, the Center investigated the impact of the restrictions on pregnant people, midwives, and midwifery students. Center staff spoke to licensed and unlicensed midwives, student midwives pursuing various training pathways, Native Hawaiian cultural practitioners, doulas, lawyers, experts in midwifery, medicine, and public health, and local birth justice advocates. Perhaps most importantly, the Center spoke to pregnant and postpartum women and their families who were being affected by the changes in the law.

Ultimately, the Center found that, by threatening skilled midwives and other perinatal support people with criminal and civil penalties, HRS 457J was adversely impacting access to culturally aligned maternal health care across Hawai'i. Many families that relied on care from midwives whose practice had been rendered illegal by HRS 457J lived in rural or medically underserved areas and were disproportionately people of color. And while HRS 457J had cut off access to their trusted support networks, the state provided no new resources to address these gaps in maternal health support.

The Center and advocates engage in human rights advocacy before the United Nations

In September 2023, the Center submitted a report to the UN Human Rights Committee (CCPR) describing these and other reproductive rights concerns in the United States.[25] In October 2023, Native Hawaiian midwives joined the Center and a delegation of human rights defenders in Geneva, Switzerland. There, they provided live testimony to members of the UN Human Rights Committee who were engaged in a periodic review of the United States. They described their roles in the community and the importance of culturally affirming care before, during, and after birth. They explained how the Midwifery Restriction Law forced them to turn away families asking for help with home births and prevented them from passing traditional knowledge down to the next generation of student midwives. When the Human Rights Committee published its concluding observations on the fifth periodic report of the U.S. (a process that monitors and promotes compliance with the International Covenant on Civil and Political Rights), it recommended that the U.S. "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."[26] This recommendation echoed a similar recommendation made by the Committee on the Elimination of Racial Discrimination (CERD) to the U.S. the year before.[27]

The Hawai'i Attorney General issues a letter confirming community fears

Amid escalating community concerns, midwives in support of the Midwifery Restriction Law publicly advanced claims that Native Hawaiian cultural practitioners, traditional birth attendants, and others could continue to practice as they always had—they just wouldn't be able to call their services "midwifery."[28] A state lawmaker, confused and concerned about the possibility that pregnant people, cultural practitioners, doulas, grandmothers, and other constituents might be adversely affected once the birth attendant exemption expired, wrote to the Hawai'i Attorney General asking for clarification. Responding to the legislator's questions in writing, the Attorney General confirmed the breadth and severity of penalties under the law.

The Attorney General confirmed that birth attendants would not be permitted to practice after July 1, 2023 and that Hawai'i's general occupational licensing law, 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" or "advertises or represents that the person is licensed to engage in midwifery," unless otherwise exempt.[29] The Attorney General also confirmed that, "[b]ecause they are unlicensed, birth professionals such as doulas or lactation consultants" were not exempt, nor were extended family members permitted to assist in care. Regarding religious and cultural practitioners, the Attorney General's letter noted that the specific Native Hawaiian healing practice protected by the state constitution is not identified and that, "while a licensed midwife can certainly include cultural practices, it is not clear what, if any, cultural practices are exempted from midwifery licensure."[30] The Attorney General's interpretation of the Midwifery Restriction Law contradicted assertions published by its supporters, which the Attorney General opined were "incorrect."[31]

Kaho'ohanohano v. Hawai'i: The Center sues Hawai'i, challenging the 2019 Midwifery Restriction Law

In early 2024, the Center, the Native Hawaiian Legal Corporation (NHLC), and the law firm Perkins Coie filed a lawsuit, *Kaho'ohanohano v. Hawai'i,* challenging the Midwifery Restriction Law in state court. The Center, NHLC, and Perkins Coie jointly represented nine plaintiffs, including midwives, midwifery students, and women who wanted to receive care from them. The lawsuit alleged that the Midwifery Restriction Law violated Native Hawaiian's rights to traditional and customary practices—rights protected under the Hawai'i Constitution. Plaintiffs also alleged that the law violated pregnant individuals' right to reproductive autonomy and was vague and overbroad.[32]

Plaintiffs asked the court to block the Midwifery Restriction Law while the case moved forward, arguing that it was causing irreparable harm to pregnant people, who could not receive assistance from the skilled midwives they trusted, and to midwives and their students, who could not practice, teach, or learn under the threat of criminal penalties.[33] A hearing on that request took place over the course of a week in June 2024. Like a "mini-trial," the hearing provided an opportunity for both Plaintiffs and the State to present detailed evidence and document relevant concerns in a manner that is different from legislative sessions or public debates.

Midwives, students, and mamas (the Plaintiffs) make their case

In written documents and live testimony, Plaintiffs and experts explained how the Midwifery Restriction Law was hurting the people it was supposed to protect.

Perspectives from women who want midwives

Women testified about how important it had been to receive care from someone who understood both the cultural and physiological significance of pregnancy and birth, as well as how the new legal restrictions would impact their decisions about future pregnancies.[34] One described her desire to birth at home with her chosen midwife as a deeply personal, spiritual decision. She viewed the birth of her daughter as a coming-of-age ceremony, describing it as something "that isn't just medical," an experience that she would "go into one way and come out another way."[35] She testified that allowing someone to touch her body and witness her in the most vulnerable moments of her life required trust.[36] For these reasons, she chose a Native Hawaiian home birth midwife invested in her physical, emotional, and cultural safety. However, when her blood pressure rose and her midwife recommended she transfer to a hospital, the rushed, disrespectful care she received at that facility was traumatizing. She testified that the hospital's health care providers aggressively pressured her into a cascade of interventions, ultimately resulting in cesarean surgery. Afterwards, she was not allowed to take her *'iewe* (placenta) home and thus could not plant it under the breadfruit tree

that had been selected to commemorate her infant daughter's birth and connect her to her ancestral land.[37]

In contrast to the disrespectful treatment she received at the hospital, the woman's chosen midwife continued to comfort her, provided attentive, personalized postpartum care for her and her family, and "carried me through that part of my life where I think I could have suffered much worse."[38] This mother testified that she wanted more children, but that her choice of provider was now illegal because of the Midwifery Restriction Law. Moreover, the OB/GYN practice that she had previously gone to had required patients to sign a form promising not to attempt a home birth. Because she did not agree to that condition, she testified, she was no longer eligible to receive health care there either.[39]

Perspectives from Native Hawaiian midwives and cultural practitioners

Midwives testified about their training in community and home birth and their efforts to learn and pass down cultural birth knowledge.[40] A Native Hawaiian cultural practitioner testified about the elders who had shaped her practice of *pale keiki* and *hoʻohānau*. She explained that the practice of *pale keiki* includes several other traditional and customary Native Hawaiian cultural practices, such as *lomilomi* (traditional bodywork), *lāʻau lapaʻau* (traditional medicines), and *hoʻoponopono* (traditional conflict resolution), but is not limited to them.[41] She described the rural area where she lives, works, and birthed her own children, and how healing it has been for the community to return birth home to those places.[42] However, with the Midwifery Restriction Law in place, she was no longer practicing *pale keiki*. Elaborating, she testified that she was known in her community, she had a family, and she couldn't risk criminal and financial penalties.[43]

Midwifery students testified about their desire and *kuleana* (responsibility) to preserve and restore their culture. One *haumāna* (student) *pale keiki* defended the rigor and value of traditional Native Hawaiian *ʻike* (knowledge) and teaching methods. She explained that neither she nor her mentors should have to assimilate or be retrained in western schools before providing information, care, or advice to community members.[44] Another Native Hawaiian midwifery student who had been pursuing the certified professional midwife credential through apprenticeship with a local midwife explained that, under the Midwifery Restriction Law, she would not be eligible for licensure. Because the law favored those who earn their CPM at one of (then) eight schools located in the continental United States, her training in Hawaiʻi—where she lives, fulfills family and cultural responsibilities, and wants to work—would not lead to legal practice or remove the threat of criminalization.[45]

A Native Hawaiian cultural practitioner testified that she had done everything possible to try to follow the exemption in the law and secure protections for Native Hawaiian maternal health practices.[46] Aware of no existing *kūpuna* councils with knowledge of *hānau* (childbirth) practices, she brought *kūpuna* who did have knowledge of *hānau* together to form a formal council.[47] On behalf of the council, she submitted an application to Papa Ola Lōkahi.[48] The council was rejected and the response from Papa Ola Lōkahi noted that the Council was not attached to a federally designated center and *hānau* practices are not one of the four traditional healing practices that are recognized.[49] She explained that she had reached out to multiple federally qualified health care entities, but none agreed to attach or affiliate with the *hānau* focused council.[50] It appeared there was not a process to do so, and the entities did not have a deep understanding of *hānau* practices.[51] She further explained that there are protocols and rules for cultural practices. As such, even if there are aspects of the four recognized practices that overlap with *hānau* practices, she felt it would be inappropriate to seek recognition for one of the four recognized practices and then claim that it protected her *hānau* practices, nor would it be appropriate for a *kūpuna* council to recognize an individual for a practice that they are not familiar with.[52] She

testified that all of this had taken a toll. There were a limited number of practitioners left with knowledge of *hānau*, and one of the *kūpuna* on the council had already passed away. "We're spending so much time doing this that we're not able to give that time to them."[53]

