NEIL ABERCROMBIE
GOVERNOR

SHAN S. TSUTSUI
LT. GOVERNOR

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PRESENTATION OF
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
REGULATED INDUSTRIES COMPLAINTS OFFICE

TO THE SENATE COMMITTEE ON HEALTH

AND

TO THE SENATE COMMITTEE ON
COMMERCE AND CONSUMER PROTECTION

AND

TO THE SENTATE COMMITTEE ON
JUDICIARY AND LABOR

TWENTY-SEVENTH STATE LEGISLATURE
REGULAR SESSION, 2014

MONDAY, FEBRUARY 10, 2014
1:30 P.M.

TESTIMONY ON SENATE BILL NO. 2569
PROPOSED SENATE DRAFT 1
RELATING TO HOME BIRTH

TO THE HONORABLE JOSH GREEN, M.D., CHAIR,
TO THE HONORABLE ROSALYN H. BAKER, CHAIR,
TO THE HONORABLE CLAYTON HEE, CHAIR,
AND TO THE HONORABLE ROSALYN H. BAKER, VICE CHAIR,
AND TO THE HONORABLE BRIAN T. TANIGUCHI, VICE CHAIR,
AND TO THE HONORABLE MAILE S.L. SHIMABUKURO, VICE CHAIR,
AND MEMBERS OF THE COMMITTEES:

The Department of Commerce and Consumer Affairs ("Department") appreciates the opportunity to testify on the proposed Senate Draft 1 of Senate Bill No. 2569, Relating to Home Birth. My name is Daria Loy-Goto, Complaints and Enforcement Officer for the Department's Regulated Industries Complaints Office ("RICO"). RICO offers the following comments on the bill.

The proposed Senate Draft 1 of Senate Bill No. 2569 establishes the Board of Midwifery ("Board") within the Department, provides for the Board's powers and duties, sets forth the qualifications and educational and training requirements for licensure, and requires recordkeeping by the licensee.

As the enforcement arm for the Department's Boards and Programs, RICO offers the following comments related to enforcement:

1) The proposed Senate Draft 1 does not contain a separate disciplinary section setting forth the Board's authority to take disciplinary action, the types of disciplinary action the Board may impose, and the conduct that would warrant disciplinary action. A separate section would conform to most of the existing regulatory chapters and would assist RICO in determining the types of conduct that would give rise to disciplinary action.

2) The proposed Senate Draft 1 does not contain language authorizing the Board to impose fines for violations of the new Chapter. RICO believes such authority (in a separate provision or within the disciplinary section) is standard.

3) Finally, the language in § -3 (Powers and duties) does not conform to the

language typically used to describe a board's general powers. Moreover, certain language in this section concerning the Board's authority to investigate complaints appears to be unnecessary and is inconsistent with usual licensing and enforcement schemes.

Thank you for this opportunity to testify on Senate Bill No. 2569. I will be happy to answer any questions that the members of the Committees may have.

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KEALI`I S. LOPEZ
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**PRESENTATION OF THE
PROFESSIONAL AND VOCATIONAL LICENSING DIVISION**

TO THE SENATE COMMITTEE ON HEALTH
AND
TO THE SENATE COMMITTEE ON
COMMERCE AND CONSUMER PROTECTION
AND
TO THE SENATE COMMITTEE ON JUDICIARY AND LABOR

TWENTY-SEVENTH LEGISLATURE
Regular Session of 2014

Monday, February 10, 2014
1:30 p.m.

TESTIMONY ON SENATE BILL NO. 2569, PROPOSED S.D. 1, RELATING TO HOME BIRTH.

TO THE HONORABLE JOSH GREEN, M.D., CHAIR,
TO THE HONORABLE ROSALYN H. BAKER, CHAIR,
TO THE HONORABLE CLAYTON HEE, CHAIR,
AND MEMBERS OF THE COMMITTEES:

My name is Celia Suzuki, Licensing Administrator of the Professional and Vocational Licensing Division, Department of Commerce and Consumer Affairs (“Department”). The Department appreciates the opportunity to provide comments on Senate Bill No. 2569, Proposed S.D. 1, Relating to Home Birth.

The purpose of Senate Bill No. 2569, Proposed S.D. 1, is to regulate the practice of midwifery care in Hawaii. It establishes a Board of Midwifery ("Board") and requires midwives to be licensed after having met minimum educational and training requirements, and requires midwives to follow record keeping and reporting requirements. It also places the Board, for administrative purposes, within the Department of Commerce and Consumer Affairs.

While the Professional and Vocational Licensing Division is not taking an official position on the bill, it offers the following comments. There is no necessity for a Board if the licensing scheme is not complicated. We would recommend that your Committees consider as an alternative a licensing program without a Board.

Also, for all new regulatory schemes, resources for additional staff and funds for start-up costs will be requested of the Legislature. A cost analysis must first be conducted to figure out the associated personnel and operational costs per fiscal year which must be borne by an estimated initial group of the number of midwives in Hawaii. Therefore, if the Department is legislated to regulate midwives, it is our hope that the Legislature will appropriately appropriate funds to hire staff and cover administrative costs.

Thank you for the opportunity to provide comments on Senate Bill No. 2569 proposed S. D. 1.

Names: Maureen Shannon, CNM, FNP, FACNM, FAAN (Chair)
Annette Manant, CNM, MN (Secretary)
Roxanne Estes, CNM, MSN (Treasurer)

Title: Executive Board of the Hawai`i Affiliate of the American College of Nurse-Midwives

Senate Committees: Health
Commerce and Consumer Protection
Judiciary and Labor

Hearing Date/Time: February 10, 2014 at 1:30 PM

Measure: 2569 SD1 Proposed

Opinion: Support

Testimony:

The Executive Board and the majority of the members of the Hawai`i Affiliate of the American College of Nurse-Midwives (HAA), after careful review and consideration, are in support of the 2569 SD1 proposed legislation to establish a Home Birth Board. Furthermore, we appreciate the efforts the committees are making to protect the health and well-being of women and infants in Hawai`i by the considering the licensure of non-regulated birth attendants under the 2569 SD1 proposed legislation. However, details about what constitutes good candidates for licensing (e.g., educational qualifications, number of births attended, etc.) and other details (e.g., clinical practice guidelines and protocol development) need additional work; therefore, HAA recommends that all representatives from those affected by this legislation should be invited to help craft this legislation.

The HAA supports excluding certified nurse-midwives (CNMs) from this legislation. We continue to recommend that CNMs NOT be included in any home birth bills, since we are already licensed and regulated as APRNs by Hawai`i's Board of Nursing under the Nurse Practice Act which allows full scope of practice for CNMs licensed in the State.

Written Testimony Presented Before the
Senate Committees on Health, Commerce & Consumer Protection, and
Judiciary & Labor
February 10, 2014 9:00 a.m.
by

Kathy Yokouchi, Policy Analyst
Hawaii State Center for Nursing
University of Hawai'i at Manoa

SB 2569 and SB 2569, S.D.1 RELATING TO HOME BIRTH

Chair Green, Vice Chair Baker, and members of the Senate Committee on Health;
Chair Baker, Vice Chair Taniguchi, and members of the Senate Committee on Commerce & Consumer Protection; and
Chair Hee, Vice Chair Shimabukuro, and members of the Senate Committee on Judiciary and Labor

Thank you for this opportunity to provide testimony in strong opposition to these measures, SB 2569 and SB 2569, SD1.

Hawaii State Center for Nursing appreciates the Committees' commitment to the address Hawai'i's health care issues.
However, the creation of a home birth safety board within the DCCA which would regulate a number of practitoners, including Certified Nurse Midwives (CNM), who are already licensed by the DCCA and national certifying boards. Home birthing is within the scope of certified nurse wifery practice. Both measures create regulatory redundancy as well as an unfair cost barrier for health care professionals who are already under state and national regulation.

Hawaii State Center for Nursing feels that SB 2569 and SB 2569, SD1 are premature. If it is the wish of these Committees to pursue this issue, a task force should be established to research whether there is a need for and resources required to establish a home birth safety board; as well as, whose safety standards will apply, how peer review will be established for all practitioners and how disciplinary action will be handled for health care professionals already regulated under the DCCA.

Therefore, Hawaii State Center for Nursing strongly opposed this measure. We respectfully request that your Committees hold SB 2569 and SB 2569, SD1 or create a task force to study the issues involved, including a cost analysis and regulatory redundancy. Thank you for the opportunity to testify.

HAWAII MEDICAL ASSOCIATION
1360 S. Beretania Street, Suite 200, Honolulu, Hawaii 96814
Phone (808) 536-7702 Fax (808) 528-2376 www.hmaonline.net

DATE: Monday, February 10, 2014
TIME: 1:30PM
PLACE: Conference Room 229

TO:
COMMITTEE ON HEALTH
Senator Josh Green, Chair
Senator Rosalyn H. Baker, Vice Chair

COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
Senator Rosalyn H. Baker, Chair
Senator Brian T. Taniguchi, Vice Chair

COMMITTEE ON JUDICIARY AND LABOR
Senator Clayton Hee, Chair
Senator Maile S.L. Shimabukuro, Vice Chair

FROM: Hawaii Medical Association
Dr. Walton Shim, MD, President
Dr. Linda Rasmussen, MD, Legislative Co-Chair
Dr. Ron Keinitz, DO, Legislative Co-Chair
Dr. Christopher Flanders, DO, Executive Director
Lauren Zirbel, Community and Government Relations

Re: SB 2569

Position: Support.

HMA respects the right of women to have home births. HMA also believe it is necessary to have some licensure standards to ensure the safety of mothers and babies.

The HMA is in support of this measure as a way to regulate practitioners who are providing services for money but have little to no clinical training in obstetrics. **If you have to get a license to cut hair you should have to get a license to deliver a baby.**

We offer this testimony because of the number of phone calls we have received from providers who have taken care of home births gone terribly wrong. Women and partially delivered babies end up in the ER and OBGYN's take on a considerable amount of liability to try to safe the lives of both the mother and the baby. Often times when home births go wrong, and the provider

Officers
President - Walton Shim, MD President-Elect – Robert Sloan
Secretary - Thomas Kosasa, MD Immediate Past President – Stephen Kemble, MD
Treasurer – Brandon Lee, MD Executive Director – Christopher Flanders, DO

has no training in obstetrics, the baby and/or mother end up dead or severely debilitated.

Many other states regulate home birth providers. **This legislation will allow mothers who choose home birth to have the security of knowing that in order to hang out a shingle, a home birth provider must meet state licensing standards.**

The most recent and largest study to date reveals that there is a four-fold increased risk of neonatal death associated with home birth. In addition, there is a seven-fold increased risk of neonatal death for first time mothers who deliver at home and a ten – fold increased risk for pregnancies more than 41 weeks gestation. [Grunebaum A, Chervenak F, etal. Society for Maternal Fetal Medicine Abstract. February 7, 2014.]

Currently, there is no licensure, and therefore no patient safety rules and regulations regarding home birth. There are many complications that can occur, particularly with high-risk pregnancies. However, even low-risk pregnancies can quickly, within a few minutes or even seconds, become high-risk during the labor and delivery process.

Twenty-six states have some kind of legal recognition of Certified Professional Midwives. Of those twenty-six, seventeen states have licensure based on the CPM certification. Seven states have established educational requirements and qualifications for professional status and legal recognition that pre-date the existence of CPM; all of these states now use the NARM (CPM) written exam as a critical part of the requirements for licensure. [1]

To ensure that all of Hawaii's mothers and babies have a safe and happy birth experience, I urge you to support the Home Birth Safety bill**. This bill will ensure that home birth providers have had formal obstetrics education to care for mothers and infants, follow patient safety regulations such as no high-risk pregnancy deliveries at home, adequately inform their patients regarding their educational background and the possible risks of home birth, and require the timely completion of birth certificates and other data for all planned home births.**

Please do something to protect our mothers and babies.

Thank you for the opportunity to provide testimony.

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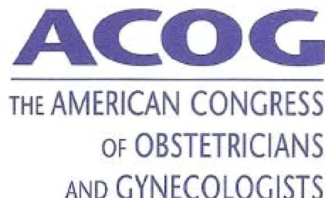
[1] North American Registry of Midwives. http://narm.org/wp-content/uploads/2012/05/State-Licensure-of-CPMs2012.pdf

American Congress of Obstetricians and Gynecologists
District VIII, Hawaii (Guam & American Samoa) Section
94-235 Hanawai Circle, #1B
Waipahu, Hawaii 96797



February 10, 2014
Monday
1:30 PM
Conference Room 229
State Capitol

To: Senator Josh Green, Chair - Committee on Health
Senator Rosalyn Baker, Chair - Committee on Commerce and Consumer Protection
Senator Clayton Hee, Chair - Committee on Judiciary and Labor

From: Lori Kamemoto, MD, MPH, FACOG, Chair
Greigh Hirata, MD, FACOG, Vice Chair

Re: SB2569 (and SB2569SD1), Relating to Health

Position: Strongly support SB2569 requiring licensure, formal education requirements, patient safety rules/regulations, informed consent, data collection, and establishment of a board to ensure Home Birth Safety in Hawaii for other home birth providers including Medical Doctors (MD), Certified Nurse Midwives (CNM), Naturopaths, and Certified Professional Midwives (CPM) - by proposed amendment in this testimony. We support the intent of SB2569SD1, but do not support SB2569SD1 as written, as it does not apply to other home birth provider categories such as MDs, CNMs, and Naturopaths, to ensure home birth safety for all of Hawaii's women and babies as does SB2569 with amendments. As we understand SB2569SD1, there are no provisions for formal obstetrics education requirements, patient safety regulations, informed consent, or data collection for providers other than CPMs who already perform home births. All of Hawaii's women deserve to have these patient safety protections in place for their home birth care.

Dear Senators Green, Baker, Hee and members of the Committees on Health, Commerce and Consumer Protection, and Judiciary and Labor:

The American Congress of Obstetricians and Gynecologists (ACOG), Hawaii Section, respectfully asks that you support the original bill SB2569, with amendments, instead of SB2569SD1 for the safety of all of Hawaii's mothers, and babies, that choose to deliver at home. As we understand SB2569SD1, this only applies to CPMs, and there are several provider categories that would be excluded from patient safety measures. In light of the

increased risk of neonatal death associated with planned home birth (4 times increased risk when compared to hospital births), all of Hawaii's women, not just those cared for by CPMs, deserve to have home birth patient safety measures in place.

Hawaii ACOG members have been very concerned about the tragic outcomes that we have seen in patients transferred to the hospital with planned home birth. It is with great sadness and dismay that we report the following preventable neonatal deaths and injury, as well as maternal complications that have resulted from a planned home birth. Unfortunately, for each tragic outcome, there are many more "near misses" increasing the morbidity and injury to mothers and babies. Unfortunately, Hawaii does not keep track of home birth outcomes as there is no licensure or jurisdiction established for home birth. Other professionals, such as hair stylists, cosmetologists and others are required to have formal education and training in their fields and are licensed. However, home birth providers, who deal with life and death medical care, do not have any educational requirements or patient safety rules and regulations. The following examples of mothers who delivered or attempted to deliver at home, many with high-risk pregnancies, is only a fraction of similar cases that have occurred in Hawaii.

Case List - Patients who had a Planned Home Birth:

1. First time mother with a known breech (butt down) presentation at over 41 weeks. Advised by her home birth provider to deliver at home. Baby noted to be in distress at home and brought to the hospital. Baby died due to prolonged distress. Standard of care is to deliver the baby within 10 minutes of severe distress to avoid permanent brain injury. Breech presentation occurs in 3-4% of all pregnancies. Part of the standard of care for this patient would have been to offer external cephalic version (turning the baby to head down) in the hospital, which has an average success rate of 58%. High risk factors for home birth: first time mother, breech presentation, over 41 weeks gestation.
2. First time mother at 43 weeks gestation advised by her home birth provider to deliver at home. Thick meconium was noted at home, indicative of fetal stress. Patient continued to labor at home. At some point in labor, the home birth provider could no longer hear a heartbeat. On arrival to the hospital, the patient had a recent intrauterine fetal demise and the baby had an abnormal face presentation not noted by the home birth provider. A face presentation makes delivery very difficult. High risk factors for home birth: over 41 weeks gestation, first time mother, thick meconium, abnormal face presentation.
3. Patient with a history of one previous cesarean section at term, advised by her home birth provider to deliver at home. Patient labored at home and developed severe lower abdominal pain and reported to the hospital. On repeat cesarean section, the uterus revealed a clear "window" (paper-thin cell layers of uterus on the verge of rupture) through which the baby could be seen. Rupture of the uterus could have occurred at any time, and outside of the hospital would have rapidly resulted in fetal death and likely maternal death from blood loss within a few minutes. The risk of uterine rupture with one previous Cesarean section is 0.7

- 0.9% and the risk with two previous Cesarean sections is 0.9 – 1.8%. High risk factors for home birth: previous Cesarean section

4. Patient with a known breech presentation at term, advised by her home birth provider to deliver at home. The butt, legs and body of the baby delivered out of the birth canal, however the baby's head was stuck in the birth canal. This is one of the risks of delivering a breech presentation when no adequate evaluation is done prior to and during early labor. The patient was brought to the hospital. There would not normally be a heartbeat in this situation due to cord compression, but the baby still had a heartbeat. Cesarean section was performed. High risk factors for home delivery: breech presentation.
5. Patient with known twins at term was advised by her home birth provider to deliver at home. First baby delivered and died at home. Second baby delivered at home and was brought to the hospital with a very low blood count requiring transfusion and transfer to the neonatal intensive care unit. The exact circumstances of the delivery and death/injury of the babies is not known. High risk factor for home delivery: twins.
6. Patient at term delivered baby at home. The home birth provider was unable to deliver the afterbirth/placenta. The patient had increased bleeding after delivering the baby at home for "hours". The placenta is normally delivered in less than 30 minutes after delivery of the baby. By the time the ambulance was called, they could not get a blood pressure on the mother and they reported there was "blood everywhere". With IV fluids, her blood pressure came back and she was transported to the hospital in critical condition and required several emergent blood transfusions. The placenta was easily delivered in the hospital. High risk factor for home delivery: patient reported having "a lot of bleeding after baby came out" and anemia with her previous pregnancy. Patients who have a history of previous postpartum hemorrhage are at increased risk of it happening again.
7. Patient at term delivered at home with her provider. Baby was brought to the hospital with Group B Strep sepsis (overwhelming infection) hours after birth in critical condition. The standard of care for all pregnancies is to do a Group B Strep test on the mother at around 35 weeks. If the test is positive, to avoid neonatal sepsis, IV antibiotics are given in labor. Sadly, the baby died in the neonatal intensive care unit due to Group B Strep sepsis. High risk factors for home birth: Group B Strep testing status during pregnancy unknown.
8. Patient at term attempted home delivery. In labor at home for several days. Footling presentation (feet down) not detected by her home birth provider in labor. Patient brought to hospital with one leg protruding completely out of the birth canal. This presentation with ruptured membranes places the patient at risk for potentially catastrophic cord prolapse. Cesarean section done. High risk factor for home birth: Footling presentation not detected during labor.
9. Patient at term delivered at home. Baby was born with a severe and life threatening fetal anomaly. This serious and large anomaly was not detected prior to birth placing the baby at risk for further complications. High risk factor for delivery: serious fetal anomaly not detected prior to birth. A simple ultrasound would have easily detected this large anomaly and the mother would have been

advised to deliver at a hospital with a neonatal intensive care unit to properly care for baby at birth.

Several studies have outlined the risks of planned home birth and are summarized below. Of note, Canadian, U.K. and other non-U.S. studies are often quoted as supportive of safe home birth in low-risk patients. However, Canada, the U.K. and other European countries have national systems of healthcare that are very different from the U.S. For patient safety and to obtain the best outcome, they require formal education in obstetrics of all their providers, and specific and detailed safety protocols are followed regarding who qualifies for home birth (low-risk pregnancies). Due to their home birth provider's close relationship with hospitals, and the fact that these same providers also work in the hospital, they have an enhanced ability to recognize complications early (formal obstetrics education and hospital experience), and they are quick to transfer to hospital care when necessary and follow standard of care pregnancy protocols for all patients. Unfortunately, our U.S. healthcare system cannot be compared to these integrated systems of obstetrics care for home birth.

Important U.S. Studies on Home Birth Safety:

1. Term neonatal deaths resulting from home births: an increasing trend. Grunebaum A, Chervenak F, etal. Society for Maternal Fetal Medicine Annual Meeting - Abstract. February 7, 2014.
   In a new study presented on February 7, 2014, at the Society for Maternal-Fetal Medicine's annual meeting in New Orleans, researchers report that babies delivered at home by midwives have a roughly **four (4) times higher risk of death** than babies delivered by midwives in the hospital.
   This retrospective cohort study is the **largest single study of its kind to date**, and reviewed U.S. Centers for Disease Control and Prevention data on nearly 14 million births between 2007 to 2009. This included 100,785 out of hospital births (78,617 midwife deliveries and 22,168 deliveries by others). Researchers found that the risk of neonatal death (defined as within 28 days of delivery) increased to about **seven-fold if this was the mother's first pregnancy**, and increased to about **ten-fold in pregnancies beyond 41 weeks**.

2. Cheyney M, etal. Outcomes of care for 16,924 planned home births in the United States: the midwives alliance of North America statistics project, 2004 to 2009. Journal of Midwifery & Women's Health. January 30, 2014.
   Some providers quote the MANA (Midwives Alliance of North America) study as supporting home birth. However, reporting to this database by midwives is **voluntary**, therefore many "bad outcome cases" may not be reported to their database. Voluntarily excluding cases from any particular research study is not acceptable for any valid study and means it is very likely that all cases were not reported. On top of this, only 20-30% of the CPMs participated and of these CPMs all of their patients also did not participate. There is also no comparison group for this voluntary data. All this results in questionable statistics in terms of studying a population. Despite all of these study flaws, the actual neonatal death

rate they report with planned home birth was comparable with other U.S. studies that compared planned home birth vs. hospital birth, in other words comparable with the increased neonatal death risk with home birth.

3. Doser L, etal. Perinatal mortality of planned out of hospital births transferred to a hospital. American College of Obstetricians and Gynecologists Annual Clinical Meeting – Abstract 51. May 8, 2012.
   This retrospective cohort study examined the outcomes of planned home births that were transferred to an Oregon tertiary care hospital. These outcomes were compared to those of hospital births. Of the 223 cases of planned home birth transferred to the hospital, there were 8 neonatal deaths. There was a **3.5 fold increased risk of neonatal death** with planned home births vs. hospital births in this study. Of these 8 neonatal deaths: 3 babies were breech presentation, 4 cases had maternal hypertension, 5 cases had meconium, 2 cases were over 41 weeks, and 1 baby had congenital anomalies.

4. Wax JR, etal. Maternal and newborn outcomes in planned home birth versus planned hospital births – a meta-analysis. American Journal of Obstetrics and Gynecology 2010;203:243.e1-8.
   Meta-analysis of 12 studies on planned home birth vs. hospital birth that included 342,056 planned home births and 207,551 planned hospital births. They found about a 2-fold increased risk of neonatal death with planned home birth vs. hospital birth. If babies with anomalies were excluded, the neonatal death rate was almost 3-fold higher with planned home birth.

Hawaii ACOG is very concerned about patient safety in Hawaii's home birth setting. We have personally cared for patients who attempted home birth who have not been told of their home birth provider's formal obstetrics or newborn education and training, have not been told of the increased risk of neonatal death associated with planned home birth or what defines a high-risk pregnancy, are often not adequately screened during pregnancy as per the standard of prenatal care, and are not aware that there are no safety regulations in place to help ensure a safe and happy delivery outcome.

It is imperative that the mother's decision to do a planned home birth must be an **informed** decision that includes understanding their provider's education and training background in obstetrics and newborn care, the risks of home delivery (four-fold increased risk of neonatal mortality that rises to 7-fold if this is her first baby, and 10-fold if she is > 41 weeks pregnant), what constitutes a low-risk and a high-risk pregnancy, and that she may need to be transferred to the hospital if she becomes high-risk while in labor and should labor as near as possible to an obstetrics hospital in case of emergency.

Currently, about 26 states have laws legalizing direct entry midwives (i.e.-no nursing degree), specifically CPMs as home birth providers. Of these, all Washington state CPMs must complete formal education at a school accredited by their Department of Health. Three states, including New York, New Jersey and Rhode Island require all midwives to meet the standard of Certified Midwives (CMs), which requires formal

education. This CM formal education is more thorough and advanced than what CPMs who have formal education receive.

Formal education in obstetrics and newborn care is key to being able to recognize which patients are high-risk or low-risk. Risk status can change very quickly in obstetrics, and someone who was low-risk can become high-risk in a just a few minutes. If high-risk status is not recognized early and hospital transfer not quickly initiated, this can result in tragic consequences as demonstrated by our case list.

Without a formal obstetrics education, anyone would find it difficult to delineate a high-risk pregnancy. Some CPMs obtain their NARM (North American Registry of Nurse Midwives) certification through the presentation of a portfolio (at least 75 deliveries over the last 10 years, including 10 deliveries in the last 2 years, 50 prenatal patients and 50 newborn exams), and requiring no formal education. Having no formal obstetrics and newborn education is not conducive to good patient care. As we understand the American College of Nurse Midwives (ACNM) position, they also recognize this dilemma with regards to CPMs and support allowing only CPMs with formal education at an accredited institution to perform obstetrics. The differences between CPM and CNM education is eloquently described in a 2009 letter from ACNM to Congress (see pages 10-11 of this testimony). We agree and urge you to make amendments to SB2569 regarding the licensing of CPMs who have had a formal education at a Midwifery Education and Accreditation Council (MEAC) accredited school.

For the safety of the mother and baby, only women with low-risk pregnancy should consider a home birth. Risk status can change very quickly, in just a few minutes, so vigilance, knowledge, and quick and reasonable transport to the hospital when risk status changes is key.

The diagnosis of high-risk pregnancy is complicated and the list is long and includes, but is not limited to the following conditions or events that require timely recognition and transfer to either a physician or hospital:
Breech
Transverse lie
Oblique lie
Footling breech
Funic presentation
Face presentation
Military presentation
Compound presentation
Non-vertex presentation
Multiple gestation – twins and higher
Twin-twin transfusion syndrome
Abnormal QUAD screen or other screening tests
Illicit drug use
Placenta previa
Placenta accreta/increta/percreta

Vasa previa
Decreased fetal movement
Intrauterine Growth Restriction
Oligohydramnios
Hydramnios
Congenital fetal anomalies
Single umbilical artery
Group B Strep positive
HIV positive
Hepatitis
Preterm labor
Preterm premature rupture of membranes
Cardiac disease
Previous stroke
Cancer
Diabetes
Thyroid problems
Chronic hypertension
Chronic kidney disease
Severe anemia
Thalasemia
Morbid obesity
Eating disorders
History of previous preterm labor
History of previous incompetent/insufficient cervix
Other medical problems
Preeclampsia
Ecclampsia
HELLP syndrome
Feto-maternal hemorrhage
Abdominal trauma
Placental abruption
Previous Cesarean section
Previous hysterotomy
Previous bariatric surgery
Pregnancy < 37 weeks
Pregnancy > 41 weeks (10 – fold increased risk of neonatal death)
Intractable headache
Pyelonephritis
Amniotic Fluid embolism
Pulmonary embolism
Cord prolapse
Non-reactive NST or poor BPP
Persistent variable decelerations
Loss of fetal variability or accelerations
Late decelerations

Prolonged deceleration
Peripartum cardiomyopathy
Fever in labor
SOB in labor
Chest pain in labor
Severe abdominal pain in labor
Chorioamnionitis
Meconium
Arrest of cervical dilation/progress in labor
Prolonged second stage of labor
Moderate to heavy bleeding during labor
Ruptured uterus
Postpartum hemorrhage or history of postpartum hemorrhage
Retained placenta (requires manual removal and/or D&C in hospital)
Extensive lacerations requiring repair
Greater than 2nd degree lacerations
Cervical laceration
Neonatal distress (bradycardia or no respiratory effort)
Neonatal tachycardia or bradycardia
Neonatal fever
Neonate with persistent grunting
Other

Although the hospital is the safest place for birth, we respect the right of a woman to make an informed decision to opt for a planned home birth, but this must be a true medically informed decision. We have personally seen the tragic preventable outcomes and cared for these patients in the hospital. We respectfully ask lawmakers, if we can prevent even one unnecessary death or serious neurologic injury to a baby, isn't it worth this effort?

To ensure that all of Hawaii's mothers and babies have a safe and happy birth experience, we urge you to support the Home Birth Safety bill SB2569 with amendments as noted in this testimony. This bill will ensure that home birth providers have had formal obstetrics education to care for mothers and infants, follow patient safety regulations such as no high-risk pregnancy deliveries at home, adequately inform their patients regarding their educational background and the possible risks of home birth, and require the timely completion of birth certificates and other data for all planned home births.

Thank you for the opportunity to submit testimony on this important patient safety issue. Please contact us if you require any further information.

Proposed Amendments to SB2569:
Bold = Add
~~Cross out~~ = Delete

Addition of Certified Professional Midwife (CPM) with formal education from an MEAC-accredited institution:
Page 3, Line 16
"…obstetrics, **certified professional midwife,** or naturopathic physician that has met the…"
Page 5, Lines 13 – 15:
"…(1) Two certified nurse midwives or certified midwives, as may be recommended by the Hawaii Chapter of the American College of ~~Certified~~ Nurse Midwives **and two certified professional midwives licensed in the state of Hawaii.**"
Page 7, Line 15:
"…by the American Midwifery Certification Board **or holding certified professional midwife certification obtained through formal education from a Midwifery Education and Accreditation Council (MEAC) accredited institution;**"
Page 7, Line 22:
"Medicine;
(E) A certified professional midwife certified through the North American Registry of Midwives (NARM) via formal education at an MEAC accredited institution;"
Page 8, Line 22:
"and approved by the board; **or**
(D) documentation of certification by NARM via formal obstetrics education at an MEAC accredited institution;"

Based on recent data released a few days ago (see page 4 of this testimony, Study #1 Grunebaum, etal), the risk of neonatal death associated with planned home birth vs. hospital birth increases by 10-fold over 41 weeks. Revising gestational age that defines low risk to less than 41 weeks gestation based on recently released data:

Page 19, Line 12:
"…thirty-seven and **forty and six/sevenths** ~~forty one and six/sevenths~~"

July 15, 2009

Dear Members of Congress,

It has come to our attention that members of Congress will be asked to consider an amendment providing for federal recognition under the Social Security Act (SSA) of Certified Professional Midwives (CPMs). On behalf of the American College of Nurse-Midwives (ACNM), I am writing to inform you that ACNM opposes this recognition because individuals holding the CPM credential lack a uniform minimum standard of accredited academic education.

There is no precedent for extending federal recognition under the SSA to a class of health care providers who have not graduated from an accredited educational program or institution. **Until the CPM community has developed a uniform process to ensure that all CPMs have graduated from an accredited education program, Congress should not recognize this class of provider in its entirety.**

Understanding Midwifery Credentials
There are three certifications in midwifery practice in the United States.

- **Certified Nurse-Midwives (CNMs)** recognized under §1861(s)(2)(L) of the Social Security Act since 1988, and licensed with prescriptive authority in all 50 states, CNMs' broad scope of practice includes primary care and gynecologic care to women of all ages as well as care during pregnancy and childbirth in all birth settings. CNMs are required to graduate from an academic program accredited by the Accreditation Council for Midwifery Education (ACME), which has been recognized by the US Department of Education (USDE) as an accrediting body since 1982. CNMs are certified by the American Midwifery Certification Board (AMCB). **As of January 1, 2011, a graduate degree is required for entry into clinical practice for CNMs.**

- Since 1996, the **Certified Midwife (CM)** credential has enabled individuals without a nursing background to pursue a career in midwifery. Like CNMs, CMs graduate from an ACME-accredited program and are certified by AMCB; they must meet the same core competencies and standards of practice as CNMs, and **as of January 1, 2011, are required to hold a graduate degree for entry into clinical practice**. The American College of Nurse-Midwives is working to gain broader state recognition of CMs as well as federal recognition under the SSA. There are nearly 12,000 combined CNMs and CMs in the US today.

- **CPMs** come from a variety of backgrounds and have a narrower scope of practice and education than CNMs /CMs. In most of the 23 states in which they are licensed, CPM practice is limited to the provision of maternity care services for out-of-hospital births. Two different educational pathways

are available to those seeking certification as a CPM by the North American Registry of Midwives (NARM): (1) graduation from an academic program accredited by the Midwifery Education Accreditation Council (MEAC), or (2) completion of apprentice training which does not have MEAC accreditation. According to CPM leaders, at least half of the estimated 1400 CPMs are apprentice-trained.

Like most certifying bodies, NARM is accredited by the National Organization for Competency Assurance's National Commission for Certifying Agencies**. This accreditation reflects an approved testing process and a psychometrically sound exam. Accreditation of the certifying body, however, is not the same as requiring graduation from a formal accredited educational program prior to taking the certification exam.**

The Role of Educational Accreditation in Quality Assurance

Accreditation is a non-governmental, peer evaluation process which serves to assure the quality of education in the United States. In health care, educational accreditation, professional certification, and state licensure each play an essential complementary role in assuring that health professionals are educated and competent to practice. The some functions of accreditation include:

- Verifying that an institution or program meets established standards;
- Assisting prospective students in identifying acceptable institutions;
- Protecting an institution against harmful internal and external pressure;
- Raising the standards of educational institutions;
- Involving the faculty and staff comprehensively in institutional evaluation and planning; and
- Establishing criteria for professional certification and licensure and for upgrading courses offering such preparation.

By statute, the USDE is required to publish a list of nationally recognized accrediting agencies deemed to be reliable authorities as to the quality of education or training provided by the higher education programs and institutions they accredit.

Midwifery Education in the Global Context

The US should promote the highest standards for the education of health care professionals—not lower standards than those of other countries. In its 2009 document "Global standards for the initial education of professional nurses and midwives," (www.who.int/hrh/nursing_midwifery/hrh_global_standards_education.pdf) the World Health Organization (WHO) has recommended standards for nursing and midwifery programs. The document calls for midwives to be educated at an accredited university program that is part of a higher education accredited institution and has criteria that meet accreditation standards for both clinical practice and academic program components.

Similarly, WHO recommends that core midwifery academic faculty be knowledgeable as educators and hold a minimum of a bachelor's degree (preferably a graduate degree). Clinical faculty should include midwives and other health professionals with a university degree and clinical and educational expertise, and midwifery schools validate clinical and educational expertise and competency of faculty and provides faculty with professional development opportunities.

To:
The Honorable Josh Green, Chair Committee Members of Health
The Honorable Roz Baker, Chair Committee on Commerce and Consumer Protection
The Honorable Clayton Hee, Chair Committee on Judiciary and Labor

Members, Senate Committee on Health
Members, Senate Committee on Commerce and Consumer Protection
Members, Senate Committee on Judiciary and Labor

Hearing: February 10, 2014, 1:30 pm, Room 229

Re: SB 2569 and SB 2569 SD 1, Relating to Home Birth
{IN OPPOSITION}

Good afternoon Chair Green, Chair Baker, and Chair Hee:

Thank you for the opportunity to offer testimony in opposition of SB 2569 and SB 2569 SD 1. My name is
SELENA M. GREEN, CPM AND PRESIDENT OF MIDWIVES ALLIANCE OF HAWAI'I (MAH)

Midwives' Alliance of Hawai'i (MAH) was founded as a non-profit organization in May 1993 by a group of Direct-Entry Midwives (DEM). Since that time, MAH has expanded to include Certified Professional Midwives (CPM), Licensed Midwives (LM) and Certified Nurse Midwives (CNM) along with supporters from various homebirth providers and many families. Most of the current board members have participated in a national certification process offered by either the North American Registry of Midwives as a Certified Professional Midwife(CPM) and/or the American Midwifery Certification Board as a Certified Nurse-Midwife (CNM). Our current board of CNMs, CPMs, and birth workers are pleased to work side by side in our efforts to provide access to safe, quality childbirth practices to the families we serve in the State of Hawaii.

Some background Bill information: In 1998, MAH introduced Bill #3123 in both the State House of Representatives and Senate. This bill proposed licensure for Certified Professional Midwives in the State of Hawai'i. The Senate did not pass the bill, and instead requested a Sunrise Analysis to assess the probable effects of regulation and which state agency would be best suited to implement any regulation. The ***Sunrise Analysis of a Proposal to Regulate Certified Professional Midwives*** was performed by the State of Hawaii's Office of the Auditor, and concluded that CPMs and lay-midwives should be regulated, but that the bill "raises concerns that must be addressed before any regulation is enacted". Since that time, no efforts have been made to further this bill.

MAH is now in her 20th year and is currently re-structuring and setting new goals as we work toward a brighter future for midwives and home birth in the Hawaiian Islands. SB2569 and SB2569 SD1 is not the way to do this! We must oppose these bills.

Hawaii should be leading the way in fostering diversity, collaboration, and culturally appropriate maternity care, not following the backward examples of states with a long history of denying women access to the care providers of their choice.

SB 2569/SD 1 will not guarantee home birth safety with over-regulation nor will it foster better collaborative care between providers, in the event of a hospital transfer.

SB 2569/SD 1 fosters fear and restricts the rights of families to deliver their keiki in settings that feel true to them and with the attendants they choose.

SB 2569/SD 1 unduly burdens the state with over-site and professional accountability that should be self-organized and self-governed by the midwives themselves who have set their own evidence based practice guidelines and understand the midwifery model of care the best.

SB 2569/SD 1 further endangers traditional practitioners of birth and cultural keepers of midwifery skill sets that are attempting to make a return through formalized apprentice model of learning.

As Policy makers you MUST honor the deep and informed investment women make in their health and in their choices to birth with whom and where. A woman's birth sovereignty and bodily autonomy is a foundational human right. Laws should be crafted to uphold this principle.

It is the right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. This bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose.

Our recommendation is as follows: Let the home birth community form their own advisory counsel with all birth practitioners represented - CPM, CNM, ND, Direct Entry, Traditional midwives, OB, Family Practitioners etc to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

Amending SB2569 OR SB2569 SD1 is **NOT** an option. Both bills are too flawed to correct given the time constraints of the legislature. A complete overhaul of these bills must ensue. Our women and families deserve better.

Mahalo nui loa.

Selena M. Green, CPM, President
Midwives Alliance of Hawai'i

Statement of Mercedes-Nicole K. Ritte, Founder, The MOM Hui
Hearing on Senate Bills 2569 & 2569 SD1 Relating to Home Birth
Before HTH/CPN/JDL Committees
Saturday, February 8, 2014

To: Senator Josh Green, Senator Rosalyn Baker, Senator Brian Taniguchi, Senator Clayton Hee, and Senator Maile Shimabukuro

The Moms On a Mission Hui (The MOM Hui), founded in May 2013, is a statewide grassroots group of forward thinking mothers who advocate for protecting the health, safety, and well being of all children, present and future.

The MOM Hui **OPPOSES** Senate Bills 2569 & 2569 SD1 relating to home birth.

According to the journal of Midwifery and Women's Health peer-reviewed study "Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009," the largest analysis of planned home births in the United States ever published, states:

- Contrary to the statement "national data reports a two to three fold increased risk of neonatal mortality with planned home birth versus hospital birth," this study confirms that among low-risk women, planned home births result in low rates of interventions without an increase in adverse outcomes for mothers and babies.

- The Midwives Alliance North America (MANA) Statistics Registry, confirms the safety and overwhelmingly positive health benefits for low-risk mothers and babies who choose to birth at home with a midwife.

- Women who planned a home birth had fewer episiotomies, pitocin for labor augmentation, and epidurals.

- Ninety-seven percent of babies were carried to full-term, they weighed an average of eight pounds at birth, and nearly 98% were being breastfed at the six-week postpartum visit with their midwife. Only 1% of babies required transfer to the hospital after birth, for non-urgent conditions.

- Data was contributed by **432 different midwives**, including: certified profession midwife, licensed midwife, licensed direct entry midwife, certified nurse midwife (CPMs/LMs/LDMs/CNMs/CMs), naturopathic midwives, **un-licensed direct-entry midwives**, and **others**.

We feel the proposed bill ultimately eliminates a woman‘s/mother‘s right to decide who they want as a home birth team/partner and their decision to individualize their prenatal, birth & post-partum plan according to her desire. Unfortunately this bill is also unfairly set up to criminalize midwives who currently deliver babies independently.

Respectfully,

Mercedes-Nicole K. Ritte

The MOM Hui - Founder

Nā Alaka‘i, Kauai
Lorilani Keohokalole-Torio
Chelsey Contrades

Nā Alaka‘i, O‘ahu
Mitsuko Hayakawa
Trisha Alari-Gonsalves

Nā Alaka‘i, Maui
Ann Evans
Faith Ewbank

Alaka‘i, Kona
Shaula Tualaulelei

"What We Love, We Will Protect!"
P.O. Box 13 Kualapuʻu, Hawaiʻi 96757
Ph: *808-213-1021* ***Website:*** *www.theMOMhui.com* ***Email:*** *admin@theMOMhui.com*

From: Dee Anne Domnick
To: HTHTestimony
Subject: SB No. 2569 & S.D. 1
Date: Sunday, February 09, 2014 1:22:44 PM

To Whom it may concern;

I am in favor of wise midwifery regulation, however, the regulatory Bills that have recently been submitted are not appropriate.

I would like to provide verbal testimony in opposition to SB-2569 & S.D.1 tomorrow, (Feb. 10, 2014) regarding home birth, at the 1:30pm hearing. Please put me on the list of those to testify.

Thank you for this opportunity,

Dee Anne Domnick, Director
Barefoot Doctors' Academy
DoulaCare Hawai'i
North Kohala Red Cross

Sent from my iPad

2/9/14

Respectfully, Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

RE: SB2569 and SB2569 SD1 Relating to Home Birth

To begin with I want it to be known that I OPPOSE both bills emphatically.

I believe in home births. Both of my beautiful, and healthy baby girls were born at home.

This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for. I believe that midwives are more skilled and adept at handling unusual births due to the fact that they have experience which doctors don't have due to their reliance on C-sections.

Let the people decide! Let the home birth community form their own advisory council with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc. to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

Thank you for your time and consideration,

Sincerely and with respect,

Kristina Domanski

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	laulani@gmail.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Sunday, February 09, 2014 1:14:10 PM

SB2569

Submitted on: 2/9/2014

Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Laulani Teale	Individual	Oppose	Yes

Comments: I strongly oppose both versions of this measure. I will be submitting testimony in opposition to both measures. This shall serve as my request to testify in person on the first measure, SB 2569. My testimony and request to testify in person on SB 2569 SD1 is forthcoming. Mahalo nui loa!

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

Do not reply to this email. This inbox is not monitored. For assistance please email webmaster@capitol.hawaii.gov

From:	Nina Millar
To:	HTHTestimony
Cc:	alohabirth@hawaiiantel.net
Subject:	Opposition for SB2569 and SB2569 SD1
Date:	Sunday, February 09, 2014 1:15:10 PM

To our Honorable Senators and those it may concern:

Please accept my testimony in opposition to SB2569 and SB2569 SD1.

As a practicing direct entry midwife of thirty five years, I have been serving women and their families here in Hawaii for the last 30 years. While I agree with licensing direct entry midwives, these proposed bills greatly restrict the rights of pregnant women and the availability of qualified attendants.

I will be attending the hearing of this legislation, February 10, 2014 at 1:30PM.

With due respect,

Nina Millar, RN, CPM
Box 1132
Honokaa, HI 96727
alohabirth@hawaiiantel.net

REGULAR SESSION OF 2014

For: Honorable Senate Committee Health Chair Green, CPN Chair Baker , JDL Chair Hee and Committee Members,

Hearing 2/10/14 1:30 pm (date) Rm 229

RE: **SB 2569 Relating to Home Birth AND SB 2569 S.D. 1 – IN OPPOSITION**

Aloha honorable chairs and committee members,

My name is James Kimo Greene and I am a strong advocate of home birthing and the human rights movement.

I strongly oppose SB 2569 and SB 2569 SD1

Members of the Hawaii Legislature session 2013, it is simply not your right to tell mothers with whom, how or where they can birth their child!

I know first hand that the primary concern of practitioners who are attending mothers having their babies at home are for mothers and babies welfare and safety.

Legislators trying to regulate home birth practitioners is a bad idea. Only the home birth community can regulate themselves, and they do. Look at the research. Home birth has and still is as safe and probably much safer than hospital births.

For these reasons and many more, please kill this bill NOW.

Aloha,
Kimo Greene

From:
Lea Minton, MSN, Certified Nurse Midwife
Constituent, Senate District 23

To:
Senator Josh Green, Chair Committee on Health; Members, Senate Committee on Health

Senator Roz Baker, Chair Committee on Commerce and Consumer Protection; Members, Senate Committee on Commerce and Consumer Protection

Senator Clayton Hee, Chair Committee on Judiciary and Labor; Members, Senate Committee on Judiciary and Labor

Hearing: February 10, 2014, 1:30 pm, Room 229

Re: SB 2569 and SB2569 SD1, Relating to Home Birth

Dear Senator Green, Senator Baker and Senator Hee,

I was born on Kaua'i into the loving hands of a midwife, in the safety and comfort of my parents home, even though my birth certificate reads "Birth Attendant: Father." I was raised to believe that birth is a normal process of our female bodies, that it is an event to be respected and supported and that it is a personal choice that each of us get to make as to where we want to be when we birth, and who we want surrounding us.

In my life path, when I came upon the decision to go into the health care field, I knew that the midwifery model of care was a perfect fit for me, and so I decided to become a midwife instead of a doctor. I feel it is important for our legislators to be reminded that we midwives came to this field not because we aren't smart enough to be doctors, but because we strongly believe in the midwifery model of care. We specialize in normal – the only specialty in health care in this field. We practice evidence based, culturally sensitive maternity care; we do not practice fear based medicine. We spend time educating our women and their families, helping to empower them with knowledge so that they can tell us what is best for them because they are the ones who know their bodies and their life circumstances. We listen attentively to women and we spend time to help them heal past transgressions that take a toll on their bodies, often bubbling to the surface during pregnancy and birth. We are deeply touched when our patients tell us things like "You didn't just help me, you took care of my whole family" because that is what we strive to do every day. That statement was made by one of my empowered mothers, one of the many mothers that I am asking you to protect today.

SB2569 and SB2569 SD1 do not protect our mothers and our babies of Hawai'i. Instead, these bills attempt to smother the voices of our women and families and disregard the knowledge that they hold about their health, their bodies and their rights. I understand that we as a community are looking to regulate out-of-hospital birth practices, with the intent to provide consumers a tool to help them in their decision making when selecting a provider. A state license is the most common tool used to quickly inform consumers, entities such as hospitals, and other providers that a specific health care practitioner is minimally competent and has met the education requirements in their field. The rest of that knowledge is often gained through word of mouth, resumes or in meeting with the provider – all of which are currently utilized by out-of-hospital birth consumers. I agree that we should provide the consumers with the additional tool of licensure, as it communicates that the provider has met national education and training standards, that they maintain current knowledge through continuing education, and that they will be disciplined appropriately if they do not protect and respect their client's health. However, SB2569 and SB2569 SD1 do not follow evidenced based law in creating this license for out-of-hospital midwives.

SB2569 and SB2569 SD1 contradict themselves from the opening statements throughout the bill bodies. SB2569 waxes long on erroneous statements not backed by any statistics provided, and are based on well known studies that have long been debunked. The fact that we would allow our laws to quote such inaccuracies and misinform our women, when the intent is for them to make informed choices, is shocking. Power and control tactics,

shunning of the consumer, discriminatory rules, and support of unsafe practices are rampant throughout both bills and are not lost on anyone in the birth community. These bills require midwives to be knowledgeable, to the standards of their training and education, yet disrespect and strip midwives of their practice.

I am aware of all of the inaccuracies, contradictions , violations and abuses that lie within SB2569 and SB2569 SD1. I'm also acutely aware of the fact that midwives were not invited to the table to help draft a bill being introduced to regulate their profession. SB2569 attempts to regulate my profession, certified nurse-midwives, which is already regulated by the state under the Board of Nursing (BON), yet the BON was never approached to discuss this bill. I'm quite sure if the BON introduced a bill to regulate OB/GYNs and bring them under the BON, that ACOG would be insulted professionally that we should disrespect their training, education, national standards, state recognition, and current licensure. SB2569 SD1 attempts to regulate certified professional midwives, whom specialize in out-of-hospital birth, but it fails miserably. Legislators decided to borrow a bill from another state and are now trying to impose it on our state, which has many cultural practice differences. It then edited the bill while it was posted and open for testimony to the public, without notifying the public of changes by either posting a new draft number or detailing changes with strikethroughs and underlining. Once again, midwives were not consulted or allowed to contribute to a bill regulating their profession all while the bill disregarded their training, education and practice standards.

SB2569 and SB2569 SD1 do not support women in their choice of where and with whom to birth, nor do they help them make an informed decision. I know that we all want the same thing – healthy mothers and babies, and I know that the state and the birth community want to provide mothers and families with a tool to help them in their informed decision. I also know that we need to take a breath, recognize that the direction we're heading is not achieving our goals, and regroup with open communication between all affected parties. Importantly, we need midwives to lead this discussion, because they know their profession and certification better than anyone, just as women know their bodies and minds better than we do. We need to support our women and families.

I strongly urge you to join me in OPPOSING SB2569 and SB2569 SD1. I welcome you to contact me with any questions and look forward to a continued discussion regarding the support of our women's right to choose.

Sincerely,
Lea Minton, MSN, CNM

REGULAR SESSION OF 2014

For: Honorable Senate Committee Health Chair Green, CPN Chair Baker , JDL Chair Hee and Committee Members,

Hearing 2/10/14 1:30 pm (date) Rm 229

RE: **SB 2569 Relating to Home Birth AND SB 2569 S.D. 1 – IN OPPOSITION**

Aloha honorable chairs and committee members,

My name is Dr. Lori Kimata, I am a fourth generation Hawaii resident., attended Punahou for 13 years, UCLA for 4 and National College for four years and my medical degree. I have been a licensed naturopathic physician and a midwife now for over twenty four years, and have been assisting mothers in having their babies at home since 1985. I have been the past-president of the Hawaii Society of Naturopathic Physicians and have sat on the board of the American Association of Naturopathic Physicians, our national organization. Chap 455 licensing naturopathic physicians has been existence in Hawaii since 1925.

I strongly oppose SB 2569 and SB 2569 SD1 for the following reasons.

1. On its face, this bill is inaccurate. It cites a flawed study, and it suggests home birth is dangerous and unsafe. I join other home birth practitioners, mothers and advocates to correct that notion. We realize that we have a responsibility to provide data and information about our home birth practices, our training, and our experiences to the legislature and community-at-large. Home birth is as safe or safer than hospital birthing.

2. This bill currently tries to define a scope of practice without an in depth understanding of the various practitioners, roles and responsibilities involved in home birth. The medical hospital-based model it imposes doesn't take into account the population it is regulating and doesn't accurately represent the different midwifery models of home birthing, each with

unique traditions, scopes of practice, varying types of practitioners and their educational backgrounds, safety protocols and standards of care that are already in place.

3. The Home Birth Safety Board outlined in SB 2569 is based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth practice. This bill assumes there is no oversight over home birth; in fact, midwives have the capacity to govern themselves. The board outlined in SB 2569SD1 is simply incomplete.

4. As written, both versions of this bill are divisive and criminalizes some midwifery practices. It is the rite/right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. Furthermore, this bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose.

5. Home birth is a deeply cultural practice that is both respected and honored. We are all descended from an ancestor who gave birth at home. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.

For all of these reasons and more, I strongly oppose this bill as it stands. The imposition of these state regulations simply does not take into account the important perspectives of the birth practitioners, the mothers, and advocates of home birth.

Yet, we recognize the need for more information and offer the following:

- We have already begun to form a Home Birth Council that reflects the variety of practices, mothers and advocates. This Council shall be self-defined and self-regulated.
- We request the opportunity to gather data, standards of care, and wise practices to present before the legislature at a later date.

Sincerely,

Dr. Lori Kimata ND, midwife

From: mailinglist@capitol.hawaii.gov
To: HTHTestimony
Cc: pococompehos@yahoo.com
Subject: Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date: Sunday, February 09, 2014 12:49:23 PM

SB2569

Submitted on: 2/9/2014
Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
poco compehos	Individual	Oppose	No

Comments: This testimony is in OPPOSITION to SB2569 SD1 Comments: Birth is a sacred event that deserves a sacred space of the family's choice. To be so proud of the two home births of my children,now a healthy 11 and 8 years of age, and to have assisted in being the first to hold and see my babies, it concerns me when these opportunities are threatened. Finding and creating sacred space is essential to my family's health happiness and security. I feel this bill causes unnecessary interference of choices families should be able to make. It's especially important that my daughter has the ability to practice her family's tradition and create the sacred space of her choice in which to give birth when the times comes. I ask that you be respectful of the ancient knowledge and traditions of all cultures and birth mothers statewide. I peacefully ask that you do not pass ANY version of the bill sb2569 OR sb2569sd1.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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Honorable Chair and Senate Committee members of Health, Commerce and Consumer Protection and Judiciary and Labor

Testimony regarding SB 2570, 2569, and 2569 SD 1
Senate Hearing February 10, 2014, 1:30 PM, Room 229

I oppose these bills as being premature and reflexive. The reason that this bill is premature, is that there is not enough data on which providers are assisting with home births, and what the outcome data are compared to hospital births. I propose a year study to actually bring the legislators up to speed on this complex issue and practice. These bills are reflexive because they were seemingly initiated in quick response to a lack of safety which may not even exist. We don't even know if the type of regulation being suggested is even necessary. My wife gave birth to two healthy babies at home after a c-section in the hospital. I feel that she was better taken care of at home than in the hospital. These bills will restrict the choice of consumers to choose their own birth plan. Hawaii is supposed to be at the forefront of health care choice

In addition, this practice is already regulated, at least in part. Naturopathic physicians who have taken advanced courses and have interned at a significant number of births already assist with home births under the Naturopathic Statute (Chapter 455) and rules.

Creating an advisory board under the medical board is clearly obstructive, as very few, if any, medical doctors perform home births, and their expertise, while great, does not cover the philosophy and practices of home birth. If such an advisory board is deemed necessary after a study of the issue, the makeup of the advisory board should be more carefully considered. As the home birth providers are licensed under several different professions, the creation of an advisory board is a very complex issue, with respect to regulation of these providers.This complexity is part of the current landscape, and provides parents a great deal of choice. This choice should be respected, as the goal of statutes should be to provide safety within the framework of free choice as much as possible.

Thank You for reading my testimony,

Sincerely,

Jack Burke, ND, LAc.

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

Hearing date 2-10-14 1:30pm room 229

RE:SB2569 SD1 Relating to Home Birth

Opposed

Please refer to my written testimony on SB2569, which I have already submitted. In addition to the points I have made in that testimony, I would like to add the following comments in regards to the amended version of the bill. I oppose this bill because the amendments do not change the fact that it has:

1. been written without understanding of or education on the midwifery model of care.
2. continues to subordinate midwives under the Hawaii medical board.
3. the scope and practice standards are based on a medical model of care, which is contradictory to the choices of home birth families.
4. it divides the home birth community, acknowledging certain types of care givers while criminalizing others. This amounts to arresting grandmas for helping their families in their traditional cultural roles, while creating unnecessary state oversight which is difficult and costly to enforce.
5. Furthermore, and most importantly, this amended bill does not respect the rights of mothers to make choices for themselves. It continues to restrict the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislature's right to decide how and where someone can birth.

We are all interested in safety. Unfortunately, this is not what this bill will provide. The legislature does not have to resort to passing a rushed and poorly written bill which includes multiple misinformation, and a strange mixture of conditions. Passing this bill into law will profoundly effect women's reproductive rights for many generations. I ask that the committee members seriously consider the ramifications of this choice.

Instead, why not allow all birth practitioners: Naturopathic Doctors, Certified Professional Midwives, Certified Nurse Midwives, Direct Entry and Traditional Midwives, Obstetricians and Family Practitioners to dialogue, gather data and form appropriate guidelines to ensure safety and quality of care across the entire spectrum of birth choices? This legislature has the opportunity to author a bill which could stand as a shining example and model for other states, if they are only willing to give it the time and effort required.

Thank You,
Tara Compehos

February 9, 2014

I am writing in opposition to SB 2569 and SB 2569 SD1. My wife and I recently celebrated the birth of our first child. In the months leading up to the birth, my wife researched the different birthing options available to her on Kauai. She chose to deliver our child at Home Birth Kauai in Wailua. The midwives at the birthing center are licensed and have years of experience in the field. The experience we had with Home Birth Kauai was one that we will remember for a lifetime. From the day we first walked in the door as an expecting couple, we knew that we were in good hands. All of our prenatal visits came with the same equipment and level of expertise as would be found in a hospital. In the days leading up to my wife beginning labor, the licensed midwives monitored her closely and provide her with the support she needed as the anxiety of experiencing childbirth grew. When labor finally came, we were welcomed into the birthing center by a team of licensed midwives that watched her closely every step of the way. The warmth of our surroundings gave a comfort to my laboring wife that could not have been accomplished in any hospital. I have no doubt that my wife's experience bringing our little girl into the world would have been far more unpleasant had she chosen to give birth in a hospital.

SB 2569 seriously threatens my wife's ability to choose the same birthing plan with our future children. While it claims to be an attempt to make home births safer, safer births will simply not be the result. In reality, what this bill will do is limit the freedom of women in Hawaii to make their own choices regarding the birth of their children. These bills create a system which will make it vastly more difficult for midwives to practice in the state of Hawaii. Women who are lucky enough to survive the bureaucratic hurdles and be approved for home birth may find that their licensed midwife of choice has been forced out of business by government overreach. These women will be forced into an already overwhelmed hospital system, leaving fewer professionals to attend to even more births. This is not a formula for safer births in Hawaii.

I urge you to reconsider the false assumption that home births are unsafe. The data presented as evidence in support of this bill is questionable at best. The stakeholders of hospitals have a vested financial interest in denying pregnant women the freedom of choice in their prenatal care. For the good of the families of Hawaii, please kill SB 2569 and SB 2569 SD1.

Sincerely,

John Kaley
5170 Apelila St.
Kapaa, HI 96746
808-652-9878

To: Honorable Chairs, Vice-Chairs and Committee members of Health, Commerce and Consumer Protection and Judiciary and Labor

From: Fawn Jade Koopman

RE: Testimony in opposition of SB2569 and SB2569 SD1
Relating to Home Birth

Hearing: Monday, February 10, 2014 1:30pm
State Capitol, Room 229

Chairs, Vice-Chairs and members of the Committee on Health, Commerce and Consumer Protection and Judiciary and Labor:

Thank you for this opportunity to testify. I am writing in strong opposition to SB2569 and SB2569 SD1, Relating to Home Birth. This legislation seeks to establish licensing, certification and registration requirements for home birth practitioners while restricting the rights of women and families to deliver their children in the home and with the attendants they choose. It creates these regulations without the understanding the education, protocol and practices already established by our birthing community.

The home birth practitioners in our community are dedicated to safety and quality care. Yet, this is not what this bill will provide. There is absolutely no data that home births are any less safe than hospital births. In fact, hospital births are more likely to induce labor, and perform Cesarean operations and episiotomies. These procedures are occurring at alarming rates in our society and often in cases where there is no medical necessity. The medical birth model is based upon the intervention and circumvention of the natural birth process. If safety is truly the impetus for this legislation, we ask for a full study on the safety risks of both models and an informed dialogue before imposing the regulations and restrictions contained in this legislation.

While SB 2569 SD1 attempts to move in the right direction in its preamble, it still largely fails to honor the personal choice of birthing mothers and families and severely curtails the authority of their chosen midwifery provider. Further, SB2569 SD 1 fails to recognize the range of practitioners for appointment to the Home Birth Board. Community members are not named to the board, nor are traditional birth practitioners.

There is a personal, political, and spiritual significance to birth. Home birth is also a time-honored and deeply cultural practice. It belongs to the culture of women. This bill restricts the rights of women and families to deliver in the home and with a birth attendant of their choice. It limits our control over our bodies, our ability to plan for our families and to safeguard our health. Legislation that specifically limits women's bodily autonomy is at the core of systematic discrimination against women. As an activist, feminist and attorney, I truly believe that law is a tool for social change. I believe we can change women's status through a reworking of the law and its approach to gender. Yet,

this legislation is a significant step in the wrong direction for the advancement of women rights in our community.

Neither version of this bill should pass in its current state. Allow the home birth community to form their own advisory counsel with all birth practitioners represented including: N.D., C.P.M., C.N.M., Direct Entry, Traditional Midwives, OB-GYN, and Family Practitioners. Allow us to gather data, conduct a survey, and begin a dialogue to form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

For these reasons I oppose SB2569 and SB2569 SD1 and respectfully urge the Committees not to pass this measure.

Thank you for the opportunity to testify,

Fawn Jade Koopman

From:	Clement Akina
To:	HTHTestimony; HMS Testimony
Subject:	OPPOSE SB2569 & SB2569 SD1
Date:	Sunday, February 09, 2014 12:42:01 PM

Aloha, I am writing in opposition to the following bills:

SB2569 AND SB2569 SD1 set for hearing on Monday February 10, 2014 at 1:30pm, conference room 229.

I am writing for my wife's right and the right of ALL women to birth where they choose, under the care provider(s) of their choice. **It is illogical** to create a**"home birth board** to adopt rules and protocols for midwives and licensure of midwives**" that does not consist of home birth midwives,** and instead, of providers that follow medical-led care that have NO experience in home birth. There is a stark contrast between the medical-led care that is conventional and the traditional midwifery model of care:
-This link will inform you **about the midwifery model of care**: http://www.mana.org/about-midwives/midwifery-model.
-And, this link will inform you on **the benefits of the midwifery model of care**: http://www.medscape.com/viewarticle/810005).

According to the CIA & WHO, in 2010, the USA tied 48th with Iran in Maternal Mortality with 21 deaths per 100,000. **Yet, less than 2% of babies are born at home in the U.S.**, indicating that the interventions, high cesarean section rates, and dehumanizing of birth that take place in hospitals, under the medical-led care, is having serious consequences. (https://www.cia.gov/library/publications/the-world-factbook/rankorder/2223rank.html AND (http://www.who.int/gho/maternal_health/countries/en/#U)

Quoted from Amnesty International: "The USA spends more than any other country on health care, and more on maternal health than any other type of hospital care. Despite this, women in the USA have a higher risk of dying of pregnancy-related complications than those in 49 other countries, including Kuwait, Bulgaria, and South Korea...Maternal deaths are only the tip of the iceberg. During 2004 and 2005, more than 68,000 women nearly died in childbirth in the USA. Each year, 1.7 million women suffer a complication that has an adverse effect on their health. This is not just a public health emergency **- it is a human rights crisis.** Women in the USA face a range of obstacles in obtaining the services they need. **The health care system suffers from multiple failures: discrimination; financial, bureaucratic and language barriers to care; lack of information about maternal care and family planning options;** lack of active participation in care decisions; inadequate staffing and quality protocols; and a lack of accountability and oversight." (http://www.amnestyusa.org/our-work/campaigns/demand-dignity/maternal-health-is-a-human-right/maternal-health-in-the-us)

These bills being proposed are an example of discrimination against

midwives. The Bills also require midwives to "use informed consent agreements with their clients", Hospitals should do the same- they should have "patients" sign these agreements before providing services, so the patients are aware of the inadequate care they will receive compared to 48 other countries!

The USA is clearly not upholding the best maternal care, despite the fact that it spends more money on maternal health care than any other type of hospital cost… It is because of these facts and statistics that some women are making the informed decision to birth at home under the care of trained midwives. HOME BIRTH is the traditional way of giving birth, and also, the alternative to the ailing conventional system the medical-led care provides. PLEASE, allow women the right to this informed decision!! And, support the rights of home birth midwives in Hawai`i to continue their practice without the scrutiny of a medical-led board.

I, and all those opposing bills SB259 & SB2569 SD1, are asking for COLLABORATION, instead of the scrutiny & discrimination based off incorrect data these bills are suggesting.

MAHALO NUI for your consideration and I look forward to hearing how SB2569 AND SB2569 SD1 have been OPPOSED and how home birth midwives will be able to manage themselves and collaborate with the medical-led providers to enhance pregnancy, antepartum and postpartum periods of the women and families here in the state of Hawai`i.

Kainoa Akina
(808) 233-9230
Kaneohe, HI

Karen Tan, ND, MAcOM, LAc.
320 Ward Ave, Suite 105
Honolulu, HI 96814
(808) 591-8778

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

Hearing date 2-10-14 1:30pm Room 229

RE: SB2569 and SB2569 SD1 Relating to Home Birth- IN OPPOSITION

I am a Naturopathic Physician and Licensed Acupuncturist and have been in practice in Honolulu since 1995.

I strongly oppose SB2569 and SB2569 SD1 for the following reasons

1. Home birth is safe, as safe if not safer than hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe? (Rising c-section rates, inductions, medications...safe?) Let's dialogue, If legislators are truly interested in learning about home birth as Green's press release indicates, then take this next year to learn about the differences between the midwifery model vs the medical model of birthing. Become educated.

2. We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth.

3. This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for.

4. Let the home birth community form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

In addition, naturopathic physicians be exempt from this measure because natural childbirth/obstetrics falls within a naturopathic physician's scope of practice, pursuant to sections 455-1 and 455-8, Hawaii Revised Statutes. Thank you for the opportunity to testify on Senate Bill No. 2569.

Karen Tan, ND, MAcOM, LAc.
320 Ward Ave, Suite 105
Honolulu, HI 96814
(808) 591-8778

Sincerely,

Karen Tan, ND, MAcOM, LAc

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	md@mauibirth.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Sunday, February 09, 2014 12:31:18 PM

SB2569

Submitted on: 2/9/2014

Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Merrily Daly	Individual	Oppose	No

Comments: To: The Honorable Josh Green, Chair, Committee on Health The Honorable Roz Baker, Vice Chair, Committee on Water & Land The Honorable Roz Baker, Chair, Committee on Commerce and Consumer Protection The Honorable Brian Taniguchi, Vice Chair, Committee on Commerce and Consumer Protection The Honorable Clayton Hee, Chair, Committee on Judiciary and Labor The Honorable Maile Shimabukuro, Vice Chair, Committee on Judiciary and Labor Members, Senate Committee on Health Members, Senate Committee on Commerce and Consumer Members, Senate Committee on Judiciary and Labor From: Merrily D. Daly Date: February 10th, 2014 Hrg: Senate Committee on Health/Senate Committee on Commerce and Consumer Protection/Senate Committee on Judiciary and Labor; Mon. February 10th 2014 at 1:30 p.m. in Rm 229 Re: SB 2569 and SB2569 SD1, Relating to Home Birth – In Opposition Thank you for the opportunity to offer testimony in opposition of SB 2569 and SB 2569 SD1, both of which attempt to regulate midwifery in the State of Hawaii. My name is Merrily Daly. I am a registered nurse since 1976 and a Certified Professional Midwife since 1995. I have lived in Hawaii since 1978 and have practiced midwifery mostly in the home birth setting since that time. I personally provide in depth education and safe medical care to the low risk pregnant mother throughout her pregnancy and postpartum period. I have delivered hundreds of babies in this state to satisfied customers and feel passionate concerning the rights of families to choose their birth options. As the C-Section rate soars in Maui County, and not one nurse-midwife works at Maui Memorial Medical Center, midwives are needed in the community to help families who want a safe alternative. Providing regulation is fine yet this bill clearly is flawed in so many ways and I oppose its approval. I would like to see a template used from an already regulated state that has legalized midwifery (e.g. Idaho) Here are some reasons why I OPPOSE SB2569 and SB2569 SD1: • Both bills take away choices for women when it comes to their reproductive health. • SB2569 threatens women's health and would all but make midwifery and home birth illegal in the state of Hawaii, forcing mothers who choose to home birth to potentially go underground in finding illegal care providers which may pose a risk to herself and her baby. The bill also infringes on patients' rights and violates their right to medical privacy. • Home birth with a trained midwife is SAFE. This bill uses false data to support it’s claim. It refers to a two to three fold increase in neonatal mortality and that is cited from a study that has

been refuted. Here are studies addressing that particular study, along with others that support home birth with a trained midwife to be just as safe as a hospital birth. (1,2,3,4,5) • We are not opposed to regulation – however the regulations in SB2569 don't make sense and neither bill promotes the health of mothers or their babies. • These bills do NOT take into account cultural practices in home birth. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law. • The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth practice. The Home Birth Safety Board should be autonomous from the Hawaii Medical Board. There should be a Home Birth Providers Board overseen directly by the DCCA . • The Home Birth Safety Board to be comprised of the home birth providers primarily, with some OB/MD representation but certainly not the majority or even half. • It is the right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. This bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose. Suggestions: Write a new bill next legislative session that addresses the concerns stated above and include home birth providers and key stakeholders in the birthing community when drafting new legislation. Amending SB2569 OR SB2569 SD1 is NOT an option. Both bills are too flawed to correct given the time constraints of the legislature. A complete overhaul of these bills must ensue. There are many suggestions for a new bill, please let's work together to create it.. Thank you for your time. I appreciate the opportunity to testify. Aloha, Merrily Daly RN, CPM, CLC, CLNC Registered Nurse, Certified Professional Midwife, Certified Lactation Counselor, Certified Legal Nurse Consultant Sources: 1. "Home Birth versus Hospital Birth: Questioning the Quality of the Evidence on Safety" article published in Birth (Volume 30, Issue 1, pages 57-63, March 2003) "In contrast, the Midwives Association of Washington State press release stated that 'Childbearing women and health policy makers should be made aware that the study contains numerous flaws and limitations...this study alone should not be used to make decisions that could restrict women's choice of birth place or access to birth attendants with expertise in home birth'" (http://onlinelibrary.wiley.com/doi/10.1046/j.1523-536X.2003.00218.x/abstract) 2. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/MCDG/wp-content/uploads/2013/02/Medscape-Wax-Critique-Michal-Janssen-Vedam-Hutton-de-Jonge.pdf) 3. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics) 4. BMJ 2005;330;1416 Outcomes of planned home birth with certified professional midwives; large prospective study in North America 5. BJOG, 2009 Aug; 116(9):1177-84 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births 6. The Myth of a Safer Hospital Birth for Low Risk Pregnancies (http://www.greenmedinfo.com/blog/myth-safer-hsopital-birth-low-risk-pregnancies) "Study validity questioned" in The American Journal of Obstetrics & Gynecology (volume 204, Issue 4, page e14, April 2011) (http://ajog.org/article/S0002-9378(10)01107-5/fulltext) 7. Home birth metaanalysis: does it meet AJOG's reporting requirements? (http://ajog.org/article/S0002-9378(11)00074-3/fulltext) 8. International data demonstrate home birth safety.

(http://www.ncbi.nlm.nih.gov/pubmed/21458614) 9. “Home birth triples the neonatal death rate”: public communication of bad science? (http://www.ajog.org/article/S0002-9378(11)00075-5/abstract) 10. http://www.ncbi.nlm.nih.gov/pubmed/23769011 11. http://www.bmj.com/content/330/7505/1416 12. Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009 http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12172/pdf

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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To: The Honorable Josh Green, Chair, Committee on Health
The Honorable Roz Baker, Vice Chair, Committee on Water & Land

The Honorable Roz Baker, Chair, Committee on Commerce and Consumer Protection
The Honorable Brian Taniguchi, Vice Chair, Committee on Commerce and Consumer Protection

The Honorable Clayton Hee, Chair, Committee on Judiciary and Labor
The Honorable Maile Shimabukuro, Vice Chair, Committee on Judiciary and Labor

Members, Senate Committee on Health
Members, Senate Committee on Commerce and Consumer
Members, Senate Committee on Judiciary and Labor

From: Dr. Madeleine Portuondo, ND, Midwife
Date: February 10th, 2014
Hrg: Senate Committee on Health/Senate Committee on Commerce and Consumer Protection/Senate Committee on Judiciary and Labor; Mon. February 10th 2014 at 1:30 p.m. in Rm 229
Re: **SB 2569 and SB2569 SD1, Relating to Home Birth – In Opposition**

I am a home birth midwife who has been practicing in Hawaii since 2008. I am voicing my opposition to SB 2569 and SB 2569 SD1. I was trained first as a Naturopathic Doctor and then did all of the additional certification requirements to be a Naturopathic Midwife. This included 2 additional years of classes, 2.5 years of residency training under a Naturopathic Midwife, taking the Naturopathic Obstetrics board exam and transitioning to being a primary midwife under supervision.

In the state of Oregon, where I did my schooling, licensing was regulated and enforced. Certified Public Midwives were licensed through one type of legislation and Naturopathic Midwives were licensed with a specialty midwifery license through the Naturopathic Doctor's board. I trained within this system and I expected to be licensed under that system when I finished with all of my requirements.

Since that time, I moved to Oahu and have been practicing here, in a State that does not mention midwifery in any legislation. I have found this to be both a blessing and a curse. Firstly, lack of ability to become licensed has kept my patients from being able to use insurance to cover their births. Another issue is inconsistency in how birth transfers are received in local

hospitals because there is no established method of handling transfers. I also worry that midwifery being allegal means that I have no protection should I ever be involved in a lawsuit. My biggest fear is that midwifery will become completely illegal if we, the homebirth community don't come together to get licensing established for midwives.

One might read all of the items I listed above and assume that I would be completely in support of the senate bills that would allow me to get licensed. On the contrary, I am firmly against these bills. I would like to be licensed, however, there are many issues with both drafts that I am concerned with:

- This is a bill drafted by the American College of Obstetricians and Gynecologists and Senator Green. These are Medical Doctors, who are unfamiliar with the unique training and model of care of midwives. I have great respect for them and their training, however, if there is going to be a bill drafted to legislate midwives, it should be originating from midwives, who are more familiar with how midwives should be regulated.

- There are multiple places in both drafts that call for oversight by Medical Doctors. These are entirely draconian standards, which presume that families cannot be responsible for researching and making medical decisions. They would need prior approval by an obstetrician before choosing a home birth. While I understand that the intention of this suggestion is to increase safety and reduce high-risk births at home, the precedence still stands that individuals retain autonomy when it comes to making health decisions. I cannot think of any other circumstance where you would need to have approval from your doctor, or any other health care provider for that matter, before making health decisions. Doctors are health advisors, not health dictators. This kind of legislation is reminiscent of the legislation in very conservative states that would require a woman to have an Ultra Sound before being approved for abortions. Personally, I am always going to oppose legislation that takes self-determination and autonomy away.

- There is a long list in SB 2569 SD1 of health concerns that would preclude a patient from being able to legally hire a midwife. While this list may seem reasonable to the layperson that is reading through it, as a Naturopathic Physician and a midwife, I

see some glaring issues. It is true that the home birth setting is better served for women who are at low-risk, however people are more than a list of ailments. I can think of many circumstances when a person may be exempt because of the list, even though they are a good candidate for home birth. For example any thyroid condition is on the list. If a person has active thyroid antibodies while pregnant, they are at an increased risk for miscarriage. That makes them slightly more high-risk in the pregnancy. However, if the thyroid hormones are well maintained throughout the pregnancy and the pregnancy makes it to full term, the birth itself is not more risky. Another scenario would be if the patient had a slight increase in sugar levels after taking the glucose test while pregnant. If that same patient was testing blood sugar throughout pregnancy and the numbers were always in the normal range, the risks associated with gestational diabetes would not be applicable. However, the patient would be restricted from seeking home birth by the diagnosis given after the blood test. There is also a restriction based on a person's Body Mass Index. Despite the slight increase in risk based on a person's weight, it would be offensively discriminatory to tell a woman that I could not agree to do her birth because she is too fat. The bottom line is that even if the choices we make come with additional risk, we still have the right to make those choices as long as we assume responsibility for those additional risks. I believe that midwives have the responsibility of informing families of any increase in risk, but that families can still choose to birth at home, as long as the midwife is comfortable with attending the birth. Personally, I don't choose to take clients if I consider them to be high-risk. But I reserve the right to consider each patient on a case-by-case basis to determine that, not to be restricted by a vague list that does not account for individual circumstances.

- Another area of concern in this draft is the limited time frame in which a patient is allowed to legally birth at home. The listed time frame is 37-42 weeks. My concern is that there is a tendency for OB/GYNs to use the Last Menstrual Period to determine the Estimated Due Date. This is fairly standard. However, I have had many patients who have historically had a shorter or longer menstrual cycle and that would mean that the LMP would not be accurate, but their physician refused to change their EDD. In one scenario, for example, one of my

patients had a typical menstrual cycle of 35 days. This would make her conception day later, meaning that her due date should have been at least half a week later. In the state she lived in at the time, there was a very strict 42-week limit on homebirths. Because she didn't go in to labor until 42 weeks and 1 day, she had to forego having the homebirth she wanted with the midwife that had been seeing her for her entire pregnancy. The unfortunate thing was that if her physician had allowed her to change her due date based on the length of her cycle, she would have been well within her window.

- The above story leads me to my next concern, which is that if MDs are given as much power over these choices as both drafts suggest, then a professional bias against homebirth could cause them to tell a patient that they aren't a good candidate for a home birth or that they aren't low risk when they very well might be. I always encourage my patients to do co-care throughout their pregnancies with an OB/GYN because then if something changes and the pregnancy becomes high-risk, they have a seamless transfer to the hospital track. Also, if there is a transport during labor, they already have an established physician, and I can call the physician and let them know that their patient is en route to the hospital and inform them of the labor details up until transfer. Finally, it is better for most of my patients to have co care because insurance is not currently covering labs or imaging ordered by Naturopathic Physicians, and it is more cost effective for them to have their MD order them. The challenge for me is that often, I send my patients to these doctors and they come back with traumatic stories of being bullied by them because of their choice of homebirth. In these scenarios, patients are sometimes being told that they are high risk or not a good candidate, but when they translate the story there was an obvious misrepresentation of information used to prove the argument. As of this moment, these patients can still birth with me. If those same doctors that are confabulating ailments are in charge of the patient's ultimate choice in home birthing, then I can imagine that I am going to be severely restricted in which people I can agree to see.

- The more patients that trained midwives must legally refuse that are determined to have a home birth, the more patients that will be choosing unassisted births at home or births attended by

untrained individuals. If home birth safety is the intention of this bill, then I think it will be failure.

- The premise of the introduction of home birth safety legislation is that home birth is unsafe and that there is a history of high morbidity and mortality with home births. While I can think of many reasons that having licensure for home birth would be beneficial, I reject the argument that home birth is less safe than hospital births. The research has unequivocally proven that to be false. ACOG has been falsely perpetuating this idea based on a study done by Wax, et al. The study was a meta analysis of multiple research papers regarding home birth. When they looked at all births that happened out of hospital, they found a 2-3 fold increase of neonatal death as compared to the hospital. However, when they made that information specific to only those births that happened under the supervision of trained midwives, the numbers showed that homebirths were equivalent to hospitals for mortality. The numbers that ACOG has been using to make their statement on home birth, include accidental out of hospital births and intentional unassisted home births. If you look at the Hawaii Department of Health statistics and midwifery records for homebirth over the last decade, you will find that they are consistent in showing that rates of morbidity and mortality are as low or lower than in the hospital. We also enjoy lower rates of c-sections, interventions, prematurity, and post partum infections and depression. Not to mention higher instances of successful nursing. If you would like to do further reading on the matter, I will include abstracts for 2 studies:
    - **Outcomes of planned home births with certified professional midwives: large prospective study in North America**
        - BMJ 2005;330:1416
        - Abstract:
        - **Objective** To evaluate the safety of home births in North America involving direct entry midwives, in jurisdictions where the practice is not well integrated into the healthcare system.
        - **Design** Prospective cohort study.

        - **Setting** All home births involving certified professional midwives across the United States (98% of cohort) and Canada, 2000.
        - **Participants** All 5418 women expecting to deliver in 2000 supported by midwives with a common certification and who planned to deliver at home when labor began.
        - **Main outcome measures** Intrapartum and neonatal mortality, perinatal transfer to hospital care, medical intervention during labor, breast-feeding, and maternal satisfaction.
        - **Results** 655 (12.1%) women who intended to deliver at home when labor began were transferred to hospital. Medical intervention rates included epidural (4.7%), episiotomy (2.1%), forceps (1.0%), vacuum extraction (0.6%), and caesarean section (3.7%); these rates were substantially lower than for low risk US women having hospital births. The intrapartum and neonatal mortality among women considered at low risk at start of labour, excluding deaths concerning life threatening congenital anomalies, was 1.7 deaths per 1000 planned home births, similar to risks in other studies of low risk home and hospital births in North America. No mothers died. No discrepancies were found for perinatal outcomes independently validated.
        - **Conclusions** Planned home birth for low risk women in North America using certified professional midwives was associated with lower rates of medical intervention but similar intrapartum and neonatal mortality to that of low risk hospital births in the United States.
    - **Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009**
        - 30 JAN 2014
        - DOI: 10.1111/jmwh.12172
        - Introduction-Between 2004 and 2010, the number of home births in the United States rose by 41%,

increasing the need for accurate assessment of the safety of planned home birth. This study examines outcomes of planned home births in the United States between 2004 and 2009.

- Methods-We calculated descriptive statistics for maternal demographics, antenatal risk profiles, procedures, and outcomes of planned home births in the Midwives Alliance of North American Statistics Project (MANA Stats) 2.0 data registry. Data were analyzed according to intended and actual place of birth.
- Results-Among 16,924 women who planned home births at the onset of labor, 89.1% gave birth at home. The majority of intrapartum transfers were for failure to progress, and only 4.5% of the total sample required oxytocin augmentation and/or epidural analgesia. The rates of spontaneous vaginal birth, assisted vaginal birth, and cesarean were 93.6%, 1.2%, and 5.2%, respectively. Of the 1054 women who attempted a vaginal birth after cesarean, 87% were successful. Low Apgar scores (< 7) occurred in 1.5% of newborns. Postpartum maternal (1.5%) and neonatal (0.9%) transfers were infrequent. The majority (86%) of newborns were exclusively breastfeeding at 6 weeks of age. Excluding lethal anomalies, the intrapartum, early neonatal, and late neonatal mortality rates were 1.30, 0.41, and 0.35 per 1000, respectively.
- Discussion-For this large cohort of women who planned midwife-led home births in the United States, outcomes are congruent with the best available data from population-based, observational studies that evaluated outcomes by intended place of birth and perinatal risk factors. Low-risk women in this cohort experienced high rates of physiologic birth and low rates of intervention without an increase in adverse outcomes.

Suggestions:
Write a new bill next legislative session that addresses the concerns stated above and include home birth providers and key stakeholders in the birthing community when drafting new legislation.
Amending SB2569 OR SB2569 SD1 is NOT an option. Both bills are too

flawed to correct given the time constraints of the legislature. A complete overhaul of these bills must ensue. There are many suggestions for a new bill, please let's work together to create it..

Thank you for your time. I appreciate the opportunity to testify.

Aloha,

Dr. Madeleine Portuondo
Oahu Resident
Naturopathic Physician, Midwife

February 10, 2014
Monday
1:30 PM
Conference Room 229
State Capitol

To: Senator Josh Green, Chair - Committee on Health
Senator Rosalyn Baker, Chair - Committee on Commerce and Consumer Protection
Senator Clayton Hee, Chair - Committee on Judiciary and Labor

From: Bliss Kaneshiro MD, MPH

Re: SB 2065/SB2065SD1, Relating to Health

Position: Strongly support licensure, patient safety rules/regulations, informed consent, data collection, and establishment of a board to ensure Home Birth Safety in Hawaii as per Hawaii ACOG testimony

Dear Senators Green, Baker, Hee and members of the Committees on Health, Commerce and Consumer Protection, and Judiciary and Labor:

I have great respect for certified nurse midwives (CNMs). I worked with many of them in my own residency training, while I practiced on the mainland and when I returned home to Hawaii. I also deeply respect the autonomy of women in making decisions for their own health and their pregnancies. Some mothers with low-risk pregnancies can safely deliver their baby at home with a CNM. However, women in Hawaii currently have no way of telling who is certified to do a home delivery and who is not. Virtually anyone can claim they are qualified to do home deliveries regardless of their training or experience in obstetrics. A licensure process would help patients to determine who is qualified to safely deliver their baby at home. A licensure process would provide women with the information they need to make their own informed decisions and therefore would respect the autonomy of women in making their own health decisions.

I have personally cared for women who experienced disastrous outcomes after attempting to deliver their baby at home with a high risk condition. I am reminded of one instance in particular where the infant was left with permanent disability.

I am very concerned about the safety of our mothers and their babies who opt for a planned home birth. The most recent and largest study to date reveals that there is a four-fold increased risk of neonatal death associated with home birth. In addition, there is a seven-fold increased risk of neonatal death for first time mothers who deliver at home and a ten – fold increased risk for pregnancies more than 41 weeks gestation.

[Grunebaum A, Chervenak F, etal. Society for Maternal Fetal Medicine Abstract. February 7, 2014.]

Currently, there is no licensure, and therefore no patient safety rules and regulations regarding home birth. There are many complications that can occur, particularly with high-risk pregnancies. However, even low-risk pregnancies can quickly, within a few minutes or even seconds, become high-risk during the labor and delivery process.

To ensure that all of Hawaii's mothers and babies have a safe and happy birth experience, I urge you to support the Home Birth Safety bill. This bill will ensure that home birth providers have had formal obstetrics education to care for mothers and infants, follow patient safety regulations such as no high-risk pregnancy deliveries at home, adequately inform their patients regarding their educational background and the possible risks of home birth, and require the timely completion of birth certificates and other data for all planned home births.

Thank you for the opportunity to submit this testimony on this very important Women's Health issue.

Bliss Kaneshiro, MD, MPH
Board Certified Obstetrician Gynecologist

From: (:Daya Akina:)
To: HTHTestimony; HMS Testimony
Subject: OPPOSE SB2569 & SB2569 SD1
Date: Sunday, February 09, 2014 12:27:15 PM

Aloha, I am writing in opposition to the following bills:

SB2569 AND SB2569 SD1 set for hearing on Monday February 10, 2014 at 1:30pm, conference room 229.

I am writing for my right and the right of ALL women to birth where we choose, under the care provider(s) of our choice. **It is illogical** to create a **"home birth board** to adopt rules and protocols for midwives and licensure of midwives" **that does not consist of home birth midwives,** and instead, of providers that follow medical-led care that have NO experience in home birth. There is a stark contrast between the medical-led care that is conventional and the traditional midwifery model of care:
-This link will inform you **about the midwifery model of care**: http://www.mana.org/about-midwives/midwifery-model.
-And, this link will inform you on **the benefits of the midwifery model of care**: http://www.medscape.com/viewarticle/810005).

I am asking, on behalf of so many mothers (and their unborn children who will benefit from traditional midwifery practices), to create an even playing field where traditional home birth midwives and birth providers can share their knowledge and work TOGETHER WITH conventional medical doctors to offer women the best of both worlds. It should not be a monopoly when it comes to birth. WOMEN DESERVE THEIR HUMAN RIGHT TO CHOOSE WHERE AND WITH WHOM THEY WANT TO GIVE BIRTH!!! Especially when they are informed about the statistics of maternal and infant care in America.

According to the CIA & WHO, in 2010, the USA tied 48th with Iran in Maternal Mortality with 21 deaths per 100,000. **Yet, only 2% of babies are born at home in the U.S.**, indicating that the interventions, high cesarean section rates, and dehumanizing of birth that take place in hospitals, under the medical-led care, is having serious consequences. (https://www.cia.gov/library/publications/the-world-factbook/rankorder/2223rank.html AND (http://www.who.int/gho/maternal_health/countries/en/#U)

Quoted from Amnesty International: "The USA spends more than any other country on health care, and more on maternal health than any other type of hospital care. Despite this,

women in the USA have a higher risk of dying of pregnancy-related complications than those in 49 other countries, including Kuwait, Bulgaria, and South Korea...Maternal deaths are only the tip of the iceberg. During 2004 and 2005, more than 68,000 women nearly died in childbirth in the USA. Each year, 1.7 million women suffer a complication that has an adverse effect on their health. This is not just a public health emergency **- it is a human rights crisis.** Women in the USA face a range of obstacles in obtaining the services they need. **The health care system suffers from multiple failures: discrimination; financial, bureaucratic and language barriers to care; lack of information about maternal care and family planning options;** lack of active participation in care decisions; inadequate staffing and quality protocols; and a lack of accountability and oversight." (http://www.amnestyusa.org/our-work/campaigns/demand-dignity/maternal-health-is-a-human-right/maternal-health-in-the-us)

These bills being proposed are an example of discrimination against midwives. The Bills also require midwives to have their clients "use informed consent agreements with their clients", Hospitals should do the same- they should have "patients" sign these agreements before providing services, so the patients are aware of the inadequate care they will receive compared to 48 other countries!

The USA is clearly not upholding the best maternal care, despite the fact that it spends more money on maternal health care than any other type of hospital cost… It is because of these facts and statistics that some women are making the informed decision to birth at home under the care of trained midwives. HOME BIRTH is the traditional way of giving birth, and also, the alternative to the ailing conventional system the medical-led care provides. PLEASE, allow women the right to this informed decision!! And, support the rights of home birth midwives to continue their practice without the scrutiny of a medical-led board.

I, and all those opposing bills SB259 & SB2569 SD1, are asking for COLLABORATION, instead of the scrutiny, discrimination based off incorrect data these bills have provided.

Another tidbit of data: The CIA reports that as of 2013, **US ranks 51st** in Infant Mortality (5.90 deaths per 1,000) behind Cuba, Hong Kong, and Monaco (1st - 1.81 deaths per 1,000). America can do better for its children, HAWAI`I can do better!!! But, NOT if midwifery is outlawed and managed by a medical-led board! The stats prove this: http://www.medscape.com/viewarticle/810005 (also posted earlier in this letter).

MAHALO NUI for your consideration and I look forward to hearing how SB2569 AND SB2569 SD1 have been OPPOSED and how home birth

midwives will be able to manage themselves and collaborate with the medical-led providers to enhance pregnancy, antepartum and postpartum periods of the women and families here in the state of Hawai`i.

ALOHA & BLESSINGS

Daya Akina
(808) 372-6092
Kaneohe, HI

2/9/14

Respectfully, Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

RE: SB2569 and SB2569 SD1 Relating to Home Birth

To begin with I want it to be known that I OPPOSE both bills emphatically.

I believe in home births.

Home births are safe, as safe if not safer than hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe? I have friends who have had successful home births and know of some who have lost babies in the hospital.

This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for. I believe that midwives are more skilled and adept at handling unusual births due to the fact that they have experience which doctors don’t have due to their reliance on C-sections.

Let the people decide! Let the home birth community form their own advisory council with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc. to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

Thank you for your time and consideration,

Sincerely and with respect,

____

2/9/14

Respectfully, Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

RE: SB2569 and SB2569 SD1 Relating to Home Birth

To begin with I want it to be known that I OPPOSE both bills emphatically.

I believe in home births.

Home births are safe, as safe if not safer than hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe? I believe my story speaks to this issue of safety. I have had two births one at the hospital and one at home. The full term birth at the hospital died and full term birth at home lived and thrives! At the hospital, I experienced incompetence on at least two counts that I would not curse on any woman. Before dying my baby suffered unnecessarily in ways that I am confident she would not have experienced in a home birth. While my second birth, which under the new amendment would not be legal, while met with complications which may have been subject to cesarean in a hospital setting, was skillfully handled by my midwife, bringing to birth my currently 25 year old healthy daughter. Not only did my daughter ultimately die at the hands of incompetence, but I was never offered a grief counselor while in the hospital and I was wheeled out of the hospital with new mothers and their babies.

While I believe and trust that we (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislature's right to decide how and where someone can birth.

This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for. I believe that midwives are more skilled and adept at handling unusual births because they do not have to the option to opt out for a C-section but instead must learn and apply the skills required to effectively deal with the challenges before them

Let the people decide! Let the home birth community form their own advisory council with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family

Practitioners etc. to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

Thank you for your time and consideration,

Sincerely and with respect,

Dhira DiBiase, LSW

February 8, 2014

Date: February 9, 2014

Time: 1:30pm

Place: Conference Room, 229, State Capitol, 415 South Beretania Street

RE: TESTIMONY IN STRONG OPPOSITION OF **SB2569** and **SB2569 SD1**

Aloha, my name is Katie Caldwell and I am a resident of Honolulu, HI. I am not a Mother, nor do I plan to be. However, I am a feminist and a strong advocate for women's rights. A few years ago, I began researching home births and midwifery for a class (I am currently in grad school at UH Manoa). I became completely engrossed in the research, as I (horrifyingly) learned that many states over-regulate and misinterpret midwifery. Essentially, this bill demands that midwives can practice only under the strict scrutiny and control of other care providers that have little to no experience with out of hospital births. Why would we, in good conscious, agree to a bill that places all of the power in the hands of people that do not understand home births? You cannot turn a home into a traveling hospital…women deserve the right to choose how they would like to bring their child into the world. This bill represents the interests of the medical model of birthing care, overseeing the midwife model of birthing care. This is like asking an ophthalmologist to oversee a dentist. It is ridiculous to ask someone to oversee and monitor something that they do not accept or care to recognize as valid. The medical model and the midwifery model are vastly different and the midwifery care model truly represents Hawai'i's cultural ties to birthing and ohana.

Women have been birthing babies since the dawn of time. Our bodies are made for this. Frankly, I am sick and tired of the government interfering with female bodies. To criminalize the way

that women have been birthing for hundreds of years and the way that the majority of the world births is appalling and unethical. There is a better way to go about this. This is not the way.

Thank you kindly for taking the time to hear this testimony.

Sincerely,

Katie Caldwell

Raydeen M Busse, MD, FACOG, RDMS
1401 S. Beretania St., Suite 310
Honolulu, HI 96814
Ph 808-524-4055
Fax 808-524-4057
E-mail rbusse@hawaii.edu

February 10, 2014
Monday
1:30 PM
Conference Room 229
State Capitol

To: Senator Josh Green, Chair - Committee on Health
Senator Rosalyn Baker, Chair - Committee on Commerce and Consumer Protection
Senator Clayton Hee, Chair - Committee on Judiciary and Labor

From: Raydeen M Busse, MD, FACOG

Re: SB 2569/SB2569SD1, Relating to Health

Position: Strongly support licensure, patient safety rules/regulations, informed consent, data collection, and establishment of a board to ensure Home Birth Safety in Hawaii as per Hawaii ACOG testimony

Dear Senators Green, Baker, Hee and members of the Committees on Health, Commerce and Consumer Protection, and Judiciary and Labor:

I have personally been involved in the care of patients who have attempted to deliver at home or who have delivered at home with subsequent complications that could have been avoided had the appropriate standard of care been followed. The least complicated was a retained placenta (after-birth did not come out on its own after a vaginal delivery) and the patient had severe bleeding when brought in by ambulance. The most complicated, avoidable and tragic complication was a fetal death from infection due to an abnormally, prolonged labor at home with a broken water bag, Had this case been managed by the usual standard of care, I believe the outcome would have been much happier and healthier.

I am very concerned about the safety of our mothers and their babies who opt for a planned home birth. The most recent and largest study to date reveals that there is a four-fold increased risk of neonatal death associated with home birth. In addition, there is a seven-fold increased risk of neonatal death for first time mothers who deliver at home and a ten – fold increased risk for pregnancies more than 41 weeks gestation. [Grunebaum A, Chervenak F, etal. Society for Maternal Fetal Medicine Abstract. February 7, 2014.]

Currently, there is no licensure, and therefore no patient safety rules and regulations regarding home birth. There are many complications that can occur, particularly with high-risk pregnancies. However, even low-risk pregnancies can quickly, within a few minutes or even seconds, become high-risk during the labor and delivery process.

To ensure that all of Hawaii's mothers and babies have a safe and happy birth experience, I urge you to support the Home Birth Safety bill. This bill will ensure that home birth providers have had formal obstetrics education to care for mothers and infants, follow patient safety regulations such as no high-risk pregnancy deliveries at home, adequately inform their patients regarding their educational background and the possible risks of home birth, and require the timely completion of birth certificates and other data for all planned home births.

Thank you for the opportunity to submit this testimony on this very important Women's Health issue.

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	imem@hawaii.rr.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Sunday, February 09, 2014 12:06:39 PM

SB2569

Submitted on: 2/9/2014
Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Ilana Maxwell	Individual	Oppose	No

Comments: To: The Honorable Josh Green, Chair, Committee on Health The Honorable Roz Baker, Vice Chair, Committee on Water & Land The Honorable Roz Baker, Chair, Committee on Commerce and Consumer Protection The Honorable Brian Taniguchi, Vice Chair, Committee on Commerce and Consumer Protection The Honorable Clayton Hee, Chair, Committee on Judiciary and Labor The Honorable Maile Shimabukuro, Vice Chair, Committee on Judiciary and Labor Members, Senate Committee on Health Members, Senate Committee on Commerce and Consumer Members, Senate Committee on Judiciary and Labor From: Ilana Maxwell, Holualoa, Hawai'i Date: February 10, 2014 Hrg: Senate Committee on Health/Senate Committee on Commerce and Consumer Protection/Senate Committee on Judiciary and Labor; Mon. February 10th 2014 at 1:30 p.m. in Rm 229 Re: SB 2569 and SB2569 SD1, Relating to Home Birth – In Opposition Thank you for the opportunity to offer testimony in opposition of SB 2569 and SB 2569 SD1, both of which attempt to regulate midwifery in the State of Hawaii. Here are some reasons why I OPPOSE SB2569 and SB2569 SD1: • Both bills take away choices for women when it comes to their reproductive health. • SB2569 threatens women's health and would all but make midwifery and home birth illegal in the state of Hawaii, forcing mothers who choose to home birth to potentially go underground in finding illegal care providers which may pose a risk to herself and her baby. The bill also infringes on patients' rights and violates their right to medical privacy. • Home birth with a trained midwife is SAFE. This bill uses false data to support it's claim. It refers to a two to three fold increase in neonatal mortality and that is cited from a study that has been refuted. Here are studies addressing that particular study, along with others that support home birth with a trained midwife to be just as safe as a hospital birth. (1,2,3,4,5) • We are not opposed to regulation – however the regulations in SB2569 don't make sense and neither bill promotes the health of mothers or their babies. • These bills do NOT take into account cultural practices in home birth. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law. • The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth practice. The Home Birth Safety Board should be autonomous from the Hawaii Medical Board. There should be a Home Birth Providers Board overseen directly by the DCCA . • The Home Birth Safety Board to

be comprised of the home birth providers primarily, with some OB/MD representation but certainly not the majority or even half. • It is the right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. This bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose. Suggestions: Write a new bill next legislative session that addresses the concerns stated above and include home birth providers and key stakeholders in the birthing community when drafting new legislation. Amending SB2569 OR SB2569 SD1 is NOT an option. Both bills are too flawed to correct given the time constraints of the legislature. A complete overhaul of these bills must ensue. There are many suggestions for a new bill, please let's work together to create it.. Thank you for your time. I appreciate the opportunity to testify. Aloha, YOUR NAME Sources: 1. "Home Birth versus Hospital Birth: Questioning the Quality of the Evidence on Safety" article published in Birth (Volume 30, Issue 1, pages 57-63, March 2003) "In contrast, the Midwives Association of Washington State press release stated that 'Childbearing women and health policy makers should be made aware that the study contains numerous flaws and limitations...this study alone should not be used to make decisions that could restrict women's choice of birth place or access to birth attendants with expertise in home birth'" (http://onlinelibrary.wiley.com/.../j.1523-536X.../abstract) 2. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/.../Medscape-Wax-Critique-Michal...) 3. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics) 4. BMJ 2005;330;1416 Outcomes of planned home birth with certified professional midwives; large prospective study in North America 5. BJOG, 2009 Aug; 116(9):1177-84 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births 6. The Myth of a Safer Hospital Birth for Low Risk Pregnancies (http://www.greenmedinfo.com/.../myth-safer-hsopital-birth...) "Study validity questioned" in The American Journal of Obstetrics & Gynecology (volume 204, Issue 4, page e14, April 2011) (http://ajog.org/article/S0002-9378(10)01107-5/fulltext) 7. Home birth metaanalysis: does it meet AJOG's reporting requirements? (http://ajog.org/article/S0002-9378(11)00074-3/fulltext) 8. International data demonstrate home birth safety. (http://www.ncbi.nlm.nih.gov/pubmed/21458614) 9. "Home birth triples the neonatal death rate": public communication of bad science? (http://www.ajog.org/article/S0002-9378(11)00075-5/abstract) 10. http://www.ncbi.nlm.nih.gov/pubmed/23769011 11. http://www.bmj.com/content/330/7505/1416 12. Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009 http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12172/pdf

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

Hearing Date 2-10-14 1:30pm rm 229

RE: Opposing SB2569 and SB2569 SD1 Relating to Home Birth

I am also a Chiropractor with a diplomat in Pediatrics and Pregnancy. I am soon to be the father of 5 children, two of which will have been born here in Manoa, HI.

There have been long fought battles to empower women and their right to choose. A woman has the right to choose who to conceive a child with and how they wish to conceive. Women have the right to choose to abort a pregnancy or to keep it, within certain parameters, regardless of the health of the baby and or the mother. They have the right to choose how and where to raise that child. Women make these choices everyday and accept the responsibility that comes with each of those decisions. So how can we tell women that they No longer have the right to choose the healthcare provider they want to deliver their baby? How can we tell women they No longer have a choice in where they can have their baby?

Midwifery is one of the oldest professions in the world. They have been around longer than doctors, obstetricians, and politicians. Midwives have been delivering babies at home across the state of Hawaii, across the nation, and around the world for centuries and are still used extensively to deliver safe, effective, and affordable care.

In the state of Hawaii the Midwifes that practice home births include; Certified Professional Midwifes (CPM), Traditional Midwifes, and Naturopathic Doctors each of whom has received extensive training in home delivery, emergency procedures, and when it is necessary for hospital intervention. The proposed legislation eliminates nearly all of those practitioners that have been aiding in the delivery of babies at home since Hawaii received its statehood. Yet the legislation grants acceptance to a host of other practitioners who have not been trained in, and in most cases have never attended, natural home birth.

As a Doctor of Chiropractic I understand the need for a governing board and a Peer review process, both of which are lacking in Hawaii's Midwifery. Midwifery should not be a-legal as it is currently, Midwifery should function as other Alternative Medical Professions function across the state. Midwifery should have an independent governing board that is full of professionals that are knowledgeable and experienced in homebirth. This Midwifery board should not be a part of a Medical board as they utilize philosophies that contradict each other and thus can lead to extreme bias as seen in the Wilk versus the AMA lawsuit in the 1970 and 1980's when the American Medical Association was found in conspiracy against the Chiropractic profession.

Our legislators should aide the Midwifes in Hawaii to craft a bill that will create an independent governing board and a peer review process that will protect women and children and their right to choose where to birth and who will aide them, not a bill that ignores the voice of the profession it attests to be aiding, or a bill that will restrict all access to qualified homebirth midwifes.

RE: SB2569 and SB2569 SD1 Relating to Home Birth

Dear Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

I am writing as a father who supported my wife as she birthed at home. The experience of our daughter coming into this world was opposite of the painful and frightening one my mother had as she was manipulated into having a premature cesarean birth with me. Laws are meant to be put into place to protect the rights of citizens, what is this bill meant to achieve? Is it to limit and take away choices made by generations?

My daughter's birth was an amazing on multiple levels which in no way could have happened in the confines of a hospital setting. I have friends and family with endless complaints about giving birth in a hospital from misinformation to pushing the use of unnecessary drugs. As a representative of the people in Hawai'i I ask that you listen to the testimony presented that oppose the bill and support the rights of women to chose where they birth.

Thank you,

Chris Pascual

Sierra Dew

45-426 Akimala St. Kaneohe, HI 96744 (808-283-3078) Sierradew.info@gmail.com

Date: February 9th, 2014

Hawaii State Capitol
415 South Beretania St.
Honolulu, HI 96813

RE: SB2569 and SB2569 SD1 Relating to Home Birth | Hearing Date 2-10-14

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary Labor.

We (the public, the home birth We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth. My mother chose to have a home birth and it is very important to me that I get to have the same choice. For me, western medicine and the approach of doctor's choosing pharmaceutical drugs over natural medicine is not my philosophy on health and wellness. It feels like a matter of my human rights that I get to choose where and how I have my future children.

Sincerely,

Sierra Dew

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

Hearing date 2-10-14 1:30pm rm 229

RE: Opposing SB2569 and SB2569 SD1 Relating to Home Birth

I am a mother of 4 children soon to be 5. I also teach childbirth classes and am a birth labor assistant. Any legislation that effects women's ability to choose with whom and where she has her baby is of utmost importance to me. I plan on having a third home birth as long as there are no counter indications. Having a trained and experienced midwife of my choosing at my home birth is being put in jeopardy by this bill.

I oppose Sb2569 for many reasons.

The main reason I oppose this bill is that it works against its intended purpose which is to increase the safety of home birth.

This legislation is written without a clear understanding of home birth practices, without input from the professionals and the industry it intends to license and regulate.

This legislation is based off a faulty study that has been proven to be inaccurate* in portraying the risks to mothers and babies. This study combines the outcomes of ALL out of hospital births including accidental out of hospital birth. Accidental births happen in the back of taxi cabs, on the side of freeways, and in hospital parking lots. The people that help with accidental out of hospital births are usually untrained unexperienced or have very little training like EMTs, cab drivers, policemen and husbands. An accidental birth is a completely different situation from a planned home birth with an experienced and trained midwife. In the study mentioned above only 30% of the data was from the outcomes of planned home births attended by a trained and experienced midwife.

Since this bill is based on faulty information and around the premise that home birth is highly dangerous for mothers and babies, many of the requirements are excessive, inappropriate and costly to the state.

It also proposes a home birth board mostly comprised of care providers that aren't trained in home birth practices, don't normally attend home births, or in most cases have never attended or even seen a home birth.

They also put the home birth board under the authority of the Hawaiian Medical board which is unnecessary and over bearing.

This bill wants to licenses providers that don't attend home births on Oahu and fails to include the professionals that do attend home births on Oahu such as certified professional midwives (CPM) or traditional midwives.

If this bill passed, it would make it impossible for the majority of midwives that currently provide home birth services on all the islands of Hawaii to receive licensure and legally practice their profession. This would force mothers who want to have a home birth to choose between having an unattended birth or having a birth in a hospital setting.

I am not opposed to having licensure for home birth care providers and some regulation; however, this bill where the all the homebirth care providers are not included and the rules and regulations micromanages homebirth in Hawaii in not the answer.

The positive aspects we can take from the bill are setting up a home birth advisor board where the majority is comprised of currently practicing in Hawaii homebirth providers. And giving that board the power to decide scope of practice and guidleines based on current research and guidelines set up by national governing boards for midwives such as MANA or NARM. Also having a peer review system set up would increase sharing of knowledge between professionals encourage best practices and quality care.

A bill should set up broad guidelines and help organize the home birth governing group but not dictate to the professionals who are practicing how they should practice. In medicine, the standard of care and guidelines change based on recent research. When a bill spells out each and everything they can and cannot do, it make it difficult for the board to change practices based on out of date studies or information.

The birth of a child is a momentous event in the life of mother and father and the entire family. I take the responsibility of choosing where and with whom I have

my babies very seriously and each time research my options and carefully select and interview the care provider that I chose to have at my birth. This is not a decision that I base on what is popular or on a whim.

Birth is a sacred experience to bring into the world another living soul. How a women is treated during her labor, birth, delivery and postpartum effects her on the deepest levels and effects in turn the mothering of her new born child. Home birth providers understand and honor this as not only a physical event, but also a emotional, spiritual and life changing sacred event in a family. I cannot have the kind of birth I want at a hospital because of policy and procedures that are set up for possible emergencies or the convenience of the staff that has to provide care to many women laboring at the same time.

I teach in my childbirth education classes that women should give birth where they feel safest based on their health conditions and not because of pressure from family or friends. For me, I feel the safest place to have my babies is at home. Recent research** supports my decision that for healthy low risk women the home birth option is as safe, if not safer, than the hospital option.

Thank you for your time and consideration. Please feel free to contact me with any question or if I can provide further clarification on any of the points or information provided.

Nancy Holbrook

*Home Birth versus Hospital Birth: Questioning the Quality of the Evidence on Safety http://onlinelibrary.wiley.com/doi/10.1046/j.1523-536X.2003.00218.x/abstract

* From Medscape Ob/Gyn & Women's Health Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong Carl A. Michal, PhD; Patricia A. Janssen, PhD; Saraswathi Vedam, SciD; Eileen K. Hutton, PhD; Ank de Jonge, PhD

Posted: 04/01/2011

** Journal of Midwifery & Women's Health www.jmwh.org Original Research Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009

I oppose SB2569 and SB2569 SD1 Relating to Home Birth for several reasons. Among them are:

1. The bill, as it is written puts forth the notion that home birth puts mothers and babies at more risk than hospital birth. There are studies that indicate the opposite. One put out by MANA (Midwives Alliance of North America), concluded that among low-risk women, home births resulted in lower rates of interventions with no increase in adverse outcomes for mothers and babies.
2. It also concerns me that the proposed "home birth safety board" would be made up largely of medical obstetricians, nurses and other medical professionals rather than midwives and health practitioners who do home births. I feel that those who practice birthing, especially home birthing should be the major decision makers in setting up a safety board for this practice.
3. It also concerns me that the bill, as it is written, may make it difficult for practicing midwives with good reputations in Hawaii to continue their work. I believe it should be easy for women to have a homebirth and a healthy, natural birthing experience if they want one. Many women are concerned with the high C-section rates at local hospitals and would much prefer to avoid other frequently used, and in many cases unnecessary, medical interventions reported at hospitals.
4. I actually agree with the idea of establishing certification or licensure of homebirth midwives, but wonder if those with obstetrics certifications would actually be qualified to do home birthing, since the practices of obstetrics and home birthing differ in many ways. I would support licensure where actual practitioners set up the requirements and the process toward this end.