> Native Hawaiian traditional and customary practices have a unique legal status in Hawai'i, which became a U.S. state in 1959. Article XII, § 7 of the Hawai'i Constitution provides, "The State reaffirms and shall protect all rights customarily and traditionally exercised for subsistence, cultural 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." The Hawai'i Supreme Court has affirmed that "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."[54]
>
> Through their testimony, the Native Hawaiian plaintiffs demonstrated that they were entitled to those protections.[55] They showed that (1) they were Native Hawaiian, with ancestors that had been in Hawai'i before western contact, and (2) their practices of *pale keiki* and *ho'ohānau* were traditional and customary Native Hawaiian practices passed down through generations. Additionally, an expert researcher of Native Hawaiian languages and Native Hawaiian traditional and customary practices examined historical documents for evidence of such practices. He attested that "the practice of *pale keiki*, which can be construed as Native Hawaiian traditional and customary midwifery, is an ancient practice and has been practiced by Native Hawaiians prior to November 25, 1892."[56]

Perspectives from other midwives and students

Native Hawaiians were not the only ones affected by the Midwifery Restriction law. One of the only Black midwives in Hawai'i testified that she had become a certified professional midwife through the Portfolio Evaluation Process pathway because it was more affordable and, as a mother of five, it provided the flexibility she needed to train closer to home, in the community she intended to serve.[57] She described the experiences that motivated her to become a midwife, including witnessing the disrespectful care that her mother had endured while giving birth in a hospital and then experiencing similar mistreatment herself.[58] In contrast, when she had the opportunity to receive care from a Black midwife, she felt connected, informed, and her births at home were "powerful" and "beautiful."[59] As a mentor and preceptor (teacher of apprentices) for local student midwives of color engaged in the Portfolio Evaluation Process, she testified that it was important to keep midwifery knowledge in Hawai'i and diversify the maternal health field.[60] However, the Midwifery Restriction Law had introduced uncertainty about her own midwifery license, would deny her students eligibility for licensure, and was undermining collaborative efforts between licensed and unlicensed providers.[61]

Another plaintiff testified about how difficult it is to obtain midwifery training that meets both the state's legal requirements and community needs, especially when the law keeps changing. She testified that, after working as a labor and delivery nurse in a hospital, she grew concerned about families that were not getting the care they deserved there.[62] She also realized that the skilled home birth midwives in her community were getting older and she left her nursing job to train with them.[63] In this new role, she was providing care for people in rural communities.[64] When the Midwifery Restriction Law passed she decided to enroll in a certified nurse midwifery program so that she could eventually get licensed. At the time, this seemed the most secure option.[65] As a CNM student, she was able to take courses online, but would also need to travel to the east coast periodically.[66] She testified that after four years in the

program, she was still having trouble finding placements in Hawai'i for the clinical training (apprenticeship style training with a CNM) that she needed to complete for her degree.[67] The two four-month long rotations that she had already completed were on a different island and required extensive support from her family.[68] In addition to the $100,000 tuition, she had accrued additional expenses from the airfare, lodging, and transportation involved in traveling back and forth between her training site and her family, which includes her two young children.[69]

Perspectives from expert witnesses

Experts in public health, midwifery, and Indigenous health testified about the maternal health disparities that Native Hawaiian and other communities of color face and how culturally respectful, concordant care can improve outcomes. A public health research scientist noted that the Midwifery Restriction Law did not provide solutions to Hawai'i's health care challenges, such as creating midwifery programs that don't require people to leave the state, and instead cut off access to healing systems that were available to people in remote areas.[70] An expert in maternal health care and Indigenous midwifery testified about differences in the ways Indigenous and non-Indigenous communities view health, the underrepresentation of Indigenous people in the field of midwifery, and the importance of recognizing cultural knowledge and systems that are already in place.[71] An expert in reproductive health and ethnic and racial inequality testified that, as is true across the country, Native Hawaiian women and other women of color in Hawai'i are more likely to experience maternal mortality. She testified that structural racism, neglect and the inability to listen to patients and believe them is associated with our inability to prevent such deaths and that the Midwifery Restriction Law would reduce the number of providers in a medically underserved geographic location.[72]

An expert on midwifery and medical anthropology testified that there was a concentrated effort in the U.S. to replace midwives with obstetricians, which midwives are still recovering from.[73] She explained the multiple pathways that exist to train midwives: for aspiring certified professional midwives, students can attend one of (then) eight MEAC accredited schools and then enter an apprenticeship phase; or enter an apprenticeship stage directly and engage in book learning through independent study, online courses, study groups, and other means (the "Portfolio Evaluation Process" or "PEP"). In both cases, when a preceptor (the midwife training the student) agrees that the student has demonstrated all of the necessary clinical skills and is ready, the student takes the NARM exam.[74] This model honors what the student knows, not how they learned it and there is no evidence that students who attend MEAC schools have better clinical outcomes than PEP students.[75] The expert also noted that demand for midwifery care and education is increasing, and with an insufficient number of MEAC schools, the PEP allows students in states without MEAC schools the opportunity to learn.[76] While some midwifery stakeholders (US MERA) have advocated to remove, by 2020, the PEP as an avenue for CPMs to obtain a midwifery license, many states have chosen to keep it.[77] Additionally, PEP meets all but one of the standards set by the International Confederation of Midwives (ICM), which requires three years of training. Because a PEP student's progress is measured by births, not years, it's possible that they could finish earlier or later.[78]

In addition to explaining the midwifery training pathways, the midwifery expert/medical anthropologist testified that criminalizing midwifery, or certain midwives, does not make people safer. Instead, it makes it difficult for those midwives to access training, peer review, and access to medical back-up and may disincentive appropriate transfers to a higher level of care.[79]

The State Defends the Midwifery Restriction Law

The State argued that the Midwifery Restriction Law was necessary to protect the health of mothers and newborns, and that no fundamental rights had been infringed.

An OB/GYN and a certified nurse midwife testified that there were inherent risks and dangers involved in childbirth. The OB/GYN testified about complications he observed among patients who had attempted a home birth and then transferred to his hospital but did not connect those instances to the need for the Midwifery Restriction Law. He conceded that complications could arise in any birth setting and had no information about who was involved in the planned home births that led to transfers, or whether the attendants were licensed midwives. In the two instances where he could identify individuals that he believed were responsible for an increase in emergency transfers, they turned out to be licensed health care providers.[80]

The OB/GYN also testified that providers at the federally qualified health center where he worked had required patients to sign a physician-patient contract. The goal he explained, was to express their professional feelings about planned delivery outside the hospital and let patients know that if they were intending to do that, the federally qualified health center would not provide them prenatal care.

The Complaints and Enforcement Officer for an agency within the Department of Commerce and Consumer Affairs (DCCA) testified about the agency's enforcement of professional licensing programs. She explained that the agency receives complaints from customers, competitors, and members of the public. Complaints can be made anonymously and all are reviewed.[81] Attorneys within the agency can decide to bring enforcement actions, including lawsuits against individuals suspected of unlicensed activity, and have the power to refer matters to the prosecutor's office.[82] While this witness testified that the agency uses discretion in investigations and enforcement, Plaintiffs argued that the potential for selective enforcement of an overbroad Midwifery Restriction Law that could lead to criminal charges was problematic.[83]

Testimony from a Papa Ola Lōkahi staff member clarified that the organization is not positioned to regulate or judge practitioners. Rather, federally qualified health centers, "look-alikes," or Native Hawaiian Health systems can apply to Papa Ola Lōkahi seeking recognition of a business relationship between the health center and a *kūpuna* council. The *kūpuna* council must have at least three Native Hawaiians proficient in one of four Native Hawaiian practices (*lāʻau lapaʻau*, *lāʻau kāhea*, *lomilomi*, and *hoʻoponopono*). Papa Ola Lōkahi's recognition of this business relationship then facilitates the integration of those specific traditional healing practices with the modern medical services offered by the health center. Federally qualified health centers typically serve a particular geographic region and each of the five *kūpuna* councils serve that same community in partnership with the federal institution.[84] This testimony helped clarify that there were many factors outside the control of *pale keiki* practitioners that would prevent them from securing recognition from a *kūpuna* council as the Midwifery Restriction Law required.