For these reasons and more, I oppose SB2569. I believe there are other ways to improve birthing practices here in Hawaii, in both home births and hospital births. Since most women want access to a safe birthing experience, where they can design a birth that meets the needs of their bodies and where their choices are respected, I hope that laws like SB2569 can be rewritten in such a way as not to interfere with this process.

Sincerely,

Diana Duff

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor

Hearing date 2-10-14 1:30pm rm 229

RE: SB2569 and SB2569 SD1 Relating to Home Birth

Oppose

Four main points:

A) Home birth is safe, as safe if not safer than hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe? (Rising c-sect rate, inductions, medications...safe?) Let's dialogue, If legislators are truly interested in learning about home birth as Green's press release indicates, then take this next year to learn about the differences between the midwifery model vs the medical model of birthing. Become educated.

B) We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth.

C) This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for.

D) Let the home birth community form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

Please consider the above points. As a home birthing mother, birth professional, and caring member of the community, I thank you.

Sincerely,
Kaela Kajiyama

The Honorable Josh Green, Chair, Committee on Health
The Honorable Roz Baker, Vice Chair, Committee on Water & Land

The Honorable Roz Baker, Chair, Committee on Commerce and Consumer Protection
The Honorable Brian Taniguchi, Vice Chair, Committee on Commerce and Consumer Protection

The Honorable Clayton Hee, Chair, Committee on Judiciary and Labor
The Honorable Maile Shimabukuro, Vice Chair, Committee on Judiciary and Labor

Members, Senate Committee on Health
Members, Senate Committee on Commerce and Consumer
Members, Senate Committee on Judiciary and Labor

From: Rachel L. Curnel Struempf, DEM
Date: February 10th, 2014
Hrg: Senate Committee on Health/Senate Committee on Commerce and Consumer Protection/Senate Committee on Judiciary and Labor; Mon. February 10th 2014 at 1:30 p.m. in Rm 229
Re: SB 2569 and SB2569 SD1, Relating to Home Birth – In Opposition

Thank you for the opportunity to offer testimony in opposition of SB 2569 and SB 2569 SD1, both of which attempt to regulate midwifery in the State of Hawaii.

Here are some reasons why I OPPOSE SB2569 and SB2569 SD1:

• Both bills take away choices for women when it comes to their reproductive health.
• SB2569 threatens women's health and would all but make midwifery and home birth illegal in the state of Hawaii, forcing mothers who choose to home birth to potentially go underground in finding illegal care providers which may pose a risk to herself and her baby. The bill also infringes on patients' rights and violates their right to medical privacy.
• Home birth with a trained midwife is SAFE. This bill uses false data to support it's claim. It refers to a two to three fold increase in neonatal mortality and that is cited from a study that has been refuted. Here are studies addressing that particular study, along with others that support home birth with a trained midwife to be just as safe as a hospital birth. (1,2,3,4,5)
• We are not opposed to regulation – however the regulations in SB2569 don't make sense and neither bill promotes the health of mothers or their babies.
• These bills do NOT take into account cultural practices in home birth. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.
• The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth practice. The Home Birth Safety Board should be autonomous from the Hawaii Medical Board. There should be a Home Birth Providers Board overseen directly by the DCCA .
• The Home Birth Safety Board to be comprised of the home birth providers primarily, with some OB/MD representation but certainly not the majority or even half.
• It is the right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. This bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose.

Suggestions:
Write a new bill next legislative session that addresses the concerns stated above and include home birth providers and key stakeholders in the birthing community when drafting new legislation. Amending SB2569 OR SB2569 SD1 is NOT an option. Both bills are too flawed to correct given the time constraints of the legislature. A complete overhaul of these bills must ensue. There are many suggestions for a new bill, please let's work together to create it..
Thank you for your time. I appreciate the opportunity to testify.

Aloha,

Rachel L. Curnel Struempf

Sources:

1. "Home Birth versus Hospital Birth: Questioning the Quality of the Evidence on Safety" article published in Birth (Volume 30, Issue 1, pages 57-63, March 2003) "In contrast, the Midwives Association of Washington State press release stated that 'Childbearing women and health policy makers should be made aware that the study contains numerous flaws and limitations...this study alone should not be used to make decisions that could restrict women's choice of birth place or access to birth attendants with expertise in home birth'" (http://onlinelibrary.wiley.com/.../j.1523-536X.../abstract)
2. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/.../Medscape-Wax-Critique-Michal...)
3. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics)
4. BMJ 2005;330;1416 Outcomes of planned home birth with certified professional midwives; large prospective study in North America
5. BJOG, 2009 Aug; 116(9):1177-84 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births
6. The Myth of a Safer Hospital Birth for Low Risk Pregnancies (http://www.greenmedinfo.com/.../myth-safer-hsopital-birth...)
"Study validity questioned" in The American Journal of Obstetrics & Gynecology (volume 204, Issue 4, page e14, April 2011) (http://ajog.org/article/S0002-9378(10)01107-5/fulltext)
7. Home birth metaanalysis: does it meet AJOG's reporting requirements? (http://ajog.org/article/S0002-9378(11)00074-3/fulltext)
8. International data demonstrate home birth safety. (http://www.ncbi.nlm.nih.gov/pubmed/21458614)
9. "Home birth triples the neonatal death rate": public communication of bad science? (http://www.ajog.org/article/S0002-9378(11)00075-5/abstract)
10. http://www.ncbi.nlm.nih.gov/pubmed/23769011
11. http://www.bmj.com/content/330/7505/1416
12. Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009 http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12172/pdf

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

Hearing date 2-10-14 1:30pm rm 229

Please Make 12 copies - Mahalo

RE: SB2569 and SB2569 SD1 Relating to Home Birth – IN OPPOSITION

I am a father of a 1 year old daughter who was born at home with the guidance of a midwife and I oppose these bills.

By imposing regulations on midwives and forcing a mother to jump through hoops in order to home birth – they interfere with my family's right to birth in the manner of which we choose.

Mahalo,

William Newton

Midwives Alliance
P.O. Box 373
Montvale, NJ 07645
info@mana.org
www.mana.org

January 23, 2014

Senator Josh Green
State Capitol, Room 215
415 S. Beretania Street
Honolulu, Hawaii 96813

Dear Senator Green,

The Midwives Alliance of North America (MANA) is a professional membership organization that promotes excellence in midwifery practice, endorses diversity in educational backgrounds and practice styles, and is dedicated to unifying and strengthening the profession, thereby increasing access to quality health care and improving outcomes for women, babies, families, and communities. We maintain a variety of essential documents pertaining to professional standards for midwifery practice, including Midwives Alliance Core Competencies for Midwifery Practice, Midwives Alliance Standards and Qualifications for the Art and Practice of Midwifery, and Midwives Alliance Statement of Values and Ethics, which inform the practice of midwives in the United States.[1]

While we support the establishment of direct entry midwifery regulation and licensure in all 50 states, we have concerns about your recently introduced legislation, SB 2569/SD1, and it's impact on women, babies, and the midwives caring for them.

The bill references a discredited study by Wax et al, which was based on unreliable vital statistics data that does not necessarily differentiate between planned and unplanned home births. *Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009*, a prospective study based on medical records, considered the gold standard for this type of research, was just published in the Journal of Midwifery and Women's Health.[2] Outcomes for planned home birth include a cesarean section rate under 6%, a transfer rate of 11% and an exclusive breastfeeding rate of 86% at six weeks. Low-risk women in this sample experienced high rates of normal physiologic birth and very low rates

of operative birth and interventions, with no concomitant increase in adverse events. This study and others found in *Home Birth: An Annotated Guide to the Literature* present a more accurate picture of outcomes and cost savings with planned out of hospital birth.[3] Read more about conflicting research in the Citizens for Midwifery document *Interpreting Home Birth Research: Understanding Conflicting Evidence.*[4]

The initial draft of the bill only recognizes certified nurse midwives (CNMs) as appropriate home birth providers, and requires a license to be issued by the Hawaii Medical Board, in addition to the license CNMs already hold as advanced practice registered nurses. This dual licensure is unnecessary and financially burdensome and may also become a barrier to practice. Certified nurse midwives are considered licensed independent providers and function in a system allowing for consultation, collaboration and referral, with oversight already in place with the HI board of nursing.

While attending out of hospital birth is well within the scope of practice of the CNM, the certified professional midwife (CPM) is the considered the expert, and this credential is recognized in 28 states and counting. The CPM credential, issued by the North American Registry of Midwives (NARM), is the only midwifery credential that requires knowledge about and experience in out-of-hospital settings.[4] Certified professional midwives safely provide care around the country with good outcomes and cost savings to states as well. Find out more about the tremendous cost savings to the state of WA in *Midwifery Licensure and Discipline Program in Washington State: Economic Costs and Benefits.*[5] There are other errors in the draft; NARM issues the credential for CPMs not Midwifery Education Accreditation Council (MEAC), MEAC accredits midwifery education programs but does not provide or accredit the CPM credential.

Another concern is the so-called home birth safety board proposed in your bill. While many states have similar boards, the members recommended and the oversight proposed do not fit with the typical advisory board. We recommend a board or committee proposed primarily of midwife peers, as is common on other advisory councils of this type, with just a few additional members such as an OB/Gyn, pediatrician and a public member. For example, the WA state Department of Health Midwifery Advisory Committee consists of three licensed midwives, one CNM, two physicians and one public member. These boards must contain members who are actively practicing the profession they advise for; it would be inappropriate to have an advisory panel composed of those who may have never been present at an out of hospital birth, let alone attend them, as out of hospital midwives in particular practice the midwives model of care, which is different than the medical model.[6]

Lastly, the conditions requiring approval of or consultation with a physician places barriers to care for women as well as restricts their rights for individual choice of provider. Many of the conditions listed as contraindications have

very little bearing on the appropriateness of out of hospital care, and in some cases there is research illustrating better outcomes with midwifery care.

For these reasons, the Midwives Alliance of North America cannot support this bill in the current formats. We look forward to the next version to aid in regulation that best serves mothers and families.

Sincerely,

Colleen Donovan-Batson, CNM
Director, Health Policy and Advocacy
Midwives Alliance of North America
MANA Board of Directors.

1. http://www.mana.org/about-midwives/professional-standards

2. Cheyney, M. et al. **Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009** http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12172/full

3. http://midwifery.ubc.ca/files/2012/12/Home-Birth-Annotated-guide-to-the-literature.pdf

4.http://www.cfmidwifery.org/pdf/Interpreting%20Home%20Birth%20Research%202014_2_6.pdf

5.http://www.washingtonmidwives.org/documents/Midwifery_Cost_Study_10-31-07.pdf

6. http://www.mana.org/about-midwives/midwifery-model

Hearing date 2-10-14 1:30pm rm 229

RE: SB2569 and SB2569 SD1 Relating to Home Birth

Oppose

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

I write to you as not only a supporter of safe and natural home birthing, not only as a mother who successfully home birthed 2 healthy boys at home in the state of Hawaii (Kauai) but also as a very healthy and happy woman who was born at home. My husband was also born at home. What better testimony/proof could I offer than 4 out of 4 of our family as living prove of how safe and healthy home birth IS.

We do NOT support further certification of NDs doing home birth at this time. NDs have been attending home births since Shape 455 (1925) and one helped me deliver my first son at home successfully. There was a minor complication and our ND handled with ease and grace because of her long experience, NOT because of any State certification.

Should there ever be a majority in favor of further certification it should be done as one unified act with ALL the home birth practitioners.

Birth should be about bringing us together, NOT dividing!

If you are truly concerned about safety than I suggest you compare and review statistics about cesarean births versus homebirths. Home birth is a midwifery model, not a medical model. Please refer to testimony given for SB2569 SD1!

Please help support heath and mothers and our keiki…not fight against what we know in our hearts to be the best for our children!

Timory McDonald
Wailua Homesteads, Kauai
96746

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	laura_sabbe@hotmail.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Saturday, February 08, 2014 8:37:29 PM

SB2569

Submitted on: 2/8/2014

Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
laura sabbe	Individual	Oppose	No

Comments: I am a Kauai resident who, within the past year and a half, has given birth in a home birth setting. It was the most empowering and joyful moment of my life, surrounded by midwives I knew and trusted, and in a familiar setting that made me feel safe and relaxed, all of which is vital for a successful labor and postpartum period. It was by far the most healthy and beautiful way for my daughter to come into his world. This opportunity should be celebrated and encouraged, I therefore oppose SB2569 in both it's versions.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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Statement of Mercedes-Nicole K. Ritte, Founder, The MOM Hui
Hearing on Senate Bills 2569 & 2569 SD1 Relating to Home Birth
Before HTH/CPN/JDL Committees
Saturday, February 8, 2014

To: Senator Josh Green, Senator Rosalyn Baker, Senator Brian Taniguchi, Senator Clayton Hee, and Senator Maile Shimabukuro

The Moms On a Mission Hui (The MOM Hui), founded in May 2013, is a statewide grassroots group of forward thinking mothers who advocate for protecting the health, safety, and well being of all children, present and future.

The MOM Hui **OPPOSES** Senate Bills 2569 & 2569 SD1 relating to home birth.

According to the journal of Midwifery and Women's Health peer-reviewed study "Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009," the largest analysis of planned home births in the United States ever published, states:

- Contrary to the statement "national data reports a two to three fold increased risk of neonatal mortality with planned home birth versus hospital birth," this study confirms that among low-risk women, planned home births result in low rates of interventions without an increase in adverse outcomes for mothers and babies.

- The Midwives Alliance North America (MANA) Statistics Registry, confirms the safety and overwhelmingly positive health benefits for low-risk mothers and babies who choose to birth at home with a midwife.

- Women who planned a home birth had fewer episiotomies, pitocin for labor augmentation, and epidurals.

- Ninety-seven percent of babies were carried to full-term, they weighed an average of eight pounds at birth, and nearly 98% were being breastfed at the six-week postpartum visit with their midwife. Only 1% of babies required transfer to the hospital after birth, for non-urgent conditions.

- Data was contributed by **432 different midwives**, including: certified profession midwife, licensed midwife, licensed direct entry midwife, certified nurse midwife (CPMs/LMs/LDMs/CNMs/CMs), naturopathic midwives, **un-licensed direct-entry midwives**, and **others**.

We feel the proposed bill ultimately eliminates a woman‘s/mother‘s right to decide who they want as a home birth team/partner and their decision to individualize their prenatal, birth & post-partum plan according to her desire. Unfortunately this bill is also unfairly set up to criminalize midwives who currently deliver babies independently.

Respectfully,

Mercedes-Nicole K. Ritte
The MOM Hui - Founder

REGULAR SESSION OF 2014
For: Honorable Senate Committee Health Chair Green, Vice Chair Baker and Committee Members,
Hearing __February 10, 2014 1:30pm (date)
Rm___229__________

RE: SB2569 AND SB2569 SD1 Relating to Home Birth – IN OPPOSITION
Dear Senators Green and Baker, and Health Chair Committee Members
My name is Sara DiGrazia. I am a registered voter, a licensed psychologist in the State of Hawai'i, and a Mom. I followed my sister's two home births in our family home with two of my own. I had healthy pregnancies and was not at risk for complications. The home birth experience that my family had with my sister and myself set the stage for a very positive family life. We believe home birth to be the healthiest way to bring children into the world *in our family* in low risk birthing cases. I will encourage my children to pursue home birth in the future, especially if our family values of low intervention and prayer our continued.
If it is not obvious already, I strongly oppose SB2569 and SB2569 SD1 for the following reasons:
1. This bill cites a flawed study and suggests home birth is dangerous and unsafe. I join other home birth practitioners, mothers and advocates to correct that

notion. There is plenty of research which supports the relative safety of birthing at home.
2. This bill is biased toward a Western medical, hospital-based model and does not take into account the spiritual, cultural, and (non hospital-based) medical beliefs which strongly underly home birth.
3. As SB 2569 and SB 2569 SD1 are written, a family's option for a legal home birth is eliminated. It was my rite, based on years of research, to birth at home, and I would be greatly saddened if other women in my state did not have this option. I hope that my lawmakers in the State of Hawai'i consider protecting the long standing cultural and spiritual practice of home birth that I was so fortunate to continue in my family.
4. Home birth is a deeply cultural practice that is both respected and honored. I, and every person that I know, is descended from an ancestor who gave birth at home. It must be viewed in the context of cultural, traditional, religious/ spiritual belief and practice, which is protected by law in our State and Nation.
For all of these reasons and more, I strongly oppose this bill as it stands. The imposition of these state regulations simply does not take into account the important perspectives of the birth practitioners, the mothers, and advocates of home birth.
Yet, I recognize the need for more information.

Professionals in the birth community that I support offer the following:
* A Home Birth Council that reflects the variety of practices, mothers and advocates. This Council shall be self-defined and self-regulated.
* They request the opportunity to gather data, standards of care, and wise practices to present before the legislature at a later date.
* They request a legislative informational hearing that provides the opportunity to present information about the spectrum of home birth practitioners, their education and training, and existing standards of care.
Thank you for your time and consideration. Sincerely,
Sara DiGrazia, Psy.D. and Family

Stephanie Ching
1205 Mamalu Street
Honolulu HI 96817

Feb 8, 2014

To: The Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

RE: SB2569 and SB2569 SD1 Relating to Home Birth
Hearing date 2-10-14 1:30pm rm 229

I am writing to state my concern regarding the bills listed above, which essentially take away a woman's right to have a home birth.
I did not have home birth myself, however, I defend every woman's birthright to have a home birth.

Having done much research on home births and having many friends who have had multiple home births, it is clear that Home birth is as safe as hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe? If legislators are truly interested in learning about home birth as Green's press release indicates, then take this next year to learn about the differences between the midwifery model vs the medical model of birthing. Birthing is the most organic and natural process and the midwife and doula has been an integral partner in this from the beginning of time.

I am very interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it **restricts the rights of families to deliver their children in the settings they believe are best for them** and with the attendants they choose. **It is not the legislatures right to decide how and where someone can birth.**

This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill.

Let the mifwife/doula community form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc to gather data, dialogue and form the best standards acceptable to all birth practitioners and the community,

and bring this back to the legislature next session.

Mahalo for standing up for every woman's birthright.

Stephanie Ching

1.To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor
2. Hearing date 2-10-14 1:30pm, Rm. 229
3. RE: SB2569 and SB2569 SD1 Relating to Home Birth
4. Oppose
5. Four main points:

A) The introduction of this bill assumes that home births are unsafe, and seeks to regulate home births. However, the research simply does not support this assumption. In fact, home birth IS safe—as safe as hospital births, if not safer. As a woman who chose home birth, I can assert that I did my research about home versus hospital births when making my decision. After reviewing the rise in C-section rates, regular introduction of medications during labor, forced inductions, and a variety of rigid protocols during labor that benefit the medical providers and not the mother and child, I decided that a home birth was a safer option for me. I had a wonderful, safe home birth in the comfort of my own home, and I was very grateful to have that option available to me.

I firmly believe the legislators who introduced this bill have missed vital information and research that would counter the assumption that birth outside of a hospital is innately unsafe. When I was pregnant, my experience with other people when I told them of my decision to do a home birth was often a reaction of worry or fear based on ignorance, not facts, about home birth. When I explained the practice in further detail, many people were very interested in learning more about home birth as an option for pregnant women. I recommend that this Committee pursue further study and education about the practice of midwifery and home births.

B) As a mother who is pregnant with her second child, I can assure you that safety surrounding labor and delivery—whether at home or in a hospital—is of utmost concern to me. However, I do not see how this bill provides additional safety regarding this matter. As I read the bill, I instead see unnecessary restrictions put upon home birth providers—one of whom already assisted me with my first pregnancy, whose practices inspired nothing but absolute confidence in her abilities to deliver my child safely. I also see blatant restrictions about my right as a patient to choose how and where I want to have my baby. I respectfully ask why members of this legislature are seeking to add obstacles to my decision to have a home birth?

C) This bill excludes and criminalizes some forms of midwifery and home birth practices; this in turn excludes and criminalizes services that people in the community desire for their home birth experience. I believe

that more options, not less, are what mothers want in making a decision about their birth service providers.

D) I suggest that the home birth community form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners, etc., to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community. In an effort to further educate this committee on home birth practices, a home birth advisory council can provide their findings to the legislature next session.

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	dulce.menta@live.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Saturday, February 08, 2014 8:11:07 PM

SB2569

Submitted on: 2/8/2014
Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
alexandra	Individual	Oppose	No

Comments: In opposition to both versions of this bill. Mothers deserve to choose how to give birth, if they believe a home birth is right for them then we should not take this right from them. Midwives are safe, home births are safe! Taking this right away will only result in more harm to the welfare, physical and emotional health of these women.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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To: The Honorable Josh Green, Chair, Committee on Health

The Honorable Roz Baker, Vice Chair, Committee on Water & Land

The Honorable Roz Baker, Chair, Committee on Commerce and Consumer Protection

The Honorable Brian Taniguchi, Vice Chair, Committee on Commerce and Consumer Protection

The Honorable Clayton Hee, Chair, Committee on Judiciary and Labor

The Honorable Maile Shimabukuro, Vice Chair, Committee on Judiciary and Labor

Members, Senate Committee on Health

Members, Senate Committee on Commerce and Consumer

Members, Senate Committee on Judiciary and Labor

From: Shay Chan Hodges

Date: February 10th, 2014

Hrg: Senate Committee on Health/Senate Committee on Commerce and Consumer Protection/Senate Committee on Judiciary and Labor; Mon. February 10th 2014 at 1:30 p.m. in Rm 229

Re: **SB 2569 and SB2569 SD1, Relating to Home Birth – <u>In Opposition</u>**

Thank you for the opportunity to offer testimony in **opposition of SB 2569 and SB 2569 SD1,** both of which attempt to regulate midwifery in the State of Hawaii.

My name is Shay Chan Hodges and I am the mother of two boys who are fifteen and seventeen years old.

Here are some reasons why I OPPOSE SB2569 and SB2569 SD1:

· Both bills take away choices for women when it comes to their reproductive health.

· It is the right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. This bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose.

Please understand that both of my children were born at Maui Memorial Hospital and though I can appreciate why many mothers would prefer to give birth at home, I have not chosen to have a home birth myself. That said, I believe that every mother has the right and the responsibility to choose how she wants to bring her children into the world.

Furthermore, if there had been an option to give birth at a birthing center that provided me with the best of both worlds, I would have chosen that. However, as long as we do not have enough facilities on neighbor islands to provide a diversity of birthing options for families, we need to work within the realities of our small island community to honor families' choices while ensuring the safety of both mother and baby.

Thus, I am not opposed to regulation. However, regulation needs to start with the acknowledgement that many families prefer a home birth option and that home birth can be as safe, if not safer, than hospital birth. The bill that is crafted needs to be sensible and it needs to include input from families and the birthing community.

Clearly, the Home Birth Safety Board should be comprised primarily of home birth providers, with some OB/MD representation, not the other way around.

Furthermore, the regulations need to be designed to promote healthy babies, not to deter people from having home births. Home birth with a trained midwife is SAFE, however by making midwifery and home birth illegal, the state may actually be putting mothers and their babies at risk.

Ultimately, these bills do not make sense and neither bill promotes the health of mothers or their babies.

I strongly urge you to write a new bill in the next legislative session that addresses the concerns stated above and includes home birth providers and key stakeholders in the birthing community when drafting new legislation. Amending SB2569 OR SB2569 SD1 is NOT an option. Both bills are too flawed to correct given the time constraints of the legislature. A complete overhaul of these bills must ensue.

Thank you for your time. I appreciate the opportunity to testify.

Aloha,

Shay Chan Hodges

Author, Mothering and Work in the 21st Century Economy

Haiku, Maui, Hawaii

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	lucasjmeyer@gmail.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Saturday, February 08, 2014 7:57:14 PM

SB2569

Submitted on: 2/8/2014

Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Lucas Meyer	Individual	Oppose	No

Comments: To: The Honorable Josh Green, Chair, Committee on Health The Honorable Roz Baker, Vice Chair, Committee on Water & Land The Honorable Roz Baker, Chair, Committee on Commerce and Consumer Protection The Honorable Brian Taniguchi, Vice Chair, Committee on Commerce and Consumer Protection The Honorable Clayton Hee, Chair, Committee on Judiciary and Labor The Honorable Maile Shimabukuro, Vice Chair, Committee on Judiciary and Labor Members, Senate Committee on Health Members, Senate Committee on Commerce and Consumer Members, Senate Committee on Judiciary and Labor From: Lucas Meyer Date: February 10th, 2014 Hrg: Senate Committee on Health/Senate Committee on Commerce and Consumer Protection/Senate Committee on Judiciary and Labor; Mon. February 10th 2014 at 1:30 p.m. in Rm 229 Re: SB 2569 and SB2569 SD1, Relating to Home Birth – In Opposition Thank you for the opportunity to offer testimony in opposition of SB 2569 and SB 2569 SD1, both of which attempt to regulate midwifery in the State of Hawaii. My name is Lucas Meyer I am a proud father of 4. I oppose SB2569 and SB2569 SD1. Two of my children were born at home and two at the hospital . I support a womans and families choice to have the type of birth they would like with whatever form of birthing support if any they choose. for most of human history births have been at tended by mid wives and not in the hospital. i see no need for any State ,County or Form of Governing agency the ability to infringe upon the all american freedoms such this. thank you for your time and consideration. Lucas Meyer Here are some more reasons why I OPPOSE SB2569 and SB2569 SD1: · Both bills take away choices for women when it comes to their reproductive health. · SB2569 threatens women's health and would all but make midwifery and home birth illegal in the state of Hawaii, forcing mothers who choose to home birth to potentially go underground in finding illegal care providers which may pose a risk to herself and her baby. The bill also infringes on patients' rights and violates their right to medical privacy. · Home birth with a trained midwife is SAFE. This bill uses false data to support it's claim. It refers to a two to three fold increase in neonatal mortality and that is cited from a study that has been refuted. Here are studies addressing that particular study, along with others that support home birth with a trained midwife to be just as safe as a hospital birth. (1,2,3,4,5) · We are not opposed to regulation – however the regulations in

SB2569 don't make sense and neither bill promotes the health of mothers or their babies. · These bills do NOT take into account cultural practices in home birth. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law. · The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn’t even reflect the participants of home birth practice. The Home Birth Safety Board should be autonomous from the Hawaii Medical Board. There should be a Home Birth Providers Board overseen directly by the DCCA . · The Home Birth Safety Board to be comprised of the home birth providers primarily, with some OB/MD representation but certainly not the majority or even half. · It is the right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. This bill currently proposes to violate a woman’s bodily autonomy and a woman’s right to choose. Suggestions: Write a new bill next legislative session that addresses the concerns stated above and include home birth providers and key stakeholders in the birthing community when drafting new legislation. Amending SB2569 OR SB2569 SD1 is NOT an option. Both bills are too flawed to correct given the time constraints of the legislature. A complete overhaul of these bills must ensue. There are many suggestions for a new bill, please let’s work together to create it.. Thank you for your time. I appreciate the opportunity to testify. With Respect, Lucas Meyer Sources:

1. "Home Birth versus Hospital Birth: Questioning the Quality of the Evidence on Safety” article published in Birth (Volume 30, Issue 1, pages 57-63, March 2003) “In contrast, the Midwives Association of Washington State press release stated that 'Childbearing women and health policy makers should be made aware that the study contains numerous flaws and limitations...this study alone should not be used to make decisions that could restrict women's choice of birth place or access to birth attendants with expertise in home birth'" (http://onlinelibrary.wiley.com/doi/10.1046/j.1523-536X.2003.00218.x/abstract) 2. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women’s Health 4/1/2011 (http://cfpcwp.com/MCDG/wp-content/uploads/2013/02/Medscape-Wax-Critique-Michal-Janssen-Vedam-Hutton-de-Jonge.pdf) 3. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics) 4. BMJ 2005;330;1416 Outcomes of planned home birth with certified professional midwives; large prospective study in North America 5. BJOG, 2009 Aug; 116(9):1177-84 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births 6. The Myth of a Safer Hospital Birth for Low Risk Pregnancies (http://www.greenmedinfo.com/blog/myth-safer-hsopital-birth-low-risk-pregnancies) "Study validity questioned" in The American Journal of Obstetrics & Gynecology (volume 204, Issue 4, page e14, April 2011) (http://ajog.org/article/S0002-9378(10)01107-5/fulltext) 7. Home birth metal analysis: does it meet AJOG's reporting requirements? (http://ajog.org/article/S0002-9378(11)00074-3/fulltext) 8. International data demonstrate home birth safety. (http://www.ncbi.nlm.nih.gov/pubmed/21458614) 9. “Home birth triples the neonatal death rate”: public communication of bad science? (http://www.ajog.org/article/S0002-9378(11)00075-5/abstract) 10. http://www.ncbi.nlm.nih.gov/pubmed/23769011 11.

http://www.bmj.com/content/330/7505/1416 12. Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009
http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12172/pdf

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	rosalyn.dias@gmail.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Saturday, February 08, 2014 7:13:52 PM

SB2569

Submitted on: 2/8/2014
Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
roz dias	Individual	Oppose	Yes

Comments: I am a hawaiian woman who like to give birth at home exercising my cultural practices of home birth, in a safe, supportive and loving environment of my choosing. I am not a proponent of the medical model and believe in naturopath, mid-wifey and doula in birthing a child. There are many benefits in having an home birth and feel that this a constitutional right of freedom of choice should not be taken away.

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From: Rosalyn Dias
To: JDLTestimony; HTHTestimony; CPN Testimony; CPCtestimony; HLTtestimony; JUDtestimony
Subject: Oppose SB2569 AND SB2569 SD1
Date: Saturday, February 08, 2014 7:24:38 PM

Aloha,

My name is rosalyn dias and here are the reasons why I support at home births:

A) Home birth is safe, as safe if not safer than hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe? (Rising c-sect rate, inductions, medications...safe?) Let's dialogue, If legislators are truly interested in learning about home birth as Green's press release indicates, then take this next year to learn about the differences between the midwifery model vs the medical model of birthing. Become educated.

B) We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth.

C) This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for.

D) Let the home birth community form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

As a native hawaiian women, I would like to exercise my cultural practice of having my child at home.

Mahalo,

Rosalyn

Sent from my iAloha...Ahui Hou

To whom it may concern:

My name is Monique Miyake. I am a childbirth educator and certified lactation counselor. I am currently in nursing school with the goal of becoming a Women's Health Nurse Practitioner. I am the mother of two children. I was born and raised in Hawaii and I am college educated.

I chose to have a very satisfying and safe homebirth with a Certified Professional Midwife. Please do not take away my right to have a homebirth with the practitioner of my choice.

I am for midwifery legislation to ensure that women have access to safe providers. However, this bill **SB2569 is modeled after some of the worst midwife laws in the country**, including Virginia, the only other state that gives the Medical Board oversight over midwife practice, rules, and regulations, which is a clear conflict of interest, and is based in the state's paternalistic "doctor knows best" history of attempting to stamp out the profession of midwifery altogether, which traditionally had been practiced primarily by women of color.

Hawaii should be leading the way in fostering diversity, collaboration, and culturally appropriate maternity care, not following the backward examples of states with a long history of denying women access to the care providers of their choice.

If SB2569 becomes law, **it will put Hawaii dead last on the list of states with family-centered midwife laws** that respect the rights of pregnant women to make informed and evidence-based decisions about their personal maternity care choices.

SB2569 is not based in evidence or best practices. It denies women who have had a previous cesarean delivery access to midwives and out-of-hospital care, forcing them to give birth in hospitals whose policies dictate surgical delivery for all women with a previous cesarean, whether it's medically indicated or not.

When women are denied access to midwives and home birth, **many will give birth with no trained attendant at all,** which results in increased risk to mothers and babies. By imposing so many arbitrary and non-evidence based limits on women's maternity care choices, **SB2569 will drive up the rates of unattended births** in Hawaii, which does not increase safety for mothers and babies.

By denying so many of Hawaii's families access to midwives and home birth, **SB2569 strips citizens of the right to make personal medical decisions in consultation with the health care provider of their choice**.

Sincerely,
Monique Miyake

DATE: February 8, 2014

TO: Honorable Chairs and Committee members of the Committee on Health, Committee on Commerce and Consumer Protection and Committee on Judiciary and Labor,

RE: SB2569 and SB2569 SD1 Relating to Home Birth

I am writing testimony in opposition to this bill.

While the intent of this measure may be to protect the health and well being of childbearing families, this particular measure is based on a fundamental misunderstanding of homebirth, and is inadequately researched and organized to do what it was intended.

Research shows that planned homebirth with a skilled and trained practitioner is as safe as low risk hospital birth. Several national organizations promote the use of direct entry midwives in out of hospital births to increase the range of maternity care choices, increase cost effectiveness, and improve infant mortality rates in the United States. . Included in these organizations are the American Public Health Association, the PEW report, the National Organization of Women, and the Coalition for Improving Maternity Services. The provisions in this bill over regulate and over medicalize pregnancy and birth, leading to a situation where homebirth will become virtually unattainable in the state of Hawaii. Rather than moving Hawaii toward improved birth outcomes, this bill will put Hawaii's women at risk of even poorer outcomes.

I fully understand the role of regulation in the practice of any trade, especially one as important and critical as midwifery. I encourage you to stop this measure from moving further. In its place, I encourage the development of a committee consisting of those intimately involved and skilled in home birth to do a more in depth study and crafting of appropriate and tenable midwifery regulation.

Thank you for your consideration and opposition to this bill.

Cheryl Eiko Cusick,
RN, MPH, IBCLC, student nurse-midwife, home birth mother of two sons

From: mailinglist@capitol.hawaii.gov
To: HTHTestimony
Cc: missz2000@rocketmail.com

Subject: Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date: Saturday, February 08, 2014 6:52:56 PM

SB2569

Submitted on: 2/8/2014
Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Zorah Meyer	Individual	Oppose	No

Comments: To: The Honorable Josh Green, Chair, Committee on Health The Honorable Roz Baker, Vice Chair, Committee on Water & Land The Honorable Roz Baker, Chair, Committee on Commerce and Consumer Protection The Honorable Brian Taniguchi, Vice Chair, Committee on Commerce and Consumer Protection The Honorable Clayton Hee, Chair, Committee on Judiciary and Labor The Honorable Maile Shimabukuro, Vice Chair, Committee on Judiciary and Labor Members, Senate Committee on Health Members, Senate Committee on Commerce and Consumer Members, Senate Committee on Judiciary and Labor From: Zorah G Meyer Date: February 10th, 2014 Hrg: Senate Committee on Health/Senate Committee on Commerce and Consumer Protection/Senate Committee on Judiciary and Labor; Mon. February 10th 2014 at 1:30 p.m. in Rm 229 Re: SB 2569 and SB2569 SD1, Relating to Home Birth – In Opposition Thank you for the opportunity to offer testimony in opposition of SB 2569 and SB 2569 SD1, both of which attempt to regulate midwifery in the State of Hawaii. Here are some reasons why I OPPOSE SB2569 and SB2569 SD1: • Both bills take away women's choices with regards for reproductive health. • SB2569 threatens women's health and would all but make midwifery and home birth illegal in the state of Hawaii, forcing mothers who choose to home birth to potentially go underground in finding illegal care providers which may pose a risk to herself and her baby. The bill also infringes on patients' rights and violates their right to medical privacy. • Home birth with a trained midwife is SAFE. This bill uses false data to support it's claim. It refers to a two to three fold increase in neonatal mortality and that is cited from a study that has been refuted. Here are studies addressing that particular study, along with others that support home birth with a trained midwife to be just as safe as a hospital birth. (1,2,3,4,5) • I'm are not opposed to regulation – however the regulations in SB2569 don't make sense and neither bill promotes the health of mothers or their babies. • These bills do NOT take into account cultural practices in home birth. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law. • The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth practice. The Home Birth Safety Board should be autonomous from the Hawaii Medical Board. There should be a Home Birth Providers Board overseen directly by the DCCA . • The Home Birth Safety Board to be comprised of the home birth

providers primarily, with some OB/MD representation but certainly not the majority or even half. • It is the right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. This bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose. Suggestions: Write a new bill next legislative session that addresses the concerns stated above and include home birth providers and key stakeholders in the birthing community when drafting new legislation. Amending SB2569 OR SB2569 SD1 is NOT an option. Both bills are too flawed to correct given the time constraints of the legislature. A complete overhaul of these bills must ensue. There are many suggestions for a new bill, please let's work together to create it.. Thank you for your time. I appreciate the opportunity to testify. Most Sincerely, Zorah Meyer Sources: 1. "Home Birth versus Hospital Birth: Questioning the Quality of the Evidence on Safety" article published in Birth (Volume 30, Issue 1, pages 57-63, March 2003) "In contrast, the Midwives Association of Washington State press release stated that 'Childbearing women and health policy makers should be made aware that the study contains numerous flaws and limitations...this study alone should not be used to make decisions that could restrict women's choice of birth place or access to birth attendants with expertise in home birth'" (http://onlinelibrary.wiley.com/.../j.1523-536X.../abstract) 2. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/.../Medscape-Wax-Critique-Michal...) 3. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics) 4. BMJ 2005;330;1416 Outcomes of planned home birth with certified professional midwives; large prospective study in North America 5. BJOG, 2009 Aug; 116(9):1177-84 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births 6. The Myth of a Safer Hospital Birth for Low Risk Pregnancies (http://www.greenmedinfo.com/.../myth-safer-hsopital-birth...) "Study validity questioned" in The American Journal of Obstetrics & Gynecology (volume 204, Issue 4, page e14, April 2011) (http://ajog.org/article/S0002-9378(10)01107-5/fulltext) 7. Home birth metaanalysis: does it meet AJOG's reporting requirements? (http://ajog.org/article/S0002-9378(11)00074-3/fulltext) 8. International data demonstrate home birth safety. (http://www.ncbi.nlm.nih.gov/pubmed/21458614) 9. "Home birth triples the neonatal death rate": public communication of bad science? (http://www.ajog.org/article/S0002-9378(11)00075-5/abstract) 10. http://www.ncbi.nlm.nih.gov/pubmed/23769011 11. http://www.bmj.com/content/330/7505/1416 12. Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009 http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12172/pdf

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From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	mamaselena.midwife@gmail.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Saturday, February 08, 2014 6:52:26 PM
Attachments:	SB2569 SD1 testimony.pages

SB2569

Submitted on: 2/8/2014

Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Selena M. Green	Individual	Oppose	Yes

Comments: I plan on testifying on SB2569 and SB2569 SD1 and I will oppose both!

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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ATTN: Honorable Chair and Committee members of Heath, Committee on Commerce and Consumer Protection and Judiciary and Labor

RE: Opposing SB2569 and SB2569 SD1 Relating to Home BIrth

This bill will restrict the rights of us as mothers to choose what is best for us and the delivery of our children. It will take away our freedom to choose where to deliver and how to deliver. As mothers we only want the best and safest means for the delivery of our children. Don't take away our freedom to choose what we know is best for our families.

Sincerely,

Lea Allocca
mother of 2

RE: **SB2569** and **SB2569 SD1** Relating to Home Birth **– <u>IN OPPOSITION</u>**

Aloha Senate Health Committee members,

My name is Jessica Lin, I moved to the Big Island in 2011 while I was pregnant with my son. As it was my first pregnancy, I did extensive research on what kind of options were available for the birth of my child. After reading many books and articles on other mother's birth experiences as well as careful thought of my own – I decided the best, most natural option for me and my son would be a home-birth with a midwife. My grandmother was a midwife in Taiwan, and I have heard stories of the loving work she served for the community in those days. I have never regretted any part of my experience and still continue to share the wonderful story of how my healthy baby boy came into the world.

I was connected to my midwife in the 5th month of my pregnancy. In talking with her, it was obvious how much knowledge and experience she had in her work. She guided me gently, every week teaching me how to listen to my body and my baby who was still in my belly. I felt confident in her and when the time came, I went into labor without fear as she had prepared me – and I knew I was in good hands. Even after my son was born, she cared for us and my recovery was incredibly smooth and fast.

In my circle of friends who have recently become mothers, the 4 of us who had home births experienced positive deliveries without complications and healthy babies. 2 of my friends who had originally wanted to have natural births without drugs in a hospital setting were medically intervened and did not have a natural birth experience as they had planned. Another 2 of my friends who had hospital births ended up in unplanned c-sections and were terribly affected with postpartum depression for months after. This is what I have personally experienced and witnessed in my circle. To say that home births are unsafe or riskier than hospital births is inaccurate.

Every mother should have the right to choose the setting in which they feel most comfortable to deliver their child. To me, there is a vast difference between choosing to birth in a hospital setting and a home birth. Although I personally feel it is safer to birth in a home setting, it is ultimately where the mother feels most comfortable and confident. I oppose this bill because it makes it difficult for the midwives in Hawaii to do their amazing work and have a safe practice for women like me who want to have a healthy and natural birth experience.

Thank you for your time, and please reconsider this bill.

REGULAR SESSION OF 2014

For: Honorable Senate Committee Health Chair Green, Vice Chair Baker and Committee Members,

Hearing 2-10-14 Rm 229

RE: SB2569 AND SB2569 SD1 **Relating to Home Birth – IN OPPOSITION**

To my Legislators: who represent the State of Hawaii:

I am writing in comment to S.B. No. 2569 and S.B. No. 2569 SD1 as a former and future Hawaii resident. I attended to UHM BSN program 2009 and am now continuing my education to become a licensed Midwife and plan to practice in the state of Hawaii.

I was proud and privileged to have a home birth in Kaneohe, HI 2010. My prenatal care, birth experience, and postpartum was everything I could have asked for in the safely and sacredness of the holistic medical monitored way of the midwifery model of care. My husband and I (photographers/videographers) created a documentary of our home birth and our film is now spreading across the nation! Please view the trailer at www.BornTwoBirth.com.

I am a registered voter.

In my opinion this bill is uninformed, inaccurate and violates of certain established rights. Currently, I'm studying to become a midwife in the state of Washington which 30 years ago established laws for out-of-hospital birth and today all states which utilize Licensed Midwives demonstrate to their communities exemplary statistics, financial sensibility, client satisfaction, appropriate utilization of resources in community collaborative management, and referral to provide integrated and uninterrupted care for women, thus families in our communities.

May evidenced-based health care practices be available and may the choice be in the hands of the individuals!

Hawaii could become the wave of the future in the model of care most evidence-based, and economically suited for these times, with their intention/goals in alignment with and producing good outcomes for all.

I strongly oppose SB 2569 and 2569 SD1 for the following reasons.

1. On its face, this bill is inaccurate. It cites a flawed study, and it suggests home birth is dangerous and unsafe. I join other home birth practitioners, mothers and advocates to correct that notion. We realize that we have a responsibility to provide data and information about

our home birth practices, our training, and our experiences to the legislature and community-at-large.

2. This bill currently tries to define a scope of practice without an in depth understanding of the various practitioners, roles and responsibilities involved in home birth. The medical hospital-based model it imposes doesn't take into account the population it is regulating and doesn't accurately represent different models of home birthing, each with unique traditions, scopes of practice, varying types of practitioners and their educational backgrounds, safety protocols and standards of care that are already in place.

3. The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth practice. This bill assumes there is no oversight over home birth; in fact, midwives have the capacity to govern themselves.

4. As written, this bill would essentially eliminate the option of finding a legal home birth attendant. It is the rite/right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. Furthermore, this bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose. Requiring a registry of home birth mothers, for example, fosters stigma around home birth, a scarlet letter. Laws are created to protect consumers and ensure safety. But lawmakers also have the obligation to protect long standing cultural practices of birth.

5. Home birth is a deeply cultural practice that is both respected and honored. We are all descended from an ancestor who gave birth at home. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.

For all of these reasons and more, I strongly oppose this bill as it stands. The imposition of these state regulations simply does not take into account the important perspectives of the birth practitioners, the mothers, and advocates of home birth.

Yet, we recognize the need for more information and offer the following:

- We have already begun to form a Home Birth Council that reflects the variety of practices, mothers and advocates. This Council shall be self-defined and self-regulated.

- We request the opportunity to gather data, standards of care, and wise practices to present before the legislature at a later date.

- We request a legislative informational hearing that provides the opportunity to present information about the spectrum of home birth practitioners, their education and training, and existing standards of care.

Thank you for your attention to this vital matter for our future!

Evidence in support of point #1

1. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/MCDG/wp-content/uploads/2013/02/Medscape-Wax-Critique-Michal-Janssen-Vedam-Hutton-de-Jonge.pdf)
2. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics)
3. BMJ 2005;330;1416 Outcomes of planned home birth with certified professional midwives; large prospective study in North America
4. BJOG, 2009 Aug; 116(9):1177-84 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births

5. The Myth of a Safer Hospital Birth for Low Risk Pregnancies (http://www.greenmedinfo.com/blog/myth-safer-hsopital-birth-low-risk-pregnancies)
6. AND MORE – add your own strongest studies, there are many!

Amy K. Halas
PO Box 925
Kane'ohe, Hawai'i
96744

February 8, 2014

To: Honorable Chair and Committee Members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor

RE: SB2569 and SB2569 SD1 Relating to Home Birth
Hearing date: 2-10-14 1:30pm, Room 229

Dear Honorable Chair and Committee Members,

I am writing to express my opposition to Senate Bill 2569 and Senate Bill 2569 SD1.

A woman's decision on where to give birth is very much her own. In light of the cascade of interventions that follows a medical induction for the purpose of forcing labor, thus contributing to the alarming rate of Cesarean Sections, home birth has become a much safer option for women and their newborns. I recommend that before enacting this piece of legislation that instead the legislators conduct a study to examine the differences between the midwifery model and the medical model of birthing. I believe that all birth options must be examined in depth before curtailing a woman's choice on where and with whom to deliver her baby.

Understandably, all members of the public are very concerned about safety and quality labor and delivery care. Unfortunately this bill will not address this concern. Instead it will drastically restrict the rights of women to choose where and with whom they wish to deliver their children. I believe that it is unethical and immoral to limit a woman's right to choose where to give birth. Furthermore, many women who are deemed to be "high risk" by the medical establishment are indeed physically and mentally capable of delivering at home with a midwife.

This bill is problematic because some forms of midwifery and home birth would consequently be excluded and criminalized. Again, this infringes upon a woman's choice on where and with whom to birth her baby. Instead, please allow the home birth community to include all practitioners who can provide support for all types of birth.

I find the blatant exclusion of certain home birth practitioners in the Home Birth Safety Board to be very troubling. Home birth is an extremely inclusive process. I question the validity of a Home Birth Safety Board with the glaring absence and omission of lay people from the home birth community.

Instead, please support the home birth community in their quest to form their own advisory board. This entity will include all birth practitioners: ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners, and others who support home birth. These individuals will gather data, dialogue, and form the appropriate standards acceptable to all birth practitioners and the community. This data will be brought back to the Capitol for the next legislative session.

Thank you.

Most Sincerely,

Amy K. Halas

To: The Honorable Josh Green, Chair, Committee on Health
The Honorable Roz Baker, Vice Chair, Committee on Water & Land

The Honorable Roz Baker, Chair, Committee on Commerce and Consumer Protection
The Honorable Brian Taniguchi, Vice Chair, Committee on Commerce and Consumer Protection

The Honorable Clayton Hee, Chair, Committee on Judiciary and Labor
The Honorable Maile Shimabukuro, Vice Chair, Committee on Judiciary and Labor

Members, Senate Committee on Health
Members, Senate Committee on Commerce and Consumer
Members, Senate Committee on Judiciary and Labor

From: Jennifer Maydan

Date: February 10th, 2014

Hrg: Senate Committee on Health/Senate Committee on Commerce and Consumer Protection/Senate Committee on Judiciary and Labor; Mon. February 10th 2014 at 1:30 p.m. in Rm 229

Re: **SB 2569 and SB2569 SD1, Relating to Home Birth – In Opposition**

Thank you for the opportunity to offer testimony in **opposition of SB 2569 and SB 2569 SD1,** both of which attempt to regulate midwifery in the State of Hawaii.

I am the mother of a five year old boy whom I gave birth to at my home on Maui. While considering becoming a parent, and while pregnant, my husband and I researched our birth options on Maui and decided to have a home birth with a midwife. It was absolutely the right decision for us. Our midwife was extremely knowledgeable and I always felt that the health of my baby and myself were always her number one priority. Home birth is not the preferred choice for everyone. But it is just that - a choice – and it MUST not be taken away from the women and families of Hawaii. If we choose to have another baby I have no doubt in my mind that I will choose to have a home birth again. Please to don't take this option away from me. Oppose SB2569 and SB2569 SD1.

Here are some reasons why I OPPOSE SB2569 and SB2569 SD1:

- Both bills take away choices for women when it comes to their reproductive health.

- SB2569 threatens women's health and would all but make midwifery and home birth illegal in the state of Hawaii, forcing mothers who choose to home birth to potentially go underground in finding illegal care providers which may pose a risk to herself and her baby. The bill also infringes on patients' rights and violates their right to medical privacy.

- Home birth with a trained midwife is SAFE. This bill uses false data to support it's claim. It refers to a two to three fold increase in neonatal mortality and that is cited from a study that has been **refuted.** Here are studies addressing that particular study, along with others that support home birth with a trained midwife to be just as safe as a hospital birth. (1,2,3,4,5)

- We are not opposed to regulation – however the regulations in SB2569 don't make sense and neither bill promotes the health of mothers or their babies.

- These bills do NOT take into account cultural practices in home birth. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.

- The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth practice. The Home Birth Safety Board should be autonomous from the Hawaii Medical Board. There should be a Home Birth Providers Board overseen directly by the DCCA .

- The Home Birth Safety Board to be comprised of the home birth providers primarily, with some OB/MD representation but certainly not the majority or even half.

- It is the right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. This bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose.

Suggestions:

Suggestions:

Write a new bill next legislative session that addresses the concerns stated above and include home birth providers and key stakeholders in the birthing community when drafting new legislation. Amending SB2569 OR SB2569 SD1 is NOT an option. Both bills are too flawed to correct given the time constraints of the legislature. A complete overhaul of these bills must ensue. There are many suggestions for a new bill, please let's work together to create it..

Thank you for your time. I appreciate the opportunity to testify.

Aloha,

Jennifer Maydan
670 Awalau Rd
Haiku, HI 96708

Sources:

1. "Home Birth versus Hospital Birth: Questioning the Quality of the Evidence on Safety" article published in Birth (Volume 30, Issue 1, pages 57-63, March 2003) "In contrast, the Midwives Association of Washington State press release stated that 'Childbearing women and health policy makers should be made aware that the study contains numerous flaws and limitations...this study alone should not be used to make decisions that could restrict women's choice of birth place or access to birth attendants with expertise in home birth'" (http://onlinelibrary.wiley.com/doi/10.1046/j.1523-536X.2003.00218.x/abstract)

2. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/MCDG/wp-content/uploads/2013/02/Medscape-Wax-Critique-Michal-Janssen-Vedam-Hutton-de-Jonge.pdf)

3. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics)

4. BMJ 2005;330;1416 Outcomes of planned home birth with certified professional midwives; large prospective study in North America

5. BJOG, 2009 Aug; 116(9):1177-84 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births

6. The Myth of a Safer Hospital Birth for Low Risk Pregnancies (http://www.greenmedinfo.com/blog/myth-safer-hsopital-birth-low-risk-pregnancies) *"Study validity questioned"* in *The American Journal of Obstetrics & Gynecology* (volume 204, Issue 4, page e14, April 2011) (http://ajog.org/article/S0002-9378(10)01107-5/fulltext)

7. Home birth metaanalysis: does it meet AJOG's reporting requirements? (http://ajog.org/article/S0002-9378(11)00074-3/fulltext)

8. International data demonstrate home birth safety. (http://www.ncbi.nlm.nih.gov/pubmed/21458614)

9. "Home birth triples the neonatal death rate": public communication of bad science? (http://www.ajog.org/article/S0002-9378(11)00075-5/abstract)

10. http://www.ncbi.nlm.nih.gov/pubmed/23769011

11. http://www.bmj.com/content/330/7505/1416

12. Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009
http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12172/pdf

Abigail Schoder

REGULAR SESSION OF 2014
For: Honorable Senate Committee Health Chair Green, Vice Chair Baker and Committee Members, Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor

Hearing: February 10, 2014 1:30 p.m.(date) Rm 229

RE: SB 2569 and SB2569 SD1 Relating to Home Birth – IN OPPOSITION

Aloha,
My name is Abigail Schoder. I had a home birth on the island of Kauai, am a registered voter in the state of Hawaii and am a long time supporter of a woman's right to birth in a way that feels safe to her, whether that be a home birth or at a hospital. Personally for me that choice was a home birth.
I know women who choose to birth at home and other women who choose to birth in a hospital. I support them all to make the choice that feels best and most safe for them individually. I am not opposed to hospital-based births if it is what the woman feels more comfortable with. I would not and do not expect that I should have the right to tell her where she has to birth. It wouldn't be fair that she be legally bound to HAVE to have a home birth if she felt safer in the hospital. I expect the same freedom of choice in being able to choose to birth at home. This choice is in fact both the mother (and the father) and the child's BIRTH RIGHT, literally. We use the term “birthright” in our language to represent different things. This freedom of choice (where and how a woman births)is fundamentally at the core of the definition of “Birth right”.
My labor and childbirth was a wonderful and challenging experience for me. There were moments of it that presented challenges. My midwives were fully competent, experienced and prepared in how to handle the situation to support both my baby and myself in having a safe delivery. They watched for signs and signals that they needed to be aware of and competently took action in a timely manner to ensure safety for both my baby and I.
Part of why I trusted my midwives is because I did my “homework” and checked out their backgrounds, experience etc. to make sure I was making a wise choice in who I would be working with in this very important process of birthing life. It is unfortunate that some people may call themselves a “midwife” and they don't have integrity to back that up. All midwives are not created equal and it is the responsibility of the client to do her research, homework, interviews etc. to make her own informed and competent decision.
This bill does not offer a woman support in making this decision. I strongly feel that it would cripple many highly skilled midwives from doing their job, not to mention rob women the right to experience the highly supportive and empowering experience of birthing in a way that is right for her and her baby. Birthing is a full fledged initiation for a woman and her child, one that deserves to be honored and supported not interfered and controlled.
I strongly oppose SB 2569 for the following reasons.
1. On its face, this bill is inaccurate. It cites a flawed study, and it suggests home birth is dangerous and unsafe. I join other home birth practitioners, mothers and advocates to correct that notion. We realize that we have a responsibility to provide data and information about our home birth practices, our training, and our experiences to the legislature and community-at-large.
2. This bill currently tries to define a scope of practice without an in depth understanding of the various practitioners, roles and responsibilities involved in home birth. The medical hospital-based model it imposes doesn’t take into account the population it is regulating and doesn’t accurately represent different models of home birthing, each with unique traditions, scopes of practice, varying types of practitioners and their educational backgrounds, safety protocols and standards of care that are already in place.
3. The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn’t even reflect the participants of home birth
practice. This bill assumes there is no oversight over home birth; in fact, midwives have the capacity to govern themselves.
4. As written, this bill would essentially eliminate the option of finding a legal home birth attendant. It is the rite/right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. Furthermore, this bill currently proposes to violate a woman’s bodily autonomy and a woman’s right to choose. Requiring a registry of home birth mothers, for example, fosters stigma around home birth, a scarlet letter. Laws are created to protect consumers and ensure safety. But lawmakers also have the obligation to protect long standing cultural practices of birth.
5. Home birth is a deeply cultural practice that is both respected and honored. We are all descended from an ancestor who gave birth at home. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.
For all of these reasons and more, I strongly oppose this bill as it stands. The imposition of these state regulations simply does not take into account the important perspectives of the birth practitioners, the mothers, and advocates of home birth.
Yet, we recognize the need for more information and offer the following:
* We have already begun to form a Home Birth Council that reflects the variety of practices, mothers and advocates. This Council shall be self-defined and self-regulated.
* We request the opportunity to gather data, standards of care, and wise practices to present before the legislature at a later date.
* We request a legislative informational hearing that provides the opportunity to present information about the spectrum of home birth practitioners, their education and training, and existing standards of care.
Thank you for your time and consideration on this very important subject,
Aloha,
Abigail Schoder
Evidence in support of point #1
1. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women’s Health 4/1/2011 (http://cfpcwp.com/MCDG/wp-content/uploads/2013/02/Medscape-Wax-Critique-Michal-Janssen-Vedam-Hutton-de-Jonge.pdf)
2. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics)
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Abigail Schoder

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REGULAR SESSION OF 2014
For: Honorable Senate Committee Health Chair Green, Vice Chair Baker and Committee Members, Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor

Hearing: February 10, 2014 1:30 p.m.(date) Rm 229

RE: SB 2569 and SB2569 SD1 Relating to Home Birth – IN OPPOSITION

Aloha,
My name is Abigail Schoder. I had a home birth on the island of Kauai, am a registered voter in the state of Hawaii and am a long time supporter of a woman's right to birth in a way that feels safe to her, whether that be a home birth or at a hospital. Personally for me that choice was a home birth.
I know women who choose to birth at home and other women who choose to birth in a hospital. I support them all to make the choice that feels best and most safe for them individually. I am not opposed to hospital-based births if it is what the woman feels more comfortable with. I would not and do not expect that I should have the right to tell her where she has to birth. It wouldn't be fair that she be legally bound to HAVE to have a home birth if she felt safer in the hospital. I expect the same freedom of choice in being able to choose to birth at home. This choice is in fact both the mother (and the father) and the child's BIRTH RIGHT, literally. We use the term "birthright" in our language to represent different things. This freedom of choice (where and how a woman births)is fundamentally at the core of the definition of "Birth right".
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Part of why I trusted my midwives is because I did my "homework" and checked out their backgrounds, experience etc. to make sure I was making a wise choice in who I would be working with in this very important process of birthing life. It is unfortunate that some people may call themselves a "midwife" and they don't have integrity to back that up. All midwives are not created equal and it is the responsibility of the client to do her research, homework, interviews etc. to make her own informed and competent decision.
This bill does not offer a woman support in making this decision. I strongly feel that it would cripple many highly skilled midwives from doing their job, not to mention rob women the right to experience the highly supportive and

empowering experience of birthing in a way that is right for her and her baby. Birthing is a full fledged initiation for a woman and her child, one that deserves to be honored and supported not interfered and controlled.
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practice. This bill assumes there is no oversight over home birth; in fact, midwives have

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor

From: Jennifer Shim
1614 Emerson St #2
Honolulu, HI 96813

Hearing date 2-10-14 1:30pm rm 229
RE: SB2569 and SB2569 SD1 Relating to Home Birth **(OPPOSED)**

Mahalo for allowing me to submit my testimony in regards to this bill today,
I'd like it known that this would be terribly unfair legislation should it be passed, as well as horribly discriminatory towards women and their rights to choose the manner in which they bring their children into this world. I'd like the following facts to be considered:

A) Home birth is safe, as safe if not safer than hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe? (Rising c-sect rate, inductions, medications...safe?) Let's dialogue, If legislators are truly interested in learning about home birth as Green's press release indicates, then take this next year to learn about the differences between the midwifery model vs the medical model of birthing. Become educated.

B) We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth.

C) This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for.

D) Let the home birth community form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

Sincerely,
Jennifer Shim
Makiki/Punchbowl

To: The Honorable Josh Green, Chair, Committee on Health
The Honorable Roz Baker, Vice Chair, Committee on Water & Land

The Honorable Roz Baker, Chair, Committee on Commerce and Consumer Protection
The Honorable Brian Taniguchi, Vice Chair, Committee on Commerce and Consumer Protection

The Honorable Clayton Hee, Chair, Committee on Judiciary and Labor
The Honorable Maile Shimabukuro, Vice Chair, Committee on Judiciary and Labor

Members, Senate Committee on Health
Members, Senate Committee on Commerce and Consumer
Members, Senate Committee on Judiciary and Labor

From: JENNIFER CAMPBELL JACKSON
Date: February 10th, 2014
Hrg: Senate Committee on Health/Senate Committee on Commerce and Consumer Protection/Senate Committee on Judiciary and Labor; Mon. February 10th 2014 at 1:30 p.m. in Rm 229
Re: SB 2569 and SB2569 SD1, Relating to Home Birth – In Opposition

Thank you for the opportunity to offer testimony in opposition of SB 2569 and SB 2569 SD1, both of which attempt to regulate midwifery in the State of Hawaii.

On April 25, 2013 at 5:19am on the Big Island of Hawaii, I gave birth to a 9.4 pound baby girl in the comfort and privacy of my own home, after 53 hours of natural normal labor, while in the care of two highly trained and skilled midwives, Nina Millar, RN, CPM and Dani Electa Kennedy, CPM. My home birth experience was the most beautiful, powerful and profound experience of my life. My home birth experience was free of unnecessary and invasive intervention often found in hospital settings. It was safe. It was compassionate. It was perfect. If bills SB2569 and SB2569 SD1 pass, women all over Hawaii will be denied their right to birth where, how and with whom they choose.

Here are some reasons why I OPPOSE SB2569 and SB2569 SD1:

- Both bills take away choices for women when it comes to their reproductive health.
- SB2569 threatens women's health and would all but make midwifery and home birth illegal in the state of Hawaii, forcing mothers who choose to home birth to potentially go underground in finding illegal care providers which may pose a risk to herself and her baby. The bill also infringes on patients' rights and violates their right to medical privacy.
- Home birth with a trained midwife is SAFE. This bill uses false data to support it’s claim. It refers to a two to three fold increase in neonatal mortality and that is cited from a study that has been refuted. Here are studies addressing that particular study, along with others that support home birth with a trained midwife to be just as safe as a hospital birth. (1,2,3,4,5)

• We are not opposed to regulation – however the regulations in SB2569 don't make sense and neither bill promotes the health of mothers or their babies.
• These bills do NOT take into account cultural practices in home birth. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.
• The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth practice. The Home Birth Safety Board should be autonomous from the Hawaii Medical Board. There should be a Home Birth Providers Board overseen directly by the DCCA .
• The Home Birth Safety Board to be comprised of the home birth providers primarily, with some OB/MD representation but certainly not the majority or even half.
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Suggestions:
Write a new bill next legislative session that addresses the concerns stated above and include home birth providers and key stakeholders in the birthing community when drafting new legislation.
Amending SB2569 OR SB2569 SD1 is NOT an option. Both bills are too flawed to correct given the time constraints of the legislature. A complete overhaul of these bills must ensue. There are many suggestions for a new bill, please let's work together to create it.
Thank you for your time. I appreciate the opportunity to testify.

Aloha,

JENNIFER CAMPBELL JACKSON

Sources:

1. "Home Birth versus Hospital Birth: Questioning the Quality of the Evidence on Safety" article published in Birth (Volume 30, Issue 1, pages 57-63, March 2003) "In contrast, the Midwives Association of Washington State press release stated that 'Childbearing women and health policy makers should be made aware that the study contains numerous flaws and limitations...this study alone should not be used to make decisions that could restrict women's choice of birth place or access to birth attendants with expertise in home birth'" (http://onlinelibrary.wiley.com/.../j.1523-536X.../abstract)
2. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/.../Medscape-Wax-Critique-Michal...)
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10. http://www.ncbi.nlm.nih.gov/pubmed/23769011
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12. Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009
http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12172/pdf

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	mccomb.andy@gmail.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Saturday, February 08, 2014 5:24:18 PM

SB2569

Submitted on: 2/8/2014
Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Andrew mccomb	Individual	Oppose	No

Comments: To: The Honorable Josh Green, Chair, Committee on Health The Honorable Roz Baker, Vice Chair, Committee on Water & Land The Honorable Roz Baker, Chair, Committee on Commerce and Consumer Protection The Honorable Brian Taniguchi, Vice Chair, Committee on Commerce and Consumer Protection The Honorable Clayton Hee, Chair, Committee on Judiciary and Labor The Honorable Maile Shimabukuro, Vice Chair, Committee on Judiciary and Labor Members, Senate Committee on Health Members, Senate Committee on Commerce and Consumer Members, Senate Committee on Judiciary and Labor From: ANDREW MCCOMB Date: February 10th, 2014 Hrg: Senate Committee on Health/Senate Committee on Commerce and Consumer Protection/Senate Committee on Judiciary and Labor; Mon. February 10th 2014 at 1:30 p.m. in Rm 229 Re: SB 2569 and SB2569 SD1, Relating to Home Birth – In Opposition Thank you for the opportunity to offer testimony in opposition of SB 2569 and SB 2569 SD1, both of which attempt to regulate midwifery in the State of Hawaii. Here are some reasons why I OPPOSE SB2569 and SB2569 SD1: • Both bills take away choices for women when it comes to their reproductive health. • SB2569 threatens women's health and would all but make midwifery and home birth illegal in the state of Hawaii, forcing mothers who choose to home birth to potentially go underground in finding illegal care providers which may pose a risk to herself and her baby. The bill also infringes on patients' rights and violates their right to medical privacy. • Home birth with a trained midwife is SAFE. This bill uses false data to support it's claim. It refers to a two to three fold increase in neonatal mortality and that is cited from a study that has been refuted. Here are studies addressing that particular study, along with others that support home birth with a trained midwife to be just as safe as a hospital birth. (1,2,3,4,5) • We are not opposed to regulation – however the regulations in SB2569 don't make sense and neither bill promotes the health of mothers or their babies. • These bills do NOT take into account cultural practices in home birth. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law. • The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth practice. The Home Birth Safety Board should be autonomous from the Hawaii Medical Board. There should be a Home Birth Providers Board overseen directly by the DCCA . • The Home Birth Safety Board to

be comprised of the home birth providers primarily, with some OB/MD representation but certainly not the majority or even half. • It is the right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. This bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose. Suggestions: Write a new bill next legislative session that addresses the concerns stated above and include home birth providers and key stakeholders in the birthing community when drafting new legislation. Amending SB2569 OR SB2569 SD1 is NOT an option. Both bills are too flawed to correct given the time constraints of the legislature. A complete overhaul of these bills must ensue. There are many suggestions for a new bill, please let's work together to create it.. Thank you for your time. I appreciate the opportunity to testify. Aloha, ANDREW MCCOMB Sources: 1. "Home Birth versus Hospital Birth: Questioning the Quality of the Evidence on Safety" article published in Birth (Volume 30, Issue 1, pages 57-63, March 2003) "In contrast, the Midwives Association of Washington State press release stated that 'Childbearing women and health policy makers should be made aware that the study contains numerous flaws and limitations...this study alone should not be used to make decisions that could restrict women's choice of birth place or access to birth attendants with expertise in home birth'" (http://onlinelibrary.wiley.com/.../j.1523-536X.../abstract) 2. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/.../Medscape-Wax-Critique-Michal...) 3. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics) 4. BMJ 2005;330;1416 Outcomes of planned home birth with certified professional midwives; large prospective study in North America 5. BJOG, 2009 Aug; 116(9):1177-84 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births 6. The Myth of a Safer Hospital Birth for Low Risk Pregnancies (http://www.greenmedinfo.com/.../myth-safer-hsopital-birth...) "Study validity questioned" in The American Journal of Obstetrics & Gynecology (volume 204, Issue 4, page e14, April 2011) (http://ajog.org/article/S0002-9378(10)01107-5/fulltext) 7. Home birth metaanalysis: does it meet AJOG's reporting requirements? (http://ajog.org/article/S0002-9378(11)00074-3/fulltext) 8. International data demonstrate home birth safety. (http://www.ncbi.nlm.nih.gov/pubmed/21458614) 9. "Home birth triples the neonatal death rate": public communication of bad science? (http://www.ajog.org/article/S0002-9378(11)00075-5/abstract) 10. http://www.ncbi.nlm.nih.gov/pubmed/23769011 11. http://www.bmj.com/content/330/7505/1416 12. Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009 http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12172/pdf

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From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	jamporee@hotmail.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Saturday, February 08, 2014 5:23:59 PM

SB2569

Submitted on: 2/8/2014

Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
jan ferguson	Individual	Oppose	No

Comments: To: The Honorable Josh Green, Chair, Committee on Health The Honorable Roz Baker, Vice Chair, Committee on Water & Land The Honorable Roz Baker, Chair, Committee on Commerce and Consumer Protection The Honorable Brian Taniguchi, Vice Chair, Committee on Commerce and Consumer Protection The Honorable Clayton Hee, Chair, Committee on Judiciary and Labor The Honorable Maile Shimabukuro, Vice Chair, Committee on Judiciary and Labor Members, Senate Committee on Health Members, Senate Committee on Commerce and Consumer Members, Senate Committee on Judiciary and Labor From: jan ferguson Date: February 10th, 2014 Hrg: Senate Committee on Health/Senate Committee on Commerce and Consumer Protection/Senate Committee on Judiciary and Labor; Mon. February 10th 2014 at 1:30 p.m. in Rm 229 Re: SB 2569 and SB2569 SD1, Relating to Home Birth – In Opposition Thank you for the opportunity to offer testimony in opposition of SB 2569 and SB 2569 SD1, both of which attempt to regulate midwifery in the State of Hawaii. I am NARM Certified Professional midwife, doula, breast feeding consultant and childbirth educator . I have lived on Maui for 43 years. Two of my three children were born at home with a qualified midwife. Here are some reasons why I OPPOSE SB2569 and SB2569 SD1: · Both bills take away choices for women when it comes to their reproductive health. · SB2569 threatens women's health and would all but make midwifery and home birth illegal in the state of Hawaii, forcing mothers who choose to home birth to potentially go underground in finding illegal care providers which may pose a risk to herself and her baby. The bill also infringes on patients' rights and violates their right to medical privacy. · Home birth with a trained midwife is SAFE. This bill uses false data to support it’s claim. It refers to a two to three fold increase in neonatal mortality and that is cited from a study that has been refuted. Here are studies addressing that particular study, along with others that support home birth with a trained midwife to be just as safe as a hospital birth. (1,2,3,4,5) · We are not opposed to regulation – however the regulations in SB2569 don't make sense and neither bill promotes the health of mothers or their babies. · These bills do NOT take into account cultural practices in home birth. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law. · The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn’t even reflect the participants of home birth practice. The Home Birth Safety

Board should be autonomous from the Hawaii Medical Board. There should be a Home Birth Providers Board overseen directly by the DCCA . · The Home Birth Safety Board to be comprised of the home birth providers primarily, with some OB/MD representation but certainly not the majority or even half. · It is the right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. This bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose. Suggestions: Write a new bill next legislative session that addresses the concerns stated above and include home birth providers and key stakeholders in the birthing community when drafting new legislation. Amending SB2569 OR SB2569 SD1 is NOT an option. Both bills are too flawed to correct given the time constraints of the legislature. A complete overhaul of these bills must ensue. There are many suggestions for a new bill, please let's work together to create it.. Thank you for your time. I appreciate the opportunity to testify. Aloha, Jan Ferguson Maui Resident CPM Sources: 1. "Home Birth versus Hospital Birth: Questioning the Quality of the Evidence on Safety" article published in Birth (Volume 30, Issue 1, pages 57-63, March 2003) "In contrast, the Midwives Association of Washington State press release stated that 'Childbearing women and health policy makers should be made aware that the study contains numerous flaws and limitations...this study alone should not be used to make decisions that could restrict women's choice of birth place or access to birth attendants with expertise in home birth'" (http://onlinelibrary.wiley.com/doi/10.1046/j.1523-536X.2003.00218.x/abstract) 2. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/MCDG/wp-content/uploads/2013/02/Medscape-Wax-Critique-Michal-Janssen-Vedam-Hutton-de-Jonge.pdf) 3. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics) 4. BMJ 2005;330;1416 Outcomes of planned home birth with certified professional midwives; large prospective study in North America 5. BJOG, 2009 Aug; 116(9):1177-84 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births 6. The Myth of a Safer Hospital Birth for Low Risk Pregnancies (http://www.greenmedinfo.com/blog/myth-safer-hsopital-birth-low-risk-pregnancies) "Study validity questioned" in The American Journal of Obstetrics & Gynecology (volume 204, Issue 4, page e14, April 2011) (http://ajog.org/article/S0002-9378(10)01107-5/fulltext) 7. Home birth metaanalysis: does it meet AJOG's reporting requirements? (http://ajog.org/article/S0002-9378(11)00074-3/fulltext) 8. International data demonstrate home birth safety. (http://www.ncbi.nlm.nih.gov/pubmed/21458614) 9. "Home birth triples the neonatal death rate": public communication of bad science? (http://www.ajog.org/article/S0002-9378(11)00075-5/abstract) 10. http://www.ncbi.nlm.nih.gov/pubmed/23769011 11. http://www.bmj.com/content/330/7505/1416 12. Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009 http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12172/pdf

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I oppose Bill SB2569 because I believe it unnecessarily limits access to midwifery care for many women.

I chose to deliver my daughter at a birth center on Kauai in April 2012. The midwives were very responsible in their care and genuinely had the best interests of the mother and child in mind. I am confident that if any risks had developed during my pregnancy that they would have acted professionally and referred me to the care of an obstetrician. I am also confident that they would have accompanied me to my delivery and helped me with any post-natal concerns, such as helping with breastfeeding, etc. Throughout my pregnancy, the attention and personal care I received from my midwives is something that cannot be easily replicated in a hospital environment. My midwives could be reached any time by phone and were always available to answer my questions and concerns.

Dear Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

Hearing Date 2-10-14, 1:30pm, Room 229
RE: SB2569 and SB2569 SD1 Relating to Home Birth
Oppose

Home birth is safe, as safe if not safer than hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe? (Rising c-sect rate, inductions, medications... safe?) Let's dialogue, if legislators are truly interested in learning about home birth as Green's press release indicates, then take this next year to learn about the differences between the midwifery model verse the medical model of birthing. Become educated.

We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth.

This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for.

Let the home birth community form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc. to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

Thank you,
Mrs. R

February 10, 2014
Monday
1:30 PM
Conference Room 229
State Capitol

To: Senator Josh Green, Chair - Committee on Health
Senator Rosalyn Baker, Chair - Committee on Commerce and Consumer Protection
Senator Clayton Hee, Chair - Committee on Judiciary and Labor

From: Colleen F. Inouye, MD

Re: SB 2065/SB2065SD1, Relating to Health

Position: Strongly support licensure, patient safety rules/regulations, informed consent, data collection, and establishment of a board to ensure Home Birth Safety in Hawaii as per Hawaii ACOG testimony

Dear Senators Green, Baker, Hee and members of the Committees on Health, Commerce and Consumer Protection, and Judiciary and Labor:

I have practiced on Maui for 29 years. Almost 25 of those years was devoted to Obstetrics. I graduated from a residency program that trained and worked with home birth providers. These true certified home birth providers trained similarly to obstetrical residents, seeing and participating in low risk to high risk deliveries. What I have seen on Maui are home birth providers that have decided that "if you see one or more deliveries or have had many children, you can do it too." Some of the home birth providers at least had a nursing education but most were/are mentored in the apprenticeship style. Now many of them have just taken an online course and have a "certificate."

Yes, there have been incidents involving home birth providers. The state is paying for the medical care of one of these babies and will for the rest of its life due to its chronic problems and medical issues from being oxygen deprived at birth. Another baby died because the home provider did not do any type of fetal monitoring. When I asked her what the rate of the baby's heart was in labor, she could not give me a rate; she just thumped out a beat. Another patient almost died due to a postpartum hemorrhage- and to think when they called, they wanted to come to the office to be checked.

I am very concerned about the safety of our mothers and their babies who opt for a planned home birth. The most recent and largest study to date reveals that there is a four-fold increased risk of neonatal death associated with home birth. In addition, there is a seven-fold increased risk of neonatal death for first time mothers who deliver at home

and a ten – fold increased risk for pregnancies more than 41 weeks gestation. [Grunebaum A, Chervenak F, etal. Society for Maternal Fetal Medicine Abstract. February 7, 2014.]

Currently, there is no licensure, and therefore no patient safety rules and regulations regarding home birth. There are many complications that can occur, particularly with high-risk pregnancies. However, even low-risk pregnancies can quickly, within a few minutes or even seconds, become high-risk during the labor and delivery process.

To ensure that all of Hawaii's mothers and babies have a safe and happy birth experience, I urge you to support the Home Birth Safety bill. This bill will ensure that home birth providers have had formal obstetrics education to care for mothers and infants, follow patient safety regulations such as no high-risk pregnancy deliveries at home, adequately inform their patients regarding their educational background and the possible risks of home birth, and require the timely completion of birth certificates and other data for all planned home births.

Thank you for the opportunity to submit this testimony on this very important Women's Health issue.

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor, regarding the hearing, which will be held on 2-10-14 at 1:30pm in room 229. **I STRONGLY OPPOSE SB2569 and SB2569 SD1** Relating to Home Birth.

Home birth is safe, as safe if not safer than hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe. Are the rising c-section rates, planned inductions, and medications used currently in hospitals safe? If legislators are truly interested in learning more about home birth as Green's press release indicates, then lets take the time to learn about the differences between the midwifery model and the medical model of birthing. Lets become educated.

We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth.

This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for.

Let the home birth community form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners, etc., to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

Hawai`i Childbirth Coalition

To: The Honorable Josh Green, Chair, Committee on Health
The Honorable Roz Baker, Vice Chair, Committee on Water & Land

The Honorable Roz Baker, Chair, Committee on Commerce and Consumer Protection
The Honorable Brian Taniguchi, Vice Chair, Committee on Commerce and Consumer Protection

The Honorable Clayton Hee, Chair, Committee on Judiciary and Labor
The Honorable Maile Shimabukuro, Vice Chair, Committee on Judiciary and Labor

Members, Senate Committee on Health
Members, Senate Committee on Commerce and Consumer
Members, Senate Committee on Judiciary and Labor

From: Samuel A Young
Date: February 10th, 2014
Hrg: Senate Committee on Health/Senate Committee on Commerce and Consumer Protection/Senate Committee on Judiciary and Labor; Mon. February 10th 2014 at 1:30 p.m. in Rm 229
Re: **SB 2569 and SB2569 SD1, Relating to Home Birth – In Opposition**

Thank you for the opportunity to offer testimony in **opposition of SB 2569 and SB 2569 SD1,** both of which attempt to regulate midwifery in the State of Hawaii.

Aloha,
My name is Sam Young,

As a future father, who is planning a home birth, I hope you can listen to this testimony below.

Here are some reasons why I OPPOSE SB2569 and SB2569 SD1:

- Both bills take away choices for women when it comes to their reproductive health.
- SB2569 threatens women's health and would all but make midwifery and home birth illegal in the state of Hawaii, forcing mothers who choose to home birth to potentially go underground in finding illegal care providers which may pose a risk to herself and her baby. The bill also infringes on patients' rights and violates their right to medical privacy.
- Home birth with a trained midwife is SAFE. This bill uses false data to support it's claim. It refers to a two to three fold increase in neonatal mortality and that is cited from a study that has been **refuted.** Here are studies addressing that particular study, along with others that support home birth with a trained midwife to be just as safe as a hospital birth. (1,2,3,4,5)
- We are not opposed to regulation – however the regulations in SB2569 don't make sense and neither bill promotes the health of mothers or their babies.

- These bills do NOT take into account cultural practices in home birth. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.
- The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth practice. The Home Birth Safety Board should be autonomous from the Hawaii Medical Board. There should be a Home Birth Providers Board overseen directly by the DCCA .
- The Home Birth Safety Board to be comprised of the home birth providers primarily, with some OB/MD representation but certainly not the majority or even half.
- It is the right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. This bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose.

Suggestions:

Write a new bill next legislative session that addresses the concerns stated above and include home birth providers and key stakeholders in the birthing community when drafting new legislation. Amending SB2569 OR SB2569 SD1 is NOT an option. Both bills are too flawed to correct given the time constraints of the legislature. A complete overhaul of these bills must ensue. There are many suggestions for a new bill, please let's work together to create it..

Thank you for your time. I appreciate the opportunity to testify.

Aloha,

Samuel A Young
Maui Resident
Archaeologist

Sources:

1. "Home Birth versus Hospital Birth: Questioning the Quality of the Evidence on Safety" article published in Birth (Volume 30, Issue 1, pages 57-63, March 2003) "In contrast, the Midwives Association of Washington State press release stated that 'Childbearing women and health policy makers should be made aware that the study contains numerous flaws and limitations...this study alone should not be used to make decisions that could restrict women's choice of birth place or access to birth attendants with expertise in home birth'" (http://onlinelibrary.wiley.com/doi/10.1046/j.1523-536X.2003.00218.x/abstract)

2. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/MCDG/wp-content/uploads/2013/02/Medscape-Wax-Critique-Michal-Janssen-Vedam-Hutton-de-Jonge.pdf)

3. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics)
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12. Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009 http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12172/pdf

TO: Chair Green, Vice Chair Baker, and Members of the Senate Committee on Health
Chair Baker, Vice Chair Taniguchi, and Members of the Senate Committee on Commerce and Consumer Protection
Chair Hee, Vice Chair Shimabukuro, and Members of the Senate Committee on Judiciary and Labor

RE: SB 2569 and SB 2569 S.D. 1 RELATING TO HOME BIRTH

Date: February 10, 2014 1:30pm

I appreciate the opportunity to provide testimony in **strong opposition** to the legislative bills SB 2569 and SB 2569 SD 1.

I am an Advanced Practice Maternal Infant Nurse in the State of Hawaii. In my 42 years practicing in the State, I have been involved with families seeking alternative ways to birth their infants both in the hospital, birth centers and in the home.

I appreciate the commitment of the Committees to address home birth issues in the State of Hawaii but I feel it is premature to address them as written in these two bills.

First, the DCCA currently regulates and licenses Certified Nurse Midwives. Further their certification continues through a national certifying board for Nurse Midwives. Presently Home Birthing is within the scope of certified nurse midwifery practice. Therefore both bills create regulatory redundancy as well as an unfair cost barrier for health care professionals who are already under state and national regulation.

Second, I feel this issue has not be thoroughly discussed with all stakeholders to determine a process for seamless, integrated, safe and respectful care for those choosing home birthing in our State.

Third, I feel the SB 2569 SD1 includes language that needs to be included in rules and regulations not a bill that would become law. The rules and regulations would be developed with further input from health professionals, and community individuals at public hearings after the passage of such legislation.

Therefore, I humbly suggest the Committees here present create a Home Birth Task Force of health professionals and community individuals to research the need for and resources required to establish a home birth safety board that would not create regulatory redundancy, and suggest a draft bill for the Legislature to address in a future session.

Thank you for the opportunity to testify.

Patricia L. Bilyk, RN, MPH, MSN, IBCLC

Hearing Date 2-10-14 1:30pm Rm 229
RE: SB2569 and SB2569 SD1 Relating to Home Birth
OPPOSITION

Aloha Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

My name is Justine Kamelamela. In both my pregnancies I was under the care of a midwife. I am writing in **OPPOSITION** to SB2569 and SB2569 SD1. Birth is a normal physiological process and I feel these bills will restrict a mothers freedom to choose where she can give birth.

My opposition is based on these foundations:

- The bill claims that the hospital as being the safest birthplace. Home birth is a safe option. More investigation needs to be done to study all birth options, home and hospital, to discern what is safer before any sort of legislation regarding this manner may proceed.
- Safety and quality of care do not seem to be the focal points of this bill. The parameters of this bill would instead restrict the rights of families to deliver their children safely in the settings that they feel true to them and with the attendants they feel most comfortable with. This is a right reserved for a mother and her family. It is not the legislatures right to decide how and where a mother should give birth.
- This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for. Hawaiʻi is diverse in the cultural protocol from mother to mother and the needs of all women need to be represented and met by the birth community, not regulated by a legislative bill.
- The American College of Obstetricians and Gynecologists, the American Academy of Pediatrics and the Hawaiʻi Legislature should not alone be making initial initiatives for home birth standards. The home birth community in Hawaiʻi needs to be involved in the process of forming its own advisory consul with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc… - in an effort to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

For these reasons I ask that you **OPPOSE** and **KILL SB2569** and **SB2569 SD1.**

Mahalo for your time,
Justine Kamelamela

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor

From: Jennifer Shim
1614 Emerson St #2
Honolulu, HI 96813

Hearing date 2-10-14 1:30pm rm 229
RE: SB2569 and SB2569 SD1 Relating to Home Birth **(OPPOSED)**

Mahalo for allowing me to submit my testimony in regards to this bill today,
I'd like it known that this would be terribly unfair legislation should it be passed, as well as horribly discriminatory towards women and their rights to choose the manner in which they bring their children into this world. I'd like the following facts to be considered:

A) Home birth is safe, as safe if not safer than hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe? (Rising c-sect rate, inductions, medications...safe?) Let's dialogue, If legislators are truly interested in learning about home birth as Green's press release indicates, then take this next year to learn about the differences between the midwifery model vs the medical model of birthing. Become educated.

B) We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth.

C) This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for.

D) Let the home birth community form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

Sincerely,
Jennifer Shim
Makiki/Punchbowl

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	est.asia@yahoo.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Saturday, February 08, 2014 10:59:27 PM

SB2569

Submitted on: 2/8/2014
Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Estasia Barrientosi	Individual	Comments Only	No

Comments: 1. To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor, 2. Hearing date 2-10-14 1:30pm rm 229 3. RE: SB2569 and SB2569 SD1 Relating to Home Birth 4. Oppose 5. Four main points: A) Home birth is safe, as safe if not safer than hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe? (Rising c-sect rate, inductions, medications...safe?) Let's dialogue, If legislators are truly interested in learning about home birth as Green's press release indicates, then take this next year to learn about the differences between the midwifery model vs the medical model of birthing. Become educated. B) We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth. C) This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for. D) Let the home birth community form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session. Most Importantly, I am a home birthing mother of 2, one home birth after cesarean. It was safe, healthy, and the way I chose to give birth. It is my tradition to home birth as my ancestors did. It is my human right to choose where I birth. This bill takes away the freedoms of traditional women and their children. I oppose this bill on the basis of freedom of choice.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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webmaster@capitol.hawaii.gov

Hawai`i Childbirth Coalition

To: The Honorable Josh Green, Chair, Committee on Health
The Honorable Roz Baker, Vice Chair, Committee on Water & Land

The Honorable Roz Baker, Chair, Committee on Commerce and Consumer Protection
The Honorable Brian Taniguchi, Vice Chair, Committee on Commerce and Consumer Protection

The Honorable Clayton Hee, Chair, Committee on Judiciary and Labor
The Honorable Maile Shimabukuro, Vice Chair, Committee on Judiciary and Labor

Members, Senate Committee on Health
Members, Senate Committee on Commerce and Consumer
Members, Senate Committee on Judiciary and Labor

From: ALEXA FONG
Date: February 10th, 2014
Hrg: Senate Committee on Health/Senate Committee on Commerce and Consumer Protection/Senate Committee on Judiciary and Labor; Mon. February 10th 2014 at 1:30 p.m. in Rm 229
Re: **SB 2569 and SB2569 SD1, Relating to Home Birth – In Opposition**

Thank you for the opportunity to offer testimony in **opposition of SB 2569 and SB 2569 SD1,** both of which attempt to regulate midwifery in the State of Hawaii.

My name is Alexa Fong. I am Maui resident and am a social worker with child and families. Many of the families I work with and personal friends have chosen the option of a home birth with their children. Child birth is a scared and personal experience. Limiting women's options will greatly affect our community. A home birth is not for every family, but families should have the right to choose base on their needs and cultural beliefs. Oversight is important, but we must move forward with the input and support of the community, especially those that have been practicing for many generations.

Here are some reasons why I OPPOSE SB2569 and SB2569 SD1:

- Both bills take away choices for women when it comes to their reproductive health.
- SB2569 threatens women's health and would all but make midwifery and home birth illegal in the state of Hawaii, forcing mothers who choose to home birth to potentially go underground in finding illegal care providers which may pose a risk to herself and her baby. The bill also infringes on patients' rights and violates their right to medical privacy.
- Home birth with a trained midwife is SAFE. This bill uses false data to support it's claim. It refers to a two to three fold increase in neonatal mortality and that is cited from a study that has been **refuted.** Here are studies addressing that particular study, along with others that support home birth with a trained midwife to be just as safe as a hospital birth. (1,2,3,4,5)

- We are not opposed to regulation – however the regulations in SB2569 don't make sense and neither bill promotes the health of mothers or their babies.
- These bills do NOT take into account cultural practices in home birth. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.
- The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth practice. The Home Birth Safety Board should be autonomous from the Hawaii Medical Board. There should be a Home Birth Providers Board overseen directly by the DCCA .
- The Home Birth Safety Board to be comprised of the home birth providers primarily, with some OB/MD representation but certainly not the majority or even half.
- It is the right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. This bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose.

Suggestions:

Write a new bill next legislative session that addresses the concerns stated above and include home birth providers and key stakeholders in the birthing community when drafting new legislation. Amending SB2569 OR SB2569 SD1 is NOT an option. Both bills are too flawed to correct given the time constraints of the legislature. A complete overhaul of these bills must ensue. There are many suggestions for a new bill, please let's work together to create it..

Thank you for your time. I appreciate the opportunity to testify.

Aloha,

Alexa Fong

Sources:

1. "Home Birth versus Hospital Birth: Questioning the Quality of the Evidence on Safety" article published in Birth (Volume 30, Issue 1, pages 57-63, March 2003) "In contrast, the Midwives Association of Washington State press release stated that 'Childbearing women and health policy makers should be made aware that the study contains numerous flaws and limitations...this study alone should not be used to make decisions that could restrict women's choice of birth place or access to birth attendants with expertise in home birth'" (http://onlinelibrary.wiley.com/doi/10.1046/j.1523-536X.2003.00218.x/abstract)

2. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/MCDG/wp-

content/uploads/2013/02/Medscape-Wax-Critique-Michal-Janssen-Vedam-Hutton-de-Jonge.pdf)

3. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics)
4. BMJ 2005;330;1416 Outcomes of planned home birth with certified professional midwives; large prospective study in North America
5. BJOG, 2009 Aug; 116(9):1177-84 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births
6. The Myth of a Safer Hospital Birth for Low Risk Pregnancies (http://www.greenmedinfo.com/blog/myth-safer-hsopital-birth-low-risk-pregnancies) *"Study validity questioned"* in *The American Journal of Obstetrics & Gynecology* (volume 204, Issue 4, page e14, April 2011) (http://ajog.org/article/S0002-9378(10)01107-5/fulltext)
7. Home birth metaanalysis: does it meet AJOG's reporting requirements? (http://ajog.org/article/S0002-9378(11)00074-3/fulltext)
8. International data demonstrate home birth safety. (http://www.ncbi.nlm.nih.gov/pubmed/21458614)
9. “Home birth triples the neonatal death rate”: public communication of bad science? (http://www.ajog.org/article/S0002-9378(11)00075-5/abstract)
10. http://www.ncbi.nlm.nih.gov/pubmed/23769011
11. http://www.bmj.com/content/330/7505/1416
12. Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009 http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12172/pdf

Hearing Date 2-10-14 1:30pm Rm 229
RE: SB2569 and SB2569 SD1 Relating to Home Birth
OPPOSITION

Aloha kākou e Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

I hope this message finds you well. I write in **OPPOSITION** to SB2569, which would establish a board to certify homebirth practitioners and consequently limit options for women and families to choose homebirth and the birth supporters that suit them. My opposition is based on these foundations:

- The bill's claims around the hospital being the safest birth place needs to be investigated. Home birth is safe, and is as safe if not safer than hospital births. More investigation needs to be done to study all birth options, home, hospital and others, to discern what is safe before any sort of legislation regarding this manner proceeds.
- Safety and quality care do not seem to be the true focal points of this bill. The parameters of this bill would instead restrict the rights of families to deliver safely their children in the settings that feel true to them and with the attendants they choose. This is a right reserved for mothers and their families, where they decide what safety and quality care means to them and in accordance with the health professionals and practitioners they choose. It is **not** the legislature's right to decide how and where someone can birth.
- This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for. Hawai'i is diverse in the cultural protocol from mother to mother and the needs of all women need to be represented and met by the birth community, not regulated by a legislative bill.
- The American College of Obstetricians and Gynecologists, the American Academy of Pediatrics and the Hawai'i Legislature should not alone be making initial initiatives for home birth standards. The home birth community in Hawai'i needs to form its own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc. – in an effort to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session. At that point, a process for standards could begin with all parties present and with all community interests represented.

For these reasons I ask that you **OPPOSE** and **KILL SB2569**.

Thank you for your time,
Meghan Leialoha Au
Kanaka Maoli health practitioner & activist, small business owner and UH Mānoa grad student

TESTIMONY Re: SB2569 and SB2569 SD1 Relating to Home Birth

Hearing Date: 2-10-14 1:30pm rm229

I OPPOSE

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection Judiciary and Labor,

I am a mother of two children born safely at home, my first son was born in California with a midwife and Doula attending their birth. My second son was born here in Hawaii at our house on the North Shore with my midwife and two other birth attendants. During both births I knew that I was in the best care and with women who had attended hundreds of births, I trusted them and there knowledge to guide me.

Home birth is safe, and is every women's right to have the choice of either home birth or hospital birth. If you take away our choice you take away our most sacred right as a women to give birth in the safety and security of our own homes with our families.

Going into my first pregnancy I had a choice to give birth at home or in the hospital. After doing a lot of research on hospitals as well as home births I made the decision that giving birth at home was the safest option for me. If I were forced to have my births at the hospital because of a law well, I would travel to another state or country and leave my home in Hawaii to be able to have that choice. You will hear from the testifiers the difference between home birth and hospital birth, you will talk until you are blue in the face, but the bottom line is this is a choice that you cannot take away from women.

Thank you for taking the time to read my testimony,

Krista Ehiku Rademacher

Haleiwa, Hawaii

310-729-5343

ehiku@mac.com

Dear Senate of Hawaii:
My name is Darby Louise Partner. I am a Certified Professional Midwife. I also a hold a midwifery license in the State of Oregon, as I lived in Oregon for 15 years before I moved to Hawaii. I live and practice in South Kona, on the Big Island. I was not able to make it to Oahu to attend the hearing today but I would like to make my voice heard.
I am not in opposition to the regulation of midwifery in Hawaii, but my support is conditional.
I oppose SB2569. I also oppose SB2569 SD1 as it stands now.
I oppose SB2569 as it does not included CPMs such as myself, and would allow only Certified Nurse Midwives to practice, causing all other midwives to be illegal and women to seek care illegally and unassisted, thus deeming birth less safe. It is a ridiculous bill that must be killed immediately.
To have my support on SB2569 SD1 the following changes would have to be made:
1: Because MIDWIFERY IS NOT THE PRACTICE OF MEDICINE, the midwifery board is NOT to be under the Medical Board, but is to be an autonomous Midwifery Board and to consist of CPMs/LMs.
2: L.M.s to be allowed to obtain, carry and use the following medications: anti-hemmorhagic medications such as pitocin and metherigine, antibiotics for use in a GBS positive woman in labor if mother chooses, but not required, and rhogham. They are also to be allowed to place I.V.s
3: L.M.s to be allowed to repair 3rd degree lacerations.
4: L.M.s to be allowed to deliver breeches and twins: In the hospital these are done almost entirely by C-section which has its own great risks. Midwives are virtually the only ones who study and practice the skills to deliver a breech baby or twins and these skills must be allowed to stay intact. An informed consent can be required, listing the risks and benefit of birthing a breech baby, or twins out-of-hospital, and it should be legal to give birth to a breech baby and twins at home with an LM.
5: No restrictions with BMI. Plus-size women have been shown to give birth safely at out-of-hospital with a midwife.
6: Vaginal births after more then one cesearean (VBACs) must be allowed. Again, an informed consent may be required, but allow the mother to choose her place and method of birth even if she has had more then one C-section in the past.
7: Immediate transfer in labor must not be required if there is meconium. This must be specified as "thick meconium" as light or medium meconium alone is not a sign of fetal distress.
8: There needs to be a Traditional Midwife clause to allow traditional midwives to practice, which can include (as Oregon is implementing) a lengthy informed consent written by the state, advertising not allowed and carrying medications not allowed.

Because this bill has so many flaws, I suggest it be laid to rest, and then, with much education for the bill-writers, and input from the midwives, a new bill be written that is fair. I do not oppose regulation as I said, but as these bills stand now, they are unacceptable and I oppose both.

Please read the study that shows planned homebirths with midwives are safe:
http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12172/abstract
I highly recommend the Senate look at Oregon's Midwifery Bills and rules and regulations which can be found online at http://www.oregon.gov/OHLA/DEM/Pages/index.aspx
They are fair regulations and have been working well for many years.
Please work to provide safe and fair midwifery laws. Please preserve women's reproductive rights and choices. Please keep human rights in childbirth intact in the state of Hawaii.
Mahalo for your time,
Darby L. Partner CPM LDM

David Schoder

REGULAR SESSION OF 2014
For: Honorable Senate Committee Health Chair Green, Vice Chair Baker and Committee Members, Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor

Hearing: February 10, 2014 1:30 p.m.(date) Rm 229

RE: SB 2569 and SB2569 SD1 Relating to Home Birth – IN OPPOSITION

Aloha,
My name is David Schoder. My wife had a home birth on the island of Kauai and am a long time supporter of a woman's right to birth in a way that feels safe to her, whether that be a home birth or at a hospital. For my wife that choice was a home birth.
I know women who choose to birth at home and other women who choose to birth in a hospital. I would support them all to make the choice that feels best and most safe for them individually. I am not opposed to hospital-based births if it is what the woman feels more comfortable with. I would not and do not expect that I should have the right to tell her where she has to birth. It wouldn't be fair that she be legally bound to HAVE to have a home birth if she felt safer in the hospital. I expect the same freedom of choice for my wife to choose to birth at home. This choice is in fact both the mother (and the father) and the child's BIRTH RIGHT, literally. We use the term "birthright" in our language to represent different things. This freedom of choice (where and how a woman births)is fundamentally at the core of the definition of "Birth right".
My wife's labor and childbirth was a wonderful and challenging experience for her. There were moments of it that presented challenges. Our midwives were fully competent, experienced and prepared in how to handle the situation to support both our baby and my wife in having a safe delivery. They watched for signs and signals that they needed to be aware of and competently took action in a timely manner to ensure safety for both our baby and my wife.
Part of why we trusted our midwives is because we did our "homework" and checked out their backgrounds, experience etc. to make sure we were making a wise choice in who we'd would be working with in this very important process of birthing life. It is unfortunate that some people may call themselves a "midwife" and they don't have integrity to back that up. All midwives are not created equal and it is the responsibility of the client to do her research, homework, interviews etc. to make her own informed and competent decision.
This bill does not offer a woman support in making this decision. I strongly feel that it would cripple many highly skilled midwives from doing their job, not to mention rob women the right to experience the highly supportive and empowering experience of birthing in a way that is right for her and her baby. Birthing is a full fledged initiation for a woman and her child, one that deserves to be honored and supported not interfered and controlled.
I strongly oppose SB 2569 for the following reasons.
1. On its face, this bill is inaccurate. It cites a flawed study, and it suggests home birth is dangerous and unsafe. I join other home birth practitioners, mothers and advocates to correct that notion. We realize that we have a responsibility to provide data and information about our home birth practices, our training, and our experiences to the legislature and community-at-large.
2. This bill currently tries to define a scope of practice without an in depth understanding of the various practitioners, roles and responsibilities involved in home birth. The medical hospital-based model it imposes doesn't take into account the population it is regulating and doesn't accurately represent different models of home birthing, each with unique traditions, scopes of practice, varying types of practitioners and their educational backgrounds, safety protocols and standards of care that are already in place.
3. The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth practice. This bill assumes there is no oversight over home birth; in fact, midwives have the capacity to govern themselves.
4. As written, this bill would essentially eliminate the option of finding a legal home birth attendant. It is the rite/right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. Furthermore, this bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose. Requiring a registry of home birth mothers, for example, fosters stigma around home birth, a scarlet letter. Laws are created to protect consumers and ensure safety. But lawmakers also have the obligation to protect long standing cultural practices of birth.
5. Home birth is a deeply cultural practice that is both respected and honored. We are all descended from an ancestor who gave birth at home. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.
For all of these reasons and more, I strongly oppose this bill as it stands. The imposition of these state regulations simply does not take into account the important perspectives of the birth practitioners, the mothers, and advocates of home birth.
Yet, we recognize the need for more information and offer the following:
* We have already begun to form a Home Birth Council that reflects the variety of practices, mothers and advocates. This Council shall be self-defined and self-regulated.
* We request the opportunity to gather data, standards of care, and wise practices to present before the legislature at a later date.
* We request a legislative informational hearing that provides the opportunity to present information about the spectrum of home birth practitioners, their education and training, and existing standards of care.
Thank you for your time and consideration on this very important subject,
Aloha,
David Schoder
Evidence in support of point #1
1. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/MCDG/wp-content/uploads/2013/02/Medscape-Wax-Critique-Michal-Janssen-Vedam-Hutton-de-Jonge.pdf)
2. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics)
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4. BJOG, 2009 Aug; 116(9):1177-84 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births
5. The Myth of a Safer Hospital Birth for Low Risk Pregnancies (http://www.greenmedinfo.com/blog/myth-safer-hsopital-birth-low-risk-pregnancies)

David Schoder

Abigail Schoder

REGULAR SESSION OF 2014
For: Honorable Senate Committee Health Chair Green, Vice Chair Baker and Committee Members, Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor

Hearing: February 10, 2014 1:30 p.m.(date) Rm 229

RE: SB 2569 and SB2569 SD1 Relating to Home Birth – IN OPPOSITION

Aloha,
My name is Abigail Schoder. I had a home birth on the island of Kauai, am a registered voter in the state of Hawaii and am a long time supporter of a woman's right to birth in a way that feels safe to her, whether that be a home birth or at a hospital. Personally for me that choice was a home birth.
I know women who choose to birth at home and other women who choose to birth in a hospital. I support them all to make the choice that feels best and most safe for them individually. I am not opposed to hospital-based births if it is what the woman feels more comfortable with. I would not and do not expect that I should have the right to tell her where she has to birth. It wouldn't be fair that she be legally bound to HAVE to have a home birth if she felt safer in the hospital. I expect the same freedom of choice in being able to choose to birth at home. This choice is in fact both the mother (and the father) and the child's BIRTH RIGHT, literally. We use the term “birthright” in our language to represent different things. This freedom of choice (where and how a woman births)is fundamentally at the core of the definition of “Birth right”.
My labor and childbirth was a wonderful and challenging experience for me. There were moments of it that presented challenges. My midwives were fully competent, experienced and prepared in how to handle the situation to support both my baby and myself in having a safe delivery. They watched for signs and signals that they needed to be aware of and competently took action in a timely manner to ensure safety for both my baby and I.
Part of why I trusted my midwives is because I did my “homework” and checked out their backgrounds, experience etc. to make sure I was making a wise choice in who I would be working with in this very important process of birthing life. It is unfortunate that some people may call themselves a “midwife” and they don't have integrity to back that up. All midwives are not created equal and it is the responsibility of the client to do her research, homework, interviews etc. to make her own informed and competent decision.
This bill does not offer a woman support in making this decision. I strongly feel that it would cripple many highly skilled midwives from doing their job, not to mention rob women the right to experience the highly supportive and

empowering experience of birthing in a way that is right for her and her baby. Birthing is a full fledged initiation for a woman and her child, one that deserves to be honored and supported not interfered and controlled.
I strongly oppose SB 2569 for the following reasons.
1. On its face, this bill is inaccurate. It cites a flawed study, and it suggests home birth is dangerous and unsafe. I join other home birth practitioners, mothers and advocates to correct that notion. We realize that we have a responsibility to provide data and information about our home birth practices, our training, and our experiences to the legislature and community-at-large.
2. This bill currently tries to define a scope of practice without an in depth understanding of the various practitioners, roles and responsibilities involved in home birth. The medical hospital-based model it imposes doesn't take into account the population it is regulating and doesn't accurately represent different models of home birthing, each with unique traditions, scopes of practice, varying types of practitioners and their educational backgrounds, safety protocols and standards of care that are already in place.
3. The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth
practice. This bill assumes there is no oversight over home birth; in fact, midwives have the capacity to govern themselves.
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Abigail Schoder

REGULAR SESSION OF 2014
For: Honorable Senate Committee Health Chair Green, Vice Chair Baker and Committee Members, Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor

Hearing: February 10, 2014 1:30 p.m.(date) Rm 229

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Part of why I trusted my midwives is because I did my “homework” and checked out their backgrounds, experience etc. to make sure I was making a wise choice in who I would be working with in this very important process of birthing life. It is unfortunate that some people may call themselves a “midwife” and they don't have integrity to back that up. All midwives are not created equal and it is the responsibility of the client to do her research, homework, interviews etc. to make her own informed and competent decision.

This bill does not offer a woman support in making this decision. I strongly feel that it would cripple many highly skilled midwives from doing their job, not to mention rob women the right to experience the highly supportive and empowering experience of birthing in a way that is right for her and her baby. Birthing is a full fledged initiation for a woman and her child, one that deserves to be honored and supported not interfered

and controlled.
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3. The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth
practice. This bill assumes there is no oversight over home birth; in fact, midwives have

From: mailinglist@capitol.hawaii.gov
To: HTHTestimony
Cc: angrybraids@aol.com
Subject: Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date: Saturday, February 08, 2014 11:53:44 PM

SB2569

Submitted on: 2/8/2014
Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Amelia Ensign	Individual	Oppose	No

Comments: I Amelia Ensign oppose SB2569 and SB2569 SD1.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	maefuimaono@yahoo.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Saturday, February 08, 2014 4:17:04 PM
Attachments:	Home Birth .pdf

SB2569

Submitted on: 2/8/2014
Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Mae Fuimaono	Individual	Support	Yes

Comments: Aloha, Thank you for hearing this very important piece of legislation. I have worked as a healthcare for over 13 years 3 of those years were as a scrub tech in OB the rest have been as a registered nurse. I feel like I have the experience both professionally and personally to speak on this topic. In the beginning I worked on a team that was basically all high risk, that included several cases of home birth gone wrong. I have personally witnessed several fetal and maternal deaths (this was a very large 2,000 bed hospital). With that said in the beginning my view of home births were very negative because I never saw good out come, the good outcomes stayed at home with their families so my only exposure was negative. As I got older and received more experience and got my masters in nursing my view towards home births shifted. Several of my friends had home births and had good experiences. So being an individual driven by data, I looked at the research. I included the most recent journal article on home birth it strongly supports this type of legislation, it shows safety of home birth when done with a properly trained individual. Out of all the births done (almost 17,000) only 900 were done by non licensed individuals. Hawaii is in desperate need of this type of legislation, last year I did a woman's health rotation and heard several horror stories of women who had bad outcomes because their midwives wasn't properly trained to do her job. This will help to open up the dialogue, between midwives and MD's a relationship that has needed work for years. Thank you

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Original Research

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

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

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

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

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

INTRODUCTION

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

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

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BACKGROUND

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

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

Quick Points

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

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

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

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

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

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

METHODS

Data Collection

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

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

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

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

Inclusion Criteria

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

Data Export and Analysis

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

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

RESULTS

Contributing Midwives

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

Demographic Characteristics

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

Antenatal Risk Status

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

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

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

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

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

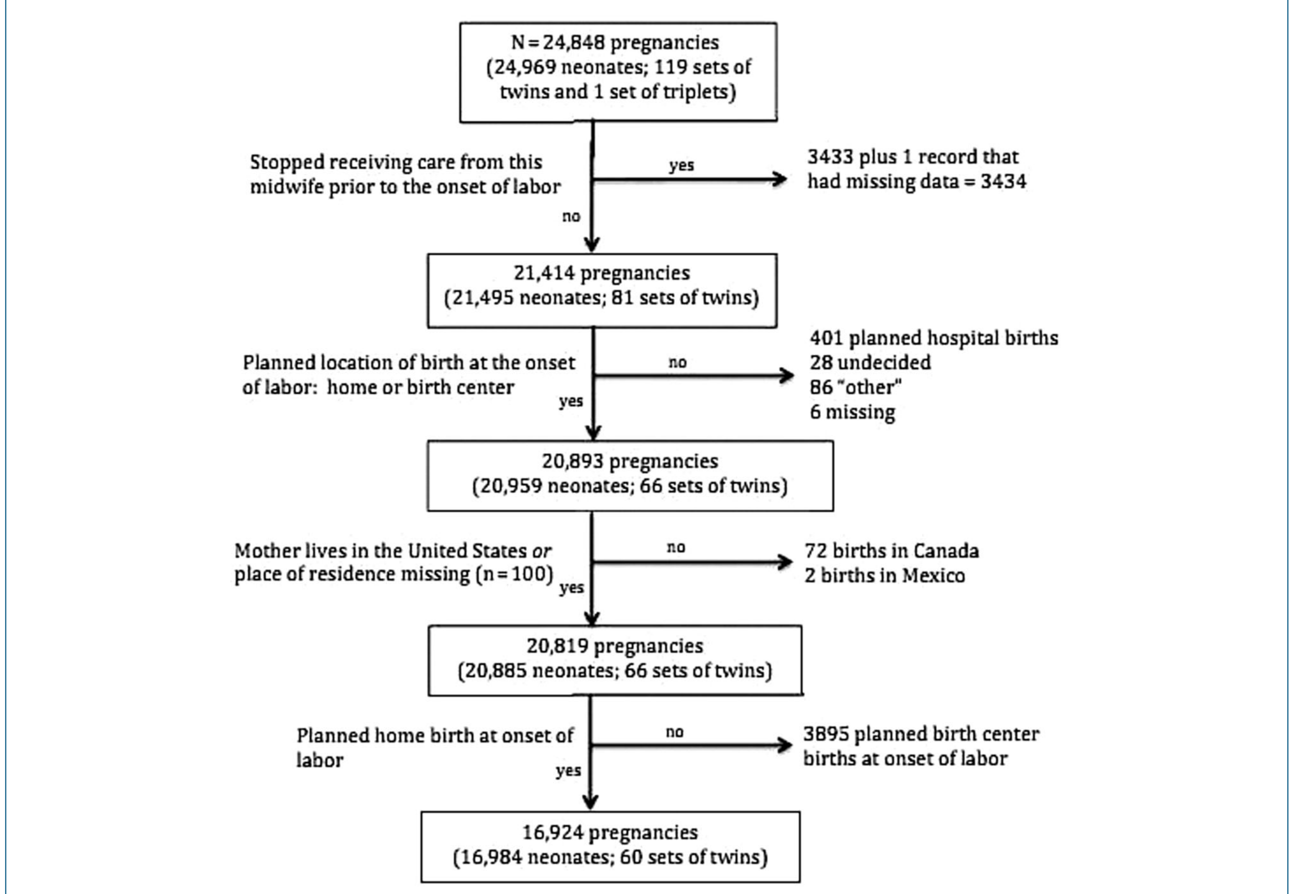

Figure 1. Sample Size Delimitation.
Delimitation begins with all records entered into the Midwives Alliance of North America Statistics Project (MANA Stats) using the 2.0 data form (birth years 2004- 2009). Final analyses are limited to women who planned home birth at onset of labor (N = 16,924).