In closing, the state argued that the Native Hawaiian Plaintiffs had not shown that their *pale keiki* practices were the same as those that existed before 1892; that the licensing requirements were reasonable because they aligned with US MERA and ICM recommendations; that the Native Hawaiian Plaintiffs could become CPMs; and that Plaintiffs could continue trying to seek *kūpuna* council recognition.[85]

The court grants Plaintiffs a partial injunction

In June 2024, the Court issued a partial preliminary injunction, blocking enforcement of the law against individuals who practice, teach, and learn traditional Native Hawaiian maternal health practices. The Court found that Native Hawaiian traditional and customary birthing and child-rearing practices, now commonly referred to as "midwifery," existed prior to western contact and that Plaintiffs were "struggling to comply with an 'amorphous pathway' in their attempt to certify [...] practices that have been performed and passed down for centuries, but have only recently become re-subjected to state control."[86] It further noted that suppression of those practices was causing ongoing, irreparable damage in the form of "threats to Plaintiffs' health, safety,

well-being, and culture" and damaging collaboration between various actors within the health system.[87] In addition to the "grave" harm already suffered, generations of Native Hawaiians were "at risk of losing their cultural knowledge and traditions."[88] The Court concluded that, to prevent certain pregnancy-related customary practices from being regulated out of existence, permissible regulation required an "*actual* and *meaningful* pathway" for Native Hawaiian cultural practitioners to exercise their rights.[89]

The Hawai'i Legislature passes a new midwifery licensure bill in 2025

When the Midwifery Restriction Law was passed, it included a sunset date five years later (June 30, 2025). This provided the legislature with an opportunity to revisit the issue, and to re-enact, modify, or discontinue the regulatory program. In response to the Court's ruling, as well as the persistent mobilization of community members demanding improvements, the state legislature passed a new, modified midwifery bill in 2025.

The intervening lawsuit was critical to reframing the legislative debate. Litigation had produced nuanced information that wasn't available to legislators the first time around, including a robust factual record and expert opinions explaining Native Hawaiian traditional and customary practices related to pregnancy; midwifery training and credentialing pathways; pervasive gaps in Hawai'i's maternal health infrastructure; and the way that Papa Ola Lōkahi operates. The judge's legal ruling dispelled misinformation that had minimized or denied the impact of the law on Native Hawaiian cultural practitioners and provided legislators with important guidance on what it would take to pass a midwifery licensure law that was constitutional, *in practice*. Politically, the litigation process had also demonstrated the national and international solidarity that Native Hawaiian cultural practitioners command. And locally, it exposed the deeply personal consequences of the law's rigidity for families of all backgrounds who value home birth with the practitioner of their choice as an exercise of autonomy, culture, and/or religion.

The legislature introduces new midwifery licensure bills

Even so, the new midwifery law's journey through the 2025 legislative session was fraught. At the beginning of session, two proposals for replacement of the Midwifery Restriction Law were introduced: one by the Midwifery Restriction Law's original sponsor and another that reflected extensive input from the home birth community. The bill introduced by the Midwifery Restriction Law's original sponsor, House Bill No. 1194, was the one that moved. As introduced, it contained many of the same components as the Midwifery Restriction Law, including MEAC-only licensure eligibility requirements, criminal penalties, and inadequate protections for Native Hawaiian cultural practitioners. As it moved through the legislative process, it drew voluminous testimony and significant amendments.[90]

Unlike some other bills that legislatures encounter, the most intense controversy surrounding midwifery licensure bills may not involve the premise of the bill, but rather the specific details of its proposed implementation. In Hawai'i, the Midwifery Restriction Law's supporters tended to focus on whether licensure for midwives was reasonable and better than no licensure, without acknowledging or engaging with the law's problematic details. Even the state auditor stuck narrowly to the question of whether midwifery is a health and safety issue reasonably justifying state regulation and noted that it didn't have the expertise to weigh in on amendments.[91] Alternatively, many of those opposing the Midwifery Restriction Law did not oppose licensure for midwives, but were instead concerned about the way the licensure program was structured (criminalizing traditional Native Hawaiian midwives and family members, and arbitrarily cutting off eligibility for skilled midwives in a state that needed every one of its knowledgeable maternal care providers).

In addition to the Center for Reproductive Rights and other civil rights groups who opposed early versions of House Bill 1194, constituents repeatedly raised concerns about the bill's proposed extension of the midwifery restriction law during legislative hearings. With babies on their hips, women told their representatives what choosing where, how, and with whom to birth had meant to them. They pleaded with lawmakers to preserve that freedom.[92] Concerns were also raised by a local newspaper, which published an editorial urging legislators to revise the "flawed midwifery bill" and to include the PEP process and exemptions for Native Hawaiian cultural practitioners as a way to "foster an industry capable of supplying an adequate number of qualified professionals." Otherwise, the paper opined, House Bill 1194 would "do more to hinder midwifery" and the people who rely on those services.[93]

The legislature amends and passes a new midwifery licensure bill

By the time House Bill No.1194 reached its final floor vote, it had been amended several times.[94] The final, revised version sought to avoid infringements on Native Hawaiian rights by distinguishing Native Hawaiian traditional and customary practices from the midwifery practices being regulated. The legislative findings state "[t]he legislature affirms that the practice of midwifery under this Act does not include Native Hawaiian traditional and customary practices."[95] To implement this distinction, the bill amended the definition of midwifery in Section 457J, ending with the statement, "'Practice of Midwifery" does not include Native Hawaiian traditional and customary practices as protected under article XII, section 7, of the Hawaii State Constitution." Additionally, in a section on exemptions, the bill states that "This chapter shall not apply to a person who is: [...] (4) Practicing Native Hawaiian traditional and customary practices as protected under article XII, section 7, of the Hawaii State Constitution."[96]

The bill's new definition of "midwifery" also addressed the overbreadth of the Midwifery Restriction Law's original definition. Instead of a short paragraph referencing common behaviors like providing "information," "care," and "advice," to pregnant or birthing people, the new definition of "midwifery" is much more detailed. Providing a more specific, tailored definition of midwifery (the conduct to be regulated), reduces the risk that people in other perinatal support roles—such as childbirth educators, lactation counselors, doulas, and family members—will be accused of practicing midwifery without a license.

The final version of House Bill 1194 also amended and expanded the eligibility requirements for CPM licensure. Under the new framework, individuals who hold the CPM credential must show proof that they have completed a midwifery education and training program, which can be (a) a program or pathway accredited by MEAC, or successor organization, or another nationally recognized accrediting agency approved by the U.S. Department of Education; or (2) a midwifery bridge certificate issued by the North American Registry of Midwives, or successor organization.[97] This allows CPMs from all training pathways to become eligible for licensure. It is also free from arbitrary date cut-offs, providing consistency that student midwives can rely on. As a result, there is now an option for local residents—including Native Hawaiians—to apprentice with in-state midwives, earn a CPM credential via the Portfolio Evaluation Process, earn a midwifery bridge certificate, and become eligible for licensure.[98]

The final floor debate was tense, as Hawai'i state representatives explained why they supported or opposed the bill. Because the bill had changed substantially between its introduction and final vote, some legislators expressed hesitation and confusion over whether the amendments were sufficient to protect Native Hawaiian rights.[99] At one point, Indigenous observers to the proceedings performed a *haka* (dance) in protest and were admonished by the Speaker of the House.[100] The bill passed with a significant majority. When it took effect May 5, 2025, it replaced the old Midwifery Restriction Law, altering Chapter 457J.

The Center reaches a settlement, solidifying protections for midwives

The newly enacted law did not satisfy everyone, but it did resolve several of the concerns raised in *Kaho'ohanohano v. Hawai'i,* including issues which the court had addressed in its preliminary injunction. Still, it left opportunities for clarification. Through a settlement agreement, the Plaintiffs that brought *Kaho'ohanohano v. Hawai'i* agreed to end the lawsuit in exchange for certain agreements by Defendants about the new Chapter 457J. In doing so, the Plaintiffs did not admit any legal or factual deficiencies in their claims and Defendants did not concede any of the legal or factual issues alleged in the Complaint. Instead, both Plaintiffs and Defendants agreed that this agreement would serve the interests of both parties, as well as the public, by providing the community with greater clarity about the new midwifery law.

The terms and conditions of the settlement address two substantive issues in the bill: (1) criminalization, and (2) protections for students and teachers involved in the Portfolio Evaluation Process.