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

Mode of Birth

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

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

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

Continued

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

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

Gestational Age and Birth Weight

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

Transfers

Intrapartum Transfers

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

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

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

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

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

Postpartum Maternal Transfers

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

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

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

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

Neonatal Transfers

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

Maternal Morbidity and Mortality

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

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

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

Fetal and Neonatal Morbidity and Mortality

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

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

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

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

Breastfeeding

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

DISCUSSION

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

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

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

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

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

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

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

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

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

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

Limitations

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

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

CONCLUSION

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

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

AUTHORS

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CONFLICT OF INTEREST

The authors have no conflicts of interest to disclose.

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To:

The Honorable Josh Green, Chair Committee Members of Health
The Honorable Roz Baker, Chair Committee on Commerce and Consumer Protection
The Honorable Clayton Hee, Chair Committee on Judiciary and Labor

Members, Senate Committee on Health
Members, Senate Committee on Commerce and Consumer Protection
Members, Senate Committee on Judiciary and Labor

From:

Grace Alvaro Caligtan

Hearing: February 10, 2014, 1:30 pm, Room 229

Re: SB 2569 and SB 2569 SD 1, Relating to Home Birth
{IN OPPOSITION}

Good afternoon Chair Green, Chair Baker, and Chair Hee:

Thank you for the opportunity to offer testimony in opposition of SB 2569 and SB 2569 SD 1. My name is Grace Alvaro Caligtan and I currently serve as a midwife apprentice at Hale Kealaua, a birth home in Makaha, led and directed by a senior certified professional midwife, Selena M. Green.

While working towards certification under the National Association of Registered Midwives (NARM), I also work as a doula, attending to the emotional birthing needs of women in both hospital and out of hospital settings. I am grateful for the excellent hands on clinical and didactic training I have received thus far and the opportunity to help support the return of the healing arts of midwifery that once thrived in Hawai'i and the Pacific.

Prior to my apprenticeship, I worked in the field of domestic violence and sex assault prevention, partnering with health providers to conduct culturally competent screenings of pregnant women for abuse and ensuring our island teens develop skills to create mutually supportive, loving, and healthy relationships. I have also worked in the field of public health, developing community conversations and capital to address health disparities, while offering my doula services to the most vulnerable and uninsured.

As someone who has given her life to creating safety for young girls and women, I believe that the model of midwifery care is the gold standard of women's health care. It is a certainly a model that respects the unique needs of many survivors of violence and trauma and a model that builds community and 'ohana as it supports women to take responsibility for their own healing and well-being.

I share the concern of everyone present in ensuring the quality care of our island mothers and families. SB 2569/SD 1, however, will not guarantee home birth

safety with over-regulation nor will it foster better collaborative care between providers, in the event of a hospital transfer. Instead, SB2569/SD 1:

- Fosters fear and restricts the rights of families to deliver their keiki in settings that feel true to them and with the attendants they choose.
- Unduly burdens the state with over-site and professional accountability that should be self-organized and self-governed by the midwives themselves who have set their own evidence based practice guidelines and understand the midwifery model of care the best
- Further endangers traditional practioners of birth and cultural keepers of midwifery skill sets that are attempting to make a return through formalized apprentice model of learning

Safety in birth is only truly guaranteed, I believe, when policy makers honor the deep and informed investment women makes in their health and in their choices to birth with whom and where. A woman's birth sovereignty and bodily autonomy is a foundational human right. Laws should be crafted to uphold this principle.

By requiring home birth midwife providers to be credentialed solely by the American Midwifery Credentialing Board (AMCB) for nurse midwives, SB2569 and SB 2569 SD 1 criminalizes all other traditional providers, ‘ohana midwives, and CPMs. While SB 2569 SD 1 attempts to amend this error, it is still lacking and fails by denying women access to midwives with the highest standard of specialized training in out-of-hospital maternity care, thereby defeating its stated purpose of increasing home birth safety.

I respectfully oppose both measures and recommend a deeper reconsideration and task force study of the midwifery model of care in Hawai'i before any regulation is considered and inflicts unintended harm. Our women and families deserve better,

Thank you and mahalo nui loa,

Grace Alvaro Caligtan, MA

2/9/14 12:29 AM

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	h96744@gmail.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Saturday, February 08, 2014 4:09:13 PM

SB2569

Submitted on: 2/8/2014

Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Heather Fowler	Individual	Oppose	No

Comments: This Testimony is for SB2569 AND SB2569 SD1 To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor, Hearing date is 2-10-14 1:30pm Room 229 RE: SB2569 and SB2569 SD1 Relating to Home Birth I strongly Oppose both of these bills. Home birth is safe. We are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth. This bill is a step backward in the safety of home birth. Please allow women the freedom to make informed choices about the care needed for themselves and their children. Thank you, Heather Fowler RN, BSN, MBA, ADN.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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Kara Mataia
PO Box 44
Laie, HI. 96762
February 8, 2014

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor
Hearing Date: 2-10-14
Time: 1:30pm
Room: 229
RE: SB2569 and SB2569 SD1 Relating to Home Birth

Dear Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,
I am writing concerning Bills SB2569 AND SB2569 SD1 relating to Home Birth. I am adamantly opposed to these bills. As a mother, you can imagine that this is a very sensitive subject for me. I would never knowingly put myself and especially my future children in harm's way. Therefore, I have done extensive research as to the safety of both mother and child throughout pregnancy and labor and based on my findings, I chose to have my children at home with a certified midwife. I am deeply concerned that these bills are taking that freedom away from me based on little research and ill-informed views.

Women have been giving birth to mankind since the beginning of time. Even Hawaii's kings were born with midwives and in natural settings such as the birthing stones in Kaniloko. Women are strong and deserve the right to birth their babies where they feel is right for them and their child. I do not feel that legislatures have the right to take that privilege away from them.

I ask that the legislator, if truly concerned about the safety of Hawaii's women and children, would do an unbiased research on both the midwifery model and the medical model of birthing, find out the differences and pros/cons and then make an educated decision next year. I personally believe if in the future, midwives were more accepted among the medical community, and there was a unified correlation between midwives, practitioners, OBs and etc…Hawaii would be at its safest without hinging on the personal freedoms of women.

I conclude that if this bill is passed now at this time, I will either have to birth my baby illegally or leave my home island to have my baby elsewhere. Both options are extremely sad and a pity. Please do not take away my freedoms as a mother and force me to leave these islands just to have my children. That's not pono!

Mahalo nui loa for your support.

Sincerely,

Kara Mataia

IN OPPOSITION TO SB2569 AND SB2569 SD1, Relating to Home Birth

Regular Session of 2014
Hearing on Monday, February 10, 2014 in Room 229

For: Honorable Chair and Vice Chair and members of Health Committee, Commerce and Consumer Protection Committee and Judiciary and Labor Committee

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Dear Sirs and Madams,

My name is Regina Gora. I a home birth mother and I strongly oppose both bills SB2569 and SB2569 SD1.

As far as I can imagine birth has been taking place at home. Every one of us present here today is a descendant of an ancestor that has birthed at home! Women around the world have been having home births for thousands of years. Whether it be for cultural, spiritual, or traditional reasons, it is the CHOICE of the mother to where and whom she would like present during her birth. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.

Home birth is safe, as safe if not safer than hospital births. I strongly believe that if you were to allow the home birth community form their own advisory counsel with all birth practitioners represented (ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family practitioners), this will allow the experts to internally gather data and create standards of care acceptable to all birth practitioners and the community, which they can present to the legislature during the next session.

We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose.

For all of these reasons and more, I strongly oppose this bill as it stands. The imposition

of these state regulations simply does not take into account the important perspectives of the birth practitioners, the mothers, and advocates of home birth.

Thank you for your time and attention.

Sincerely,

Regina Gora

To: The Honorable Josh Green, Chair, Committee on Health
The Honorable Roz Baker, Vice Chair, Committee on Water & Land
The Honorable Roz Baker, Chair, Committee on Commerce and Consumer Protection
The Honorable Brian Taniguchi, Vice Chair, Committee on Commerce and Consumer Protection
The Honorable Clayton Hee, Chair, Committee on Judiciary and Labor
The Honorable Maile Shimabukuro, Vice Chair, Committee on Judiciary and Labor
Members, Senate Committee on Health
Members, Senate Committee on Commerce and Consumer
Members, Senate Committee on Judiciary and Labor

Hearing date 2-10-14 1:30pm rm 229
RE: SB2569 and SB2569 SD1 Relating to Home Birth

From: Elisa M Spring
Date: February 10th, 2014
Hrg: Senate Committee on Health/Senate Committee on Commerce and Consumer Protection/Senate Committee on Judiciary and Labor; Mon. February 10th 2014 at 1:30 p.m. in Rm 229
Re: SB 2569 and SB2569 SD1, Relating to Home Birth – In Opposition

Thank you for the opportunity to offer testimony in opposition of SB 2569 and SB 2569 SD1, both of which attempt to regulate midwifery in the State of Hawaii.

Here are some reasons why I OPPOSE SB2569 and SB2569 SD1:

• Both bills take away choices for women when it comes to their reproductive health.

• SB2569 threatens women's health and would all but make midwifery and home birth illegal in the state of Hawaii, forcing mothers who choose to home birth to potentially go underground in finding illegal care providers which may pose a risk to herself and her baby. The bill also infringes on patients' rights and violates their right to medical privacy.

• Home birth with a trained midwife is SAFE. This bill uses false data to support it's claim. It refers to a two to three fold increase in neonatal mortality and that is cited from a study that has been refuted. Here are studies addressing that particular study, along with others that support home birth with a trained midwife to be just as safe as a hospital birth. (1,2,3,4,5)

• We are not opposed to regulation – however the regulations in SB2569 don't make sense and neither bill promotes the health of mothers or their babies.

• These bills do NOT take into account cultural practices in home birth. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.

• The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth practice. The Home Birth Safety Board should be autonomous

from the Hawaii Medical Board. There should be a Home Birth Providers Board overseen directly by the DCCA .

• The Home Birth Safety Board to be comprised of the home birth providers primarily, with some OB/MD representation but certainly not the majority or even half.

• It is the right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. This bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose.

Suggestions:
Write a new bill next legislative session that addresses the concerns stated above and include home birth providers and key stakeholders in the birthing community when drafting new legislation. Amending SB2569 OR SB2569 SD1 is NOT an option. Both bills are too flawed to correct given the time constraints of the legislature. A complete overhaul of these bills must ensue. There are many suggestions for a new bill, please let's work together to create it.

Thank you for your time. I appreciate the opportunity to testify as I have experienced wonderful care and love in the context of choosing a homebirth with my last child. And I wish this to continue to be a legal choice for all women now and in the future!

Aloha,

Elisa Spring

Sources:

1. "Home Birth versus Hospital Birth: Questioning the Quality of the Evidence on Safety" article published in Birth (Volume 30, Issue 1, pages 57-63, March 2003) "In contrast, the Midwives Association of Washington State press release stated that 'Childbearing women and health policy makers should be made aware that the study contains numerous flaws and limitations...this study alone should not be used to make decisions that could restrict women's choice of birth place or access to birth attendants with expertise in home birth'" (http://onlinelibrary.wiley.com/.../j.1523-536X.../abstract)
2. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/.../Medscape-Wax-Critique-Michal...)
3. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics)
4. BMJ 2005;330;1416 Outcomes of planned home birth with certified professional midwives; large prospective study in North America
5. BJOG, 2009 Aug; 116(9):1177-84 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births
6. The Myth of a Safer Hospital Birth for Low Risk Pregnancies (http://www.greenmedinfo.com/.../myth-safer-hsopital-birth...)
"Study validity questioned" in The American Journal of Obstetrics & Gynecology (volume 204, Issue 4, page e14, April 2011) (http://ajog.org/article/S0002-9378(10)01107-5/fulltext)
7. Home birth metaanalysis: does it meet AJOG's reporting requirements? (http://ajog.org/article/S0002-9378(11)00074-3/fulltext)

8. International data demonstrate home birth safety. (http://www.ncbi.nlm.nih.gov/pubmed/21458614)
9. "Home birth triples the neonatal death rate": public communication of bad science? (http://www.ajog.org/article/S0002-9378(11)00075-5/abstract)
10. http://www.ncbi.nlm.nih.gov/pubmed/23769011
11. http://www.bmj.com/content/330/7505/1416
12. Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009 http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12172/pdf

1. To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,
2. Hearing date 2-10-14 1:30pm rm 229
3. RE: SB2569 and SB2569 SD1 Relating to Home Birth
4. OPPOSE

I am strongly opposed to this bill because its purported objective is to make homebirth "safer" in Hawaii, where there no indication that homebirth is dangerous, unless you are basing these assertions off of flawed information. Homebirth is already as safe, if not safer than, hospital births. It appears that the false presumptions made in this bill are based on the Wax study, and we should absolutely not move forward with any proposed legislation stemming from such misinformation.

In an article written by a team of OB-GYN doctors, they conclude that this research was conducted without the most basic standards of methodological rigor.

> "The statistical analysis upon which this conclusion was based was deeply flawed, containing many numerical errors, improper inclusion and exclusion of studies, mischaracterization of cited works, and logical impossibilities. In addition, the software tool used for nearly two thirds of the meta-analysis calculations contains serious errors that can dramatically underestimate confidence intervals (CIs), and this resulted in at least 1 spuriously statistically significant result. Despite the publication of statements and commentaries querying the reliability of the findings, [2-6] this faulty study now forms the evidentiary basis for an American College of Obstetricians and Gynecologists Committee Opinion, [7] meaning that its results are being presented to expectant parents as the state-of-the-art in home birth safety research."

It is very disappointing that this research was not fully vetted before this legislation was drafted, and an obvious signal that there is a gap in knowledge and a need for further exploration. It would be a grave disservice to women, children and families to place restrictions on the practice of homebirth and midwifery, which this legislative body has very little understanding of.

Women have a basic right to science-based maternity care. In the interest of safety, and the best interest of mothers and babies, we should examine this issue much more closely. The science clearly says that vaginal births after most previous cesarean sections are safe, and women should not be barred from birthing in the safety and sanctity of their chosen space when the risk of a uterine rupture is less than 2%. If we ban women seeking a VBAC (Vaginal Birth after Cesarean) from birthing outside of the hospital, then we are also limiting their options of

achieving a non-surgical birth. Many hospitals in our state have policies that disallow VBACs, even though there is more than sufficient evidence to prove its safety. These restrictive policies are not supported by the National Institute of Health or by ACOG. If we truly want to make birth safer for women, then the first place to start should be in the hospitals, which have a C-section rate of over 30%. A cesarean section is major abdominal surgery, and carries risks for the mother and infant as well as a long recovery time. In fact, only one hospital in our state even qualifies as "Baby Friendly", as outlined by UNICEF/WHO's Baby-Friendly Hospital Initiative." Any effort to legislate safety into birth should start with ensuring that hospitals are adhering to science-based pre-natal and maternity care. To single out the midwifery model of care is absurd, and not supported by any evidence of negligence. We need an informational hearing to review studies and examine data, especially data pertaining to our own unique population.

I also object to this bill's proposal for a regulatory board to be established that is made up of individuals that practice entirely outside of the scope of the homebirth and midwifery model of care. An OB-GYN who has been appointed by the governor has hardly any positive contributions to make in supervising a group of birth practitioners outside of a hospital setting. There has been an unfortunate adversarial position taken up by the ACOG and by the AAP when it comes to birthing outside of the hospital, and I would like to point out that there may be a conflict of interest. The homebirth community should form their own advisory council with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners , any and all who are birth practitioners. These are the care providers who are intimately engaged with the demographics of those who choose birth outside of the hospital. With their knowledge and understanding of this particular paradigm, they are the best equipped to form a common standard of care, and articulate practices and policies.

It is a woman's right to choose where and with whom she births. Requiring the licensing of midwives will lead to banning unlicensed practitioners, and will ultimately deprive our community of valued and knowledgeable birth practitioners. We all want mothers to birth safely, and with dignity. This bill does NOT provide for that. Instead, it severely limits a mother's rights in choosing where and with whom to birth. The birth practitioners who assist with births outside of the hospital go through the risk assessment process with the family, they inform them as to the risks and potential need for transfer, and follow through with the best methods of care. Mothers who wish to birth at home do their research for months in order to come to this decision. They interview birth practitioners, read studies, watch birth videos, and meet with women who have had home births. We are intelligent enough to make these decisions for ourselves, and do not need the permission or advice of a legislative body to do so.

Hawaii is a state that is in an incredible position to establish a model of care that encompasses multi-cultural and multi-traditional birth practices. There has already been a precedent set in our laws in respecting Hawaii's native cultural practices. One of those sacred practices is Ohana

birth, and it is being threatened by this proposed legislation. If the legislature is attempting to control the birth choices and birth processes of women here in Hawaii, it will fail. If the legislature can scrap this flawed bill and start from scratch, then we can start to focus on what is important here. That is to protect mothers and babies, and foster a more cohesive relationship between traditional midwifery care and the hospital model of care. We have an opportunity to establish a unique birth model here in Hawaii, a model that respects the diverse birth cultures that already exist, and fosters a safe and dignified standard for care while respecting a woman's inherent rights.

This bill does NOT make homebirth safer. It makes homebirth harder to achieve, and forces women into hospitals when there is no medical need. It restricts a woman's right to choose where to birth and with whom to birth. Please scrap this bill and start over. We can do better.

Thank you.

References

Carl A. Michal, PhD, Patricia A. Janssen, PhD, Saraswathi Vedam, SciD, Eileen K. Hutton, PhD, Ank de Jonge, PhD " Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong." Medscape Multispecialty. Medscape , 1 Apr. 2011. Web. 9 Feb. 2014.

TESTIMONY FOR SB2569 AND SB2569 SD1

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

Hearing date 2-10-14 1:30pm rm 229

RE: SB2569 and SB2569 SD1 Relating to Home Birth

I am writing to Oppose the above bills (SB2560 and SB2569 SD1). I am a mother who took great care in educating myself about childbirth and birthing option during my first pregnancy as I wanted my baby to have the best possible start in life and to have the safest and healthiest birth possible. My extensive research, led me to choose home birth, and I couldn't be more satisfied with the experience. Both my children were home-birthed by a competent, extraordinary and devoted CNM with years of experience assisting at births, mostly in a hospital setting. I am honored to have had my CNM as part of my birth experience, and will never forget her. In her care, I felt comfortable, safe and secure and was able to birth my babies in a natural, stress-free manner, the way humans were meant to enter this world and the way nature designed us. My own experience has left me with the deepest respect for Certified Nurse Midwives and their work. Sadly, not many of my friends with hospital-birth experiences can say the same of the doctors who attended them. I suppose it is natural for those devoted to birth through their profession to be more attentive and caring towards mothers and babies.

My research prior to choosing a natural birth led me to learn that Home birth is as safe if not safer than hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe? (Rising c-sect rate, inductions, medications...safe?) Let's dialogue, If legislators are truly interested in learning about home birth as Green's press release indicates, then take this next year to learn about the differences between the midwifery model vs the medical model of birthing. Become educated. I did! Surprisingly, many in the medical community have a limited education about what natural birth entails and what it's benefits are. In this field, as in others, the US lags behind more progressive countries who only use doctors for emergencies, for which their training suits them, leaving the care of expectant and laboring mothers to CNMs if no special concerns or conditions exist, as is usually the case. Research also shows it is not coincidental that there has been an increase in complications in mothers and babies post-partum with the rise of voluntary and recommended cesarean section births, which rather than being left as a last resort options, because of the risks it carries being a major surgical procedure, is at unnaturally high levels in the US. Same goes for use of unnecessary drugs from onset of labor vs. letting the body do what it was designed to do quite well and what mothers have been doing since time immemorial, bring other human beings into the world. Interfering with the orchestration of hormones that provide natural pain relief and release bonding hormones is doing a disservice to both mother and baby.

We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth. The government is interfering in too many personal issues, including spying on the populace, tapping our phones, reading our personal correspondence, regulating what we are allowed to eat and now trying to control how we birth, and it is not right and not suiting to a democratic nation. I was born in a formerly totalitarian-ruled nation of Central Europe and what is happening here is eerily reminiscent of the system that existed there, control of each and every aspect of people's lives. It must stop if we are to remain a free democracy.

This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for. Individuals are different and the circumstances for their births differ as well.

Let the home birth community form their own advisory council with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

Thank you for taking my evidence and experience into consideration.

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	priscillapraia@hotmail.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Sunday, February 09, 2014 2:35:24 AM

SB2569

Submitted on: 2/9/2014
Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Priscilla Sobrinho	Individual	Oppose	No

Comments: Aloha, I am writing to oppose bill SB2569 and SB2569 SD1. I have had 2 babies, one at a great hospital and the other a home birth, both were wonderful births I might add. Yet, I would rather choose an out of hospital birth due to the limitations and regulations on laboring women. Simple things such as, the ability to move/walk, eat, or labor/birth in water is why I chose a home birth with my second pregnancy. These actions actually have been proven to help not harm a laboring mother and baby. I feel mothers and families have the right to have this choice, an educated decision to where they will have their babies. Some key points that I do not agree with: 1) At its core the bill does not honor or respect women and families right to choose their birth attendant and birth setting. 2) The bill restricts nurse midwives and other practitioners from practicing within the scope of their practice. 3) The proposed regulating board consists almost exclusively of individuals with no experience in home birth, many of whom have a vested financial interest in keeping birth in the hospital. 4) The bill systematically poses unnecessary barriers for qualified, licensed providers such as nurse midwives. 5) The supporting 'evidence' in the bill is based on biased, weak, and controversial data. 6) The bill would NOT achieve its stated purpose of making home birth safer. It would instead create a hostile relationship between home and hospital providers that does not serve families. To genuinely optimize the safety of home birth, communication and collaboration between home and hospital based providers should be improved. This bill does nothing to achieve that goal. I hope you may understand how important this is to so many families here on Hawaii and that with your help, this bill does not move forward. Mahalo, Priscilla Sobrinho Kauai Resident

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

Do not reply to this email. This inbox is not monitored. For assistance please email webmaster@capitol.hawaii.gov

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

Hearing date 2-10-14 1:30pm rm 229
RE: SB2569 and SB2569 SD1 Relating to Home Birth

I am writing to urge you to please stop SB2569 relating to Home Birth. It will limit women's already limited options to birth out-of-hospital. I am an educated professional (Chemical Engineering BS) who, upon becoming pregnant with my first son, decided to research why the U.S. ranks 50th in the world for maternal mortality (ref. http://www.amnestyusa.org/sites/default/files/deadlydeliveryoneyear.pdf). Maternal and infant morbidity (and infant mortality) are also terrible. I found out that a midwife-based model of care with the norm being out-of-hospital births is the model followed by the safest countries for mothers to birth their babies. There are many varied reasons why this is, but I chose to birth my son out-of-hospital because of this data, and because I felt safe doing so after researching and finding an extremely experienced midwife on island. SB2569 will criminalize all midwives who are not Certified Nurse-Midwives, including the one I used who has 25+ years of experience and is a Naturopathic Physician. In addition, when I had my second son I turned 35 just 4 months before his birth. Just being over 35 could have categorized my pregnancy as high-risk and, under SB2569, would have denied care to me if I chose to do another home birth. There are many reasons why I think this bill is a terrible idea, but the biggest is that it limits women's choices to birth their babies in the way they feel safest.

Please please PLEASE do not vote for SB2569. It does not even come close to making birth safer for women and in my opinion will actually make birth more unsafe for a minority of women who chose to follow a care model that is used by the safest places in the world to birth babies.

Mahalo,
Jill Sims
2347 Beckwith St.
Honolulu, HI 96822

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

Hearing date 2-10-14 1:30pm rm 229

Please Make 12 copies - Mahalo

RE: SB2569 and SB2569 SD1 Relating to Home Birth – IN OPPOSITION

Good Morning,

I am a supporter of home birth and autonomous health care

I oppose Senate Bill 2569 and Senate Bill 2569 SD1 for the following reasons.

1. Home birth is safe, as safe if not safer than hospital births. This bill has been made under the assumption that home birth is unsafe and does not take into account the wide body of knowledge that exists about home birth. We should study both settings of birth, hospital and home, to determine which setting really is safer. Here is a question based on a simple observation, why do hospital births end in a caesarean section more often than home births?

2. We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. The bill does not provide that. Instead is restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislature's right to decide how and where someone can birth.

3. This bill excludes and criminalizes some forms of midwifery/home birth practices. The homebirth community wants to include all practitioners who can then provide support and care for all the different types of birth experiences the community is asking for.

4. The homebirth community desires care that differs from the obstetrics/medical model of care. This bill intends to allow the regulation of midwifery and home birth practitioners using the obstetrics/medical model. Let the homebirth community form their own advisory counsel with all birth practitioners represented – ND, CPM, CNM, Direct Entry, Traditional Midwives. OB, Family Practioners etc. to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the next legislative session.

Thank you for your time and consideration,

Rocio Bueno

For: Honorable Senate Committee Health Chair Green,
Vice Chair Baker and Committee Members,

Hearing: February 10, 2014 @ 1:30pm
Conference Room 229

RE: SB 2569 and SB 2569 SD1 - Relating to Home Birth

IN OPPOSITION

My name is Rebekah Stewart Botello.

I am a woman. I am a wife. I am a mother of two, soon to be a mother of three, and perhaps, in the future, a mother of four or more! I am a highly educated professional with 4 collegiate degrees, two of which are Master's Degrees. I am a Pastor. I am a registered voter in the State of Hawaii. I am a doula, childbirth educator, and student midwife. I am a life-long Homebirth Advocate.

I have sacrificed many hours of precious sleep in order to read the entirety of SB 2569 with all of its flaws and draft this testimony you are about to read. Why? I believe so strongly that you are on the brink of either making the BEST decision for the people of Hawaii or a most disastrous one! I have given up time with my husband, my young children, and others in order to come here to stress the VITAL RESPONSIBILITY you have to terminate SB 2569 and any bill that is related to it currently or in the future (Note: SB 2070). There is no way in this written or verbal testimony that I have the time to state all my objections to SB 2569 or SB 2070. Suffice to say, there are many. For brevity, I am compelled to limit my comments, but be assured, these comments express only the bare beginnings of my vehement opposition to this bill!

From the time I was a child, I knew I would birth my children in the privacy, sanctity, and safety of my home. The bill you are proposing, SB 2569, is an affront to my personhood, to my intelligence and education, to my citizenry, and to the future of my children and grandchildren. Should my testimony by limited by time constraints, let me detail the three most important reasons why I STRONGLY OPPOSE SB 2569.

First and foremost, homebirth is sacred and safe - if not safer than hospital birthing. Homebirth operates on a midwifery model of care and not a medical model.

Hospital birth trends show rising cesarean rates, indiscriminate use of induction and augmentation techniques, rising medication usage, rising fetal distresses, and more. This is not for me! This is not for many women who prefer natural childbirth at home.

My first birth occurred when I was almost 36, my second at almost 38, and will give birth to my third child at age 39. Should this bill have been proposed and passed in previous years, it would have stripped me of my choice to do so. Why? Because my age (over 35) would have classified me, according to ACOG, as "high risk" even though that is completely false! (See SB 2569, Page 21: Line 5-6)

Let me tell you of my glorious birth experiences that contradict all uneducated claims that homebirth is not safe!

My first labor was 5 hours with an active delivery time of 26 minutes. My second labor was 1.5 hours with and active delivery time of 10 minutes. These incredible birth experiences validated what I have been raised whole life to believe and what I have been educated to understand is true: Homebirth is safe. Homebirth is beautiful. Homebirth is sacred. Especially now, I would NEVER CHOOSE a hospital birth experience for myself. This bill has a very narrow definition of a "low risk" mother (See SB 2569. Page 18: Line 20 through Page 19: Line 15).

Under these ridiculous definitions, I would be forced to give birth in a hospital, a place where I would feel an overwhelming sense of fear and anxiety, thus hindering me from giving birth safely and naturally. This is simply unacceptable!

If passed, this bill would require, not merely suggest, a woman, such as myself, to be examined by a medical physician even though I am in excellent health and have no medical indications otherwise. Again, this is simply unacceptable!

This bill would require me to deliver possible future children in a hospital setting if I was having a VBAC, twins or other multiples, or if my baby was not in the vertex position!

This bill would force me to have an ultrasound, which I oppose for many reasons, to determine the position of my baby. HIGHLY unacceptable! I choose not to use ultrasounds or other medical devices because I believe they are

disadvantageous to the health of the baby in my womb. This is MY choice. MY choice!

This bill would compel me to undergo medical interventions that could jeopardize my health, my safety, the health and safety of my unborn child, and possibly subject me to even further interventions such as a cesarean birth which I would never choose unless my life depended on it! How is this acceptable? It is not!

This bill would violate my medical privacy by requiring any possible homebirth providers I would speak with to report my "intent to give birth at home" to the State Department of Health. Yet I say again, this is simply unacceptable!

For centuries upon centuries and even till today, woman all over the world give birth at home surrounded by those who love them and with whom they have close personal relationship. Hospitals do not provide loving, long-standing, personal relationships. You know that. I know that.

The pomposity of the American Medical Society to believe that the medical model of birthing is superior to the midwifery model and homebirth model is preposterous. The Homebirth model of childbirth cannot be viewed, understood, or regulated by the Medical Model of birth, just as our American culture cannot be viewed, understood, or regulated by any other culture. They are simply just not the same! They are not related!

Dr. Wah Kai Chang, my great grandfather, was a well respected homebirth doctor in the early 1900's. He would be appalled by this ludicrous legislative proposal. He delivered more babies at home in his distinguished career than were ever recorded. He raised my grandmother to believe in the beauty and sanctity of homebirth. She, in turn, passed this legacy to my mother, a highly skilled birth advocate, who raised me to believe in the beauty and sanctity of homebirth as well. And this unshakeable belief is what I will pass to my two sons, and hopefully future daughters.

Hospital birthing does NOT prevent all fetal or maternal injury or death. To propose such is inane! In fact, many a woman and child has been injured or even killed because of obstetricians with aggressive birthing practices. Let's be real! Unforeseen emergencies happen in hospitals, as they do in homebirth settings as well. Let me again emphasize the words - UNFORESEEN emergencies. That's all they are. Unforeseen.

Hospitals are designed to treat maladies, sicknesses, terminal conditions. Pregnancy is NOT a sickness and birthing is NOT, in its purest form, a medical

procedure. It is a natural process of life that NO ONE can control nor should try to control or regulate.

If passed, this bill would force me to entrust my personal care and that of my unborn child to someone who is "certified" by a medical board rather than allowing me to trust my birthing experiences to a highly trained, highly prepared, highly experienced Naturopathic Doctor as well as my mother who has had 37 years of attending births as a doula and student midwife. This is simply, unacceptable!

Moreover, if I want to experience my own "planned home birth" with ABSOLUTELY no one there to "assist" me, that is my right! It is my body. It is my child. No one "assisted" me in getting pregnant in the first place. With the exception of my husband's participation, I did that all on my own, thank you! I didn't need any help to birth my first two children, and I don't need any help to birth my third child or any other children I may choose to have in the future.

The only birthing assistance that I would feel the need to personally request would be in the case of an unforeseen emergency where I feel my life or the life of the child I am about to birth is in eminent danger.

Other than that, I do not want nor require the assistance of any other human being. MY body is pregnant. MY body was designed to conceive, grow, and deliver a baby. And the fact that I need to stress that point here today is quite astonishing to me! If I invite anyone to my birthing experience it is because I value their presence at the sacred event, not because I require their help. I simply, don't.

Secondly, it is audacious for the Hawaii State Legislature to pass laws that have legalized abortion - the premeditated termination or, dare I say, murder of live unborn fetuses - and then turn around and attempt to legislate the birth procedure for women who have chosen to keep their babies alive long enough to birth them. While there are some of you on this committee who are Pro-Life, there are some of you who are Pro-Choice.

To those who are Pro-Choice I say, it makes no sense whatsoever that you will support abortion rights yet want to tell a women where to birth her child if she has chosen NOT to terminate her pregnancy. I repeat myself again. This is unacceptable!

According to current Hawaii State law, any woman can have an abortion up to week #24 of her pregnancy. Imagine that, as little as 3 weeks ago, when I could

feel my baby kicking, punching, squirming in my womb, I could have decided to terminate its life! Medicare even pays for abortions here in the State of Hawaii. Moreover, minors under the age of 18 can get an abortion without even notifying their parents or guardians!

SB 2569 Page 23: Line 9-11 states, “an increased risk of neonatal mortality associated with homebirth.” This is grossly inaccurate. What about neonatal mortality associated with abortion? Isn’t that statistically FAR GREATER than any neonatal mortality rate associated with homebirth?

To those of you who are Pro-Life, I plead with you! You cannot in good conscience give any credence whatsoever to this bill. You must fight for a woman’s right to birth the life inside of her in a way that is conducive to her own educated understandings and to her own moral, ethical, and spiritual beliefs as much as you have fought for the right of a live fetus to live and not be aborted!

Thirdly, SB 2569 is NOT about women’s health. It is about control and, as far as I can tell, rests heavily on egotistical, self serving, and pompous thinking as well as gross misinformation and misrepresentation of the truth of homebirth efficacy and safety.

It is not the State Senate’s prerogative, nor anyone else’s prerogative, to legislate how I care for my own body and what happens in it. Aside from how I nourish and care for my own body, the greatest decision I can make in regards to my body is whether or not I choose to have children, and if so, where, when, how, and with whom I choose to experience the birth process!

SB 2569 far overreaches the scope of any kind of legislative authority and responsibility granted to the Hawaii State Legislature by the United States Constitution. It doesn’t protect women’s rights. It destroys them. I respectfully remind you that is your sworn duty as public servants and elected government officials to uphold the Constitution of the United States, a document I have read more than once!

THE UNITED STATES CONSTITUTION:
ARTICLE VI
Section 3: The Senators and Representatives before mentioned, and the Members of the several State Legislatures, and all executive and judicial Officers, both of the United States and of the several States, shall be bound by Oath or Affirmation, to support this Constitution; but no religious Test shall ever be required as a Qualification to any Office or public Trust under the United States.

No where in the Constitution does it give the legislative branch the right to control the bodies of American citizens!

If you are going to tell women when, where, and how they can or cannot birth their children, will future bills be proposed to legislate WHICH women are and are not allowed to conceive? Will you attempt to tell women, like myself, what I can and cannot eat while I am pregnant? Will you attempt to legislate breastfeeding and mandate that women only feed their infants baby formula? Where does it end? Women's bodies, MY BODY, is my own. It is my own property. It is sacred. It is private. No governing body can ever never change that.

Killing SB 2569 bill doesn't force women to have planned homebirths. No. Women ho want to birth in hospitals still can do so. Killing this bill will do what is right - protect the right of ALL WOMEN to choose the appropriate avenue of maternity care for themselves.

As a free born citizen of the United States of America, I do not need to document or prove to anyone what my personal maternity choices are. It is no one's business except my own. No obstetric health care provider, ACOG board, medical board, State Legislator, or any other single person has any right to dictate my personal "standards of antepartum, intrapartum, or postpartum" care nor demand that I show proof of such.

Home birth is a deeply cultural practice that is both respected and honored. We are all descended from an ancestor who gave birth at home. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.

In closing, it is horrifying to think that under this proposed bill, my friend and trusted advisor, Naturopathic Doctor, Lori Kimata, as well as my mother who is a 37 year veteran Birth Advocate, doula, childbirth educator, and student midwife, could be prosecuted or penalized under SB 2569 for being present to support me in my childbirth experiences! If the "gray areas" of this bill could be further

extended to prosecute or penalize my husband, other family members, or friends who are aware of my choice to have a “planned homebirth experience” and choose not to “report me to proper authorities,” I am equally horrified!

Should my husband and I choose to birth any further children following the proposed July 1, 2015 date for SB 2569 to take effect, you can be assured that we will birth them in the privacy, sanctity, and safety of our own home. Do not deny us that right to choose homebirth regardless of whether or not it matches the “medical standards” proposed by this outlandish bill.

If the numbers of people calling, writing, or otherwise testifying to oppose this bill don’t meet your expectations, don’t be fooled! There simply has not been enough time given for people to find out about this disadvantageous piece of propose legislation and to voice their concerns. Should you choose to give SB 2569 a longer chance to be viewed and discussed by concerned citizens of Hawaii, you will undoubtedly hear more voices of opposition. You must listen! You must do what is pono!

You MUST VOTE NO regarding something you are likely woefully misinformed on!!! I implore you to do your own extensive research on the safety and efficacy of homebirth here in Hawaii, in America, and across the world. I implore you to trust the experts!

Who are the experts? Not Senator Green and others who only have experience in the Medical Model of Birth.

Trust the experts... Mothers like me, Homebirth Doulas, Midwives, and Educators who have countless years of experience as their foundation for assisting mothers, fathers, and children.

If you do your research well, if you trust the experts and not those who perhaps have ulterior motives, I believe your conclusions will lead you to no other conclusion than this...

SB 2569 bill is bad for women/mothers, bad for children, bad for men/fathers, bad for our State of Hawaii and our future generations!

If you pass this bill, please know this. You are NOT an advocate for women. You are not an advocate for children. You are NOT an advocate for the mothers, fathers, and children of today or generations to come. You are not advocates for your own children and grandchildren’s rights to choose the maternity care that is appropriate for them.

I implore you. Kill this bill TODAY. Do not allow governmental bureaucracy to infringe on women's rights to care for their own bodies in the way they see fit, to choose the maternity care options that are right for them as individuals, and to follow their own moral, ethical, and spiritual beliefs about pregnancy and childbirth.

Thank you to those on this committee who have the intelligence, courage, and foresight to kill this bill immediately! Thank you for protecting my right to birth any future children that I may choose to have in the privacy, sanctity, and safety of my own home and with those who I choose to invite to my birthing experience. Thank you for protecting the right of my children's and grandchildren's rights to do the same when their time comes to grow a family of their own.

I am - we all are - relying on you to do the right thing. Terminate SB 2569 and 2569 SD1

Respectfully,
Mrs. Rebekah Stewart Botello

Written Testimony Presented Before the
Senate Committees on Health, Commerce & Consumer Protection, and
Judiciary & Labor
February 10, 2014 9:00 a.m.
by
Dale Allison, PhD, WHNP-BC, FNP, APRN-Rx, FAAN
Hawaii State Center for Nursing
University of Hawai'i at Manoa

SB 2569 and SB 2569, S.D.1 RELATING TO HOME BIRTH

Chair Green, Vice Chair Baker, and members of the Senate Committee on Health;
Chair Baker, Vice Chair Taniguchi, and members of the Senate Committee on Commerce & Consumer Protection; and
Chair Hee, Vice Chair Shimabukuro, and members of the Senate Committee on Judiciary and Labor

Thank you for this opportunity to provide testimony in strong opposition to these measures, SB 2569 and SB 2569, SD1.

Hawaii State Center for Nursing appreciates the Committees' commitment to the address Hawai'i's health care issues.
However, the creation of a home birth safety board within the DCCA which would regulate a number of practitoners, including Certified Nurse Midwives (CNM), who are already licensed by the DCCA and national certifying boards. Home birthing is within the scope of certified nurse wifery practice. Both measures create regulatory redundancy as well as an unfair cost barrier for health care professionals who are already under state and national regulation.

Hawaii State Center for Nursing feels that SB 2569 and SB 2569, SD1 are premature. If it is the wish of these Committees to pursue this issue, a task force should be established to research whether there is a need for and resources required to establish a home birth safety board; as well as, whose safety standards will apply, how peer review will be established for all practitioners and how disciplinary action will be handled for health care professionals already regulated under the DCCA.

Therefore, Hawaii State Center for Nursing strongly opposed this measure. We respectfully request that your Committees hold SB 2569 and SB 2569, SD1 or create a task force to study the issues involved, including a cost analysis and regulatory redundancy. Thank you for the opportunity to testify.

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	empoweredmidwife@gmail.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Sunday, February 09, 2014 6:53:28 AM
Attachments:	Opposition Testimony 2569 and 2569SD1.docx

SB2569

Submitted on: 2/9/2014

Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Cassaundra R. Jah	Individual	Oppose	No

Comments:

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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From: Katherine E Kauffman
44-282 Mikiola Dr.
Kane'ohe HI 96744

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor

Hearing date: February 10th, 2014; 1:30 pm; Room 229

RE: SB2569 and SB2569 SD1 Relating to Home Birth

Position: I OPPOSE these bills

I am opposed to this bill because it fails to protect women and their offspring, while also limiting the ability of individuals to decide for themselves if and when to seek medical care. While intense and not without risk, birth-giving is **not** inherently a medical situation. ***Birthing women, just like all citizens, must not be forced into medical care*** that they neither desire nor require.

As a scientist with a master's degree in biology who has thoroughly researched the scientific literature on prenatal and birth care, as well as postnatal physical and emotional health of families, ***I am disturbed by the inaccuracies presented as medical and safety facts in this bill***. While the bill claims the laudable and universally supportable premise of improving health and safety for pregnant women and their offspring, it would in fact implement restrictions and regulations that are detrimental to the health and safety of women who prefer to give birth under the midwifery model. Homebirth with a skilled midwife is as safe as, if not safer than, giving birth in a hospital with an obstetrician.

As a mother who gave birth to my firstborn at home last year, and intends to birth future children at home as well, I am horrified and livid at the provisions of this bill. I am an intelligent and cautious person who wants the very best outcome for my babies and myself. These desires led me to choose homebirth with a skilled midwife, with supplemental prenatal care from an obstetrician. I am very satisfied with the care I received and would choose it again. ***I am beyond angry that this bill could prevent me from choosing my own birthing environment for future pregnancies***, by placing narrow limits on the definition of "low-risk" pregnancies, and arbitrary restrictions on the definition of "normal labor progression".

As a person raised in a family of physicians and other medical professionals, I believe that ***the medical model of healthcare is effective and useful in many circumstances, but is not ideal in other situations, such as caring for healthy women during pregnancy and birth***. The medical model differs from the midwifery model in key aspects of defining and managing labor and birth. It is a conflict of interest and nonsensical to allow medical professionals to define "normal" and "safe" for the pregnant women and midwives who hold different

viewpoints. ***The community of homebirth professionals would not be adequately represented in the oversight body proposed by this legislation***. Homebirth should be guided and regulated by those who are knowledgeable and supportive of it; not by obstetricians and other hospital-based health providers who oppose it.

As a taxpayer in the State of Hawaii, I cannot support this bill. By channeling more pregnant and birthing women into the medical system and away from the midwifery model of care, healthcare costs will increase. ***The midwifery model of care, including homebirths, provides cost savings to individuals and to the state*** in two ways: by costing less for an uncomplicated birth, and by accomplishing **lower** rates of complications and escalations in care. By supporting women who choose homebirth, and supporting skilled midwives who provide care to pregnant and birthing women, legislators would be making a fiscally responsible decision. This bill will have the opposite effect.

As a voting citizen of the State of Hawaii, I am thoroughly opposed to this bill because it unnecessarily restricts the freedoms of citizens. I support the right of women to choose their own birthing locations and birthing attendants. Birthing at home or in a birth center with a skilled midwife is equally safe as, or safer than, birthing in a hospital. ***I want all pregnant and birthing women, and their offspring, to be safe and comfortable, and this bill will severely restrict their options for reaching these goals for themselves.***

In summary, homebirth is a safe and reasonable alternative to hospital birth. Homebirth is chosen by some women based on strong personal preferences, extensive research, and after much deliberation regarding how to achieve the best outcome for themselves and their families. Rather than making birth safer, this bill could lead women who desire a non-medicalized birth to consider less preferable alternatives, such as flying to another state while pregnant, or giving birth without skilled attendants. While the U.S. healthcare system as a whole is slowly but surely recognizing and incorporating aspects of alternative care because they improve health outcomes and reduce costs, it would be a mistake for Hawaii to move in the opposite direction with this bill.

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,
Hearing date 2-10-14 1:30pm rm 229
RE: SB2569 and SB2569 SD1 Relating to Home Birth

Dear Honorable Chair and Committee Members of Health, Committee on Commerce and Consumer Protection, and Judiciary and Labor:

I oppose this bill. I believe it will erode my family's safety, quality of care and access to care.

I am making this statement based on serious and lengthy research and data, anecdotal evidence and personal experience. All of these things lead me to believe that home birth is the best option for me because the hospital system cares less about me and my family than my midwife, cannot provide any service that is better than that provided by my midwife and doula (except in emergencies), and has much to profit by this legislation.

With regard to the data, there is an abundance that shows how a hospital delivery, in most cases, is less safe than a homebirth with a trained midwife and/or doula. The data that stands out the most to me relates to c-section rates in the US and how they compare to c-section rates in the rest of the modern world. The data shows that these high rates are not necessary and are very detrimental to the long-term health and mortality of mothers. What would your mother say?

Furthermore, a legitimate concern about quality of care is my ability to make a connection to my care provider. I can achieve a much better connection to my midwife and doula than to an obstetrician because of the time they are willing to spend with me and because their way of thinking aligns closer to my own.

With regard to access to care, clearly this bill will reduce my choices.

Frankly, I would expect this bill from the Republicans, not such a strong Democratic government as ours. To me, this bill is clearly bad for the common person and good for the business interests of the medical industry in Hawaii. If you are truly interested in safety, this bill should be laughed into oblivion.

Kindest regards,

Jason Sears

From:	Evan Silberstein
To:	CPN Testimony; HTHTestimony; JDLTestimony
Subject:	Testimony - Strong Opposition to SB2569 and SB2569 SD1
Date:	Saturday, February 08, 2014 1:43:15 PM

Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

RE: SB2569 and SB2569 SD1 Relating to Home Birth

I am writing in STRONG oppositions to BOTH versions of the bill.

Midwifery and home births have been happening for millennia. In modern times, midwives have created the highest professional standards; helping countless women to have minimal medical intervention in the most profound and sacred experience available to a human, child birth. Meanwhile, the insurance driven biomedical model is crumbling with skyrocketing costs and overly complex regulatory systems that have greatly reduced the quality and attention of care that people receive.

There is no good evidence that home births are any less safe than hospital birth. In fact, many questions about the safety of hospital births exist. Particularly, as it relates to the percentage of Cesarian sections that are happening at alarming rates in our society. I'd like to point the committee's attention to this article in the Journal of Midwifery and Homebirth, a detailed multi year study chronicling the efficacy of nearly 17,000 home births:

http://onlinelibrary.wiley.com/store/10.1111/jmwh.12172/asset/jmwh12172.pdf?v=1&t=hrfh5cy9&s=b966382fad975ed2b90088fca23c2615a1133131

Further, this bill restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth. At a time when we are still learning how to honor and uphold the rights of the women in our society, even debating this issue is a step in the wrong direction for women's rights. Passage of this bill in current form is draconian, barbaric and would be an embarrassment to the State of Hawai'i in the national and international birthing communities.

Finally, if you truly intend to learn more about this issue, allow the home birth community to form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

Thank you for your careful consideration of this issue and support of home births in Hawai'i.

Sincerely,
Evan Silberstein
HSBA #9241
WSRSL Class of 2009
18 South Forty Pier
Sausalito, CA 94965

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	candee675@gmail.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Saturday, February 08, 2014 1:36:59 PM
Attachments:	homebirthtestomopn.rtf

SB2569

Submitted on: 2/8/2014
Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Candace Mendoza	Individual	Oppose	No

Comments: We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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Candace Ponce-Mendoza Home birth testimony

I am a long time supporter of the home birth movement since 2007. I have had 3 home births and 1 hospital birth.

January 15, 2003 I had given birth to my first child at Kapiolani Children's Hospital. Prenatal care and birth from ObGYN. There were several complications with the care of my Ob GYN. First, OB GYN and staff had mislabeled my blood work. Doctor had diagnose me B- and administered me with a shot because our blood types differ. During birth, I've learned OB gyn's are no where to be found. I was given 2 different IV's. One to help me sleep and another to speed contractions. Both times very painful. I could tell nurse was very inexperience poking me with a needle, continuously missing my vein. And also, blood drawn every hour within 24 hours of given birth.Also very painful while nurse moves the needle while in my skin, looking for a vein. I ended up with bruises on my arm and hand. Turns out, I'm B blood type and baby is baby is B positive. Which means, their incompetence would not have happen if doctor and Staff did their job correctly! Secondly, NO genuine service. I'm 39 weeks, concern of unusual bleeding. I called my Doctor's personal number, which she provided. Her response was "You're fine. NEVER CALL THIS NUMBER AGAIN." Lastly, Doctor LOST needle while stitching me after birth. Room was in lockdown. Blood all over me, my wound wide open, while she searched the room for the needle for over an hour. I remember shot back pains at the spot of where Anesthesia administered.

I thought hospital birth was my only choice until I watched a documentary on Lifetime Channel about water births. So many different women experiencing water birth at a facility in Miami or comfort at home, and most of them were in their 2nd or even 3 birth. That's when I CHOOSE to have a water birth with a midwife. I did my research, talked to mom's who given birth at hospitals and moms who had the only choice to home birth.

I experience of my very first home birth 2007. These experience has proven to me the benefits and importance of my right to choose where I give birth and with whom I can trust, which was my midwife and husband. Every birth is different. Few examples of

natural remedies of home birth were Acupuncture to intensify contractions, walking up a hill, also helped. Kale to help iron defeincey. Breastfeeding help with my postpartum recovery and baby's immune system. Home visits, to help me recovery safely and so baby wouldn't be exposed. Giving birth relieved my painful contractions. Home birth has delivered my 3 children safely, recovered safely, and provided excellent prenatal care prescribed by my midwife. Since then I have and always be a supporter of home birth movement.

We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth.

Candace Ponce-Mendoza

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor
RE: SB2569 and SB2569 SD1 Relating to Home Birth

My name is Andrea Keliʻikanoe Mahi and I oppose both bills listed above.

I have four main points:

A) Home birth is as safe, if not safer, than hospital births. If safety is what the legislators are concerned about, there should be a study of all birth options, home and hospital to discern what is safe. There are rising c-section rates, inductions, and medications. Are those safe?

B) We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead, it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth.

C) This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for.

D) Let the home birth community form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, and Family Practitioners to gather data and form appropriate standards acceptable to all birth practitioners and the community and bring this back to the legislators next session.

E) Midwifery Model of Care is different than the Medical Model of Care that Dr. Green has written the bill and wants the board to be comprised of. This is never going to work.

Respectfully,

Keliʻikanoe Mahi

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	moke84404@yahoo.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Saturday, February 08, 2014 1:28:22 PM

SB2569

Submitted on: 2/8/2014
Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Moke Stephens	Individual	Oppose	No

Comments: 1. To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor, 2. RE: SB2569 and SB2569 SD1 Relating to Home Birth 3. Oppose 4. Four main points: A) Home birth is safe, as safe if not safer than hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe? (Rising c-sect rate, inductions, medications...safe?) B) We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth. C) This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for. D) Let the home birth community form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners to gather data and form appropriate standards acceptable to all birth practitioners and the community and bring this back to the legislators next session. E. Midwifery Model of Care is different than the Medical Model of Care that Dr. Green has written the bill and wants the board to be comprised of. This is never going to work."

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REGULAR SESSION OF 2014

For: Honorable Senate Committee Health Chair Green, Vice Chair Baker and Committee Members,

Hearing ____Proposed SD1 of SB 2569 Status and Testimony__(date) Feb 10, 2014 Rm_229___________

Please make (# of copies) copies. Mahalo

RE: **SB 2569 Relating to Home Birth – IN OPPOSITION**

E aloha mai kākou,

I am a registered voter, Hawaiian health practitioner, and student at the University of Hawaiʻi at Mānoa. I come from a long line of home births and plan to birth my children at home. I am long time supporter of the home birth movement.

I strongly oppose SB 2569 for the following reasons.

1. On its face, this bill is inaccurate. It cites a flawed study, and it suggests home birth is dangerous and unsafe. I join other home and cultural birth practitioners, mothers and advocates to correct that notion. We realize that we have a responsibility to provide data and information about our home birth practices, our training, and our experiences to the legislature and community-at-large.

2. This bill currently tries to define a scope of practice without
an in depth understanding of the various practitioners, roles and responsibilities involved in home birth. The medical hospital-based model it imposes doesn't take into account the population it is regulating and doesn't accurately represent different models of home birthing, each with unique traditions, scopes of practice, varying types of practitioners and their educational backgrounds, safety protocols and standards of care that are already in place.

3. The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth practice. This bill assumes there is no oversight over home birth; in fact, midwives have the capacity to govern themselves.

4. As written, this bill would essentially eliminate the option of finding a legal home birth attendant. It is the rite/right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. Furthermore, this bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose. Requiring a registry of home birth mothers, for example, fosters stigma around home birth, a scarlet letter. Laws are created to protect consumers and ensure safety. Lawmakers also have the obligation to protect long standing cultural practices of birth.

5. Home birth is a deeply cultural practice that is both respected and honored. We are all descended from an ancestor who gave birth at home. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.

For all of these reasons and more, I strongly oppose this bill as it stands. The imposition of these state regulations simply does not take into account the important perspectives of the birth practitioners, the mothers, and advocates of home birth.

Yet, we recognize the need for more information and offer the following:

- We have already begun to form a Home Birth Council that reflects the variety of practices, mothers and advocates. This Council shall be self-defined and self-regulated.

- We request the opportunity to gather data, standards of care, and wise practices to present before the legislature at a later date.

- We request a legislative informational hearing that provides the opportunity to present information about the spectrum of home birth practitioners, their education and training, and existing standards of care.

[Gratitude and Salutation]

Evidence in support of point #1

1. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/MCDG/wp-content/uploads/2013/02/Medscape-Wax-Critique-Michal-Janssen-Vedam-Hutton-de-Jonge.pdf)
2. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics)
3. BMJ 2005;330;1416 Outcomes of planned home birth with certified professional midwives; large prospective study in North America
4. BJOG, 2009 Aug; 116(9):1177-84 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births
5. The Myth of a Safer Hospital Birth for Low Risk Pregnancies (http://www.greenmedinfo.com/blog/myth-safer-hsopital-birth-low-risk-pregnancies)
6. AND MORE – add your own strongest studies, there are many!

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	telekat@gmail.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Saturday, February 08, 2014 1:18:17 PM

SB2569

Submitted on: 2/8/2014

Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Noa Helela	Individual	Oppose	Yes

Comments: I was born out of the hospital. I oppose all versions of this measure. Further testimony will be uploaded later. Mahalo.

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TESTIMONY AGAINST SB 2569

Aloha-
My name is Jade McGaff, MD.
I have been a board certified OB GYN DOCTOR / Fellow of the American College of Ob GYn-for 25 years. I have been a bridge between many varieties of health care practitioners. I am eternally grateful for the Midwives who have shown me how magnificent and Sacred Birth can be...I am grateful to Traditional Midwives who have taught me not to fear birth...And I am saddened by the current state of fear and intervention in hospital births. And let me tell you: babies die in the hospital setting,too, sometimes right before your eyes....

And I would remind this Hearing that the United States is 37th in the world for maternal and fetal mortality. If hospital birth was so excellent, why do 36 countries have better outcomes than U.S.? Why are only a third of women breastfeeding at 6 months? and why do only 75% of women initiate breastfeeding at the hospital birth?

Healthy people come from healthy communities: it is the midwives, Naturopath, acupuncturists, herbalists, la'au lapa'au, etc, the caregivers that live and work among our people to keep them healthy. If we truly want to create health in our Islands, we will support the community healers. This means midwives of all backgrounds, as well as the specialties that are already licensed in our state.

More regulation is not the answer. Education is ALWAYS the answer. Please consider a committee to research the true data for our islands, not based on one or two flawed studies. Collaboration not confrontation is our solution. Let us ALL be a part of the solution.

Finally, I have experienced the burden of malpractice in our healthcare system; One of the reason doctors leave our Island.. The ultimate question remains: who is in charge of whether someone lives or dies? Am I in charge of someones Soul? Is a person responsible for their own medical path? Could we turn this whole disastrous course of 'blame' around by educating each person to create their health?

Please do not support SB2569 nor any other bill that was written by a small select group without the communities' participation. Every woman has the right to birth how, where, and with whom she desires. Help us educate ourselves and govern ourselves so we can create healthy communities.

From: mailinglist@capitol.hawaii.gov
To: HTHTestimony
Cc: katie_spam@hotmail.com
Subject: Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date: Saturday, February 08, 2014 12:37:35 PM

SB2569

Submitted on: 2/8/2014
Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Katie	Individual	Oppose	No

Comments: Aloha! I object to both versions of this bill. When you get to be old, do you want to be forced into a hospital to be hooked up to tubes against your will? Making it illegal for a conscious, sane person to choose to stay home and instead be forced to go to the hospital for undesired medical procedures is taking away a basic fundamental human right. There is no reason to make it illegal for women to choose to give birth on their own at home, and to ask for a midwife to assist them if they wish. This bill also interrupts freedom of religion for those people who do not believe in hospitals. The bill states that home births have been shown as unsafe, when that is not true- planned home births have been shown to be as safe or safer, and most first world countries support home birth and have higher safe birth statistics than the US. If you wish you encourage women to come in to the hospital instead of having a home birth, you are free to do so. If you wish to offer a system to give midwives hospital privileges, that would be great. Forcing women (or any grown, conscious person) to come to a hospital against their will is simple unacceptable. NO on SB 2569. Mahalo for hearing us.

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February 10, 2014
Monday
1:30 PM
Conference Room 229
State Capitol

To: Senator Josh Green, Chair - Committee on Health
Senator Rosalyn Baker, Chair - Committee on Commerce and Consumer Protection
Senator Clayton Hee, Chair - Committee on Judiciary and Labor

From: Ronnie Texeira, MD

Re: SB 2569/SB2065SD1, Relating to Health

Position: Strongly support licensure, patient safety rules/regulations, informed consent, data collection, and establishment of a board to ensure Home Birth Safety in Hawaii as per Hawaii ACOG testimony

Dear Senators Green, Baker, Hee and members of the Committees on Health, Commerce and Consumer Protection, and Judiciary and Labor:

I personally have helped to care for patient (s) who have attempted to deliver at home and were misinformed or were not brought to the hospital in time and suffered either a neonatal loss or a maternal complication. I believe this bill will allow for safe homebirths and will make the home birth attendants in Hawaii stop practicing out of his or her scope of practice and in the end prevent infant and maternal deaths.

I am very concerned about the safety of our mothers and their babies who opt for a planned home birth. The most recent and largest study to date reveals that there is a four-fold increased risk of neonatal death associated with home birth. In addition, there is a seven-fold increased risk of neonatal death for first time mothers who deliver at home and a ten – fold increased risk for pregnancies more than 41 weeks gestation. [Grunebaum A, Chervenak F, etal. Society for Maternal Fetal Medicine Abstract. February 7, 2014.]

Currently, there is no licensure, and therefore no patient safety rules and regulations regarding home birth. There are many complications that can occur, particularly with high-risk pregnancies. However, even low-risk pregnancies can quickly, within a few minutes or even seconds, become high-risk during the labor and delivery process.

To ensure that all of Hawaii's mothers and babies have a safe and happy birth experience, I urge you to support the Home Birth Safety bill. This bill will ensure that home birth

providers have had formal obstetrics education to care for mothers and infants, follow patient safety regulations such as no high-risk pregnancy deliveries at home, adequately inform their patients regarding their educational background and the possible risks of home birth, and require the timely completion of birth certificates and other data for all planned home births.

Thank you for the opportunity to submit this testimony on this very important Women's Health issue.

In opposition to SB2569 and SB2569 SD1, Relating to Homebirth
From: Wayne Bow
I strongly oppose SB2569 and SB2569 SD1, Relating to Homebirth.
I find it deeply offensive that this bill makes no exemptions for religious or cultural practitioners. As
such this bill directly violates my freedom of religion to choose a traditional homebirth, a traditional
cultural practice that goes back 10's of 1000's of years. The government knows nothing about
homebirth with respect to my traditional practice, so how DARE this government presume to
have the expertise necessary to regulate it?
Our Child was born in a hospital. We CHOSE to do this because the risk to Mom and Baby's health was greater than we were willing to risk. However, until 1 month prior to the delivery, we planned for a home birth attended by a skilled and capable midwife. I know many people who have chosen homebirths. When asked how they would feel if their births at home had been outlawed, they were
understandably horrified. Our midwives are heros! They should not be criminalized I understand
this bill even threatens jail time. Hasn't our society finally evolved beyond the witchhunts against
women?
The medical system is a fantastic CHOICE for most people. But don't force all of us to opt into a
medical birth (even a medical homebirth) if we don't want it. There are religious exemptions for
vaccines! How can my kids’ homebirth be any less important to my traditional and religious practice
than vaccines?
As I understand the statistics, thre is a much higher incidence of complications in an institutional setting. A landmark study by Johnson and Daviss in 2005 examined over 5,000 U.S. and Canadian women intending to deliver at home under midwife. They found equivalent perinatal mortality to hospital birth, but with rates of intervention that were up to ten times lower, compared with low-risk women birthing in a hospital. The rates of induction, IV drip, episiotomy, and forceps were each less than 10% at home, and only 3.7% of women required a cesarean (c-section). As I understannd it, institutional births are primarily for the convenience of the doctor..not the for the experience or health of the Mother and Child.
This Bill is an absurd overreach of governmental power and it MUST not pass.

Mahalo for your consideration.

Wayne Bow
A Person who Votes

February 10, 2014
Monday
1:30 PM
Conference Room 229
State Capitol

To: Senator Josh Green, Chair - Committee on Health
Senator Rosalyn Baker, Chair - Committee on Commerce and Consumer Protection
Senator Clayton Hee, Chair - Committee on Judiciary and Labor

From: Kainoa Toomata, Native Hawaiian and concerned father

Re: SB 2569/SB2065SD1, Relating to Health

Position: Strongly support licensure, patient safety rules/regulations, informed consent, data collection, and establishment of a board to ensure Home Birth Safety in Hawaii as per Hawaii ACOG testimony

Dear Senators Green, Baker, Hee and members of the Committees on Health, Commerce and Consumer Protection, and Judiciary and Labor:

I am very concerned about the safety of our mothers and their babies who opt for a planned home birth. The most recent and largest study to date reveals that there is a four-fold increased risk of neonatal death associated with home birth. In addition, there is a seven-fold increased risk of neonatal death for first time mothers who deliver at home and a ten – fold increased risk for pregnancies more than 41 weeks gestation. [Grunebaum A, Chervenak F, etal. Society for Maternal Fetal Medicine Abstract. February 7, 2014.]

Currently, there is no licensure, and therefore no patient safety rules and regulations regarding home birth. There are many complications that can occur, particularly with high-risk pregnancies. However, even low-risk pregnancies can quickly, within a few minutes or even seconds, become high-risk during the labor and delivery process.

To ensure that all of Hawaii's mothers and babies have a safe and happy birth experience, I urge you to support the Home Birth Safety bill. This bill will ensure that home birth providers have had formal obstetrics education to care for mothers and infants, follow patient safety regulations such as no high-risk pregnancy deliveries at home, adequately inform their patients regarding their educational background and the possible risks of home birth, and require the timely completion of birth certificates and other data for all planned home births.

Thank you for the opportunity to submit this testimony on this very important Women's Health issue.

REGULAR SESSION OF 2014

For: Honorable Senate Committee Health Chair Green, Vice Chair Baker and Committee Members, Hearing February 10, 2014, 1:30 pm conference room 229

RE: **SB 2569 and SB2569 SD1 Relating to Home Birth – IN OPPOSITION**

My name is Joel Hamamura. I am a registered voter and I want to voice my opposition to SB 2569 and SB2569 SD1 for the following reasons.

1. This bill communicates that home birth is dangerous and unsafe to the point that women should be dissuaded from considering it a legitimate option for birthing. My wife (Laine Hamamura, who is also voicing her opposition) and I have two children. Our first was born at Kapiolani Medical Center without the use of medical drugs or intervention, with the help and supervision of a team of doulas and my wife's OBGyn. With our second child, we chose to birth at home with the same team of doulas and a midwife. With the birth of our two children we were free to choose *where* to give birth, *how* we wanted to give birth, and *who* we wanted to assist the births. I fear these bills will cripple our choices, or they will lead to the eventual removal of our freedom of choice.

2. One of the things I treasure about our country is our freedom to choose what I believe to be the best for my family and myself. When my wife and I chose to give birth without medication at the hospital we chose to do so freely over a long period of time where we educated ourselves on our options, had many conversations on safety and practicality, and set in place backup plans in the event that my wife would need medical intervention for her and our child's safety and health. We made these decisions intelligently and responsibly, with respect to the wonderful hospital staff and medical practitioners.

When we chose to give birth to our second child at home, we went through the same long process of educating ourselves, weighing our options, talking many hours about safety and practicality, and we are happy that we were able to choose a reliable and experienced midwife along with the same doulas who assisted in the birth of our first child. Even in the case of our home birth, we did not rule out the very real possibility that we would go to the hospital to give birth if it was clear to our doulas, our midwife, and myself that my wife or the baby required it. We were free to make wise, educated, and responsible choices regarding two of the happiest days of my life and I do want that choice taken from me.

3. I believe in the priority of safety during birthing, and in the utmost importance of ensuring that midwives are well educated and qualified. We should make sure that there are standards in place, but not to the point that home birth becomes illegal or very difficult to secure by parents whose free choice should be respected.

4. Our laws are progressively giving more rights and protection for pregnant women to choose abortion. It doesn't make sense that we give every American woman the right to

choose how and when to terminate their pregnancy, but then take away their right to choose how, when, and where to carry out their full term of pregnancy and give birth at the place of their choosing. This is about the freedom to choose what every American citizen deems best, given that they go about educating themselves and making the wisest choices for their situations. This stands at the very core of why it is such a privilege to be an American citizen. Do not remove this privilege.

5. Please let the home birth community form their own advisory council with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc. to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session. Our midwife is incredibly intelligent and very educated on birthing practices. She takes into account the safety of my wife and our children and when we have our third child I would very much want her overseeing that birth, wherever my wife and I choose to give birth.

For all of these reasons and more, I strongly oppose this bill as it stands.
Yet, the home birth community recognizes the need for more information and offers the following:

- We have already begun to form a Home Birth Council that reflects the variety of practices, mothers and advocates. This Council shall be self-defined and self-regulated.

- We request the opportunity to gather data, standards of care, and wise practices to present before the legislature at a later date.

- We request a legislative informational hearing that provides the opportunity to present information about the spectrum of home birth practitioners, their education and training, and existing standards of care.

Thank you for your time in hearing my testimony.
Sincerely,
Joel Hamamura

Committees on Health, Commerce & Consumer Protection, and Judiciary

Re: SB2569 and proposed SD1 relating to Home Births

Monday 1:30pm Rm 229

Aloha Hon Chairs Green, Baker & Hee, Vice Chairs Baker, Taniguchi, & Shimabukuro and committee members:

My Name is Darrow Hand and I am a naturopathic physician. While I support the intent of these bills, I oppose the current revisions.

Unfortunately maternal mortality has increased over the past few decades in the US and measures need to be taken to address why this is so and what can be done to reverse this. Estonia, Greece, and Singapore have the lowest maternal mortality rates in the world, and their programs should be studied in the process.

Safety is a major concern for all pregnancies, and I think that collaboration between various types of health practitioners will best serve patients. In reading through both SB2569 and the proposed SD1, it seemed to me that such collaboration was lacking and thus I oppose both revisions of the bill. Thank you for the opportunity to testify.

Sincerely,

Darrow Hand, ND

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	kauaicrystal@gmail.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Sunday, February 09, 2014 8:21:16 AM

SB2569

Submitted on: 2/9/2014

Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
crystal jefferson	Individual	Oppose	No

Comments: I also oppose sb2569 sd1 version of this bill. Thank you Aloha Crystal jefferaon

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IN OPPOSITION TO SB2569 AND SB2569 SD1, Relating to Home Birth

Regular Session of 2014
Hearing on Monday, February 10, 2014 in Room 229

For: Honorable Chair and Vice Chair and members of Health Committee, Commerce and Consumer Protection Committee and Judiciary and Labor Committee

Dear Sirs and Madams,

My name is Suzanna Kinsey and I am a registered voter and a home birth mother to three wonderful children. I strongly oppose SB2569 and SB2569 SD1.

Under the bills, as they are written, there is no provision for women who choose to birth at home for traditional, cultural, and spiritual reasons. Any midwife who attends such births could be charged with misdemeanor and, possibly, felony. Also, the bills limit the full scope of midwifery practice in it's ability to use and apply the full scope of tools and remedies of the trade. This is unacceptable as it would severely limit a woman's choice in birth practitioner and, ultimately, affect safety in birth.

We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what these bills will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the governments' right to decide how and where someone can birth.

This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for.

Please let the home birth community form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners, etc. to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature.

For all of these reasons and more, I strongly oppose these bills. The imposition of these state regulations simply do not take into account the important perspectives of the birth practitioners, the mothers, and the advocates of home birth.

Thank you for your time and effort in this matter.
Yours truly,

Suzanna Kinsey.

Written Testimony Presented Before the
Senate Committees on Health, Commerce & Consumer Protection, and
Judiciary & Labor
February 10, 20149:00a.m.
by

Lenora Lorenzo DNP, APRN, FAANP
Family, Geriatrics and Diabetes Nurse Practitioner
Region 9 Director, American Association of Nurse Practitioners

SB 2569 and SB 2569, S.D.1 RELATING TO HOME BIRTH

Chair Green, Vice Chair Baker, and members of the Senate Committee on Health;
Chair Baker, Vice Chair Taniguchi, and members of the Senate Committee on Commerce & Consumer Protection; and Chair Hee, Vice Chair Shimabukuro, and members of the Senate Committee on Judiciary and Labor

Thank you for this opportunity to provide testimony in **strong opposition** to these measures, SB 2569 and SB 2569, SD1.

The American Association of Nurse Practitioners and I as an APRN appreciates the Committees' commitment to the address Hawai'i's health care issues. However, the creation of a home birth safety board within the DCCA which would regulate a number of practitoners, including Certified Nurse Midwives (CNM), who are already licensed by the DCCA and national certifying boards. Home birthing is within the scope of certified nurse wifery practice. Both measures create regulatory redundancy as well as an unfair cost barrier for health care professionals who are already under state and national regulation.

The American Association of Nurse Practitioners and I as an APRN feels that SB 2569 and SB 2569, SD1 are premature.If it is the wish of these Committees to pursue this issue, a task force should be established to research whether there is a need for and resources required to establish a home birth safety board; as well as, whose safety standards will apply, how peer review will be established for all practitioners and how disciplinary action will be handledfor health care professionals already regulated under the DCCA.

Therefore, the American Association of Nurse Practitioners and I as an APRN strongly opposed this measure. We respectfully request that your CommitteesholdSB 2569 and SB 2569, SD1 or create a task force to study the issues involved, including a cost analysis and regulatory redundancy. Thank you for the opportunity to testify.

To respected members of the Hawai'i Legislature,

I am writing today as a midwife, mother, nurse and advocate for women worldwide.

I first came to Maui in 1998 and had a beautiful homebirth with my son who is soon to be 15. At that time, I had no idea what the status of midwifery in Hawai'i was. I did not care. I just wanted to have the choice to give birth how I wanted to. I felt I had that right. I just knew that I was in the hands of a caring, competent woman who treated me with the utmost respect and made me feel safe in my choice to have a home birth.

Shortly after, I became her apprentice and began to learn midwifery as a Direct Entry midwife, this is a midwife with no formal training, one who learns by doing. I assisted this midwife for 10 years. There were no maternal deaths in that time frame. There was one fetal demise, a baby with a heart defect. I felt like I was providing a needed service for the women of Hawai'i. Women were able to give birth peacefully, with no judgement, in the comfort of their homes.

We provided safe practices. There were many factors that ruled a woman out of a home birth and we were firm about those. We also tried to work hard with hospital staff to ensure that if a woman needed to be transferred to the hospital, that it was smooth and seamless and that the woman got the best care she could get. This was not always the case. Unfortunately, in some cases, if the staff knew the woman was attempting to have a home birth, she was treated less than adequate. This is not right, this must change. We must bridge this gap. There must be a respectful collaboration between the homebirth community and hospital staff.

I since have had 2 more home births. I was 43 at the last birth and chose not to go to doctors because I would have been considered high risk and would have had to go through a battery of tests and would have had to be notified of all of the risks. I decided that these fears were not good for me and not good for my baby. I exercised my choice, had my baby at home. He is now 5 and is a healthy and happy boy.

The thing is, women are going to give birth at home, regardless of what is legislated. As a nurse who has received her Bachelor's Degree and is soon to start a master's degree program (in Women's Health and Certified Nurse Midwifery), I feel even more strongly that women should be able to have a choice as to how they give birth and whom they give birth with.

The dialog is starting. This is good. But, this bill SB2569 needs to be thrown out as it is written because it is not does not allow for adequate choices for the women in our Hawaiian Islands. It is time for Midwives, Doctors, Nurses, Doulas, Mothers, Legislators to get together and start a healthy dialog and to come up with a bill that is evidence based, respectful of Hawaiian cultural values and that will respect women for their choices.

We need committees in all of the islands and I would love to be part of the Maui contingent.
Respectfully,

Robin Garrison, RN BSN
1001 Ulele St.,
Makawao, HI 96768
(808)463-2210

RE: SB2569 and SB2569 SD1 Relating to Home Birth
Hearing date 2-10-14 1:30pm rm 229
Oppose

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

I, Babatunji Heath, oppose SB 2569, SD1 RELATING TO HOME BIRTHS because despite the statement of it's noble purpose in Section 1 it will in fact greatly restrict the rights of families to deliver their children in the settings of their choice with attendants of their choice. I point to the long list of restrictions, in Section 2 – 4 Rulemaking part (5), prohibiting Midwives from providing care to expecting mothers as one clear example of this contradiction.

As a concerned and voting citizen of Hawaii I appreciate Senator Green's concern for mothers and their babies. However, if safer births and healthier mothers and babies are truly his and the State of Hawaii's goal then we should be examining all births and birth attendants in Hawaii as well as the education and health care that is provided to our mothers to be. Fear mongering based on false data and rumors is not responsible leadership and does not serve to truly protect people. Education, communication and cooperation are needed to improve the safety and quality of all births in Hawaii.

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	vanessacpmwaldorf@gmail.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Saturday, February 08, 2014 10:48:40 AM
Attachments:	final draft testimony 2569.doc

SB2569

Submitted on: 2/8/2014

Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Vanessa Jansen	Individual	Oppose	No

Comments: Home birth is a deeply cultural practice that is both respected and honored. We are all descended from an ancestor who gave birth at home. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.

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REGULAR SESSION OF 2014

For: Honorable Senate Committee Health Chair Green, Vice Chair Baker and Committee Members,
Hearing 2-10-14 Rm 229
Please make (# of copies) copies. Mahalo

RE: **SB 2569 and SB 2569 SD1 Relating to Home Birth – IN OPPOSITION**

Hello and Aloha Committee members,

I am a registered voter living in Kahala and a grades school teacher within a large community of well-informed naturally, minded folks from all over the world; and it includes Ohana that are from the Hawaiian islands. The culture I am surrounded in is concerned with evidenced-based practices and in keeping life's transitions as close to inherently natural as possible. I hope that the truth will shed light on some of the fears that may have developed in those that are to take care of us in the legislature. The reason is because I have birthed my children at home and any future children I birth will be born at home and I hope to have the midwife of my choice helping me to do that. I feel that is my right and freedom as a citizen of the United States and of Hawaii. Please protect my rights.

I strongly oppose SB 2569 for the following reasons.

1. On its face, this bill is inaccurate. It cites a flawed study, and it suggests home birth is dangerous and unsafe. I join other home birth practitioners, mothers and advocates to correct that notion. We realize that we have a responsibility to provide data and information about our home birth practices, our training, and our experiences to the legislature and community-at-large.

2. This bill currently tries to define a scope of practice without an in depth understanding of the various practitioners, roles and responsibilities involved in home birth. The medical hospital-based model it imposes doesn't take into account the population it is regulating and doesn't accurately represent different models of home birthing, each with unique traditions, scopes of practice, varying types of practitioners and their educational backgrounds, safety protocols and standards of care that are already in place. SB 2569 SD1 is closer and the effort shows, but it has many areas that restrict the practice of midwifery at home anyway. i.e not mentioning Pitocin or other anti-hemorrhagic medications as allowed medications. Instead, we should fully rely and choose to use NACPM and NARM's criteria with Hawaii's licensing guidelines.

3. The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth practice. This bill assumes there is no oversight over home birth; in fact, midwives have the capacity to govern themselves. SB 2569 SD1's, suggestion of a board still does not reflect a home birth, midwifery model as written, with 3 OB/GYNs and a midwife group of only, 3 consisting of different certifications. It should have all members being experts in home birth, consisting of CPMs, NDs, Traditional Midwives, Direct-Entry Midwives, CNMs, in order to regulate what is safe. If needed, only 1 physician is necessary and chosen by the home birth community.

4. As written, this bill would essentially eliminate the option of finding a legal home birth attendant. It is the rite/right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. Furthermore, this bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose. Requiring a registry of home birth mothers, for example, fosters stigma around home birth, a scarlet letter.
Laws are created to protect consumers and ensure safety. But lawmakers also have the obligation to protect long standing cultural practices of birth.

5. Home birth is a deeply cultural practice that is both respected and honored. We are all descended from an ancestor who gave birth at home. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.

6. This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for.
7. Home birth is safe, as safe if not safer than hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe? (Rising c-sect rate, inductions, medications...safe?) Let's dialogue, If legislators are truly interested in learning about home birth as Green's press release indicates, then take this

next year to learn about the differences between the midwifery model vs the medical model of birthing. Become educated.

For all of these reasons and more, I strongly oppose these bills as they stand. The imposition of these state regulations simply does not take into account the important perspectives of the birth practitioners, the mothers, and advocates of home birth.

Yet, we recognize the need for more information and offer the following:

- We have already begun to form a Home Birth Council that reflects the variety of practices, mothers and advocates. This Council shall be self-defined and self-regulated.

- We request the opportunity to gather data, standards of care, and wise practices to present before the legislature at a later date.

Thank you for your time,
Vanessa Jansen

Evidence in support of point #1

1. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/MCDG/wp-content/uploads/2013/02/Medscape-Wax-Critique-Michal-Janssen-Vedam-Hutton-de-Jonge.pdf)
2. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics)
3. BMJ 2005;330;1416 Outcomes of planned home birth with certified professional midwives; large prospective study in North America
4. BJOG, 2009 Aug; 116(9):1177-84 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births
5. The Myth of a Safer Hospital Birth for Low Risk Pregnancies (http://www.greenmedinfo.com/blog/myth-safer-hsopital-birth-low-risk-pregnancies)

6. **Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009. http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12172/full**

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	ssimscnm@gmail.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Sunday, February 09, 2014 8:48:41 AM

SB2569

Submitted on: 2/9/2014

Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Susan Sims	Individual	Oppose	No

Comments: I oppose SB2569 SD1 for this bill is proposed without the inclusion of voices or conversation of midwives. This bill criminalizes women who decided to give birth at home with the traditional midwife. This violates women's rights to give birth within their cultural practices and self determination.

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From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	amanda.bub.litton@gmail.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Saturday, February 08, 2014 10:47:31 AM
Attachments:	image.jpg

SB2569

Submitted on: 2/8/2014

Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Amanda Litton	Individual	Oppose	No

Comments: 1. To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor, 2. Hearing date 2-10-14 1:30pm rm 229 3. RE: SB2569 and SB2569 SD1 Relating to Home Birth 4. Oppose 5. Four main points: A) Home birth is safe, as safe if not safer than hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe? (Rising c-sect rate, inductions, medications...safe?) Let's dialogue, If legislators are truly interested in learning about home birth as Green's press release indicates, then take this next year to learn about the differences between the midwifery model vs the medical model of birthing. Become educated. B) We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth. C) This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for. D) Let the home birth community form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

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IN OPPOSITION TO SB2569 AND SB2569 SD1, RELATING TO HOMEBIRTH

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

Hearing date 2-10-14 1:30pm rm 229

RE: SB2569 and SB2569 SD1 Relating to Home Birth

Dear Sirs and Madams:

My name is Karen Dizney and I am a mother to three children, two of whom were born at home. I strongly oppose SB2569 and SB2569 SD1. I have written and submitted separate testimony for SB2569 so I will write why I am specifically opposed to SB2569 SD1.

I feel that the wording of this bill will not protect women and children but only further restrict the true model of evidence based care that homebirth follows.

One particular part of the bill that I find unnecessarily restrictive is in regards to the timeframe with which a woman is allowed to birth at home. It states that only between 37 and 42 weeks is permissible. As some may not know, women do not menstruate all on a 28 day cycle. However, a 28 day cycle is how the due date is calculated. For those who have longer cycles, they may not fit this 37 to 42 week window.

I have personal experience with this because I am one of those women. All three of my children measured at 6-8 days smaller at their 20 week anatomy scan. With my third child, the OB refused to move the due date stating that it wouldn't matter. Well, it did. I was forced to undergo testing at 42 weeks and 1 day that would not have happened if my due date was moved. I was in reality only 41 weeks and 2 days so not outside the parameters of the law in Virginia.

I ended up being bullied, manipulated and lied to by the OB at the hospital that my baby was in jeopardy and I could not birth at home as it would not be safe. I was told that the only way was to come into the hospital and be induced that night. I asked if I could go home and come back in the morning if I didn't deliver on my own and I was told that I should rush home, pack a bag and get back without delay or my baby would die. I was told that they saw meconium in the water on my scan. The last being a complete lie as it is impossible to see meconium on an ultrasound.

My husband was deployed and I was alone and scared so I rushed home and packed my bag. I got back to the hospital as soon as possible. When I got there, I thought for sure that I would be rushed off into a room and pumped full of pitocin so we could get this baby out immediately. This was not the case. Why? Because my baby was not in imminent danger. I was lied to and manipulated by the OB to get me to come in.

The next part of my story is quite a miracle, I was blessed with an OB that had studied with a couple of Certified Professional Midwives (CPMs). In fact, he informed me that he learned more about birth in the few months he studied with them than he did in all of his years in medical school. He told me that he knew that I must be disappointed to not be at home and he wanted to do what I felt (as long as me and baby were safe) I needed to do to let birth progress naturally. I couldn't have been more surprised after the other OB's stance on what was needing to happen.

In the end, I did not receive pitocin. With the supervision of my midwife (who acted as my doula since she had no rights to practice in the hospital), I was induced by a breast pump. Nipple stimulation is a technique that midwives sometimes recommend to speed up labor. Within a few hours of arriving at the hospital, I birthed my beautiful baby into to this world, catching her myself as I would have had I been at home. There was no meconium in the water as the first OB claimed.

I was incredibly blessed and lucky as my story could have gone very differently. I could have had the OB that was not willing to honor me and my choices and evaluate things based solely on what the medical model dictates. I might have had an unnecessary cesarean section if me or my baby had not responded well to the pitocin. Me or my baby could have died during the surgery. There are a number of outcomes that could played out that luckily didn't.

The point of my story is that this that by putting a strict date on when a woman should birth her baby instead of using an evidence based approach, there could be difficult outcomes. I know people might read this story and say, the only thing that matters is that the mother and baby were fine, both survived. That isn't all that matters. To this day, almost two years later, I am still emotionally scarred about the treatment I received by that first OB. It is a pain that lives in my heart every day. In the medical model, the woman is treated as if she is purely the vessel for the baby. She has no rights, no feelings, no knowledge. In the evidence based model, the woman is honored, respected and trusted to know how to birth. We have been birthing since the beginning of time and without that innate knowledge, we would not be here today.

I beg you to reconsider passing this law. I don't feel that it honors women nor will it save any by taking more of our rights away.

Thank you for your time,

Karen Dizney

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	abensley80@yahoo.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Saturday, February 08, 2014 10:45:57 AM

SB2569

Submitted on: 2/8/2014

Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Adam Bensley	Individual	Oppose	No

Comments: I oppose SB 2569 and SB 2569 SD1. Parents should have the right to choose whatever birthing method they want. The birth process should not be regulated by the "state." Adam Bensley 47-441 Hui Nene Street Kane'ohe, 96744

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February 9, 2014

Subject: Hearing date: February 10, 2014; 1:30pm; Room 229 for SB2569 & SB2569 SD! Relating to Home Birth

Dear Honorable Chair & Committee Members of Health, Committee on Commerce & Consumer Protection, Judiciary & Labor,

I am submitting my testimony online opposing SB2569 & SB2569 SD1 for the following reasons:

1. Home birth is safe, as safe if not safer than hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe? (The c-section birth rates in hospitals have been rising which is major abdominal surgeries happening along with a rise in induction rates & medications being used at hospital births) If legislators are truly interested in learning about home birth as Green's press release indicates, then take this next year to learn about the differences between the midwifery model versus the medical model of birthing. Become educated as I was when I attended my first child birth education class over 5 years ago and have been keeping myself updated annually by at least attending 1 class each year because what I learned at these classes have blown my mind away.

2. We (the public, the home birth practitioners, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislature's right to decide how, where & with whom someone can birth.

3. This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for.

4. Let the home birth community form their own advisory council with all birth practitioners represented (ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc) to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

Please do not go ahead with these bills. It takes away a woman's right to choose the type of birth experience she wants and will have a major impact on how her birth may turn out. One important factor of a birth progressing is for the mother to be in an environment that she is comfortable in and surrounded by people she can trust and be supported for the way she chooses to birth. Many women choose to do home births because that's what they can have.

Respectfully submitted,
Kristl Woo

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	drjoeka@gmail.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Saturday, February 08, 2014 10:43:36 AM
Attachments:	sb2569 rev.pdf

SB2569

Submitted on: 2/8/2014
Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
joe kassel	Individual	Oppose	Yes

Comments: this testimony is intended in opposition to both SB2569 and SB2569sd Dr. Joseph Kassel, N.D., L.Ac. P.O.B. 400 Holualoa, Hawaii 96725 (808) 329-6442 2/08/2014 Dear Senators: I am writing in opposition SB2569SD. I appreciate the efforts to revise SB2569, likely in response to a significant hue and cry from a small percentage of those effected by this proposed legislation. My testimony against SB2569 still stands primarily unaddressed by these changes. The revised bill is still based on a medical model paradigm. It is still dominated by other health professionals on an scale unprecedented on any other board that I am aware of. As elucidated in my previous testimony on the original bill, people have a right to carry out this sacred experience where and with whom they choose. Not everyone views every experience in terms of medical evaluations and interventions. Many people experience birth as a natural process,which is fundamentally interfered with when carried out in a medical environment. The world view of the birth attendant verbally and non-verbally significantly affects the birth setting and process. In establishing a board controlling the practice of midwifery based on the medical model of birthing, the State will be making it impossible for people to find birth attendants who do not share this medical view of the birth process. We see the world through the glasses of our training. This legislation basically bans midwives who see the world outside of the medical model, unless they happen to be an immediate blood relative. Specific but not exclusive problems that ensure the validity of my concerns include: The inclusion of 3 obstetricians on the board. The shared seats of midwives with either CPM's or CNM's. The role of the board as advisory to the Medical board. The inclusion of extensive medical standards determining who can birth at home. These provisions guarantee that the medical paradigm will permeate and dominate all births in Hawaii, against the will of a well informed diverse home birth community. Mahalo and aloha, Dr. Joe Kassel N.D.,L.Ac

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webmaster@capitol.hawaii.gov

Dr. Joseph Kassel, N.D., L.Ac.
P.O.B. 400
Holualoa, Hawaii 96725
(808) 329-6442

I am writing this letter in opposition to Senator Green's Senate bill 2569. I am a practicing Naturopathic Physician and Licensed Acupuncturist since 1988, I was also a Med-Surg R.N. since 1979. I have 3 adult children, who were all born at home. Even 30 years ago, this was a decision that was well informed and not taken lightly. These home birth experiences were profound, beautiful, natural, empowering and not replicable within the hospital based medical model of care.

This bill is fundamentally flawed from inception through planned implementation. While Dr. Green purports to be an advocate of home birth, he demonstrates no understanding of what is involved for families making and implementing this choice. The bill also demonstrates no understanding of the challenges faced by home birth attendants in the medico-legal environment of the 21 Century. Due to these inadequacies, this bill will make it impossible for families who choose home births to find any attendant at all, resulting in higher risks for these families.

This bill will require all home birth attendants to have a minimum of a Master's degree in midwifery. This training is all based on the Medical model of care. Anyone with this training will not likely to be able to acquire doctor backup or malpractice insurance to attend home births, therefore, very few home birth attendants will be available in Hawaii. It is also extremely rare for anyone indoctrinated in this model of care to be able to create and support the nurturing home birth environment provided by traditional birth attendants, which is exactly what is most often sought by those seeking a home birth experience. There is a fundamental difference between the midwifery model of care and the medical model of care. It is the medical model of obstetric care that Dr. Green and his ACOG associates seek to promulgate at the expense of our families freedom to choose.

Do understand that many people who choose home births are rejecting the medical model of care in the birthing process. The United States implementation of this model is profoundly flawed and many well educated people understand this and reject it. Traditional midwifes often assist doctors, nurses and nurse midwives who know the medical model inside out and choose to birth at home. Our c-section rate is the 5th worst of 29 OECD countries. 33 countries have lower maternal mortality, 37 have lower neonatal mortality. All this with the highest price tag on earth averaging over 2 1/2 times the cost in other developed countries.

We have a very high rate of interventions that are not improving outcomes but are profoundly interfering with the important (both psychologically, physiologically and spiritually) transition into this world, family bonding and initiation of nursing and lactation. This is a remarkable dance, different for each woman and family and unfortunately in our technological medical model it is reduced to a series of interventions and procedures, often leaving families disempowered and alienated in the process. People have and will protect their right to choose, not only where to

shepherd their children into this world, but how and with whoever best supports their vision. Within the midwifery community, there is a wide spectrum of practitioners, adhering more or less to medical or midwifery models. This allows parents a spectrum of options.

I have watched as the establishment of midwifery boards invariably leads to the medical model of care becoming the dominant paradigm. This insidiously removes options for families. Hawai'i must respect the rights of all it's diverse inhabitants, including it's traditional and indigenous peoples to carry on their lives and sacred ceremonies (which birth is traditionally) as they choose, free of the intervention, control and monitoring by our medico-legal technocratic corporate (yes health industry is the big invisible gorilla in the room) bureaucracy.

People are choosing to have their children at home to reduce unnecessary and ineffective interventions in an alien environment, they do recognize that there are some risks in this choice, but also many benefits, not the least of which include uninterrupted maternal/paternal neonatal bonding, improved breast feeding and lactation, not to mention the psycho-spiritual implications of being born into a warm welcoming home.

For the single study that Dr. Green references regarding the risks of home birth there are many well done studies refuting it's findings. In medicine a single study is of little value, especially if it is not replicated. The most recent study on home births between 2004 and 2009 published in the Journal of Midwifery and Maternal Health shows no difference in negative outcomes between home births and national averages.

It is a fundamental right for families to choose how to birth. Enforcing a flawed medical paradigm on those who make this choice, instead of improving communication with and access to medical care when it is necessary is not only flawed thinking, it is abrogating peoples fundamental rights. This bill is a prime example of the bullying of the medical profession against traditional practitioners of all types that has gone on for centuries, it is self serving, self righteous and arrogant.

It is important to note that Dr.Green was awarded legislator of the year by Hawaii Assoc. of Obstetricians and Gynecologists (ACOG), he appears to still be meeting their political objectives to dominate and eliminate traditional birth attendants. In fact his statements and proposals are taken almost verbatim from ACOG's policy statements, policies which are not supported by the vast majority of midwives or home birth proponents. Shame on Dr. Green for passing off a medical political power play for legitimate health promoting legislation and abusing the public trust.

In the past,I sat on a state health licensing board. I understand the limitations, political turf fighting and other challenges faced by these boards. As written, Dr. Greens board is guaranteed (intended?) to prevent traditional birth attendants from being able to practice, govern or regulate themselves. No other board that I have ever known is dominated by other health professionals, no less has annual renewals. I welcome the day that Dr. Green's Medical board is dominated by Naturopathic and Chiropractic Physicians.

Please dismiss this proposed bill. If members of the committee are committed to improving birth outcomes there are many areas that could use constructive

engagement. These could include improving communication and avenues for transfer of care between various disciplines that now often encounter prejudices (such as this legislation) and sectarian divisions. Perhaps we should look at the escalating use of monitoring in the hospitals which has resulted in escalating interventions without any improvement in outcomes, one of many factors encouraging more families to, in fact, birth at home.

Thank you for your time and attention to this matter.

Dr. Joe Kassel N.D., L.Ac.

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

Hearing date 2-10-14 1:30pm rm 229

RE: SB2569 and SB2569 SD1 Relating to Home Birth – in OPPOSITION

Aloha Honorable Chair and Committee Members,

My name is Audrey Alvarez, a mother of two healthy and thriving children who were both born at home on Oahu under the care of a traditional birthing attendant (midwife) and doula.

I strongly oppose SB2569 and SB2569 SD1 for the following reasons:

Based on my personal experiences, I know that home birth is safe, as safe if not safer than hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe? Are inductions, medications, c-sections safe? If legislators are truly interested in learning about home birth as Senator Green's press release indicates, then let us take time this next year to learn about the differences between the midwifery model vs. the medical model of birthing.

We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth.

This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for.

Let the home birth community form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

Home birth is a deeply cultural practice that is both respected and honored. We are all descended from an ancestor who gave birth at home. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.

For all of these reasons and more, I strongly oppose this bill as it stands. The imposition of these state regulations simply does not take into account the important perspectives of the birth practitioners, the mothers, and advocates of home birth.

Thank you for your time. I appreciate the opportunity to testify.

Aloha,

Audrey Alvarez
audrey262@yahoo.com

From: Brenna Hunziker
To: HTHTestimony
Subject: Testimony in opposition to SB2569 and SB2569 SD1
Date: Sunday, February 09, 2014 9:31:38 AM

Aloha,

I am writing in opposition to SB2569 and SB2569 SD1. This bill, although seeming to have the best interest of Hawai'i's women and children in mind, in actuality would produce the opposite effect. It is our inherent right as women to choose how, where, and with whom we birth our babies. This fundamental right must not be impeded by legislation which would ban the practice of traditional midwives in our state.

The study which this bill sites is fundamentally flawed. I did a lot of research prior to my decision to birth at home with a traditional midwife, and it is clear from the vast studies done that home birth is as safe, if not more so than hospital birth.

Low-risk, healthy pregnancies are not a medical condition. Pregnancy and birth is a natural occurrence which our ancestors have done for millennia. Should I become pregnant again, I would choose to birth at home with the same midwife, legal or not. Yet if this bill passes it would put both of us in an unnecessary compromised legal position. To tell my midwife who has birthed thousands of babies over the past three decades that she needs to go back to school is insulting. To tell me who I can and cannot birth with is equally as insulting. Please consider this aspect when you vote on this bill. Thank you for your concern about the welfare of Hawaii's women and children, but I assure you this bill is not the answer.

Sincerely,

Brenna Hunziker

Captain Cook, HI

Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,
Hearing date 2-10-14 1:30pm rm 229
RE: SB2569 and SB2569 SD1 Relating to Home Birth

I firmly Oppose

In June 2012 I did extensive research and preparation for my home birth. My labor was challenging and had some minor complications, however, I always felt that I was in an absolutely safe place and in the very best care with my Certified midwives in attendance. My beautiful son was born safetly in our sun lit bedroom with a room for of loving capable people. It was a powerful and beautiful experience-one of the best in my life. My midwives told me that the same kind of birth in the hospital setting would have most certainly resulted in an epsiotomy at the least and mostly like a c-section along with many other interventions. Many people ask me why I chose to have a home birth and I immediately tell them that I believed that safest place for a low risk women to give birth is at home. Hospital are for sick people. Pregnancy is not an illness or disease.

Home birth is safe, as safe if not safer than hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe? (Rising c-sect rate, inductions, medications...safe?) Let's dialogue, If legislators are truly interested in learning about home birth as Green's press release indicates, then take this next year to learn about the differences between the midwifery model vs the medical model of birthing. Become educated.

We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth.

This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for.

I do not want the government involved in the decision making process for my care practitioners.

Please oppose this bill.

Denise Karabinus
225 Queen Street
Honolulu, HI 96812

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	Andystarn@yahoo.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Saturday, February 08, 2014 10:25:58 AM
Attachments:	HomebirthHawaii.docx

SB2569

Submitted on: 2/8/2014

Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Andy Starn	Individual	Oppose	Yes

Comments: I have a beautiful healthy 10 Month old Daughter who was born at our home in Niu Valley. I have a beautiful healthy 6 year old step daughter who was born at home. Child birth has risk in any venue. We as parents make a decision how we would like to bring our children into the world. Whatever that decision there is benefits and risk. For the legislature to think that they have the right to come into our homes and dictate to their constituency how and where they may bring their children into this world is unconscionable. Whoever brought this bill forward should be ashamed of themselves. And, I will be watching closely anyone who supports this bill and they will not have my support in any elections from this time forward. Sincerely, Andy Starn

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To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,
Hearing date 2-10-14 1:30pm rm 229
RE: SB2569 and SB2569 SD1 Relating to Home Birth
Oppose
Four main points:

A) Home birth is safe, as safe if not safer than hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe? (Rising c-sect rate, inductions, medications...safe?) Let's dialogue, If legislators are truly interested in learning about home birth as Green's press release indicates, then take this next year to learn about the differences between the midwifery model vs the medical model of birthing. Become educated.

B) We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth.

C) This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for.

D) Let the home birth community form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

Thank you,

Andy Starn

1. To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

   2. Hearing date 2-10-14 1:30pm rm 229

   3. RE: SB2569 and SB2569 SD1 Relating to Home Birth

   4. Oppose

   5. Four main points:

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   B) We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth.

   C) This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for.

   D) Let the home birth community form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

   6. I had a beautiful homebirth on 8December2013 in the comfort of my own home. Under your proposed law, my home birth would have been illegal due to having HPV. According to the CDC, ANYONE who has sex will get HPV.

   7. Let the true professionals that handle home birth DAILY decide on a board, or make up a drafted law. Not from OBs that have no real knowledge of how home births are done.

REGULAR SESSION OF 2014

For: Honorable Senate Committee Health Chair Green, Vice Chair Baker and Committee Members,

Hearing February 10, 2014, 1:30 pm conference room 229

RE: **SB 2569 and SB2569 SD1 Relating to Home Birth – IN OPPOSITION**

My name is Laine Hamamura and I am a registered voter who had a hospital birth and a home birth. My first son was born without medical intervention and vaginally at Kapiolani Hospital with the support of my doula birthing team and my OBGyn, Dr. Donn Tokairin. Three years later, I chose to have my second son, birthed at home with my midwife, Dr. Lori Kimata, and my doula birthing team. The birth of my second son compared to my first son's birth was more medically safe, absolutely comfortable, and non-stressful.

I strongly oppose SB 2569 and SB2569 SD1 for the following reasons.

1. This bill is inaccurate as it cites a flawed and outdated study, and it suggests home birth is dangerous and unsafe. I join other home birth practitioners, mothers and advocates to correct that notion. From my personal experience, home birth was a much safer model of care for me and my baby. For example, at Kapiolani Hospital, I was advised that I should have them pop my water bag to speed up my labor. After the water bag was popped, that put me and my baby at risk for infection and it increased the pain of the contractions. However, during my home birth, my second son was born in half the time and still encased in his water bag. This prompts me to believe that it was unnecessary for the water bag in my first pregnancy to be manually popped. Mainly, there are practices in home birth that I know are much safer for the mother and baby, which I feel the hospitals and OBGyn doctors should adopt.

2. This bill currently tries to define a scope of practice without an in depth understanding of the various practitioners, roles and responsibilities involved in home birth. The medical hospital-based model it imposes does not take into account the population it is regulating and does not accurately represent different models of home birthing, each with unique traditions, scopes of practice, varying types of practitioners and their educational backgrounds, safety protocols and standards of care that are already in place. Please do not allow people who have no personal experience with home birth to dictate and regulate people who do have that knowledge and experience.

3. The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It does not reflect the participants of home birth practice, either. This bill assumes there is no oversight over home birth; in fact, midwives have the capacity to govern themselves.

4. As written, this bill would essentially eliminate the option of finding a legal home birth attendant. I have the freedom, as a birthing mother to choose where, with whom, and how to

best birth my child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. Furthermore, this bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose. Requiring a registry of home birth mothers, for example, fosters stigma around home birth, a scarlet letter. This could also potentially create discrimination for the mothers and the children of home birth. Laws are created to protect consumers and ensure safety. Lawmakers also have the obligation to protect long standing cultural practices of birth.

5. Home birth is a deeply cultural practice that is both respected and honored. We are all descended from an ancestor who gave birth at home. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law. My decision to have both of my children vaginally and without medical intervention is rooted in my belief that there is a higher power, whom I worship and call God, who intelligently created me to give birth in that way. In the home birth model of care, my religious beliefs were never infringed upon, whereas in the hospital model of care, there was a very real threat to my beliefs and my personal choices.

6. Please let the home birth community form their own advisory council with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc. to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session. My midwife is incredibly intelligent and much more educated on birthing practices than my OBGyn. There were things that she and I discussed in detail in our hour long prenatal visits that my OB had no knowledge about as I asked him about those things in his 10 minute office visits.

For all of these reasons and more, I strongly oppose this bill as it stands. The imposition of these state regulations simply does not take into account the important perspectives of the birth practitioners, the mothers, and advocates of home birth.

Yet, the home birth community recognizes the need for more information and offers the following:

· We have already begun to form a Home Birth Council that reflects the variety of practices, mothers and advocates. This Council shall be self-defined and self-regulated.

· We request the opportunity to gather data, standards of care, and wise practices to present before the legislature at a later date.

· We request a legislative informational hearing that provides the opportunity to present information about the spectrum of home birth practitioners, their education and training, and existing standards of care.

Thank you for your time in hearing my testimony.
Sincerely,
Laine Hamamura

Maraya Ben-Joseph

P.O. Box 33

Honaunau, Hawaii, 96726

Dear Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

This letter is in regards to the meeting that you all will be holding on the date of February 10, 2014 at 1:30pm in room 229 to discuss bill SB2569 and SB2569 SD1 Relating to Home Birth.

I AM STRONGLY OPPOSES BOTH THESE BILLS because of four main points:

1) Home birth is safe, as safe if not safer than hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe? (Rising c-section rates, inductions, medications...safe?) Let's dialogue. If legislators are truly interested in learning about home birth as Green's press release indicates, then take this next year to learn about the differences between the midwifery model vs. the medical model of birthing. Please, Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor, become educated.

2) We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right AT ALL to decide how and where someone can birth.

3) This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for.

4) Let the home birth community form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

I would also like to state for the record that I am very disappointed that I cannot attend this hearing due to the fact that I do not have the monetary means to buy a plain ticket to Oahu, pay for lodging, transportation and childcare. Why is there not video conferencing available for citizens of other islands? If our county here in Hawaii provides that service, why can’t the state? This is unjust and unfair

that I am not able to exercise my rights simply because of a monetary issue. This is shutting out the poor and working class citizens. Please consider this strongly for the future. Again, as a women who birth my baby at home with a midwife, I oppose these two bills.

Thank- You

Maraya Camila Gonzalez Ben-Joseph

9 February 2014

My purpose in writing this testimony today is to speak out against bills SB2569 * SB2569 SD1 and SB2070 * SCR25.

I urge all voting members of the house to vote "NO" against these two measures, as they undermine a woman's right to choose the time, place and person(s) who will deliver her baby and is the antithesis of what the ACA and the USC intend.

Furthermore, these bills fail to address the very real safety concerns and increased rate of infant mortality associated with the increased use of interventions that are the hallmark of care by medical doctors at medical facilities.

My personal experience compels me to support other women in their quest for sovereignty over their bodies. In 1986, during what was supposed to be a routine pre-natal examination, healthcare providers at Tripler Army Medical Center determined that I was in pre-term labor and I was admitted into their ICU.

Because Tripler's neonatal unit was not sophisticated enough to care for a fetus that young (28 weeks), within three days I was transferred to Kapiolani Medical Center.

At Kapiolani I was given the highest level of medical care from the facilities and the staff, including Drs. Ralph Hale (who delivered my son, on February 10, 1987) and Robin Willcourt (a visiting specialist).

Were it not fetal distress at 35 weeks and an intervening C-section (from my naval to my pubic bone – the most severe type of incision, through three layers of muscle), I would have delivered vaginally and without anesthesia – as originally planned.

In spite of this episode and the continuing complications related to abruptio placenta that followed me into my second pregnancy, Dr. Stephen Lin, a physician at Kapiolani, who treated me throughout my second high-risk pregnancy, allowed me to deliver vaginally (VBAC).

It was a thrill and a blessing for my spouse and myself, as were both able to participate in the birth of our daughter - him helping to cut the umbilical cord and me being rewarded with the chance to breast-feed in the delivery room.

That was in 1991. I still have the photos, and because I was not sedated, I remember every minute of my daughter's birth.

And, while "medicine" has advanced quite a bit, somehow, political attitudes about women making choices about their bodies doesn't seem to have kept pace with those advances. Even worse, it appears that we are sliding backward in that regard.

The bill sponsors would have you believe that theirs is a quest to ensure patient safety and not curtail the right to choose. I see very little merit to their argument and more fear mongering, than anything.

As a mother and grandmother, and as a long time advocate of traditional healthcare practices (upon which contemporary medicine is built), I disagree with the decision to impose further (and unwarranted) legislation onto women and their healthcare providers involved in the birthing process, and this is why:

- Less than 1% of all births occur at home – the majority occur in the hospital
- The USA – though it ranks #1 in healthcare costs – is #45 in infant mortality (which means that 44 other countries have lower infant mortality rates) and that's for services rendered in a hospital facility
- The leading cause of infant mortality within the first year of life is birth defects and there is nothing to correlate birth defects with at home births, rather birth defects are often associated with much younger/older mothers, as well as higher rates of interventions at medical facilities
- The second leading cause of infant mortality within the first year of life is premature/low birth weight – again this is not due to at-home births and is often correlated with births associated with interventions, such as hospital births
- Birth defects and premature/low birth rates account for 37% of infant mortality
- 1 in every 8 infants born in the USA is pre-term
- A 2004 report revealed that 16% births were to teens under 18 and 17% births to women over 40 – most will deliver in a hospital, not at home
- Pre-term infants are 15x more likely to die in the first year
- Every year 32K infants born before 32 weeks and are 75X more likely to die
- On average, a bay is born/minute to a teen mother in the USA

- Besides birth defects, premature/low birth weight, other factors, such as infections, smoking, drugs, extreme weight and stress contribute to infant mortality

- Obesity rates for women 18-44 has increased from 12.6% in 1995, to 21.7% in 2005

- The use of interventions, such as induction, epidural and C-sections have increased dramatically since 1965

- C-section rates went from 4.5% in 1965, to 31.1% in 2006, a 50% increase from 20.7% in 1996

- The World Health Organization (WHO) recommends that the optimal rate of interventions is between 5-10% of births and that rates over 15% may cause more harm than good

- The rates of induced labor have gone up 135% from 1990-2005 (and reporting is suspected to be underestimated by 45%)
- According to one study, "planned c-sections may lead to medically caused prematurity"

- The rates of pre-term births appear to correlate with planned C-sections – so, the question we should be asking ourselves is – is hospital birth, with all its attendant "interventions", truly safer than at home birth? Or, does at home birth, because of the lack of interventions, present a safer – and more traditional – option for birthing?