First, the new midwifery law states that "[n]othing in this chapter shall be construed as establishing any criminal penalty."[101] When the legislators made that amendment to House Bill 1194, they indicated that it "responds to community concerns that conduct regulated under the midwives chapter could result in criminal penalties."[102] However, as the lawsuit illustrated, the criminal penalties that community members feared were not established solely by chapter 457J. Rather, they stemmed from how chapter 457J interacts with chapter 436B, the Uniform Professional and Vocational Licensing Act. To help avoid further confusion, and consistent with the legislature's intent, the settlement agreement states that "Under Hawai'i law, there are no criminal penalties for practicing midwifery without a license."[103] It notes that "HRS Chapter 436B applies in instances where the licensing laws or rules for a vocation or profession are silent," and that the new midwifery law was not silent.[104] As a result, the (civil) penalties "described in HRS § 457J-13, and discussed in HRS § 457J-6(c), prevail over those set out in HRS § 436B-27."[105]

Second, when the legislators added language to House Bill 1194 permitting students who earn their CPM credential through the Portfolio Evaluation Process to become eligible for licensure (if they also obtain a midwifery bridge certificate and meet all other eligibility requirements), they did not update the definition of "qualified midwife preceptor" (teacher) or the language exempting student midwives. As a result, teachers are still defined as those participating in the clinical education of students enrolled in MEAC programs.[106] Similarly, the exemption for students refers to individuals "currently enrolled in a midwifery educational program and under the direct supervision of a qualified midwife preceptor."[107] Consistent with the legislature's intent to enable midwifery students in Hawai'i to engage in the Portfolio Evaluation Process as a pathway to licensure, the settlement stipulates that "[w]hile students are engaged in the Portfolio Evaluation Process or a program accredited by the Midwifery Education Accreditation Council, they are exempt from licensure under HRS § 457J-6(a)(3)."[108] It further states that "'Qualified Midwife Preceptors' include those overseeing or participating in the education of student midwives engaged in the Portfolio Evaluation Process.[109]

In addition to these stipulations, the Department of Commerce and Consumer Affairs agreed to include Plaintiffs as interested parties during any future rulemaking under Chapter 457J and agreed to notify them of such actions.[110]

Hawai'i's current midwifery law (HRS § 457J):

- A state issued license is required to practice midwifery
- Hawai'i now provides licensure frameworks for all three national midwifery credentials: Certified Professional Midwives, Certified Midwives, and Certified Nurse Midwives (CNMs continue to be regulated under a di fferent law pertaining to nursing)
- For Certified Professional Midwives, there are multiple pathways to licensure, including (1) attending a MEAC accredited school, or (2) completing the Portfolio Evaluation Process and earning a Bridge certificate; (Preceptors and students engaged in the Portfolio Evaluation Process are not breaking the law)
- The Midwifery law does not apply to Native Hawaiian practitioners of *pale keiki* or other traditional and customary maternal health practices
- There are civil penalties for unlicensed practice of midwifery, but no criminal penalties

Conclusion

In the name of health and safety, the Midwifery Restriction Law (2019) upended the lives of midwives, students, pregnant people, and families. It threatened skilled maternal health practitioners and forced them to choose between helping their neighbors or potentially going to jail. It paused the personal and professional trajectories of students who were preparing to take on important roles in their community. And it deprived women and newborns of spiritually significant birth experiences and the culturally competent care that they deserved. What was taken from these individuals cannot be returned. Lessons learned, however, can be shared. Moving forward, there will be more choices and opportunities available to midwives and pregnant people in Hawai'i because legislators chose to correct course and either champion or accept a more equitable solution. And yet, that outcome was only possible because an extremely dedicated group of birth justice advocates spent years claiming their rights—at the UN, the state legislature, the courthouse, and through their private decisions to continue birthing at home, surrounded by the people and practices they chose.

Looking ahead: recommendations for maternal health advocates and lawmakers interested in midwifery licensure

The following recommendations derive from the Center's case study of Hawaii's midwifery licensure reform efforts (2019-2025). They distill key takeaways for those working on midwifery licensure in other states, or at the national level. As such, this is not an exhaustive list of midwifery policy recommendations.

Ensure that midwifery regulation appropriately defines the people and conduct to be regulated and does not limit pregnant people's access to other important sources of information and support

- Midwifery laws should not occupy the entire field of pregnancy-related support. Just as autonomous midwifery care can be undermined by a legal framework that views all healthcare as "the practice of medicine" belonging to physicians, a midwifery statute that defines midwifery too broadly and/or does not adequately account for exceptions can undermine the positive contributions of doulas, lactation support providers, childbirth educators, and even family members.

- Lawmakers and advocates should assess midwifery bills holistically, ensuring that the definitions and exceptions they choose work together to clearly indicate what conduct will require licensure, and what conduct will not.

At a minimum, provide for the licensure and independent practice of midwives that hold national midwifery credentials (Certified Nurse Midwives, Certified Midwives, and Certified Professional Midwives)

- States that do not license and enable all their trained midwives are missing opportunities to address the U.S. maternal health crisis and shrink maternity care deserts.
- All states currently license Certified Nurse Midwives. Certified Midwives are very similar to Certified Nurse Midwives and should have access to licensure and recognition on similar terms.
- Certified Professional Midwives are licensed in many states, but not all. Because CPMs have expertise in home birth and often staff independent birth centers, they are critical to ensuring that a state's residents have safe, meaningful options for where to birth.
- States can ensure that CNMs, CMs, and CPMs are eligible for licensure without necessarily requiring that all midwives licensed in the state hold one of those credentials.
- If skilled midwives are excluded from state licensure based on arbitrary or discriminatory criteria, patients and consumers may not see licensure status as an accurate or trustworthy indicator of safety.

Ensure that education and training requirements are equitable, sustainable, and that there is at least one pathway to legal midwifery practice attainable within the state

- If a state has no MEAC accredited midwifery school within reach, requiring attendance at one and refusing to recognize alternative training pathways is a recipe for the exclusion and elimination of direct-entry midwives. The Midwifery Education Accreditation Council has existed since 1991. There are currently eleven MEAC accredited midwifery schools located across just nine states.[111] A decade of promoting (MEAC only) licensure requirements that disqualify skilled midwives because of how they learned midwifery has not produced the boom in MEAC midwifery schools that some hoped it would. Laws may help push the midwifery field forward, but they should also be compatible with current resources and realities.
- Individuals of all backgrounds should have access to the pre-requisites of licensure within their own state. At this time, many midwifery students—including many students of color and students from rural areas—rely on the PEP pathway and the Bridge certificate to acquire midwifery skills and training, including core competencies recommended by the International Confederation of Midwives. Because both MEAC accredited schools and the PEP pathway prepare student midwives to take and pass the NARM exam and earn the same Certified Professional Midwife credential, all pathways to the CPM credential should be included in licensure laws.
- Lawmakers can support the development and sustainability of midwifery training and education in their jurisdiction by supporting funding for midwifery schools, birth centers, instructors, student scholarships, and student loan forgiveness.
- Narrow or overly specific licensure requirements may also make midwifery vulnerable when changes in economic, political, and institutional conditions occur. Recent efforts to dismantle the U.S. Department of Education and

MEAC's withdrawal of its petition for U.S. Department of Education recognition are current examples.[112] Midwifery laws should leave flexibility for alternative or successor organizations, pathways, and institutions to carry on core functions if needed.

- International NGOs should inform—not replace—national midwifery infrastructure and decision-making. The International Confederation of Midwives (ICM) is a resource that should complement decisions about U.S. midwifery, but it does not alleviate the need for strong U.S. midwifery institutions and guidance adapted to the U.S. context. There is no legal body tasked with translating and adjudicating whether a specific program meets ICM standards, and both ICM standards and U.S. midwifery programs/institutions are subject to change over time. Limiting licensure to graduates of MEAC programs is not a sustainable proxy for implementing ICM standards and may even preclude some CPMs who have met those standards. It may also make it more difficult to innovate solutions that align U.S. midwifery programs with evolving ICM standards.

Respect Indigenous sovereignty and work with Indigenous people to ensure that midwifery laws do not infringe Indigenous rights

- Midwifery laws should proactively ensure that the Indigenous community within its jurisdiction will not be penalized for continuing their traditional maternal health practices.
- Indigenous people have a fundamentally different relationship to national and sub-national governments than other residents. This includes reserved rights to Indigenous land and culture that are recognized under U.S. law. Lawmakers and advocates must take the time to ensure that any references to specific laws or institutions relating to Native Hawaiian, Alaska Native, or Native American people and practices are accurate and appropriate.
- Ignorance about Indigenous cultures and rights to self-governance can have the same harmful impact as animus. In the case of Hawai'i's Midwifery Restriction Law, a barrier disguised as a protection may have even helped facilitate passage of flawed legislation, while Native Hawaiians who detected the problem were repeatedly dismissed and ignored.
- Advocates should recognize that licensure frameworks are more than just administrative exercises. Law has been an essential tool to advance and justify colonization, and Indigenous survival has often required resistance. *Kaho'ohanohano v. Hawai'i* was the first lawsuit challenging restrictions on Native Hawaiian midwives, but it was not the first time that restrictions had been imposed. Had Native Hawaiians fully complied with prior laws that suppressed or banned their traditional health practices, they would have lost those important cultural traditions generations ago.
- In June 2026 the International Confederation of Midwives temporarily suspended its position statement on "Partnership between Indigenous and Non-Indigenous Midwives."[113] At the ICM Triennial Congress, attendees protested the decision.[114] In response, the two ICM member associations from the U.S. (the Association of Certified Nurse Midwives (ACNM) and the National Association of Certified Professional Midwives (NACPM)) issued a joint statement expressing solidarity with Indigenous midwives.[115] ICM issued its own statement explaining the decision, committed to continued engagement with midwives from Indigenous communities, and put out a call for input.[116]

- Moving forward, U.S. midwifery association leaders should continue cooperating with one another, and with Indigenous communities, to address equity concerns.
- Internationally, ICM should work with Indigenous midwives to develop an updated statement that respects Indigenous people's rights. This will help ensure that laws intended to advance the midwifery profession include and uplift Indigenous cultures and communities, rather than threaten them.