For all these reasons and for one simple one – there is no good justification – I urge all lawmakers to vote "NO" to these and any bills that would either confuse, cherry pick, or otherwise manipulate the data in order to undermine a woman's right to chose and force her to give birth in a medical facility.

Perhaps the real questions we should be asking ourselves an lawmakers is:

Why - with all the data that suggests that hospital interventions and other factors, such as a woman's age and higher rates of female obesity, are the true culprits of increased rates of infant mortality and not at home births - are hospital births preferred by our lawmakers, over at home births? Is this legislative decision being made to enhance the safety of at home births, or discourage women from this choice and thus force them back into a hospital setting, where hospital providers will chose for the mother? What does the law have against tradition and women's choice?

Mahalo.

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	lovemchance@hotmail.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Saturday, February 08, 2014 10:12:09 AM
Attachments:	HomebirthHawaii.docx

SB2569

Submitted on: 2/8/2014

Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
love	Individual	Oppose	Yes

Comments: I am a mother of two home births. I strongly oppose this bill. We need our freedom to choose how we will bring the next generation into this world. My family has been having home births for 7 generations and will not stop now.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,
Hearing date 2-10-14 1:30pm rm 229
RE: SB2569 and SB2569 SD1 Relating to Home Birth
Oppose
Four main points:

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B) We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right to decide how and where someone can birth.

C) This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for.

D) Let the home birth community form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

Thank you ,
Love Chance

IN OPPOSITION TO SB 2569 and SB 2569 SD 1

Please do not pass SB 2569 and SB 2569 SD 1.

All four of our grandchildren have been born in our home by two of our daughters. A third daughter will be having a home birth this year. All of the children were delivered by a midwife/N.D. All of the children so born were healthy at birth and thriving now, at ages two through twelve. We attribute the grandchildren's health and vibrancy to the overwhelming love and affection greeting their birthing arrival by their entire extended family.

These birthings, as witnessed inter-generationally by family members, were among the highest and best experiences of our lives. The family bond created at a home birthing has no equal in one's life and cannot be replicated as completely in an artificial hospital environment—unless of course the latter is needed due to personal parental choice or for medical reasons.

Home births are as safe or safer than hospital births, especially when medical and hospital personal act as backup for midwives, N.D.'s, and other qualified and trained individuals who deliver babies in a non-hospital setting. Such cooperation should be the hallmark of 21st century integrative medical practice and encouraged in every way possible by the Legislature.

Instead of outlawing critical aspects of home birthing, the Legislature should encourage and lay the legal groundwork for a system of self-regulation for midwives and home birth practitioners. When relatively rare home birthing mishaps occur, an industry wide appropriate dispute resolution process should be created to efficiently and equitably handle such cases.

In a democracy, we have the right to decide under what birthing circumstances our children are born. Our fundamental constitutional right to such choice should not be abridged unless one's choice is harming another or one's actions are negligently or grossly criminal.

The key is education of parents-to-be in the birthing choices available and the consequences of informed parental choice of birthing alternatives. By providing education to parents and minimal regulation by non-midwives and non-birthing practitioners, our State will enhance our ability to bring healthy and happy children into *Hawai'i Nei.*

Mahalo nui loa for your kind attention and appropriate action in opposing SB 2569.

In peace,

Tom & Lu DiGrazia and Family

REGULAR SESSION OF 2014

To Honorable Chair and Committee Members of Health, Committee on Commerce and Consumer Protection, and Judiciary and Labor,

Hearing 2-10-14 1:30pm Rm 229_

Please make (12 copies) copies. Mahalo

RE: **SB 2569 and SB2569 SD1 Relating to Home Birth – IN OPPOSITION**

Good Afternoon,

I am a supporter of homebirth.

I strongly oppose SB 2569 and SB2569 SD1 for the following reasons.

1. On its face, this bill is inaccurate. It cites a flawed study, and it suggests home birth is dangerous and unsafe. I join other home birth practitioners, mothers and advocates to correct that notion. We realize that we have a responsibility to provide data and information about our home birth practices, our training, and our experiences to the legislature and community-at-large.

2. This bill currently tries to define a scope of practice without an in depth understanding of the various practitioners, roles and responsibilities involved in home birth. The medical hospital-based model it imposes doesn't take into account the population it is regulating and doesn't accurately represent different models of home birthing, each with unique traditions, scopes of practice, varying types of practitioners and their educational backgrounds, safety protocols and standards of care that are already in place.

3. The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth

practice. This bill assumes there is no oversight over home birth; in fact, midwives have the capacity to govern themselves.

4. As written, this bill would essentially eliminate the option of finding a legal home birth attendant. It is the rite/right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. Furthermore, this bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose. Requiring a registry of home birth mothers, for example, fosters stigma around home birth, a scarlet letter. Laws are created to protect consumers and ensure safety. But lawmakers also have the obligation to protect long standing cultural practices of birth.

5. Home birth is a deeply cultural practice that is both respected and honored. We are all descended from an ancestor who gave birth at home. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.

For all of these reasons and more, I strongly oppose this bill as it stands. The imposition of these state regulations simply does not take into account the important perspectives of the birth practitioners, the mothers, and advocates of home birth.

Yet, we recognize the need for more information and offer the following:

- We have already begun to form a Home Birth Council that reflects the variety of practices, mothers and advocates. This Council shall be self-defined and self-regulated.

- We request the opportunity to gather data, standards of care, and wise practices to present before the legislature at a later date.

- We request a legislative informational hearing that provides the opportunity to present information about the spectrum of home birth practitioners, their education and training, and existing standards of care.

Thank you for your time and consideration,

Monika Catanzaro

Evidence in support of point #1

1. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/MCDG/wp-content/uploads/2013/02/Medscape-Wax-Critique-Michal-Janssen-Vedam-Hutton-de-Jonge.pdf)
2. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics)
3. BMJ 2005;330;1416 Outcomes of planned home birth with certified professional midwives; large prospective study in North America
4. BJOG, 2009 Aug; 116(9):1177-84 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births
5. The Myth of a Safer Hospital Birth for Low Risk Pregnancies (http://www.greenmedinfo.com/blog/myth-safer-hsopital-birth-low-risk-pregnancies)
6. AND MORE – add your own strongest studies, there are many!

You can also submit testimony for both SB2569 and SB2569 SD1 via email to: HTHtestimony@capitol.hawaii.gov).

I am writing to oppose SB2569 and SB2569 SD21 on the premise that these bills do not allow women to choose their preferred method of child birth. It is my understanding that what was proposed by our community of midwives during the drafting process is not what is being presented in these bills, and that the language and modifications presented are not acceptable by the midwifery communities, especially among those who contributed to this process. These bills have morphed into heavy handed restrictions with limited direct care by midwives, and it does not sufficiently provide legal protection for midwifery. Moreover and most importantly, it lacks recognition to current Hawaiian cultural traditions, which I find contradictory in the opening statements of SB2569 SD21.

> "The legislature finds that the practice of midwifery has been a part of Hawaii's culture and tradition since before Hawaii joined the Union as a state. For personal, religious, and economic reasons, some Hawaii residents choose midwifery care.
>
> The legislature further finds that establishing a home birth board in Hawaii will preserve the rights of families to deliver their children in a setting of their choice; provide additional maternity care options for Hawaii's families; protect the public health, safety, and welfare; and provide a mechanism to assure quality care."

While you recognize that midwifery IS a part of Hawaiian culture and traditions, among your rulings in Section 4 is to prohibit other legend drugs. This bill does not address use of laʻau lapaʻau which would be associated with hoʻoponopono, both very essential practices by kahuna pale keiki.

These bills need to go back to the drawing board and needs to successfully present what was agreed to by the midwifery community. Any and all revisions need to have their consent!

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

Hearing date 2-10-14 1:30pm rm 229
RE: SB2569 and SB2569 SD1 Relating to Home Birth

Oppose

My name is Malia Salmon. I am a Kailua resident of 36 years. I strongly oppose bill SB2569 and SB2569 SD1.

I am a small business owner of Hawaii Birth Photography. I am a labor and delivery photographer. I have witnessed and photographed 30 births. 5 homebirths, and 25 hospital births.

I have seen peaceful, safe hospital births with high-risk and low risk moms. I have seen hospital births, where unnecessary interventions were made to low-risk moms, and created a snowball of more interventions which led to distress on the mother and baby. The peaceful births I witnessed were led by an in hospital midwife. The others, where overseen by an OB.

Of all 5 homebirths if witnessed, they were, calm, peaceful, safe, and led by educated, wise and very experience midwives. Mom and baby were never in distress. I've witness 2 vaginal birth after Cesarean Section. Both went very well and there were absolutely no complications.

I'm in support of giving women the choice of homebirth or hospital and choosing their provider. I believe there is a way for OB's and midwives to work together to respect and support women's rights of where they want to birth.

I urge you to kill the bill. It is not a bill that would support women's rights to birth at home. It is very limited and the studies are flawed and one sided. More research on both sides is necessary to make an informed decision on this bill.

Respectfully Yours,

Malia Salmon

REGULAR SESSION OF 2014

For Honorable Senate Committee Health Chair Green, Vice Chair Baker and Committee Members, Hearing _______________(date) Rm____________ Please make (# of copies) copies. Mahalo

RE: **SB2569 and SB2569 SD1 Relating to Home Birth- IN OPPOSITION**
RE: **SB2070 Relating to Naturopathy- IN OPPOSITION**

My name is Kelly Patterson I have my Bachelors of Science in Nursing and have been working in the Emergency Room at Queens Medical Center for over 11 years. In addition, I have been studying Midwifery for 3 years and I have also completed the class to become a certified doula. With all of that said, I am a long time supporter of home birth, I am a registered voter and I strongly oppose bill #2569 and #SB2569 SD1. The facts cited in the bill are inaccurate and the statistic and numbers stated are false.

With the birth of my first child, I had intended to have a home birth but after a long labor and under the advice of my midwife, I transferred to the hospital. It was a very disappointing experience for me. As soon as the epidural was placed, the baby's hear rate dropped into the 20's which forced the staff to emergency protocols. I ended up with a C-section which was a terrible experience for me. I had a lot of blood loss and it took me much longer to recovery in the post-operative period which kept me

away from baby longer. I also had a post-operative infection, poor breastfeeding due to the anesthesia and my baby had a tough time regaining her weight. She was also jaundice. I had a long recovery at home and unable to walk the stairs in our 2 story house for 4 weeks. With all of these factors, it made it more difficult to care for my newborn in the first month.

I continued to do more research and with my Emergency Room experience, midwifery studies and doula education, I decided to have my second child at home. In the medical model, this would be considered more dangerous because it would now be a VBAC (vaginal birth after C-section) in addition I would be giving birth at home. I was fully aware of the risks and if I wanted an OB/GYN, then I had many good ones to choose from, as I work in the medical field. However, I didn't want a medical doctor and choose my same midwife to supervise my home birth.

This experience was much safer and fulfilling for me as a mother and a woman. I had less bleeding, my baby breastfed immediately, I had a fast recovery and my newborn put on weight much quicker. She also had no jaundice and her APGAR scores were perfect. I felt extremely safe the entire time and empowered to be able to honor my choice as a woman.

Laws are written to protect the people, not to promote harm. This bill is intended to protect women, however if passed, it could actually do the contrary. Women may continue to have home births underground or 'illegally' which leaves women and babies at greater risk for harm. I would hate to hear a tragic story result because this bill

was passed and stripped women of their rights.

In conclusion, just a woman has the freedom of choice over her own body and the right to have an abortion, why wouldn't a woman have the same freedom of choice over her own body and the right to give birth to her own baby the way she chooses? I am blessed to live in America and I am proud to be an America where I have the right and freedom of choice over my body and my children. Thank you very much.

February 9, 2014

Chairs and Members of the Senate Committee on Health, and the Senate Committee on Commerce and Consumer Protection
Hawaii State Legislature
State Capitol
415 South Beretania St.
Honolulu, Hawaii

RE: SB2569 and SB2569SD1 Relating to Home Birth

Aloha mai Kakou,

I hereby testify against the SB2569 and SB2569SD1 Relating to Home Birth, as a parent who was blessed with the natural birth of his daughter thanks to the dedicated work of a traditional practitioner in the art of midwifery.

I believe that the effectiveness of traditional knowledge such as midwifery significantly rests on a nurturing and supportive environment, autonomous from the governmental regulations and interventions that would distort and weaken its knowledge base. We can easily visualize the devastating consequence of such intervention by imaging what would happen if the state were to regulate and intervene in other traditional arts such as navigation, hula, lua, lāʻau lapaʻau, hoʻoponopono.

I also believe that the state and the medical community would benefit tremendously from their supportive and nurturing role for the perpetuation of the art and knowledge of midwifery. The state's role as the supervisory authority over midwifery is simply incompatible with midwifery's actual authority that has a much longer history than the state laws and the modern medicine.

Ke Aloha ʻĀina,

Masahide T. Kato, Ph.D.
47-383 Lulani St.
Kāneʻohe, Hawaiʻi 96744
mtkato@hawaii.edu

To: The Honorable Josh Green, Chair, Committee on Health
The Honorable Roz Baker, Vice Chair, Committee on Water & Land

The Honorable Roz Baker, Chair, Committee on Commerce and Consumer Protection
The Honorable Brian Taniguchi, Vice Chair, Committee on Commerce and Consumer Protection

The Honorable Clayton Hee, Chair, Committee on Judiciary and Labor
The Honorable Maile Shimabukuro, Vice Chair, Committee on Judiciary and Labor

Members, Senate Committee on Health
Members, Senate Committee on Commerce and Consumer
Members, Senate Committee on Judiciary and Labor

From: Sonya Niess, MPH, women's health advocate
Date: February 10th, 2014
Hrg: Senate Committee on Health/Senate Committee on Commerce and Consumer Protection/Senate Committee on Judiciary and Labor; Mon. February 10th 2014 at 1:30 p.m. in Rm 229
Re: **SB 2569 and SB2569 SD1, Relating to Home Birth – In Opposition**

Thank you for the opportunity to offer testimony in **opposition of SB 2569 and SB 2569 SD1,** both of which attempt to regulate midwifery in the State of Hawaii.

My name is Sonya Niess and I am a Maui resident who opposes both SB 2569 and SB2569 SD1. I received my B.A in Anthropology where I studied home vs hospital births in the United States & birthing practices throughout the world. I then received my Masters in Public Health with emphasis on Maternal and Child Health at UH Manoa. There I continued research on birth and maternity care systems in industrialized nations in comparison to the U.S.

Here are some reasons why I OPPOSE SB2569 and SB2569 SD1:

- Both bills take away choices for women when it comes to their reproductive health.
- SB2569 threatens women's health and would all but make midwifery and home birth illegal in the state of Hawaii, forcing mothers who choose to home birth to potentially go underground in finding illegal care providers which may pose a risk to herself and her baby. The bill also infringes on patients' rights and violates their right to medical privacy.
- Home birth with a trained midwife is SAFE. This bill uses false data to support it's claim. It refers to a two to three fold increase in neonatal mortality and that is cited from a study that has been **refuted.** Here are studies addressing that particular study, along with others that support home birth with a trained midwife to be just as safe as a hospital birth. (1,2,3,4,5)
- We are not opposed to regulation – however the regulations in SB2569 don't make sense and neither bill promotes the health of mothers or their babies.

- These bills do NOT take into account cultural practices in home birth. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.
- The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth practice. The Home Birth Safety Board should be autonomous from the Hawaii Medical Board. There should be a Home Birth Providers Board overseen directly by the DCCA .
- The Home Birth Safety Board to be comprised of the home birth providers primarily, with some OB/MD representation but certainly not the majority or even half.
- It is the right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. This bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose.

Suggestions:

Write a new bill next legislative session that addresses the concerns stated above and include home birth providers and key stakeholders in the birthing community when drafting new legislation. Amending SB2569 OR SB2569 SD1 is NOT an option. Both bills are too flawed to correct given the time constraints of the legislature. A complete overhaul of these bills must ensue. There are many suggestions for a new bill, please let's work together to create it.

Thank you for your time. I appreciate the opportunity to testify.

Aloha,

Sonya Niess, MPH
Maui Resident

Sources:

1. "Home Birth versus Hospital Birth: Questioning the Quality of the Evidence on Safety" article published in Birth (Volume 30, Issue 1, pages 57-63, March 2003) "In contrast, the Midwives Association of Washington State press release stated that 'Childbearing women and health policy makers should be made aware that the study contains numerous flaws and limitations...this study alone should not be used to make decisions that could restrict women's choice of birth place or access to birth attendants with expertise in home birth'" (http://onlinelibrary.wiley.com/doi/10.1046/j.1523-536X.2003.00218.x/abstract)

2. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/MCDG/wp-content/uploads/2013/02/Medscape-Wax-Critique-Michal-Janssen-Vedam-Hutton-de-Jonge.pdf)

3. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics)
4. BMJ 2005;330;1416 Outcomes of planned home birth with certified professional midwives; large prospective study in North America
5. BJOG, 2009 Aug; 116(9):1177-84 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births
6. The Myth of a Safer Hospital Birth for Low Risk Pregnancies (http://www.greenmedinfo.com/blog/myth-safer-hsopital-birth-low-risk-pregnancies) *"Study validity questioned"* in *The American Journal of Obstetrics & Gynecology* (volume 204, Issue 4, page e14, April 2011) (http://ajog.org/article/S0002-9378(10)01107-5/fulltext)
7. Home birth metaanalysis: does it meet AJOG's reporting requirements? (http://ajog.org/article/S0002-9378(11)00074-3/fulltext)
8. International data demonstrate home birth safety. (http://www.ncbi.nlm.nih.gov/pubmed/21458614)
9. "Home birth triples the neonatal death rate": public communication of bad science? (http://www.ajog.org/article/S0002-9378(11)00075-5/abstract)
10. http://www.ncbi.nlm.nih.gov/pubmed/23769011
11. http://www.bmj.com/content/330/7505/1416
12. Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009 http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12172/pdf

REGULAR SESSION OF 2014

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor

Hearing 02/10/2014, 1:30PM, Conference Room 229

RE: SB 2569 & SB2569 SD1 Relating to Home Birth

OPPOSE

Greetings:

My name is Heather Ramirez and I am a supporter of the home birth movement but also a firm believer in, with an educated and informed decision, the autonomy of a pregnant woman's right of where she chooses to give birth.

When I became pregnant, I assumed I would be giving birth in a hospital. But, after extensive research into the domino-like effect of medical interventions along with the environment of having multiple unknown attendants during labor and the disrespect of being told to do something without full disclosure of risks and side effects or knowledge of other options made me look into another course of action. I believe that giving birth is a natural function of the female body and not to be treated as a disease.

I do have respect for the medical practices in terms of emergency care for women. I am aware that emergency care may be needed during birth and that the hospital is fully capable and functional to handle such situations. My standpoint is that natural childbirth, in its entirety, is not an emergency situation.

I can understand why the western medicine doctors believe home births to be dangerous; they are not specialists in this field and have no working knowledge of its practices. It is common knowledge that to become a doctor, and to have authority in their field, they need to complete the courses that are recognized in their field and an externship at a hospital. So, for western medicine doctors to try to speak with authority in a field where they have not done any courses or have hands-on experience is just as incomprehensible as someone who doesn't know law trying to represent a client in court or someone who is not a surgeon doing surgery. Therefore, it makes no sense for western medicine doctors to determine homebirth's viability and safety or to oversee the practice with authority.

The western medical world has transformed birth into a large-scale business; the embarrassing high cost of a vaginal birth in America has had international coverage in conventional media and Internet. Since this is now also a business, I am a consumer, and I have the protected right to decide where I want to spend my money.

I strongly oppose SB 2569 for the additional following reasons.

1. On its face, this bill is inaccurate. It cites a flawed study, and it suggests home birth is dangerous and unsafe. I join other home birth practitioners, mothers and advocates to correct that notion. We realize that we have a responsibility to provide data and information about our home birth practices, our training, and our experiences to the legislature and community-at-large.

2. This bill currently tries to define a scope of practice without an in depth understanding of the various practitioners, roles and responsibilities involved in homebirth. The medical hospital-based model it imposes doesn't take into account the population it is regulating and doesn't accurately represent different models of home birthing, each with unique traditions, scopes of practice, varying types of practitioners and their educational backgrounds, safety protocols and standards of care that are already in place.

3. The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth practice. This bill assumes there is no oversight over home birth; in fact, midwives have the capacity to govern themselves.

4. As written, this bill would essentially eliminate the option of finding a legal home birth attendant. It is the rite/right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. Furthermore, this bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose. Requiring a registry of home birth mothers, for example, fosters stigma around home birth, a scarlet letter. Laws are created to protect consumers and ensure safety. But lawmakers also have the obligation to protect long standing cultural practices of birth.

5. Home birth is a deeply cultural practice that is both respected and honored. We are all descended from an ancestor who gave birth at home. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.

For all of these reasons and more, I strongly oppose this bill as it stands. The imposition of these state regulations simply does not take into account the important perspectives of the birth practitioners, the mothers, and advocates of home birth.

Yet, we recognize the need for more information and offer the following:

• We have already begun to form a Home Birth Council that reflects the variety of practices, mothers and advocates. This Council shall be self-defined and self-regulated.

• We request the opportunity to gather data, standards of care, and wise practices to present before the legislature at a later date.

• We request a legislative informational hearing that provides the opportunity to present information about the spectrum of home birth practitioners, their education and training, and existing standards of care.

Thank you for your consideration of reviewing my testimony.

Evidence in support of point #1

1. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/MCDG/wp-content/uploads/2013/02/Medscape-Wax-Critique-Michal-Janssen-Vedam-Hutton-de-Jonge.pdf)

2. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics)

3. BMJ 2005;330;1416 Outcomes of planned home birth with certified professional midwives; large prospective study in North America

4. BJOG, 2009 Aug; 116(9):1177-84 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births

5. The Myth of a Safer Hospital Birth for Low Risk Pregnancies (http://www.greenmedinfo.com/blog/myth-safer-hsopital-birth-low-risk-pregnancies)

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	makaiolani33@gmail.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Sunday, February 09, 2014 10:06:43 AM

SB2569

Submitted on: 2/9/2014

Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Harmony Wright	Individual	Oppose	No

Comments: Dear Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor, This letter is in regards to the meeting that you all will be holding on the date of February 10, 2014 at 1:30pm in room 229 to discuss bill SB2569 and SB2569 SD1 Relating to Home Birth. I AM STRONGLY OPPOSES BOTH THESE BILLS because of four main points: 1) Home birth is safe, as safe if not safer than hospital births. If safety is what the legislators are concerned about, let's study all birth options, home and hospital to discern what is safe? (Rising c-section rates, inductions, medications...safe?) Let's dialogue. If legislators are truly interested in learning about home birth as Green's press release indicates, then take this next year to learn about the differences between the midwifery model vs. the medical model of birthing. Please, Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor, become educated. 2) We (the public, the home birth practitioners and community, and the legislators) are all interested in safety and quality care. Unfortunately, this is not what this bill will provide. Instead it restricts the rights of families to deliver their children in the settings they feel true to them and with the attendants they choose. It is not the legislatures right AT ALL to decide how and where someone can birth. 3) This bill is divisive because some forms of midwifery/home birth practices would be excluded and criminalized in this bill. The home birth community is unifying, and wants to include all practitioners who can then provide support for all the different types of birth experiences the community is asking for. 4) Let the home birth community form their own advisory counsel with all birth practitioners represented - ND, CPM, CNM, Direct Entry, Traditional midwives, OB, Family Practitioners etc to gather data, dialogue and form appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session. I would also like to state for the record that I am very disappointed that I cannot attend this hearing due to the fact that I do not have the monetary means to buy a plain ticket to Oahu, pay for lodging, transportation and childcare. Why is there not video conferencing available for citizens of other islands? If our county here in Hawaii provides that service, why can’t the state? This is unjust and unfair that I am not able to exercise my rights simply because of a monetary issue. This is shutting out the poor and working class citizens. Please consider this strongly for the future. Again, as a women who birth my baby at home with a midwife,

I oppose these two bills. Thank- You

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

Do not reply to this email. This inbox is not monitored. For assistance please email webmaster@capitol.hawaii.gov

From: Darlene Rodrigues
To: JDLTestimony; CPN Testimony; HTHTestimony
Subject: Testimony on SB2569, SB2569SD1, SB2570 and SCR25
Date: Sunday, February 09, 2014 10:09:33 AM

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1. To: Honorable Chair and Committee members of Health and Committee on Commerce and Consumer Protection, 2. Hearing date 2-10-14 1:15pm rm 229

I strongly oppose SB2569, SB2569SD1, SB2570 and SCR25.

Please start over with these measures and include those who are involved in the crafting of legislation. Please include the voices of women who come from different sectors of our society; women from various ethnic and cultural communities, women who have different body sizes with BMI's over 40. Please include women who suffer from sleep apnea or psychosocial disorders. Please include women who have given birth through vaginal delivery after a caesarean birth. Please include women who have had bariatic surgery or who have used drugs. I am sure that if you convened them, they would ask for something different than the measure you are presenting today.

They would be asked to be treated as whole beings instead of as bodies with a medical problem which need regulation and oversight with an eye towards liability. They would be asked to be treated with the utmost care and respect in regards to the health and safety of themselves and the children they are carrying.

As a doula I know that women feel empowered throughout their pregnancy and birthing process when they have been given choices and everything has been fully explained with patience and understanding. Studies have shown that this empowerment creates the best outcomes when it comes to birthing and mothering. The legislation proposed concerning women with the above described conditions treats them as damaged bodies who do not have the ability to determine how to go about their birth.

These measures further medicalizes birth and sends the message to women and girls in this society that birth is not a natural part of our lives but something that is fraught with danger and merely a medical procedure. It sends the message that when women choose something different than the current societal norm, they need regulation and oversight. Work with all the women involved, the naturopaths, the cultural practitioners, the medical midwives, the women and their ohana and the MDs and create something that respects all Models of Care. We should trust that all have the health and well-being of pregnant women involved.

Laws should empower all women and respect their choices. Do not fall into the trap of fear and hurry this process or not involve the cross-sector of women and all people involved.

Mahalo for the opportunity to testify and for your consideration.
Darlene Rodrigues, Mililani 96789

RE: **SB 2569 and SB2569 SD1 Relating to Home Birth – IN OPPOSITION**

Aloha Senate Health Committee members,

First of all thanks for what you do, it is not an easy job. My name is Misha Kassel, I was born at home along with my two other siblings. I am a practicing emergency medicine physician here at Kapiolani and Pali Momi medical centers. I went to medical school at JABSOM and after my fiancé finished her anesthesia training and me my emergency medicine training we happily moved back home. Someday we plan on having multiple successful home births and I am not afraid to do so. I feel it is a better and safer experience for mother and baby in majority of cases.

I have seen ~75 home births and about equal number of hospital births as part of my medical training. There are times for a hospital birth but being a part of the home births they were a much more gentle much more amazing experience for all involved. The rate of tears is much lower, babies get immediate bonding and breastfeeding. Of course the traditional midwives need to be prepared when emergencies happen. Also having some greater collaboration between OB/GYN, hospitals, emergency physicians and midwives need to happen. There are a very limited number of traditional midwives on the islands (I think ~20) and provide valuable resource to a lot of the residents, most at a very nominal fee. To create a board and the costs that go with it for such a small group of midwives does not make a lot of sense. Having a resolution and getting the midwives together along with other health care providers to try to think of ways to make home births even safer and better avenues to transfer patients faster and more safely makes a lot more sense. A couple of ideas are standardizing transfer forms and having those filled out prior to birth (leaving spots open for time of water breaking, any fever, set of vitals at time of transfer, presence of meconium etc to better help hospitals/emergency physicians and OB/GYNs) to better help ensure best outcome possible when transfers are needed.

One of my concerns with this bill is that it will have people have unattended home births or other situations that are much more unsafe because you have taken away the avenue that some feel safest and most comfortable with. Having the delivering mother and baby comfortable and without fear is one of the key elements of a success birth and when those two elements are present things almost always go very smoothly. I understand that there have been some bad outcomes at home recently; there are also bad outcomes in the hospital. They are not always preventable, same with cerebral palsy, and other neurological outcomes at birth. This is despite attempts to greatly reduce them with continuous fetal monitoring, which only significantly increased c-section rates, which have their own complications, and other interventions. We are all trying to do our best in the challenging health care environment we face and if we want to make real changes we need to look at issues such as the medical malpractice environment and all of the tests and costly interventions they lead to because people are afraid of being sued.

I strongly oppose SB 2569 for the following reasons.

1. On its face, this bill is inaccurate. It cites a flawed study, and it suggests home birth is dangerous and unsafe. I join other home birth practitioners, mothers and advocates to correct that notion. We realize that we have a responsibility to provide data and information about our home birth practices, our training, and our experiences to the legislature and community-at-large.

2. This bill currently tries to define a scope of practice without an in depth understanding of the various practitioners, roles and responsibilities involved in-home birth. The medical hospital-based model it imposes doesn’t take into account the population it is regulating and doesn’t accurately represent different models of home birthing, each with unique traditions, scopes of practice, varying types of practitioners and their educational backgrounds, safety protocols and standards of care that are already in place.

3. The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth practice. This bill assumes there is no oversight over home birth; in fact, midwives have the capacity to govern themselves.

4. As written, this bill would essentially eliminate the option of finding a legal home birth attendant. It is the rite/right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. Furthermore, this bill currently proposes to violate a woman's bodily autonomy and a woman's right to choose. Requiring a registry of home birth mothers, for example, fosters stigma around home birth, a scarlet letter. Laws are created to protect consumers and ensure safety. But lawmakers also have the obligation to protect long standing cultural practices of birth.

5. Home birth is a deeply cultural practice that is both respected and honored. We are all descended from an ancestor who gave birth at home. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.

For all of these reasons and more, I strongly oppose this bill as it stands. The imposition of these state regulations simply does not take into account the important perspectives of the birth practitioners, the mothers, and advocates of home birth.

Yet, we recognize the need for more information and offer the following:

- We have already begun to form a Home Birth Council that reflects the variety of practices, mothers and advocates. This Council shall be self-defined and self-regulated.

- We request the opportunity to gather data, standards of care, and wise practices to present before the legislature at a later date.

- We request a legislative informational hearing that provides the opportunity to present information about the spectrum of home birth practitioners, their education and training, and existing standards of care.

Thank you for your valuable time and I hope you strongly reconsider this bill,

Misha Kassel

Emergency Medicine Physician

Evidence in support of point #1

1. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/MCDG/wp-content/uploads/2013/02/Medscape-Wax-Critique-Michal-Janssen-Vedam-Hutton-de-Jonge.pdf)
2. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics)
3. BMJ 2005;330;1416 Outcomes of planned home birth with certified professional midwives; large prospective study in North America
4. BJOG, 2009 Aug; 116(9):1177-84 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births
5. The Myth of a Safer Hospital Birth for Low Risk Pregnancies (http://www.greenmedinfo.com/blog/myth-safer-hsopital-birth-low-risk-pregnancies)
6. AND MORE – add your own strongest studies, there are many!

REGULAR SESSION OF 2014

To: Honorable Chair and Committee Members of heaktht, Committee on Commerce and Consumer Protection and Judiciary Labor.

Hearing Date: 2.10.2014, 1:30pm, Rm 229

RE: **SB2569 and SB2569 SD1 Relating to Home Birth – IN OPPOSITION**

Aloha Senators and all who are present,

My name is Katja Bajema. I am the mother of 3 children, two who were born at Castle Medical and my youngest who was born in our home. I am also a childbirth educator and doula and a supporter of home birth.

I strongly oppose SB 2569 for the following reasons:

There are many reasons, but I want to respect everyone's time and understand most of those reasons will be explained in depth by other supporters of home birth. First off, the notion that home birth is unsafe is simply inaccurate. The study cited in this bill is flawed and there are many good studies that show homebirth is safe.

Second, the bill makes no distinction between different providers, their background, training, or scope of practice. It is important to know that there are big differences between the training midwives receive who work in hospitals and those who work outside of hospitals. This bill would only allow midwives with no special out-of-hospital training to actually attend home births. And it poses such major restrictions on other potential providers and the women who seek their care that it really eliminates the option of having a legal provider attend a birth.

Third, I am really concerned about safety when access to a legal, trained home birth provider becomes non-existent. Women will continue to birth their babies at home, whether it is legal or

not. Some women will choose to have an unassisted birth and without anyone caring for her and the baby things could become very dangerous.

Most families who now choose home birth do so because they are well educated on the subject of birth. Many have done their research and learned that hospitals do not practice evidence based care. And worse, most don't even practice simple respect. Women in hospitals are treated horribly while they are their most vulnerable. Their space is not respected, they are being told they are doing things wrong and are killing their babies when there is not even the slightest indication of a problem. Women's privates are being touched without consent, and they are often bullied into doing what the medical staff wants without their being any medical reason. PTSD after childbirth is more commonly reported today than ever before, and I know there are many more women suffering in silence because they had a healthy baby and according to our society's standards that is all that matters.

Many women who choose home birth today choose consciously for a different model of care. In my case I had had two hospital births which were actually pretty good with respect to the way I was treated. It took quite a bit of work beforehand and my husband had to 'protect' my space while I was in labor. For the birth of our third child my husband would not be present, he would still be deployed with the HI Army National Guard. To me, that meant that 'my protector' would not be there to shield me from unnecessary medical intervention. In addition, I already had two children and I did not want to be separated from them for 24-48 hours while I brought their baby brother into the world. We made the decision to have a home birth and once I switched to a home birth midwife (CPM) and experienced the difference in careI knew we had made the right choice and I felt I could finally breathe again. Each prenatal visit the midwife would spend an our with me at least, she would talk to me about how I was doing outside of the physical part of pregnancy. How was I handling my husband being away and pregnant with 2 little ones? She would actually touch my belly with caring, loving hands, feeling my baby. She took the time to explain to my oldest what she was doing, she let her listen to her baby brother's heart etc. It was wonderful, every prenatal visit was what it was

supposed to be, a check of my and baby's physical well-being, but also my emotional and mental state of mind was assessed.

When I finally went into labor and was able to stay at home, surrounded by loving people like, my mom, my children, my doula, my midwife and her assistant things just went well. Even though it was my third, it was my most difficult birth. But I was supported and encouraged and told I could do it, instead of made to feel like my body was a failure. And I did it, I birthed my son, in our home, in our bed, into our family where he belongs. And an hour later as we were all snuggled up in bed I got to read my other children their bed time story before kissing them good night. And that is what birth is all about. It is about bringing life into a family, it is a normal physiological event that is much better understood and respected by providers who are trained specifically for this.

I wish my other children were born at home. I was, my brother was, my parents were and their parents before them. I want my children to have the option to safely bring their children into the world in their homes if that is what they choose. Home birth is a deeply cultural practice that should be respected and honored. Especially here in Hawaii with its cultural multitude it must be viewed in the context of cultural, traditional, spiritual beliefs and practices, which are protected by law.

For all of these reasons and more, I strongly oppose this bill as it stands. The imposition of these state regulations simply does not take into account the important perspectives of the birth practitioners, the mothers, and advocates of home birth. I don't believe that some amendments to this bill will make it any better. I ask for time, to let the homebirth community form their own advisory council with all practitioners represented –ND, CPM, CNM, Direct Entry, Traditional Midwives, OB and Family Practitioner to gather data, form a dialogue and come up with appropriate standards acceptable to all birth practitioners and the community, and bring this back to the legislature next session.

I thank you for your time and pray that you will not take the option of homebirth of the table. I ask that you take the time this year to learn about the differences between the midwifery model vs the medical model of birthing. Please become educated on the topic and work with us to make it safe and accessible to those who choose it for their families.

Mahalo and aloha,

Katja Bajema

Evidence in support of home birth safety:

1. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/MCDG/wp-content/uploads/2013/02/Medscape-Wax-Critique-Michal-Janssen-Vedam-Hutton-de-Jonge.pdf)
2. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics)
3. BMJ 2005;330;1416 Outcomes of planned home birth with certified professional midwives; large prospective study in North America
4. BJOG, 2009 Aug; 116(9):1177-84 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births
5. The Myth of a Safer Hospital Birth for Low Risk Pregnancies (http://www.greenmedinfo.com/blog/myth-safer-hsopital-birth-low-risk-pregnancies)

More information on PTSD after childbirth:

- http://pattch.org/resource-guide/

From: Summer-Lee Faria
To: HTHTestimony
Subject: OPPOSE SB2569 and SB2569 SD1 Regarding Home Birth
Date: Saturday, February 08, 2014 2:14:34 AM
Attachments: 2013SmoothTransitionsProjectManual.pdf
Cesarean CDC Brief.pdf
WHO Costs of Cesareans.pdf

Aloha Senators of the Committee on Health,

I write to you all today to ask that you kill bills SB2569 and SB2569 SD1

In this time that the state and the nation are looking for ways to not only lower costs but still provide quality care to our people, the regulation of home birth and midwives, is not in the best interest to the state, the nation and especially not to mothers and babies.

Attached and at the link provided is information I feel you'll find beneficial in seeing the wonderful possibilities there are, if we use the Midwife Model of Care and work collaboratively with hospitals and medical staff
.
"Midwives Improve Outcomes - Cochrane Review":
http://www.medscape.com/viewarticle/810005

Women and families will choose to birth at home, no matter what. It would behoove everyone and make birth less safe, to make it illegal and to limit access to quality out of hospital care providers.

Cesarean surgeries are the most common surgery done in hospitals and are done by physicians and should stay that way. Allowing Midwives to practice within their scope of care by caring for the normal, low-risk pregnant families.

I'm looking forward to what will come about, as we kill SB2569 & SB2569 SD1 and take this opportunity to be the model for the rest of the developed world on what quality, culturally respectful care can look like.

Mahalo for your time,
Summer Faria

Aloha Senators,

SB2569 & SB2569 SD1 must be killed in order for the stakeholders and those who actually do out of hospital births, to collectively provide the state with information and details needed to make this bill viable.

From the start, home birth/out of hospital births are not ‘riskier’ than those in hospitals. If that were true, we wouldn’t have as many people on the planet we have today, as hospitals have only been bringing births there the past 100 years.

Women have been birthing since the beginning of time, in various places.

We know that the cost of health care is astronomical in the nation and the state, and that collaborative care is essential to balancing budgets, while maintaining quality care. This is where the Midwife model of care is so efficient. Within the realm of being a midwife, you are a well woman care provider, counselor, a dietician, a therapist, a friend, a centering pregnancy community gatherer, a lactation consultant, well baby care provider, parent educator and someone knowledgeable and trained in birth practices for ANY setting.

This bill addresses only one type of midwife, who is not necessarily trained in out of hospital settings. Leaving out the possibility for a pregnant family to access quality, well trained, out of hospital specialists.

Women have a birth culture that has been replaced by a profession that fears normal physiological birth and sees women’s bodies as mysteries, something that needs to be controlled. This is not a place that government should regulate. We are perfectly capable of loving ourselves and our bodies, understanding our needs and knowing what makes for healthy pregnant women and babies.

I urge you to stop SB2569 & SB2569 SD1 from moving any further until an appropriate body of midwives and supporters are consulted on proper language for looking at midwives and out of hospital births.

Look forward to working with you to address Hawai`i’s unique opportunity to stand out and have precedence as the quality model of maternity care for the rest of the developed world to follow.

Mahalo for your time,

Summer Faria

2553 Komo Mai Drive

Pearl City, HI 96782

808-387-1098

Smooth Transitions:

Enhancing the Safety of Planned Out-of-Hospital Birth Transports

A Quality Improvement Initiative of the Washington State Perinatal Collaborative

Project Manual

This manual was developed by the LM/MD Workgroup, a subcommittee of the Washington State Perinatal Advisory Committee

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Planned Out-of-Hospital Birth Transfer Quality Improvement Project Manual

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Planned Out-of-Hospital Birth Transfer Quality Improvement Project

Introduction

Thank you for your interest in the Planned Out-of-Hospital Birth Transfer Quality Improvement Project. We hope that after reading this manual, you will want to become a participant in this important project.

A subcommittee of the Statewide Perinatal Advisory Committee has developed a voluntary quality improvement project to assist hospitals providing obstetrical services in developing their own program to facilitate transfers of pregnant women, postpartum women or newborns who had planned to deliver in an out-of-hospital setting.

The goal of the quality improvement process is to improve the efficiency of transfers, improve communication between providers, decrease liability, and ultimately improve the safety of the birth process in these specific situations.

Washington has licensed midwives since 1980. Licensed midwives deliver about 2100 babies per year in Washington in birthing centers or in a home environment. Approximately 15 percent of the women who plan an out-of-hospital birth develop intrapartum, or postpartum complications or their babies develop conditions that merit transfer to an acute care hospital. The vast majority of these transfers are for non-emergent indications. In some communities, these transfers are smooth and efficient, while in others there seem to be barriers that can lead to delays.

The voluntary quality improvement process would begin with a brief informational meeting with your obstetrical services committee to explain the program. Volunteer obstetrician and licensed midwife representatives from the State Perinatal Advisory Committee LM/MD workgroup will be available to present information about the quality improvement project and to provide consultation for the process. A similar meeting will be held with the licensed midwives that provide services in your area.

For the quality improvement project, a local transfer protocol will be developed, that lists:

- □ who the licensed midwife should contact when a transfer becomes indicated,
- □ where in the hospital the mother should be brought,
- □ what records should be transferred,
- □ what the role of the licensed midwife should be in the hospital with respect to her relationship with her client and how to contact the licensed midwife to return the mother to her care following hospital discharge, where appropriate

A sample hospital transfer protocol is included in the appendix and can be easily adapted by your institution.

In order to gather information on each transfer, a sample survey tool has been developed. (See appendix). Prior to hospital discharge, the physician team, the nursing team, the patient, and her

midwife are each given a short survey to complete. This can also be done as an interview. The survey reviews what was successful about the transfer process and what could use improvement. The completed surveys would then be reviewed by the local perinatal transfer committee, providing feedback to both the local obstetrical services committee and the local licensed midwives (who could be part of the local perinatal transfer committee). It is expected that after a year or two, the transfer review process should function smoothly, and be incorporated in the local hospital's quality improvement system. The perinatal transfer committee would be disbanded.

Please share this material with your obstetrics leadership team, institutional quality improvement unit and hospital administration for review. If you would like to have a presentation of the Project by a member of the Licensed Midwife/Physician workgroup or have any questions about the project, please contact the project coordinator: smoothtransitions.pc@gmail.com.

Midwives in Washington State - Background

Midwives attend more than 10% of all births in Washington State and virtually all of the planned out-of-hospital births. There are three categories of midwives practicing in the state: licensed midwives, certified nurse-midwives and unlicensed or lay midwives. This paper provides a brief overview of each category and more detailed information about licensed midwives, who attend the majority of births taking place at home or in birth centers.

Licensed Midwives

Licensed midwives provide care during the normal childbearing cycle. They are licensed to perform all of the procedures that may be necessary during the course of normal pregnancy, birth and the postpartum/newborn period, including the administration of selected medications. They consult with physicians when a case deviates from normal and refer clients if complications arise. In an emergency, a midwife is trained and equipped to carry out life-saving measures. Licensed midwives generally provide care to women planning to give birth at home or in a birth center. Twelve of the thirteen licensed birth centers in Washington State are owned by licensed midwives.

Licensed midwives are regulated by the State of Washington Department of Health, Midwifery Advisory Committee and disciplined by the State of Washington Department of Health, Health Professions Quality Assurance Division. Professional liability insurance is available in Washington State to licensed midwives through the Midwifery and Birthing Center Professional Liability Insurance Joint Underwriting Association. Licensed midwives are reimbursed for their services by most private insurers and the state Medicaid program (Department of Social and Health Services).

To qualify for licensure in Washington State, a midwife must complete a three-year program or the equivalent approved by the state; participate in a minimum of 100 births; provide primary care, under supervision, for a minimum of 50 women in the prenatal, intrapartum and postpartum periods; and successfully pass the national examination administered by the North American Registry of Midwives as well as an additional state-specific test.

Licensed midwives are described as “direct-entry” midwives because their educational requirements do not include prior training in nursing. Nationally, direct-entry midwives are licensed in 24 states and are qualified for national certification by the North American Registry of Midwives as Certified Professional Midwives. The Midwifery Education Accreditation Council is recognized by the U.S. Secretary of Education as the national accrediting agency for direct-entry midwifery education.

The law regulating midwifery practice in Washington State dates to 1917 when professional midwives were first recognized by the state legislature. There were no in-state training programs at that time and most midwives were foreign-trained professionals who immigrated to Washington. The number of midwives in practice declined into the 1940s and only began to grow again after 1978 when the Seattle Midwifery School was founded and began training midwives to contemporary international standards.

The number of midwives and the percentage of midwife-attended births have grown steadily over the years. There are now approximately 110 licensed midwives in Washington State and in 2009 they attended 2,130 births or 2.5% of the total births in the state. Four counties reported 6% or more of all

births were attended by licensed midwives.[1] According to data collected nationally, approximately 12% of women who begin the process of a planned out-of-hospital birth require transport to an acute-care hospital either during labor, or during the postpartum period. Most of these transports are for non-emergent conditions.[2]

Licensed midwives may start intravenous fluids, maintain saline or heparin locks, administer prophylactic ophthalmic medication, postpartum oxytocin, vitamin K, Rh-immune globulin, local anesthesia for repair, magnesium sulfate for prevention of maternal seizures pending transport, epinephrine for use in maternal anaphylaxis pending transport, terbutaline for non-reassuring fetal heart tones and/or cord prolapse pending transport, antibiotics for intrapartum prophylaxis of Group B streptococcus, anti-hemorrhagic drugs to control postpartum hemorrhage, such as misoprostel per rectum, methylergonovine maleate (oral or intermuscular), prostaglandin 15-methyl F2 alpha (Hemabate), and MMR vaccine to non-immune postpartum and HBIG and HBV for neonates born to hepatitis B-positive mothers. Licensed midwives also carry oxygen and resuscitation equipment and are required to renew their neonatal resuscitation certification (NRP) every two years.

Licensed midwives are required by law to consult with a physician whenever there are "significant deviations from normal" in either the mother or the infant. The Midwives Association of Washington State maintains a list of conditions, informed by the latest evidence, that warrant physician consultation and may require referral and/or transfer of care. This document, "Indications for Consultation in an Out-of-Hospital Midwifery Practice,"[3] is meant to be used in conjunction with clinical judgment and expertise.

Members of the Midwives Association of Washington State must participate in the Quality Management Program,[4] a quality improvement program approved by the State of Washington in 2004. The program includes both peer review and incident review procedures. The peer review process generally occurs at the regional level and provides for both routine retrospective educational review and prospective evaluation. Incident reviews are initiated when a midwife self-reports certain sentinel events or requests a review or when a complaint is received from another party. The Midwives Association of Washington State Quality Management Program reviews complaints citing professional members only. In the event that a complaint is filed citing an unlicensed or non-member midwife the party filing the complaint will be notified and directed to file the complaint with the Department of Health.

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[1] Washington State Department of Health, Center for Health Statistics. Birth Data Tables: Natality Table C7. Birth Attendant by County of Occurrence, 2008.
http://www.doh.wa.gov/ehsphl/chs/chs-data/birth/download/2008.xls

[2] Johnson, Kenneth, C. and Daviss, Betty-Anne. Outcomes of planned home births with certified professional midwives: large prospective study in North America. British Medical Journal. 2005; 330:1416.

[3] Midwives Association of Washington State. Indications for Consultation in an Out-of-Hospital Midwifery Practice (revised 2008). http://www.washingtonmidwives.org/assets/MAWSindications-4.24.08.pdf

[4] Midwives Association of Washington State. Quality Management Program.
http://www.washingtonmidwives.org/about-maws/quality-mgmt.html

Certified Nurse-Midwives

All certified nurse-midwives in Washington are licensed as Advanced Registered Nurse Practitioners (ARNPs). They may attend deliveries in hospitals, birth centers, and homes, though most are employed by physicians or hospitals. Certified nurse-midwives can provide gynecological, family planning, and primary care. They have full prescribing authority for both legend and controlled drugs (Drug Enforcement Admission Schedules II—V).

Certified nurse-midwives receive training first as registered nurses and then obtain a graduate degree in the field of nurse-midwifery, focusing on women's health, pregnancy, birth, and postpartum care. In Washington State, certified nurse-midwives are independent health care providers who work in collaborative relationships with obstetricians, should complications arise. Many hospitals, in the course of granting certified nurse-midwives hospital privileges, require some degree of formal physician supervision or back-up.

Certified nurse midwives carry professional liability insurance provided through a number of carriers. They are reimbursed for their services by all major public and private insurance companies. They are licensed by the State of Washington Department of Licensing, and regulated and disciplined by the State of Washington Department of Health, Nursing Care Quality Assurance Commission.

Unlicensed or Lay Midwives

There are also individuals who attend births in Washington State, providing assistance with labor and delivery, who are not licensed by the state. The law regulating direct-entry midwifery practice exempts these individuals from the required licensure so long as they do not advertise or accept payment for their services, including cash, trade, or goods-in-kind. The term "lay midwife" is commonly used to designate an uncertified or unlicensed midwife. Other terms sometime used to describe uncertified or unlicensed midwives are traditional midwife, traditional birth attendant, granny midwife and independent midwife. Some lay midwives refer to themselves as Christian Birth Attendants, or "religious practitioners. Generally, state law exempts religious practitioners from governmental oversight or regulation in recognition of the principle of the state not interfering with the practice of religion. Lay midwives, because they are not licensed by the state, are not the regulated by any state agency or committee.

Persons who feel that they have been injured by a lay midwife have few options. If the lay midwife billed for services, had business cards or advertised their services, the injured party might appeal to the local county prosecuting attorney to file criminal charges relating to the unlicensed practice of midwifery.

Physician-Licensed Midwife Work Group

In 2004, Roger Rowles, MD, of Yakima, WA, Chair of the State of Washington Department of Health Statewide Perinatal Advisory Committee appointed a task force to study and improve the process of transferring women and their babies from a planned out-of-hospital birthing location to an acute-care hospital when a higher level of care becomes necessary. This task force is a cooperative effort of obstetrician-gynecologist physician leaders and licensed midwifery leaders as well as those with expertise in public health and policy. The licensed midwife members, working with the Midwives' Association of Washington State, a voluntary education and advocacy group, have developed a document titled "Planned Out-Of-Hospital Birth Transport Guidelines" *(Appendix B).* These Guidelines have been reviewed and approved by members of the Statewide Perinatal Advisory Committee, the Midwives Association of Washington State, and the Physician-Licensed Midwife Work Group.

Liability Issues

Hospitals and physicians will want to consult their legal counsel; however, it is our understanding that the professional liability insurance companies who provide obstetricians and gynecologists with professional liability insurance ask that their insureds not form formal, written consultation agreements with licensed midwives, which might be interpreted as the "loaning" of the physician's liability policy limits to the licensed midwife. It is our further understanding that these companies do cover their insureds when their insureds are assigned to emergency obstetrical call as a condition of hospital privileges, and are then asked to care for any woman brought into the hospital for obstetrical care, including those women being transported who have been under the care of a licensed midwife.

How to Incorporate the Planned Out-of-Hospital Birth Transfer Quality Improvement Project in Your Hospital

1. Review the materials you have received with your obstetrical leadership team, quality improvement staff and your hospital administration.

2. Contact the project coordinator, smoothtransitions.pc@gmail.com, to request a presentation about the project for your obstetrical leadership team and hospital administration by one of the volunteer team members of the Licensed Midwife-Physician workgroup. This meeting should include obstetricians, family physicians and certified nurse midwives who practice obstetrics, obstetrical nursing leaders, quality improvement staff, hospital administration representatives, and possibly emergency department physician and nursing leadership. We will send one of our physician team members and if desired, one of our licensed midwife team leaders, to make the presentation and answer questions.

3. Decide if your hospital wishes to participate in the project. If you decide to participate, please contact the project coordinator, smoothtransitions.pc@gmail.com.

4. Designate a lead for this group, who will set up and facilitate the meetings. If available, a hospital quality improvement staff member would be an ideal choice for group leader.

5. Develop a Notification Procedure for Planned Out-of-Hospital Birth Transfers. See sample in the Appendix A. *(Word file available for use and customization upon request)*

6. Develop survey tool. See sample in Appendix C. *(Word file available for use and customization upon request)*

7. Identify the licensed midwives who provide out-of-hospital births in your hospital's service area. Schedule a meeting with your obstetrical physician and nursing leadership team, your local licensed midwives, and a representative of the local emergency medical services. The purpose of this meeting is to get to know each other, describe your interest in participating in this project, and review the notification procedure that you would like your staff and the licensed midwives to follow in case of a transfer. Review and finalize the survey tools., Determine where the surveys will be stored, whether they will be written for interview, how they are distributed, and where they should be returned when completed. Determine staff who will disseminate surveys or complete interviews and who will compile the surveys.

8. Form a Planned Out-of-Hospital Birth Perinatal Transfer Committee, to meet several times a year to review the completed surveys, and provide feedback to improve the efficiency and safety of these Perinatal Transfers. This committee should include physician, nursing, quality improvement staff, licensed midwifery leaders, and a representative of local emergency medical services.

9. We ask that once a year, this committee send a brief summary statement to the project coordinator, smoothtransitions.pc@gmail.com. The summary statements of participating hospitals will be reviewed by the Licensed Midwife/Physician Workgroup in order to evaluate

and improve the project and then aggregated and presented to the Perinatal Advisory Committee. Once the perinatal transfer system has been integrated into the hospital's Quality Improvement program at the participating hospital, the committee can be discontinued. *(Word file available for use and customization; Example provided Appendix D)*

Appendix A

Notification Procedure for Out-of-Hospital Birth Perinatal Transfers

Sample

Generic General Hospital

1. In case of life-threatening emergency, please call 9-1-1 and request an emergency transfer of your patient to the nearest acute-care hospital that provides obstetrical services

2. In non-life-threatening situations, licensed midwives who are attending a planned out-of-hospital birth who need to transfer a laboring woman, a postpartum woman, or a newborn to our hospital are asked to notify the (insert: Obstetrical Charge Nurse or Nursing Supervisor or other designated responsible party at (***) ***-****) to notify the hospital about a perinatal transfer. This responsible hospital staff member will take the following steps:

   A. Notify the Nursing Supervisor about the transfer
   B. Notify the Obstetrical Charge Nurse about the transfer
   C. Notify the Emergency Department about the transfer
   D. Notify the Admitting Office about the transfer
   E. Notify the Obstetrician, Family Physician or Pediatrician on unassigned patient call about the transfer

3. The licensed midwife should give the responsible hospital staff member the patient's name, date of birth, reason for transfer, brief obstetrical history, brief medical and surgical history, medications and allergies, and any additional information that would help the hospital prepare for the transfer. The licensed midwife should describe the method of transfer (ambulance, private vehicle), and the approximate estimated time of arrival. The responsible hospital staff member should advise the licensed midwife where the patient should be brought to the hospital (Emergency Department, Admitting, Labor and Delivery).