Consider the impact of midwifery laws on all marginalized communities

- Non-Indigenous groups do not have legal protection for their cultural practices the way that some Indigenous people do, but lawmakers can still take steps to consider and preserve other community midwifery traditions. For instance, Black midwives in the U.S. have provided midwifery care and cultural connection to families for generations. Legal barriers have endangered this legacy, but laws can also be crafted to facilitate reparatory justice.[117] This could include maintaining the most accessible pathways to licensure, funding student scholarships, "grandfathering-in" experienced midwives, or licensure frameworks that acknowledge a role for traditional midwives or birth attendants.

Reject the use of criminal penalties to punish the unlicensed practice of midwifery

- Midwifery licensure frameworks often include both civil and criminal penalties. However, criminalizing the unlicensed practice of midwifery is not necessary to promote compliance with occupational licensure laws and it comes with risks for both patients and providers.
  - Adding threats of criminal punishment to reproductive health situations may drive unlicensed providers further underground and discourage patients and practitioners from reaching out for help when needed.
  - Criminal penalties may also escalate unjust government intrusions into individual reproductive choices. People of color are disproportionately targeted by the criminal legal system and midwives and pregnant people of color have reasons to fear criminalization, surveillance, and scapegoating by the state.[118]
- If an unlicensed practitioner's behavior leads to harm, there are other criminal laws that will likely apply to that conduct.
- Omitting criminal penalties from a midwifery licensure bill may not be sufficient to eliminate them. Advocates and legislators should check to see what other laws apply to occupational licensure in their state and proactively address those implications in their bill.

Include coherent, affirmative protections for reproductive autonomy and access

- Decisions about birth are deeply personal expressions of autonomy that deserve strong protections—yet courts around the country have largely failed to recognize them as such. Legislators can help advance this understanding by explicitly naming their intent to support pregnant people's right to decide the manner and circumstances in which they birth.
- Simply stating that a law does not restrict reproductive choices won't make it true. For example, if individuals want to give birth at home or on their ancestral lands, criminalizing the people in their community who know how to make that experience safer or more meaningful will burden that choice.

- Lawmakers can help ensure that midwives are available and economically accessible to all patients by mandating public and private insurance coverage of all state licensed/regulated midwifery care providers in all birth settings (home, birth center, hospital).

Directly impacted individuals, lawyers, lawmakers, and government agencies all have roles to play in ensuring that midwifery laws accomplish what they intend to

- Midwifery legislation should be developed in partnership with midwives and people who seek midwifery care.
- Resolving disagreements among key stakeholders and consulting lawyers early in the bill development process can help mitigate or avoid unintended consequences, community conflict, and expensive litigation.
- When necessary, litigation can help block harmful laws, clarify complex legal issues, and validate voices and viewpoints that have been dismissed or marginalized during the legislative process.
- Licensure frameworks require support for successful, timely implementation, including an adequately resourced administrative body that is knowledgeable about midwifery and able to manage relevant rules and processes.

For physicians and hospitals: work with midwives and patients towards shared safety goals

- The health care system and individual hospitals must share responsibility for ensuring that pregnant people (1) have choices about where they birth, (2) are able to access care when they need it, and (3) maintain bodily autonomy in every setting.
- Hospitals and health care systems should enact policies that promote respectful collaboration and communication between health care providers, as well as safe patient transfers. They should prohibit retaliation against patients who choose home birth or culturally specific care.
- Governments should use their funding and regulatory power to incentivize cooperation between community midwives, emergency medical services, and nearby hospitals.

For midwifery leaders: Update policy positions and seek alignment with one another where possible

- Legislators engage with a vast number of subjects and viewpoints and often have to make decisions on tightly compressed timelines. Multiple stakeholder groups and an abundance of midwifery related acronyms add complexity. Conflicting guidance can make it difficult for legislators to understand the issues and act constructively.
- As history continues to demonstrate, introducing new licensure restrictions while ignoring their likely impact on poor, rural, Indigenous, and Black communities may produce short-term gains for midwifery professionalization, but undermines the field's credibility, unity, and success in the long-term.
- The 2015 US MERA statement on the "Licensure of Certified Professional Midwives" is actively contributing to confusion and inequity. It should be retired, clearly labeled as such, and the relationship between ICM standards and U.S. midwifery standards should be thoughtfully clarified.

What lawmakers should know about the US MERA statement on the "Licensure of Certified Professional Midwives (CPM)"

US Midwifery Education, Regulation, and Association ("US MERA") was a coalition formed in 2013.[119] The founding members were seven U.S. midwifery organizations interested in developing a unified voice on U.S. midwifery issues that would endorse a global vision of the midwifery profession set forth by the International Confederation of Midwifery ("ICM").[120] ICM is a non-governmental organization registered in the Netherlands that aims to champion midwives associations and the profession of midwifery globally.[121] It has no legal authority over U.S. or international midwifery laws, though creating connection and alignment among midwives across the world is an effort that many U.S. midwifery leaders support.[122]

In 2009, ICM developed a set of documents that describe aspirational standards for professional midwifery, which the US MERA coalition then voluntarily sought to promote.[123] The primary output of US MERA was a 2015 "Statement on the Licensure of Certified Professional Midwives (CPM)" that encourages states to grant licensure to some CPMs, but not others.[124] The Memorandum of Understanding governing the US MERA coalition expired in 2020 and some member organizations have disbanded or changed their positions since then.[125] Yet, as the Hawai'i case demonstrates, more than ten years after it was published, the U.S. MERA "Statement on the Licensure of CPMs" continues to influence—and confuse—legislators and other influential stakeholders.[126]

The US MERA statement on the Licensure of Certified Professional Midwives recommends that US states narrow pathways to legal practice and conflate ICM standards with graduation from a MEAC school.

The statement, which at the time of this publication remains available on the U.S. MERA website, asserts that the US MERA organizations "support legislative language stating that by 2020, all new applicants for midwifery licensure must have successfully completed an educational program or pathway accredited by an organization recognized by the US Department of Education (USDE) ***or*** obtained the Midwifery Bridge Certificate" (emphasis added).[127] Also according to the statement, the Midwifery Bridge Certificate requires 50 hours of accredited education that aligns with the ICM core competencies.

Thus, the opening line of the statement could be interpreted to mean that a midwife who completes the Portfolio Evaluation Process ("PEP"), passes the National Association of Registered Midwives ("NARM") exam, earns the CPM credential, and then completes the Midwifery Bridge Certificate has satisfied the requirement and is aligned with ICM standards. This would also seem to be consistent with another US MERA document, "Principles for Model U.S. Midwifery Legislation and Regulation" approved just months later that recommends states impose standards for midwifery education that are consistent with those adopted by the national certifying body (NARM) and recommends that states also rely on NARM to establish criteria and processes to assess midwives educated in other countries and assess equivalence of applicants who do not meet the requirements of a U.S. accredited midwifery education.[128]

However, the statement on licensure of CPMs goes on to provide suggested language for new midwifery licensure bills that phases out licensure for midwives who do not graduate from Midwifery Education Accreditation Council ("MEAC") schools. The suggested licensure eligibility language requires midwives who earn a CPM through a non-accredited pathway before 2020 to obtain a Midwifery Bridge Certificate, and those who earn a CPM after 2020 to complete an educational program accredited by MEAC. According to maps published by NACPM, this latter approach has now been adopted in multiple states.[129] It is also the approach that Hawai'i took when writing the Midwifery Restriction Law in 2019.

The U.S. MERA statement was used to draft and defend Hawaii's Midwifery Restriction Law and may continue to undermine the CPM credential in courtrooms and legislatures across the country

While defending the Midwifery Restriction Law against the Center's lawsuit in 2024, the state presented a declaration from the Board President of the Midwives Alliance of Hawai'i asserting that the Portfolio Evaluation Process does not meet the ICM global standards for midwifery education and explaining that the Midwifery Restriction Law contains language "directly from the US MERA document that requires CPMs to attend an accredited midwifery program to be licensed."[130] Similarly, in 2025 when the Hawai'i legislature reconsidered the midwifery licensure program, The American College of Obstetricians and Gynecologists submitted oral and written testimony supporting a version of the bill that would only allow licensure for CPMs that earned their credential through MEAC schools, stating that ACOG aligns with US MERA, and that the bill implements ICM standards.[131]

The US MERA statement elevates form over function—to the detriment of U.S. midwifery access and the diversity and geographic distribution of the U.S. midwifery workforce.

States that use the US MERA language may face a variety of complications because of its rigid framework. First, there are not enough MEAC schools in the U.S. to meet the demand for midwifery training and education. (There are currently eleven).[132] Second, students from populations underrepresented in the health care field continue to rely on the Portfolio Evaluation Process to earn the CPM credential and mitigate economic, geographic, and racial/ethnic disparities in maternal health. There is no evidence that MEAC students have better clinical outcomes than PEP students.[133] A primary criticism of the PEP pathway surrounds a discrepancy in how a student's progress is measured. ICM recommends that midwives undergo three years of training, whereas the PEP pathway tracks the number of training experiences and skills demonstrated (which could take more or less than three years, depending on the individual and their training environment).[134] Rather than addressing these differences in ways that preserve flexibility and educational opportunity, the US MERA recommendation elevates some CPMs over others . . . inviting doubt about the credential's value overall, and risking further entrenchment of divisions over race, privilege, and access to education that have threatened midwifery since the beginning of the field's professionalization. Additionally, in July 2026, MEAC announced that it had withdrawn its petition for re-recognition by the U.S. Department of Education (USDE), raising new questions about access to student financial aid and licensure in states that reference USDE recognition in their statutes or regulations.[135]

The US MERA statement on CPM Licensure is outdated and does not reflect a true "consensus" among U.S. midwifery leaders

One of the original US MERA organizations no longer exists and another has rebranded and evolved.[136] New midwifery organizations have also emerged since 2015, including many that champion midwives of color and a focus on equity that was missing from the original collaboration.[137] Perhaps most notably, the U.S. MERA statement on Licensure of CPMs does not even reflect the current policy positions of some of its core members. For example, the National Association for Certified Professional Midwives' ("NACPM") website indicates that states should "honor all pathways to the Certified Professional Midwife ("CPM") credential when licensing midwives to ensure equity and maintain a diverse and competent workforce."[138]

Meanwhile, the National Association of Registered Midwives ("NARM") continues to recognize multiple pathways to the CPM credential that do not require MEAC schools, including the Portfolio Evaluation Process and pathways for UK registered midwives, state licensed midwives, and CNMs and CMs. As NARM's website indicates, the standards that midwives seeking a CPM credential must meet are based on

demonstrated competency, including "documentation of comprehensive training and testing of knowledge and skills that are relevant to real-life job conditions, as determined by psychometric research within the profession."[139] It also notes that the CPM credential is accredited by the National Commission on Certifying Agencies and has been evaluated by independent researchers.[140] Thus, if lawmakers look to US MERA's oversimplified interpretation and implementation of ICM standards and make MEAC graduates the only midwives eligible for licensure, they risk barring skilled midwives from legal practice—including some whose training may actually align with ICM's goals.

A more nuanced approach to CPM licensure is needed to enhance midwifery quality and access in the U.S.

The US MERA statement remains the most visible statement on how ICM standards should be implemented in the United States. However, lawmakers should understand its limitations and should not rely on it. Instead, they should consult local and national midwifery leaders to better understand current challenges and determine the most equitable and sustainable solutions for their jurisdiction. Midwifery leaders—particularly those who participated in the US MERA coalition—could provide additional clarity by addressing the status of the US MERA statement on CPM Licensure and proactively contextualizing ICM standards within the United States. Working together, midwives and lawmakers can enhance the availability and resiliency of midwifery, ensuring that restrictions do not get ahead of supportive policies and infrastructure.

Endnotes

[1] *Maternal mortality and maternity care in the United States Compared to 10 other Developed Countries*, The Commonwealth Fund (Nov 18, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries.
[2] *WHO calls for global expansion of midwifery models of care*, World Health Organization (June 18, 2025), https://www.who.int/news/item/18-06-2025-who-calls-for-global-expansion-of-midwifery-models-of-care.
[3] Anika Nayak, *The history that explains Today's Shortage of Black Midwives*, TIME (Feb 29, 2024), https://time.com/6727306/black-midwife-shortage-history/.
[4] *Id.*
[5] *Id.*
[6] Hawaii Revised Statutes (HRS) § 457J (2019).
[7] 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) (2019).
[8] *Midwifery Should Be Regulated, for Safety Of Consumers And Community*, Honolulu Civil Beat (Mar. 8, 2023), https://www.civilbeat.org/2023/03/midwifery-should-be-regulated-for-safety-of-consumers-and-community/.
[9] The law required 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-6, 457J- 5 (2019).
[10] HRS § 457J-8 (2019).
[11] *Id.*; 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).
[12] HRS § 457J-8(4)(B) (2019).
[13] HRS § 457J-13 (2019).
[14] HRS § 457J-12 (2019).
[15] HRS § 436B-27(c) (2019).
[16] HRS §§ 457J 5, J-13 (2019).
[17] 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(3), 436B-19(2) (2019).
[18] HRS § 436B-27(b) (2019).
[19] HRS § 436B-27(a) (2019).
[20] HRS § 457J-6(b) (2019).
[21] *Id.*
[22] HRS § 457J-6 (2019).
[23] S.B. 1033, 30th Leg., Reg. Sess. § 1 (2019), (2019 Hawai'i Act 32).
[24] *See* Lea Minton, *Midwifery Should Be Regulated For Safety Of Consumers And Community*, Honolulu Civil Beat (Mar. 8, 2023), https://www.civilbeat.org/2023/03/midwifery-should-be-regulated-for-safety-of-consumers-and-community/; Mahealani Richardson, *Fearing the future of their work, traditional midwives rally at state Capitol*, Hawaii News Now (March 6, 2023), https://www.hawaiinewsnow.com/2023/03/07/traditional-midwives-hold-rally-fearing-their-future/.
[25] Ctr. for Reprod. Rts. et. al., *Retrogression in U.S. Reproductive Rights: The Ongoing Fight for Reproductive Autonomy, A report for the Human Rights Committee* (2023), tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2FCCPR%2FCSS%2FUSA%2F55909&Lang=en.
[26] 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.
[27] 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/1-12 (Sept. 21, 2022), https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CERD%2FC%2FUSA%2FCO%2F10-12&Lang=en.
[28] Lea Minton (identified in the article's author bio as a midwife and the Board President of the Midwives Alliance of Hawai'i), *Midwifery Should Be Regulated, for Safety Of Consumers And Community*, Honolulu Civil Beat (Mar. 8, 2023), https://www.civilbeat.org/2023/03/midwifery-should-be-regulated-for-safety-of-consumers-and-community/.
[29] Letter from Deputy Att'y Gen. Shari Wong, Haw., at 4–5 (Jan. 17, 2024) (referring to HRS § 436B-27(b)) (on file with the Ctr. for Reprod. Rts.).
[30] *Id.* at 4.
[31] *Id.* at 5.
[32] *Kaho'ohanohano v. State of Hawai'i*, 1CCV-24-0000269 (Haw. Cir. Ct. 2024).
[33] Pls.' Mot. for Prelim. Inj., *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269, (Haw. Cir. Ct. Feb. 28, 2024).
[34] Kawehi Ku'ailani Decl. ISO Pls.' Mot. for Prelim. Inj., *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269 (Haw. Cir. Ct. Feb. 28, 2024).
[35] Morea Mendoza Tr. 142: 17–18, Hr'g on Pls.' Mot. for Prelim. Inj., *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269 (Haw. Cir. Ct. June 10, 2024).

[36] *Id.* at 143: 6–11.
[37] *Id.* at 151:21–152:17.
[38] *Id.* at 154:9–10.
[39] *Id.* at 156:17–157:22.
[40] Ki'inaniokalani Kaho'ohanohano Decl. ISO Pls.' Mot. for Prelim. Inj., *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269 (Haw. Cir. Ct. Feb. 28, 2024).
[41] Ki'i Tr. 69:2–19, Hr'g on Pls.' Mot. for Prelim. Inj., *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269 (Haw. Cir. Ct. June 10, 2024).
[42] *Id.* at 73:5–25.
[43] *Id.* at. 68:10–19.
[44] Makalani Franco-Francis Decl. ISO Pls.' Mot. for Prelim. Inj., *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269, (Haw. Cir. Ct. Feb. 28, 2024).
[45] Pi'ilani Schneider-Furuya Decl. ISO Pls.' Mot. for Prelim. Inj., *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269, (Haw. Cir. Ct. Feb. 28, 2024).
[46] Laulani Teale Tr. 49:2–12. Hr'g on Pls.' Mot. for Prelim. Inj., *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269 (Haw. Cir. Ct. June 12, 2024).
[47] *Id.* at 19:11–20:20; 83:14–19, 23–24.
[48] *Id.* at 38:12–15.
[49] *Id.* at 39:22–41:11.
[50] *Id.* at 22:1–37:19.
[51] *Id.* at 34:1–18.
[52] *Id.* at. 53:25–54:9.
[53] *Id.* at 50:4–5.
[54] *Flores-Case 'Ohana v. Univ. of Hawai'i*, 153 Hawai'i 76, 88, 526 P. 3d 601, 613 (2023).
[55] A person claiming a protected right under Article XII, § 7 must show: (1) the person qualifies as a "native Hawaiian" — meaning a descendant of the native Hawaiians who inhabited the islands prior to 1778, regardless of blood quantum; and (2) the claimed right is a genuine "customary or traditional native Hawaiian practice," proven by an adequate foundation in the record connecting the claimed right to a firmly rooted traditional or customary native Hawaiian practice and based on "actual practice" rather than assumption. *State v. Hanapi*, 89 Haw. 177, 186–87, 970 P.2d 485, 494–95 (1998).
[56] Decl. of Noah Ha 'alilio Solomon ISO Pls.' Mot. for Prelim. Inj., *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269, (Haw. Cir. Ct. Feb. 28, 2024).
[57] Ezinne Dawson Tr. 179:3–9, Hr'g on Pls.' Mot. for Prelim. Inj., *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269 (Haw. Cir. Ct. June 10, 2024).
[58] *Id.* at 172: 14–19.
[59] *Id.* at 175:9–22.
[60] *Id.* at 179:15–22; 181:1–7.
[61] *Id.* at 181:8–182:12.
[62] Kiana Rowley Tr. 211:21–212:9, Hr'g on Pls.' Mot. for Prelim. Inj., *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269 (Haw. Cir. Ct. June 10, 2024).
[63] *Id.* at 211: 6–20.
[64] *Id.* at 213:4–8.
[65] *Id.* at 214:10–13.
[66] *Id.* at 214:3–7.
[67] *Id.* at 214:23–217:23.
[68] *Id.* at 216:4–21; 217:24–218:13.
[69] *Id.* at 214:20–22; 218:1–17.
[70] Dr. Maile Taualii Tr. 200:1–12, Hr'g on Pls.' Mot. for Prelim. Inj., *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269 (Haw. Cir. Ct. June 12, 2024).
[71] Nicolle Arthun Tr.167:13–169:12; 173:8–21, Hr'g on Pls.' Mot. for Prelim. Inj., *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269 (Haw. Cir. Ct. June 12, 2024).
[72] Dr. Monica McLemore Tr. 13:22–18:4, Hr'g on Pls.' Mot. for Prelim. Inj., *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269 (Haw. Cir. Ct. June 13, 2024).
[73] Dr. Melissa Cheyney Tr. 116:22–117:2, Hr'g on Pls.' Mot. for Prelim. Inj., *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269 (Haw. Cir. Ct. June 12, 2024).
[74] *Id.* at 130:23–132:14.
[75] *Id.* at 132:6–8; 137:10–15.
[76] *Id.* at 132:8–14; 137:2–9.
[77] *Id.* at 140:15–24.
[78] *Id.* at 142:14–24.
[79] *Id.* at 150:6–151:4.
[80] Duffy Casey Tr. 160:6–162:11, Hr'g on Pls.' Mot. for Prelim. Inj., *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269 (Haw. Cir. Ct. June 13, 2024).
[81] Esther Brown Tr. 119:19–120:7, Hr'g on Pls.' Mot. for Prelim. Inj., *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269 (Haw. Cir. Ct. June 13, 2024).
[82] *Id.* at 110:4–111:11.
[83] *Id.* at 118:7–16; Pls.' Closing Argument Tr. 61:4–13, Hr'g on Pls.' Mot. for Prelim. Inj., *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269 (Haw. Cir. Ct. June 14, 2024).
[84] Kia'i Lee Tr. 19:15–20:7, Hr'g on Pls.' Mot. for Prelim. Inj., *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269 (Haw. Cir. Ct. June 14, 2024).

[85] Def.'s Closing Argument Tr. 64:8–57:25, Hr'g on Pls.' Mot. for Prelim. Inj., *Kahoʻohanohano v. State of Hawaiʻi*, No. 1CCV-24-0000269 (Haw. Cir. Ct. June 14, 2024).
[86] Findings of Fact, Conclusions of Law, and Order Granting in Part & Denying in Part Pls.' Mot. for Prelim. Inj. at 9, ¶¶ 26–27 and 34, ¶ 52, *Kahoʻohanohano v. State*, No. 1CCV-24-0000269 (Haw. 1st Cir., July 23, 2024) [hereinafter Kahoʻohanohano Order].
[87] Kahoʻohanohano Order at 43, ¶ 83 and 36, ¶ 56.
[88] Kahoʻohanohano Order at 43, ¶ 84.
[89] Kahoʻohanohano Order at 40, ¶ 68.
[90] *See* Off. of the Auditor, *Sunset Analysis: Regulation of Midwives, A Report to the Governor and the Legislature of the State of Hawaiʻi* (2025), https://www.capitol.hawaii.gov/session/archives/measure_indiv_Archives.aspx?billtype=HB&billnumber=1194&year=2025.
[91] *Id.* at 16.
[92] *See* Hawai'i State Senate, *HHS Public Hearing 03-14-2025* (Youtube, Mar. 14, 2025), https://www.youtube.com/watch?v=kOkDa7A6JhQ.
[93] Honolulu Star Advertiser, "*Editorial: Flawed midwifery bill needs rework*," Apr. 7, 2025.
[94] H.R. 1194, 33rd Leg., Reg. Sess. (Haw. 2025); *see also 2025 Archives: HB1194 HD2 SD3*, Hawai'i State Legislature, https://www.capitol.hawaii.gov/session/archives/measure_indiv_Archives.aspx?billtype=HB&billnumber=1194&year=2025.
[95] H.R. 1194, 33rd Leg., Reg. Sess. (Haw. 2025) at § 1, https://www.capitol.hawaii.gov/sessions/session2025/bills/HB1194_SD3_.htm.
[96] H.R. 1194, 33rd Leg., Reg. Sess. (Haw. 2025) at § 8(a)(4).
[97] HRS § 457J-8(c)(2) (2025).
[98] HRS § 457J (2025).
[99] Hawaiʻi House of Representatives, *House Chamber - Mon Apr 14, 2025, 11:30 AM HST - Day 50* (YouTube, April 14, 2025), https://www.youtube.com/live/hKFT6Pf0Y0Q. (at approximately 51-1:38 minutes); *See also Midwife Bill Advances in Hawai'i Senate but Causes Confusion*, ACLU (April 2, 2025), https://www.acluhi.org/news/midwife-bill-advances-hawaii-senate-causes-confusion/.
[100] Hawaiʻi House of Representatives, *House Chamber - Mon Apr 14, 2025, 11:30 AM HST - Day 50* (YouTube, April 14, 2025), https://www.youtube.com/live/hKFT6Pf0Y0Q (at approximately 50 minutes).
[101] HRS § 457J-6(c) (2025).
[102] Hawaiʻi State Senate, *Senate Floor Session April-8-2025 10 am*, (YouTube, April 8, 2025), https://www.youtube.com/watch?v=0poy2Rl6roY (at approximately 8 minutes).
[103] Joint Stipulation and Settlement Order; Ex. A, at 3, *Kahoʻohanohano v. Hawaiʻi*, No. 1CCV-24-0000269 (Haw. Cir. Ct. Oct. 15, 2025).
[104] *Id.*
[105] *Id.*
[106] HRS § 457J-2 (2025).
[107] HRS § 457J-6(a)(3) (2025).
[108] Joint Stipulation and Settlement Order; Ex.A, at 4, *Kahoʻohanohano v. Hawaiʻi*, No. 1CCV-24-0000269 (Haw. Cir. Ct. Oct. 15, 2025).
[109] *Id.*
[110] *Id.* at 3.
[111] *Find a MEAC-accredited midwifery school*, Midwifery Education Council (MEAC), https://www.meacschools.org/schools (last visited Sep. 16, 2026).
[112] Collin Binkley & Annie Ma, *The Education Department is being dismantled. Here's what that means*, AP News (Nov. 18, 2025, at 5:25 PM), https://apnews.com/article/trump-education-department-dismantle-close-b0ae8b677a63273a9b06c2b4005dee4d; *A message to our member schools, students, and the public on MEAC's withdrawal of its petition for U.S. Department of Education re-recognition*, Midwifery Education Accreditation Council (July 2026), https://www.meacschools.org/news/newsletter/nl-2026-07-transitions.
[113] Int'l Confederation of Midwives, *Statement on the Temporary Suspension of the Position Statement on Partnership Between Indigenous and Non-Indigenous Midwives* (June 17, 2026), https://internationalmidwives.org/statement-on-the-temporary-suspension-of-the-position-statement-on-partnership-between-indigenous-and-non-indigenous-midwives/.
[114] *Id.*; Melissa Avery et al., *Solidarity, Justice, and the Future of Midwifery at the International Confederation of Midwives 34th Triennial Conference*, 71 J. Midwifery Womens Health 503-505 (July 29, 2026), https://pmc.ncbi.nlm.nih.gov/articles/PMC13460732/.
[115] Am. College of Nurse-Midwives and Nat'l Assoc. of Professional Midwives, *A Joint Statement on Indigenous Midwifery, Native Maternal Health, and Solidarity from ACNM and NACPM* (Jun. 18, 2026), https://midwife.org/wp-content/uploads/2026/06/A-Joint-Statement-on-Indigenous-Midwifery-Native-Maternal-Health-and-Solidarity-from-ACNM-and-NACPM.pdf.
[116] Int'l Confederation of Midwives, *Statement on the Temporary Suspension of the Position Statement on Partnership Between Indigenous and Non-Indigenous Midwives* (June 17, 2026), https://internationalmidwives.org/statement-on-the-temporary-suspension-of-the-position-statement-on-partnership-between-indigenous-and-non-indigenous-midwives/; Int'l Confederation of Midwives, *Consultation on ICM's Position Statement on Midwifery Care for Indigenous Communities* (Oct. 14, 2026), https://internationalmidwives.org/consultation-on-icms-position-statement-on-midwifery-care-for-indigenous-communities/.

[117] *See* Comm. on the Elimination of Racial Discrimination, *General recommendation - No.40 on Reparatory justice for the harms and continuing consequences of colonialism, the trafficking in enslaved Africans across the Atlantic and other routes, and racialized chattel slavery - Advance unedited version*, U.N. Doc. CERD/C/GC/40 (Aug. 31, 2026), https://www.ohchr.org/en/documents/general-comments-and-recommendations/general-recommendation-no40-reparatory-justice-harms.

[118] *See Defending Texas Midwife Accused of Violating State Abortion Ban*, Center for Reproductive Rights, https://reproductiverights.org/cases/defending-texas-midwife-accused-of-violating-state-abortion-ban/ (last visited Sep. 30, 2026).

[119] *History: Timeline of important US MERA events*, US Midwifery Education, Regulation, & Association (USMERA), https://usmera.org/index.php/history/ (last visited Sep. 16, 2026).

[120] US MERA, *Executive Summary: History and Future of the US MERA Joint Project* (Aug. 2013), https://midwife.org/wp-content/uploads/2024/10/History-and-Future-of-the-US-MERA-Joint-Project-Executive-Summary.pdf.

[121] *About ICM*, Int'l Confederation of Midwives, https://internationalmidwives.org/who-we-are/ (last visited Sep. 16, 2026).

[122] The original members of US MERA were National Association of Certified Professional Midwives (NACPM), North American Registry of Midwives (NARM), Midwives Alliance of North America (MANA), Midwifery Education Accreditation Council (MEAC), American College of Nurse Midwives (ACNM), American Midwifery Certification Board (AMCB), Accreditation Commission for Midwifery Education (ACME). The International Center for Traditional Childbearing (ICTC) was added later in 2016. *See US MERA welcomes International Center for Traditional Childbearing (ICTC) to the coalition*, US MERA (Feb. 11, 2016), https://usmera.org/index.php/2016/02/11/us-mera-welcomes-international-center-for-traditional-childbearing-ictc-to-the-coalition/.

[123] *See* Int'l Confederation of Midwives, *Professional Framework for Midwifery*, at 7 (2025), file:///C:/Users/ChiaraPadilla/Downloads/Professional-Framework-2025.pdf; US MERA, *History and Future of the US MERA Joint Project* (Aug. 2013), https://midwife.org/wp-content/uploads/2024/10/History-and-Future-of-the-US-MERA-Joint-Project-Executive-Summary.pdf.

[124] US MERA Professional Regulation Committee, *Statement on the Licensure of Certified Professional Midwives (CPM)*, US MERA (July 1, 2015), https://usmera.org/index.php/2015/07/01/statement-on-the-licensure-of-certified-professional-midwives-cpm/.

[125] US MERA Work Group, *Memorandum of Understanding (MOU)* (May 5, 2015), https://usmera.org/wp-content/uploads/2015/07/US-MERA-MOU-5015-05.pdf.

[126] *Id.*

[127] US MERA Professional Regulation Committee, *Statement on the Licensure of Certified Professional Midwives (CPM)*, US MERA (July 1, 2015), https://usmera.org/index.php/2015/07/01/statement-on-the-licensure-of-certified-professional-midwives-cpm/.

[128] US MERA, *Principles for Model U.S. Midwifery Legislation & Regulation*, at 6–7 (2015), https://usmera.org/wp-content/uploads/2015/11/US-MERALegislativeStatement2015.pdf; Then and now, NARM sets the standard for the competency-based Certified Professional Midwife or "CPM" credential, which is accredited by the National Commission for Certifying Agencies. North American Registry of Midwives (NARM), https://usmera.org/wp-content/uploads/2015/11/US-MERALegislativeStatement2015.pdf. . NARM maintains multiple routes to the CPM credential, including (1) the Portfolio Evaluation Process, (2) MEAC accredited midwifery schools, and (3) midwives who hold other midwifery credentials or (4) are already legally recognized in U.S. states or countries that have been evaluated for educational equivalency). *CPM Application Routes*, NARM, https://narm.org/certification-recertification/cpm-application/ (last visited Sep. 17, 2026).

[129] *What CPM Educational Pathways Lead to Licensure in Each State?*, NACPM, https://www.nacpm.org/what-cpm-pathways-are-honored-by-each-state (last visited Sep. 16, 2026). https://www.nacpm.org/what-cpm-pathways-are-honored-by-each-state.

[130] Lea Minton Decl. in Opposition to Pls.' Mot. for Prelim. Inj., at 4, *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269, (Haw. Cir. Ct. May 10, 2024).

[131] HAWAI'I STATE SENATE, *HHS Public Hearing 3-24-2025*, Dr. Ricardo Molero Bravo on behalf of ACOG at 13:30 (YouTube March 24, 2025), https://www.youtube.com/watch?v=kOkDa7A6JhQ; Am. College of Obstetricians and Gynecologists, District VIII Section, *Re: HB 1194 - Relating to the Licensure of Midwives, Position: Support*, H.B. 1194 Testimony 77–78 (Feb. 10, 2025), https://www.capitol.hawaii.gov/sessions/Session2025/Testimony/HB1194_TESTIMONY_HLT-CPC_02-10-25_.PDF.

[132] *Find a MEAC-accredited midwifery school*, Midwifery Education Council (MEAC), https://www.meacschools.org/schools (last visited Sep. 16, 2026).

[133] Dr. Melissa Cheyney Tr. 132:6–8; 137:10–15, Hr'g on Pls.' Mot. for Prelim. Inj., *Kaho'ohanohano v. State of Hawai'i*, No. 1CCV-24-0000269 (Haw. Cir. Ct. June 12, 2024).

[134] *Id.* at 142:14–24.

[135] *A message to our member schools, students, and the public on MEAC's withdrawal of its petition for U.S. Department of Education re-recognition*, Midwifery Education Accreditation Council (July 2026), https://www.meacschools.org/news/newsletter/nl-2026-07-transitions.

[136] The Midwives Alliance of North America (MANA) dissolved and named NACPM as its successor. *See Midwives Alliance of North America (MANA)*, NACPM, https://www.nacpm.org/mana-documents (last visited Sep. 16, 2026). The International Center for Traditional Childbearing (which was not invited to the original US MERA table and only joined the coalition after the statement on licensure was issued) has since transitioned to become the National Association to Advance Black Birth.

[137] Newer organizations in the U.S. midwifery space that are championing equity include Birth Center Equity and the National Alliance of Black Midwives.
[138] *What CPM Educational Pathways Lead to Licensure in Each State?*, NACPM, https://www.nacpm.org/what-cpm-pathways-are-honored-by-each-state (last visited Sep. 16, 2026).
[139] *About NARM*, North American Registry of Midwives (NARM), https://narm.org/about/ (last visited Sep. 16, 2026).
[140] *Id.*