4. The licensed midwife should accompany the patient to the hospital, and then transfer all care of her client to the hospital team. The licensed midwife should provide the hospital staff with a complete copy of her client's antepartum, intrapartum, (and postpartum, if applicable) records, including all laboratory and ultrasound reports. If the licensed midwife only has the originals, the hospital will make a copy, and return all of the originals to the licensed midwife. The licensed midwife should also give a verbal report about her client's status to the nursing staff and the physician.

5. Once being admitted to the hospital, the patient's care is transferred entirely to the hospital staff, with the licensed midwife's role changing from that of primary care provider before arrival at the hospital to companion/support person after arrival at the hospital. Respectful recognition of all parties' roles can only facilitate patient safety and satisfaction. To this end, the licensed midwife should take care to facilitate rather than disrupt communication and trust between the

patient and the hospital staff. Additionally, hospital staff should strive to foster and express a collegial attitude towards the licensed midwife. *(Each hospital may insert conflict resolution details, policies or support already in place to mediate complaints or concerns of patients or transferring midwives.)*

6. After delivery, or at time of discharge from the hospital, four surveys will be distributed: one each to the patient, to the licensed midwife, to the nursing staff, and to the physician, seeking feedback about the transfer process and how it could be improved. These surveys will be returned to the Generic General Hospital's Perinatal Transfer Committee for review. The Perinatal Transfer Committee should meet several times a year, review the surveys, and report the cumulated results to the medical and nursing staff, highlighting the successes of the program and what steps should be taken to improve the program. Ideally, this Perinatal Transfer Committee should include obstetrical nursing and physician leaders, hospital administration, and representatives from the local licensed midwifery community.

7. After the patient is discharged from the hospital, where possible, a copy of the dictated admission history and physical examination, operative report and pathology report if appropriate, and the discharge summary should be sent to the licensed midwife, and where appropriate, the woman should be returned to the licensed midwife's care for postpartum follow-up.

Appendix B

Appendix C

Planned Out-of-Hospital Birth Transport

Quality Improvement Interview Questionnaire Sample

Date of Transport:
Transferring Midwife's Name:
Receiving Physician's Name:
Receiving Nurse's Name:

1. What was/were the indication(s) for transport?

2. Describe how the transport occurred. What were the steps? (For example, did the mother arrive at the hospital ER? Did midwife call ahead? Did EMS transport? etc.)

3. Describe the hospital course, including the delivery, applicable. Please include a brief summary of progress.

4. Do you have any concerns about the timeliness of patient transport, or of hospital care provided?

   If so, what are your concerns?

   How might they be handled differently?

5. Do you have any concerns about communication between providers before transport, during delivery or postpartum? (Probe for concerns about respect, sense of trust, and expectations)

   If so, what are your concerns?

   How might this have been handled differently?

6. Do you have any concerns about communication between the patient and providers before transport, during delivery or postpartum? (Probe for concerns about respect, sense of trust, and expectations)

   If so, what are your concerns?

   How might they be handled differently?

7. How well do you feel the midwife, EMS staff and hospital staff worked together, and jointly supported/assisted the mother? (Probe for concerns about patient records, patient/LM consultation in decision-making)

8. Do you have any concerns about postpartum care and follow-up?

   If so, what are your concerns?

   How might they be handled differently?

9. Which of these procedures were involved in the patient's care?

   Maternal

   - Pain relief
   - Vacuum
   - Cesarean
   - Pitocin
   - Forceps
   - Transfusion
   - Other:

   Infant

   - NICU admission
   - Other:

10. Additional comments?

Appendix D

Planned Out of Hospital Birth Transfer Quality Improvement Project

Annual Transfer Summary Sample

Reporter

Name: ____

Position: ____

Phone: ____

Email:____

Today's date: ____

Hospital Name: ____

Reporting Year: _____________

Number of transfers received from January 1 through Dec 31 of reporting year:_______

Number of transfers for whom entire team (Attending physician, OB nurse, Pediatrician, Midwife, Mother) were interviewed/completed written survey: _______

Number of transfers for whom only part of team interviewed/completed/written survey: ____________

General summary of transfer experiences:

Please do not include specific identifying information, but describe the overall sense of how well the program is working in terms of:

a) infant and maternal health
b) ease of communication/care transfer from midwife to hospital staff intrapartum
c) ease of communication/care transfer from hospital staff to midwife postpartum
d) maternal satisfaction
e) provider satisfaction (from all perspectives)
f) resource use

Please describe any concerns/barriers identified during the interviews.

Please describe any actions taken to address these concerns/barriers.

Please describe any other actions taken to improve transports.

Please describe any additional technical assistance needed from the Licensed Midwife/Physician Workgroup or the Washington State Perinatal Collaborative:

NCHS Data Brief ■ No. 35 ■ March 2010

Recent Trends in Cesarean Delivery in the United States

Fay Menacker, Dr. P.H., and Brady E. Hamilton, Ph.D.

Key findings

Data from the Natality Data File, National Vital Statistics System

- The cesarean rate rose by 53% from 1996 to 2007, reaching 32%, the highest rate ever reported in the United States.
- From 1996 to 2007, the cesarean rate increased for mothers in all age and racial and Hispanic origin groups. The pace of the increase accelerated from 2000 to 2007.
- Cesarean rates also increased for infants at all gestational ages; from 1996 to 2006 preterm infants had the highest rates.
- Cesarean rates increased for births to mothers in all U.S. states, and by more than 70% in six states from 1996 to 2007.

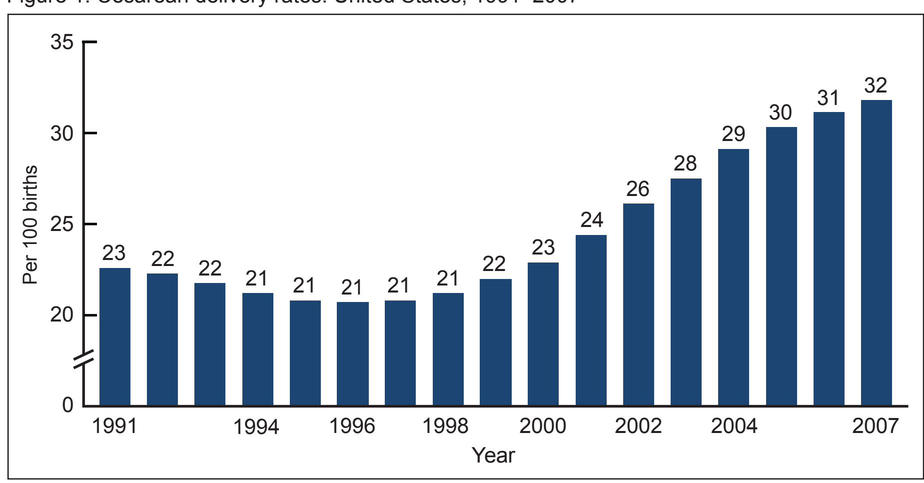
In 2007, nearly one-third (32%) of all births were cesarean deliveries (1). Although there are often clear clinical indications for a cesarean delivery, the short- and long-term benefits and risks for both mother and infant have been the subject of intense debate for over 25 years (2). Cesarean delivery involves major abdominal surgery, and is associated with higher rates of surgical complications and maternal rehospitalization, as well as with complications requiring neonatal intensive care unit admission (3–5). In addition to health and safety risks for mothers and newborns, hospital charges for a cesarean delivery are almost double those for a vaginal delivery, imposing significant costs (6).

This report shows trends in cesarean delivery since 1991, focusing on the period from 1996 to 2007 when cesarean rates began to rise following a decline in the early 1990s. Data for 2007 are preliminary and 2006 data are presented when preliminary 2007 data are not available (1,7).

Keywords: cesarean delivery • race and Hispanic origin • gestational age • state specific rates

In 2007, the cesarean rate was the highest ever reported in the United States.

Figure 1. Cesarean delivery rates: United States, 1991–2007



SOURCE: CDC/NCHS, National Vital Statistics System.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics
SAFER • HEALTHIER • PEOPLE™

There were 1.4 million cesarean births in 2007, representing approximately one-third of all births in the United States.

Following a decline in the early 1990s, the cesarean rate increased by 53% from 1996 to 2007, from 21% to an all-time high of 32% (Figure 1).

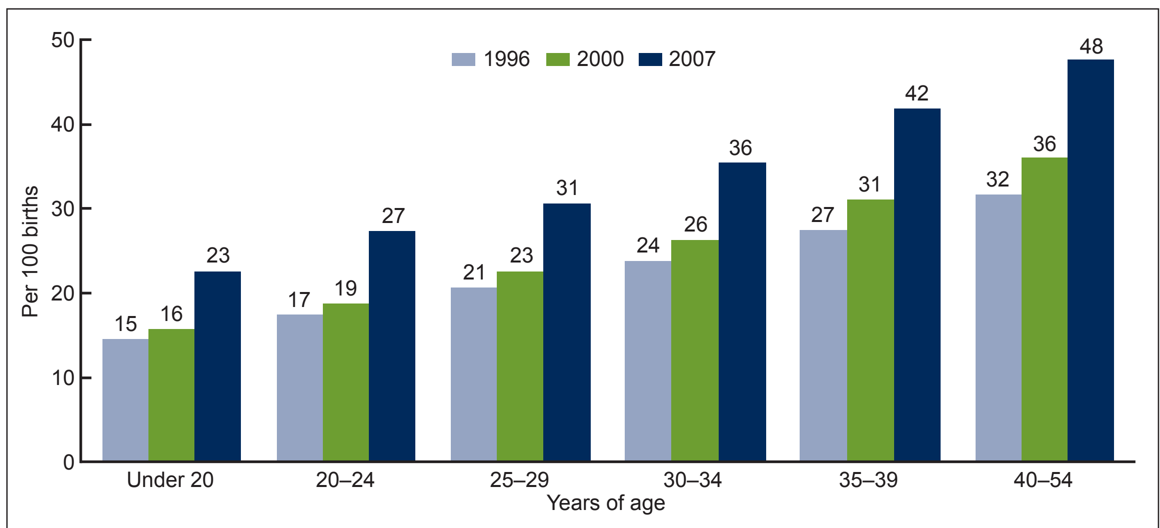
The *number* of cesarean births increased by 71% from 1996 (797,119) to 2007 (1,367,049).

Cesarean rates rose for women in all age groups in the last decade.

Cesarean rates rose for women in all age groups from 1996 to 2007 (Figure 2). Rates for all age groups increased modestly from 1996 to 2000, then rose more than 33% from 2000 to 2007. Women under age 25 experienced the greatest increases in cesarean deliveries from 2000 to 2007 (57%).

Rates of cesarean delivery typically rise with increasing maternal age. As in 1996 and 2000, the rate for mothers aged 40–54 years in 2007 was more than twice the rate for mothers under age 20 (48% and 23%, respectively).

Figure 2. Cesarean delivery rates, by age of mother: United States, 1996, 2000, and 2007



SOURCE: CDC/NCHS, National Vital Statistics System.

Cesarean rates rose for women in all racial and ethnic groups from 1996 to 2007.

All racial and ethnic groups experienced large increases in cesarean rates from 1996 to 2007 (Figure 3). The rate increased moderately for all groups from 1996 to 2000 (by about 12%), then accelerated with each group experiencing increases of around 40% from 2000 to 2007.

In 2007, cesarean delivery rates were slightly higher for non-Hispanic black women compared with non-Hispanic white women (34% and 32%, respectively). American Indian or Alaska Native women had the lowest cesarean delivery rate (28%).

Figure 3. Cesarean delivery rates, by race and Hispanic origin of mother: United States, 1996, 2000, and 2007

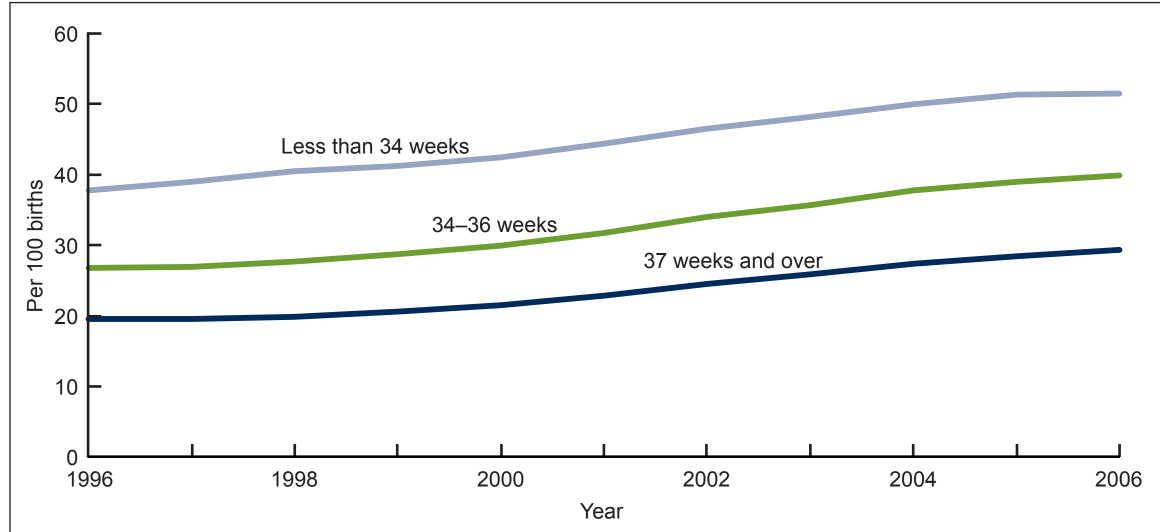
SOURCE: CDC/NCHS, National Vital Statistics System.

Cesarean rates increased for infants of all gestational ages in the last decade.

Cesarean rates increased for births at all gestational ages from 1996 to 2006 (Figure 4). During the decade, the cesarean rate for early preterm infants (less than 34 completed weeks of gestation) increased by 36%. Rates for infants born late preterm (34 to 36 completed weeks of gestation) and term and over (37 or more completed weeks of gestation) rose by almost 50%.

From 1996 to 2007, cesarean rates were higher for both early and late preterm infants than for term births.

Figure 4. Cesarean delivery rates, by gestational age, United States, 1996–2006



SOURCE: CDC/NCHS, National Vital Statistics System.

Cesarean rates varied widely by state.

Rates varied considerably by state. In 2007, cesarean rates ranged from less than 25% in Alaska, Idaho, New Mexico, and Utah, to over 35% in Florida, Louisiana, Mississippi, New Jersey, and West Virginia.

Cesarean rates rose significantly in each state from 1996 to 2007 (see table). The magnitude of the increases varied. Six states (Colorado, Connecticut, Florida, Nevada, Rhode Island, and Washington) had increases of over 70%. In 34 states, cesarean delivery rates increased by 50% or more.

Table. Cesarean delivery rates, by state: United States, 1996 and 2007 and percent change, 1996–2007

	1996	2007	Percent change 1996–2007
United States	20.7	31.8	54
Alabama	23.3	33.8	45
Alaska	16.7	22.6	35
Arizona	16.1	26.2	63
Arkansas	25.3	34.8	38
California	20.6	32.1	56
Colorado	15.1	25.8	71
Connecticut	19.8	34.6	75
Delaware	21.0	32.1	53
District of Columbia	21.3	32.6	53
Florida	21.6	37.2	72
Georgia	20.9	32.0	53
Hawaii	17.5	26.4	51
Idaho	16.0	24.0	50
Illinois	19.3	30.3	57
Indiana	20.3	29.4	45
Iowa	18.6	29.4	58
Kansas	19.2	29.8	55
Kentucky	21.3	34.6	62
Louisiana	26.4	35.9	36
Maine	20.8	30.0	44
Maryland	21.6	33.1	53
Massachusetts	19.8	33.5	69
Michigan	20.2	30.4	50
Minnesota	16.9	26.2	55
Mississippi	26.6	36.2	36
Missouri	20.4	30.3	49
Montana	19.1	29.4	54
Nebraska	19.8	30.9	56
Nevada	19.3	33.1	72
New Hampshire	20.3	30.8	52
New Jersey	24.0	38.3	60
New Mexico	17.2	23.3	35
New York	22.9	33.7	47
North Carolina	21.1	30.7	45
North Dakota	18.9	28.4	50
Ohio	19.0	29.8	57
Oklahoma	22.5	33.6	49
Oregon	16.9	28.2	67
Pennsylvania	19.4	30.1	55
Rhode Island	17.7	32.2	82
South Carolina	22.6	33.4	48
South Dakota	20.8	26.6	28
Tennessee	21.7	33.3	53
Texas	23.1	33.7	46
Utah	15.9	22.2	40
Vermont	16.5	26.8	62
Virginia	21.1	33.5	59
Washington	16.8	29.0	73
West Virginia	22.8	35.2	54
Wisconsin	15.6	25.0	60
Wyoming	18.3	26.9	47

NOTE: The cesarean rate is the percentage of all live births by cesarean delivery.

Summary

In 2007, approximately 1.4 million women had a cesarean birth, representing 32% of all births, the highest rate ever recorded in the United States and higher than rates in most other industrialized countries (8).

From 1996 to 2007, cesarean rates increased for all women, regardless of age, race and Hispanic origin, or state of residence. In 2006, cesarean delivery was the most frequently performed surgical procedure in U.S. hospitals (9). Cesarean rates also increased for infants of all gestational ages and may be partly related to the increased rate of multiple births (7), because infants in multiple births are much more likely than singletons to be cesarean births (10). However, cesarean delivery rates for singletons increased substantially more than cesarean rates for infants in multiple deliveries (data not shown).

In addition to clinical reasons, nonmedical factors suggested for the widespread and continuing rise of the cesarean rate may include maternal demographic characteristics (e.g., older maternal age), physician practice patterns, maternal choice, more conservative practice guidelines, and legal pressures (11–13).

Definitions

Cesarean delivery: Extraction of the infant, placenta, and membranes through an incision in the maternal abdominal and uterine walls.

Cesarean rate: Number of cesarean births per 100 live births.

Race and Hispanic origin: These items are reported separately on birth certificates. Persons of Hispanic origin may be of any race. Persons of non-Hispanic ancestry are further classified by race because there are substantial differences in fertility and maternal characteristics between Hispanic and non-Hispanic persons. Persons of American Indian or Alaska Native and Asian or Pacific Islander ancestry are not classified separately by Hispanic origin because the majority of these persons are non-Hispanic. Multiple race data reported since 2003 were bridged to single-race categories for trend analysis (7).

Preterm birth rate: The number of births delivered at less than 37 completed weeks of gestation per 100 total births.

Early preterm birth rate: The number of births delivered at less than 34 completed weeks of gestation per 100 total births.

Late preterm birth rate: The number of births delivered at 34 to 36 completed weeks of gestation per 100 total births.

Rate of term and later births: The number of births delivered at 37 completed weeks of gestation and over per 100 total births.

Data source and methods

This report contains data from the Natality Data File from the National Vital Statistics System (NVSS). The NVSS includes information for all live births reported in the United States. The Natality Data File is the primary data file for analyzing birth trends and patterns in the United States. Data may be accessed from NCHS at http://www.cdc.gov/nchs/data_access/VitalStatsOnline.htm and http://www.cdc.gov/nchs/VitalStats.htm.

Terms such as "higher than" and "less than" indicate statistically significant differences.

Computations exclude records with missing data.

About the authors

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Mario Merialdi and Fernando Althabe

World Health Report (2010)
Background Paper, 30

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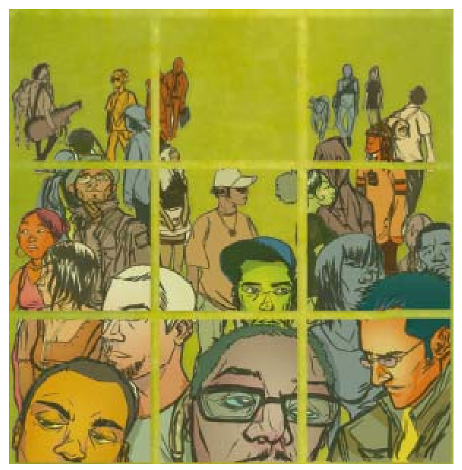

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The Global Numbers and Costs of Additionally Needed and Unnecessary Caesarean Sections Performed per Year: Overuse as a Barrier to Universal Coverage

World Health Report (2010) Background Paper, No 30

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Abstract

Objective

To estimate the additional number of needed CS (cesarean section) that would be required in countries with lower than recommended national rates, as well as the number of excess CS in countries in which the procedure is arguably overused and to understand the resource-use implications of the 'needed' and 'excess' CS.

Methods

We obtained data on the number of CS performed in 137 countries, accounting for approximately 95% of global births for that year. Countries with C-section rates below 10% were considered to show underuse, while countries with rates above 15% were considered to show overuse. We estimated the units costs and the quantities of the physical inputs needed in performing CS. Only the marginal costs of the C-section procedure itself were included.

Results

A total of 54 countries had C-section rates below 10%, whereas 69 showed rates above 15%. 14 countries had rates between 10 and 15%. We estimated that in 2008, 3.18 million additional CS were needed and 6.20 million unnecessary sections were performed. The cost of the global "excess" CS was estimated to amount to approximately U$S 2.32 billion, while the cost of the global "needed" CS on approximately U$S 432 million.

Conclusions

Worldwide, CS that are possibly medically unnecessary appear to command a disproportionate share of global economic resources. CS arguably function as a barrier to universal coverage with necessary health services. 'Excess' CS can therefore have important negative implications for health equity both within and across countries.

Introduction

Cesarean section (CS) was introduced in clinical practice as a life saving procedure both for the mother and the baby. As other procedures of some complexity, its use follows the health care inequity pattern of the world: underuse in low income settings, and adequate or even unnecessary use in middle and high income settings. [1-4]

Several studies have shown an inverse association between CS rates and maternal and infant mortality at population level in low income countries where large sectors of the population lack access to basic obstetric care. [2-4] On the other hand, CS rates above a certain limit have not shown additional benefit for the mother or the baby, and some studies have even shown that high CS rates could be linked to negative consequences in maternal and child heath. [2,3,5-8]

Bearing in mind that in 1985 the World Health Organization (WHO) stated: "There is no justification for any region to have CS rates higher than 10-15%", [9] we set out to update previous published estimates of CS rates worldwide [2-3], and calculate the additional number of CS that would be necessary in those countries with low national rates as well as the number of CS in excess in countries in which CS is overused. In addition to understand the resource-use implications of the 'needed' and 'excess' procedures, we performed a global costing analysis of both categories of C-section.

Methods

Sources of data and estimation of national CS rates

We obtained national cesarean section rates from several data sources as explained below.

I. CS rates from routine statistical surveillance systems reports or national surveys from government health offices were considered to provide nation-wide estimates (12 countries).
II. CS rates retrieved from the WHO Health Indicators Database [10], the WHO European Health for all database [11], or the 2005 WHO World Health Report [12] were assumed as national CS rates unless stated otherwise (52 countries).
III. CS rated reported in national surveys including the Demographic and Health Surveys (DHS). The DHS reports from surveys conducted since 1990 [13] were included and considered nationally representative (59 countries).

IV. CS rates published in the literature (13 countries) or personal comunication by the ministry of health (1 country) were considered to provide country-level estimates if they specifically stated that the figures represented country rates. In published manuscripts reporting hospital CS rates (only considering births occurred at hospital level), we considered them national rates if the country had a proportion of deliveries at health facilities >90%. For countries with a proportion of hospital deliveries <90% the same assumption would result in overestimates of CS national rates. Thus, in those cases we adjusted the rate by multiplying the CS rate by the proportion of births in health facilities. When the proportion of hospital deliveries was not available, we used the proportion of births attended by skilled health personnel (4 countries).

When country data were available for several years or several sources, the most recent data were retrieved. In cases in which data from different sources differed, the most reliable source was used at the authors' judgement. Sources of data for each included country are shown in Web Table 1

Estimation of worldwide number of CS needed and in excess

The annual number of CS performed in each country was calculated multiplying the CS rate by the annual number of births. The number of births was obtained from health statistics provided by UNICEF for year 2008 [14]. Data by country is available in web table 1.

The adequate range for the CS rate in a country remains a matter of debate. [9,15-17] We based our decisions on the following assumptions:

1. The recommended minimum necessary CS rate at population level to avoid death and severe morbidity in the mother lays between 1-5%, according to WHO and others. [15-17] Regarding neonatal outcomes, studies evaluating the association of CS rates with neonatal death have shown outcome improvements up to a CS rate of 10%. [2,3,6] Thus the minimum threshold for a population level CS rate could be considered to lay between 5-10%.
2. Regarding the upper level, the best known recommended upper limit is 15%, suggested by WHO in 1985. [9] Although these figures are based on theoretical estimates, two recent observational studies support that recommendation. [3,6] Both studies assessed the association between CS rates and mortality and morbidity in mothers and neonates, and found no reductions in those indicators when frequency of caesarean section was more than 15%. Moreover, one study showed that an increased rate of intervention was associated with higher mortality and morbidity in mothers and neonates. [6] Until further research gives new evidence, rates >15% may result in more harm than good. [1]

On the basis of the two assumptions above, we primarily classified countries in three groups according the national rates of CS: (i) Countries where CS is underused: those with CS rates <10%; (ii) countries with adequate use of CS: those with rates between 10% to 15%; and (iii) countries where CS is overused: with rates >15%. In a secondary more conservative analysis, we expanded the range of the "adequate use of CS" category to 5%-20%.

In countries with CS rates <10%, we calculated the number of additionally needed CS as those required to raise the national rate to 10% and were obtained by multiplying the annual number of births by ten minus the CS rate. In countries with CS rates >15% we calculated the CS in excess as those performed above 15% and were obtained by multiplying the annual number of births by the CS rate minus fifteen. We followed the same approach for the secondary analysis using the 5% as the limit to classify underuse and the 20% as a limit to classify oversuse.

Estimation of the cost

A standardized ingredients approach was used to measure the costs of CS. This approach requires information on the quantities of the physical inputs needed and on their unit costs. Only the marginal resources directly associated with the C-section procedure were costed; in other words, none of the routine costs associated with antenatal care visits were included, nor were other services that would be considered part of normal vaginal delivery (such as the costs of skilled birth attendants, tetanus prophylaxis or clean cord practices).

The quantities of inputs required at the point of care were estimated from various sources, including expert opinion and treatment practice guidelines. [18,19] A standardized profile for C-section inputs at point of care was used for all countries, and included: initiation of labour at referral level, diagnosis of obstructed labour and referral, C-section associated devices and medicines, operative facility time, medical human resources time, management of shock including hysterectomy and blood transfusion (assumed for 1% of CS performed), and post-operative hospital stay for stabilization.

The point-of-care input profile was further augmented by standardized estimates of the resources required to establish and maintain these point-of-care services, including programme administration, training, and the corresponding office space, electricity and other services, as well as a variety of standard consumables and equipment. [20-22]

For point-of-care inputs, the cost of 'needed' CS was calculated as the cost of the resources required to bring the country's C-section rate up to 10% (as a proportion of live births in that country); the cost of 'excess' CS was calculated as the cost of the resources involved in

performing CS in excess of 15% (of live births in that country). For the costs of programme administration etc., which are not incurred at the point of care, only the proportional component of the costs attributable to the 'excess' or 'needed' CS, respectively, was included in estimates of total costs.

Unit costs for the inputs identified were derived from a search of published and unpublished literature and databases, as well as from consultation with costing experts. For goods traded internationally, the most competitive international price identified was used. For example, drug prices were estimated on the basis of the median supply price published in the International Drug Price Indicator Guide, with a standardized mark-up applied to account for transportation and distribution. [23] For goods available only locally (e.g. human resources, inpatient bed days) costs have been shown to vary substantially across countries [22], so cross-country regressions accounting for national income levels and local characteristics of the supply of health care were used to generate estimates of unit costs. [20, 24]

Results

CS rates were obtained for 137 countries from 192 United Nations member states of the world [25], representing 95% of global births in the year 2008 [14]. In 133 countries the available CS rates were considered national rates. For 4 low and middle income countries, national figures were estimated from hospital rates adjusted as explained above (Web Table 1).

We calculated that approximately 18.5 million cesarean sections are performed yearly worldwide. About 40% of the countries have CS rates <10%, about 10% have CS rates between 10 and 15%, and approximately 50% have CS rates >15% (Table 1). 54 countries with CS rates <10% account for only 25% (4.5 millions) of the global CS but for 60% (77 millions) of the total number of births worldwide. On the other hand, 73% (13.5 millions) of the total number of CS are performed in the 69 countries with CS rates >15% where 37.5% (48.4 millions) of the total number of births occur.

Table 2 and 3 list the CS rate and the numbers of additionally needed CS and CS in excess by country. We calculated that 3.2 million additional CS would be needed in the 54 countries with CS rates <10%. The vast majority of these countries are from Africa (68.5%), 29.6% from Asia and 1 country from Latin America and the Caribbean.

Table 2 shows that 6 countries (Nigeria, India, Ethiopia, Congo Democratic Republic, Pakistan and Indonesia) account for 50% of the total number of additional CS needed. Using 5% as the threshold rate to define the underuse of CS, nearly 1 million CS would be additionally needed in 33 countries.

On the other hand, Table 3 shows that 6.2 million CS in excess are yearly performed. China and Brazil account almost for 50% of the total number of unnecessary CS. Using 20% as the threshold rate to define the overuse of CS, 4 million CS are in excess in 46 countries.

The cost of global 'excess' CS in 2008 was estimated to amount to approximately US$ 2.32 billion (all costs are denominated in 2005 constant $), while the cost of the global 'needed' CS in 2008 was estimated to amount to approximately US$ 432 million (Table 2 and 3). In countries with 'needed' CS, the average cost of a C-section was estimated to be approximately US$ 135; whereas in countries with excess CS, the average cost of the procedure was estimated as approximately US$ 373, meaning that CS are estimated to be about 2.8 times more expensive in countries with 'excess' procedures than in those where procedures are 'needed'. The lowest cost per ('needed') procedure was found to be in Nepal (US$ 97), whereas the highest cost per ('excess') procedure was found to be in Iceland (US$ 18,040). Furthermore, the number of global 'excess' CS in 2008 exceded the number of 'needed' ones by a factor of approximately 1.9.
However, since 'excess' CS occur in countries with, on average, substantially higher costs (mainly on account of higher average income levels), the combined implications of higher costs per procedure and a higher number of procedures is that the total cost of 'excess' CS in 2008 was approximately 5.4 times the cost of the 'needed' procedures.
'Excess' CS could thus potentially finance the 'needed' ones over 5 times over; in other words, if all the resources currently devoted to 'excess' CS could be directed towards countries where additional procedures are 'needed', the 'needed' procedures could be fully financed and there would in addition be a surplus of resources with a value of nearly US$ 2 billion.

Discussion

This analysis shows that every year in the world there is an additional need for 0.8 – 3.2 million CS in low income countries where 60% of the world's births occur. Simultaneously, 4.0-6.2 million CS in excess are performed in middle and high income countries where 37.5% of the births occur. From a population based approach, those CS in excess are likely to be medically unjustified and should be then considered unnecessary CS.

This analysis has several strengths. We were able to retrieve nationally representative CS rates from 137 countries representing more than 95% of the world annual number of births. The sources of these estimates are considered reliable and valid, and are all publicly available. The DHS programme represents the largest worldwide effort to obtain nationally representative demographic and health data from household surveys in developing countries. Surveys are implemented by institutions in the host country, usually government statistical offices, and 5,000–30,000 women of childbearing age are interviewed in a standard survey. As the DHS use standardized questionnaires and methods of training, data collection and processing, they are often considered the 'best available gold standard' for many health indicators in developing countries and are used for global monitoring efforts. [26,27] DHS figures are considered valid estimations of actual CS rates at country level, although they might be imprecise. [28]

The CS rates limits used to define underuse and overuse may be a matter for discussion since any classification has some constraints. The 15% upper limit suggested by WHO in 1985 could be less valid nowadays taken in account changes of the population in high income countries, such as mother's age at the first child, birthweight and other factors that may result in needing more or less CS. However, as we mentioned above, recent studies have shown that until now there is no evidence of benefit for the health of mothers and babies in populations with values of CS above 15%. [2,3,5-8] Regarding the lower limit, it has been argued that CS rates of 5% could achieve major improvement on maternal outcomes. However, for neonatal health, rates between 5% and 10% have been reported to attain better outcomes. [1-4] Yet, and acknowledging the debatable nature of these limits, we made a secondary analysis broading the range of cesarean section rates that can be considered adequate use. The figures are nonetheless striking.

The study has limitations mainly related to the data quality that cannot be excluded as possible explanations of the findings. The validity of the analyses presented is crucially dependent on the extent to which CS rates are representative of each country. [29-30] It is more likely that CS rates were more imprecise in low-income countries than in middle- or high-income countries. 45% of the estimates are from DHS surveys, or needed to be adjusted from hospital rates, all of them low-income countries. Therefore it is more likely that the needed number of CS is a much more imprecise figure than the number of CS in excess, which is based on much more reliable data.

These results show an unequal distribution of a major medical intervention. On one hand, low and some middle income countries should improve accessibility to this intervention which could reduce adverse maternal and perinatal outcomes. [2-5] At the other extreme, in high and

in some middle income countries, excessive use of this surgical procedure could result in added morbidity and no discernable benefits. [8,31-32]

Worldwide, CS that are possibly, in the large majority at least, medically unnecessary appear to command a disproportionate share of global economic resources. Since these resources could potentially be directed towards other, medically necessary, objectives, both in the countries where the 'excess' procedures occur and elsewhere, in the face of limited resources, 'excess' CS (as well as other overused procedures, drugs and services) can function as a potent barrier to universal coverage with necessary health services. 'Excess' CS can therefore have important negative implications for health equity both within and across countries.

Concerted actions need to be taken to offer timely CS to women in need and to advocate for a rationale use of CS in countries with a surplus and unnecessary use of this procedure. One possible outcome of this approach would be to progressively engage professional associations, health care organizations and the general public in richer countries to support programes aimed at providing emergency obstetric care in very low resource settings. The argument of some countries having more of what others totally lack, which for example has been used in the past to generate awareness and stimulate international action in cases of food crisis and famine in the third world, could apply to the lack of CS and emergency obstetric care as well.

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Authors contributions

JMB, LG and JAL participated in the conception of the study. All the authors were involved in the design of the study. LG, APB and JAL performed the data collection. LG and JAL participated in the analysis of the data. All authors participated in the interpretation of data and in the first drafting and final version of the manuscript.

Table 1. Distribution of countries and number of cesarean sections and births according to the cesarean section rate categories

Cesarean Section Rates	Countries		Annual number of cesarean sections (thousands)		Annual number of births (year 2006) (thousands)	
	N	%	N	%	N	%
<10%	54	39.4	4,556	24.7	77,417	60.0
Between 10 and 15%	14	10.2	414	2.2	3,177	2.5
>15%	69	50.4	13,479	73.1	48,390	37.5
Total	137	100.0	18,449	100.0	128,984	100.0

Table 2. Cesarean section rates, number of needed cesarean sections and estimated cost for year 2008 for those countries showing cesarean section rates below 10% sorted according the contribution on number of needed cesarean section

Country	Cesarean section rate (%)	Cesarean sections needed for year 2008			Estimated cost per year (US dollars)
		N	%	Cumulative %	
Nigeria	1.8	494,296	15.5	15.5	68,411,688
India	8.5	403,695	12.7	28.2	42,213,047
Ethiopia	1.0	278,370	8.7	36.9	36,940,008
Congo Democratic Republic	4.0	173,160	5.4	42.4	22,755,622
Pakistan	7.3	144,099	4.5	46.9	22,179,934
Indonesia	6.8	135,040	4.2	51.1	19,532,824
United Republic of Tanzania	3.2	120,428	3.8	54.9	16,790,318
Uganda	3.1	101,154	3.2	58.1	14,225,390
Kenya	4.0	90,360	2.8	60.9	12,563,130
Bangladesh	7.5	85,750	2.7	63.6	8,411,331
Sudan	3.7	81,648	2.6	66.2	12,771,298
Yemen	1.4	72,756	2.3	68.5	11,345,196
Niger	1.0	71,190	2.2	70.7	9,032,588
Mozambique	1.9	70,956	2.2	72.9	9,732,704
Burkina Faso	0.7	67,053	2.1	75.0	9,369,356
Madagascar	1.0	61,830	1.9	77.0	7,942,153
Cameroon	2.0	56,320	1.8	78.7	8,135,070
Nepal	2.7	53,436	1.7	80.4	5,167,033
Chad	0.4	47,808	1.5	81.9	6,671,882
Mali	1.6	45,528	1.4	83.3	6,122,609
Malawi	3.1	41,331	1.3	84.6	5,502,267
Zambia	3.0	37,940	1.2	85.8	5,635,761
Guinea	1.7	32,536	1.0	86.9	4,230,705
Senegal	3.3	31,490	1.0	87.8	4,450,548
Morocco	5.4	29,716	0.9	88.8	5,011,048
Cambodia	1.8	29,602	0.9	89.7	4,390,270
Rwanda	2.9	28,613	0.9	90.6	3,932,504
Algeria	6.0	28,560	0.9	91.5	5,720,662
Côte d´Ivoire	6.4	25,992	0.8	92.3	3,980,374
Ghana	6.9	23,467	0.7	93.1	3,190,301
Benin	3.6	21,888	0.7	93.7	3,099,599
Uzbekistan	6.3	20,461	0.6	94.4	2,757,576
Zimbabwe	4.8	19,656	0.6	95.0	2,749,128
Haiti	3.0	19,110	0.6	95.6	2,950,103
Sierra Leone	1.5	18,955	0.6	96.2	2,406,541
Togo	2.0	17,040	0.5	96.7	2,255,330
Tajikistan	2.1	15,247	0.5	97.2	2,043,552

Table 2. Cesarean section rates, number of needed cesarean sections and estimated cost for year 2008 for those countries showing cesarean section rates below 10% sorted according the contribution on number of needed cesarean section (cont.)

Country	Cesarean section rate (%)	Cesarean sections needed for year 2008			Estimated cost per year (US dollars)
		N	%	Cumulative %	
Eritrea	2.7	13,286	0.4	97.6	1,851,706
Central African Republic	1.9	12,474	0.4	98.0	1,957,447
Philippines	9.5	11,180	0.4	98.4	1,699,029
Liberia	3.5	9,425	0.3	98.7	1,278,555
Mauritania	3.2	7,344	0.2	98.9	1,184,720
Turkmenistan	3.8	6,882	0.2	99.1	1,237,991
Kyrgyzstan	5.8	5,040	0.2	99.3	693,914
Azerbaijan	7.6	3,984	0.1	99.4	597,711
Libyan Arab Jamahiriya	7.5	3,675	0.1	99.5	1,831,130
Tunisia	8.0	3,280	0.1	99.6	1,148,971
Lesotho	5.1	2,891	0.1	99.7	584,603
Mongolia	5.0	2,500	0.1	99.8	466,605
Oman	6.6	2,074	0.1	99.8	1,262,700
Gabon	5.6	1,760	0.1	99.9	635,007
Viet Nam	9.9	1,494	0.0	99.9	223,244
Comoros	5.3	987	0.0	100.0	139,393
Swaziland	7.9	735	0.0	100.0	165,915
Total		**3,185,492**	**100.0**		**431,578,091**

Table 3. Cesarean section rates, number of unnecessary cesarean sections and estimated cost for year 2008 for those countries showing cesarean section rates above 15% sorted according the contribution on number of unnecessary cesarean section

Country	Cesarean section rate (%)	Unnecessary cesarean sections for year 2008			Estimated cost per year (US dollars)
		N	%	Cumulative %	
China	25.9	1,976,606	31.8	31.8	326,574,644
Brazil	45.9	960,687	15.4	47.2	226,777,248
United States	30.3	673,047	10.8	58.0	687,167,996
Mexico	37.8	467,172	7.5	65.5	122,783,410
Iran	41.9	373,372	6.0	71.5	108,495,217
Egypt	27.6	253,890	4.1	75.6	41,085,585
Argentina	35.2	139,178	2.2	77.9	32,742,409
Italy	38.2	126,672	2.0	79.9	103,505,894
Colombia	26.7	107,406	1.7	81.6	23,027,552
Republic of Korea	37.7	102,604	1.6	83.3	30,381,162
Germany	27.8	85,248	1.4	84.6	72,307,555
Turkey	21.2	83,576	1.3	86.0	17,738,346
South Africa	20.6	61,096	1.0	87.0	12,241,688
Venezuela	25.1	60,499	1.0	87.9	15,395,020
Dominican Republic	41.9	60,256	1.0	88.9	16,125,808
Peru	24.1	55,663	0.9	89.8	11,316,358
Spain	25.9	53,519	0.9	90.7	39,899,298
United Kingdom	22.0	52,010	0.8	91.5	38,814,108
Russian Federation	18.0	46,350	0.7	92.3	32,191,503
Ecuador	29.8	41,650	0.7	92.9	9,574,142
Australia	30.3	40,851	0.7	93.6	37,990,115
Canada	26.3	39,889	0.6	94.2	47,598,044
Chile	30.7	39,407	0.6	94.9	11,107,876
France	18.8	28,576	0.5	95.3	23,122,636
Paraguay	32.2	26,466	0.4	95.7	5,701,984
Japan	17.4	24,816	0.4	96.1	28,186,982
Cuba	35.6	24,308	0.4	96.5	23,457,645
Thailand	17.4	23,448	0.4	96.9	3,948,376
Portugal	34.0	19,950	0.3	97.2	23,885,569
Romania	23.6	18,404	0.3	97.5	4,546,021
Hungary	28.0	12,870	0.2	97.7	25,833,427
El Salvador	25.0	12,400	0.2	97.9	3,024,630
Switzerland	28.9	10,147	0.2	98.1	20,277,952
Bolivia	18.6	9,468	0.2	98.2	1,573,282
Austria	27.1	9,196	0.1	98.4	10,232,906
Bulgaria	26.8	8,614	0.1	98.5	2,296,566
Uruguay	31.8	8,400	0.1	98.7	3,289,353
Nicaragua	20.6	7,890	0.1	98.8	1,488,783

Table 3. Cesarean section rates, number of unnecessary cesarean sections and estimated cost for year 2008 for those countries showing cesarean section rates above 15% sorted according the contribution on number of unnecessary cesarean section (cont.)

Country	Cesarean section rate (%)	Unnecessary cesarean sections for year 2008			Estimated cost per year (US dollars)
		N	%	Cumulative %	
Ireland	26.2	7,728	0.1	98.9	14,925,165
Israel	19.1	5,740	0.1	99.0	3,648,685
Jordan	18.5	5,495	0.1	99.1	1,688,279
Lebanon	23.3	5,478	0.1	99.2	2,237,762
Belarus	20.5	5,280	0.1	99.3	2,994,307
Albania	25.6	4,876	0.1	99.3	1,058,556
Costa Rica	20.8	4,350	0.1	99.4	1,149,694
Poland	16.1	4,092	0.1	99.5	1,031,147
Denmark	21.4	3,968	0.1	99.5	6,106,812
Georgia	22.2	3,744	0.1	99.6	693,756
Czech Republic	18.4	3,706	0.1	99.7	2,753,787
New Zealand	20.4	3,132	0.1	99.7	5,752,100
Slovakia	20.0	2,750	0.0	99.8	847,305
Sweden	17.3	2,461	0.0	99.8	3,263,538
Panama	18.2	2,240	0.0	99.8	687,235
Latvia	23.3	1,909	0.0	99.9	10,989,789
Lithuania	20.5	1,705	0.0	99.9	3,698,045
Belgium	15.9	1,071	0.0	99.9	861,686
Norway	16.6	928	0.0	99.9	1,915,956
Estonia	20.0	800	0.0	99.9	5,333,068
Finland	16.3	767	0.0	100.0	810,936
Malta	32.0	680	0.0	100.0	570,687
Croatia	16.4	588	0.0	100.0	736,864
Luxembourg	24.0	450	0.0	100.0	1,624,920
The FYR of Macedonia	16.9	418	0.0	100.0	489,542
Slovenia	16.8	342	0.0	100.0	648,372
Serbia	16.9	152	0.0	100.0	86,426
Bahrain	16.0	140	0.0	100.0	76,645
Qatar	15.9	135	0.0	100.0	563,930
Andorra	23.7	87	0.0	100.0	219,653
Iceland	15.6	30	0.0	100.0	541,213
Total		**6,220,844**	**100.0**		**2,323,712,950**

Web table 1. Cesarean sections rates and sources of data by country sorted by cesarean section rate

Country	Cesarean section			Births (per 1,000)
	Rate	Source	Year´s Source	
Brazil	45.9	Ministério de Saúde Brasil. Departamento de Informática do SUS (Accessed February 10, 2010. Available at: http://tabnet.datasus.gov.br/cgi/tabcgi.exe?idb2008/f08.def)	2006	3105
Dominican Republic	41.9	Centro de Estudios Sociales y Demográficos (CESDEM) y Macro International Inc. 2008. Encuesta Demográfica y de Salud 2007. Santo Domingo, República Dominicana: CESDEM y Macro International Inc. (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR205/FR205.pdf)	2007	224
Iran	41.9	Shahla Chaichian, Ali Akhlaghi, Firouzeh Rousta, Mahboobeh Safavi. Experience of Water Birth Delivery in Iran. Archives of Iranian Medicine, Volume 12, Number 5, 2009: 468 – 471 (Accessed December 10, 2009. Available at: http://www.ams.ac.ir/aim/09125/007.pdf)	2000	1388
Italy	38.2	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2005	546
Mexico	37.8	Villar J, et al. Caesarean delivery rates and pregnancy outcomes: the 2005 WHO global survey on maternal and perinatal health in Latin America. Lancet. 2006 Jun 3;367 (9525):1819-29.	2005	2049
Republic of Korea	37.7	Lee SI, Khang YH, Lee MS. Women's attitudes toward mode of delivery in South Korea. A society with high cesarean sections rates. Birth 2004;31:108-116	2003	452
Cuba	35.6	Villar J, et al. Caesarean delivery rates and pregnancy outcomes: the 2005 WHO global survey on maternal and perinatal health in Latin America. Lancet. 2006 Jun 3;367 (9525):1819-29.	2005	118
Argentina	35.2	Villar J, et al. Caesarean delivery rates and pregnancy outcomes: the 2005 WHO global survey on maternal and perinatal health in Latin America. Lancet. 2006 Jun 3;367 (9525):1819-29.	2005	689
Portugal	34.0	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2005	105
Paraguay*	32.2	Villar J, et al. Caesarean delivery rates and pregnancy outcomes: the 2005 WHO global survey on maternal and perinatal health in Latin America. Lancet. 2006 Jun 3;367 (9525):1819-29.	2005	154
Malta	32.0	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	4
Uruguay	31.8	Betrán AP, Merialdi M, Lauer JA, Bing-Shun W, Thomas J, Van Look P, Wagner M. Rates of caesarean section: analysis of global, regional and national estimates. Paediatric and Perinatal Epidemiology 2007; 21:00 98-113.	2007	50

Chile	30.7	Betrán AP, Merialdi M, Lauer JA, Bing-Shun W, Thomas J, Van Look P, Wagner M. Rates of caesarean section: analysis of global, regional and national estimates. Paediatric and Perinatal Epidemiology 2007; 21:00 98-113.	2002	251
Australia	30.3	Laws PJ, Abeywardana S, Walker J & Sullivan EA 2007. Australia's mothers and babies 2005. Perinatal statistics series no. 20. Cat. no. PER 40. Sydney: AIHW National Perinatal Statistics Unit (Accessed February 10, 2010. Available at: http://www.aihw.gov.au/publications/per/amb05/amb05.pdf)	2005	267
United States	30.3	Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary data for 2007. National vital statistics reports, Web release; vol 57 no 12. Hyattsville, MD: National Center for Health Statistics. Released March 18, 2009 (Accessed February 10, 2010. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_12.pdf)	2007	4399
Ecuador**	29.8	Villar J, et al. Caesarean delivery rates and pregnancy outcomes: the 2005 WHO global survey on maternal and perinatal health in Latin America. Lancet. 2006 Jun 3;367 (9525):1819-29.	2005	281
Switzerland	28.9	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2005	73
Hungary	28.0	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	99
Germany	27.8	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2006	666
Egypt	27.6	El-Zanaty, Fatma and Ann Way. 2009. Egypt Demographic and Health Survey 2008. Cairo, Egypt: Ministry of Health, El-Zanaty and Associates, and Macro International (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR220/FR220.pdf)	2008	2015
Austria	27.1	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	76
Bulgaria	26.8	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	73
Colombia	26.7	Ojeda G, Ordoñez M, Ochoa LH. Salud Sexual y Reproductiva en Colombia. Encuesta Nacional de Demografía y Salud 2005 (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR172/10Cap%C3%ADtulo10.pdf)	2005	918
Canada	26.3	British Columbia Perinatal Health Program. Caesarean Birth Task Force Report 2008. Vancouver, BC. February 2008 (Accessed February 10, 2010. Available at: http://www.canadianmidwives.org/pdf/CBTF_FinalApril08.pdf)	2005-2006	353
Ireland	26.2	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2005	69
China	25.9	Ronsmans C, Holtz S, Stanton C. Socioeconomic diff erentials in caesarean rates in developing countries: a retrospective analysis. The Lancet, Volume 368, Issue 9546, Pages 1516 - 15236	2003	18134

Spain	25.9	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2006	491
Albania	25.6	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	46
Venezuela	25.1	Betrán AP, Merialdi M, Lauer JA, Bing-Shun W, Thomas J, Van Look P, Wagner M. Rates of caesarean section: analysis of global, regional and national estimates. Paediatric and Perinatal Epidemiology 2007; 21:00 98-113.	2002	599
El Salvador	25.0	Asociación Demográfica Salvadoreña, CDC, USAID. República de El Salvador, CA. Encuesta Nacional de Salud Familiar. Informe final. FESAL-2008	2008	124
Peru†	24.1	Villar J, et al. Caesarean delivery rates and pregnancy outcomes: the 2005 WHO global survey on maternal and perinatal health in Latin America. Lancet. 2006 Jun 3;367 (9525):1819-29.	2005	609
Luxemburg	24.0	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2004	5
Andorra	23.7	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	1999	1
Romania	23.6	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	214
Latvia	23.3	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	23
Lebanon	23.3	Betrán AP, Merialdi M, Lauer JA, Bing-Shun W, Thomas J, Van Look P, Wagner M. Rates of caesarean section: analysis of global, regional and national estimates. Paediatric and Perinatal Epidemiology 2007; 21:00 98-113.	1999–00	66
Georgia	22.2	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	52
United Kingdom	22.0	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2004	743
Denmark	21.4	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	62
Turkey	21.2	Hacettepe University Institute of Population Studies, Turkey Demographic and Health Survey, 2003. Hacettepe University Institute of Population Studies, Ministry of Health General Directorate of Mother and Child Health and Family Planning, State Planning Organization and European Union.Ankara, Turkey (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR160/10chapter10.pdf)	2003	1348

Costa Rica	20.8	Belizan JM, Althabe F, Barros FC, Alexander S. Rates and implications of cesarean sections in Latin America: Ecological study. BMJ 1999;319:1397-1400.	1993	75
Nicaragua‡	20.6	Villar J, et al. Caesarean delivery rates and pregnancy outcomes: the 2005 WHO global survey on maternal and perinatal health in Latin America. Lancet. 2006 Jun 3;367 (9525):1819-29.	2005	140
South Africa	20.6	Department of Health, Medical Research Council, OrcMacro. 2007. South Africa Demographic and Health Survey 2003. Pretoria: Department of Health (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR206/FR206.pdf)	2003	1091
Belarus	20.5	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	96
Lithuania	20.5	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	31
New Zealand	20.4	Betrán AP, Merialdi M, Lauer JA, Bing-Shun W, Thomas J, Van Look P, Wagner M. Rates of caesarean section: analysis of global, regional and national estimates. Paediatric and Perinatal Epidemiology 2007; 21:00 98-113.	1999	58
Estonia	20.0	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	16
Slovakia	20.0	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2005	55
Israel	19.1	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	140
France	18.8	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2003	752
Bolivia	18.6	Ministerio de Salud y Deportes (MSD), Programa Reforma de Salud (PRS), Instituto Nacional de Estadística (INE) y Macro International. 2009. Encuesta Nacional de Demografía y Salud ENDSA 2008. La Paz, Bolivia: MSD, PRS, INE y Macro International (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR228/FR228%5B08Feb2010%5D.pdf)	2008	263
Jordan	18.5	Department of Statistics [Jordan] and Macro International Inc. 2008. Jordan Population and Family Health Survey 2007. Calverton, Maryland, USA: Department of Statistics and Macro International Inc. (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR209/FR209.pdf)	2007	157
Czech Republic	18.4	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2006	109
Panama	18.2	Belizan JM, Althabe F, Barros FC, Alexander S. Rates and implications of cesarean sections in Latin America: Ecological study. BMJ 1999;319:1397-1400.	1996	70

Russian Federation	18.0	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2006	1545
Japan	17.4	Maternal and Child Health Statistics of Japan. Published by Mothers' & Children's Health Organization, Tokyo, Japan, 2007.	2005	1034
Thailand	17.4	Betrán AP, Merialdi M, Lauer JA, Bing-Shun W, Thomas J, Van Look P, Wagner M. Rates of caesarean section: analysis of global, regional and national estimates. Paediatric and Perinatal Epidemiology 2007; 21:00 98-113.	2001	977
Sweden	17.3	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2006	107
Serbia	16.9	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	8
The FYR of Macedonia	16.9	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2006	22
Slovenia	16.8	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	19
Norway	16.6	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2006	58
Croatia	16.4	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	42
Finland	16.3	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	59
Poland	16.1	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	1997	372
Bahrain	16.0	World Health Organization. The world health report 2005. Basic Indicators (Accessed at December 10, 2009. Available at: http://www.who.int/whr/2005/annex/indicators_country_a-f.pdf)	1995	14
Belgium	15.9	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	1999	119
Qatar	15.9	Betrán AP, Merialdi M, Lauer JA, Bing-Shun W, Thomas J, Van Look P, Wagner M. Rates of caesarean section: analysis of global, regional and national estimates. Paediatric and Perinatal Epidemiology 2007; 21:00 98-113.	1998	15
Iceland	15.6	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2005	5

Syrian Arab Republic	15.0	Khawaja M, Choueiry N, Jurdi R. "Hospital-based Caesarean section in the Arab region: an overview". Eastern Mediterranean health journal. 2009;15(2):458–69 (Accessed December 10, 2009. Available at: http://www.emro.who.int/emhj/1502/15_2_2009_0458_0469.pdf)	2002	590
Ukraine	14.2	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2006	459
Armenia	14.1	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	47
Netherlands	13.5	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2005	185
Honduras	13.0	Secretaría de Salud [Honduras], Instituto Nacional de Estadística (INE) y Macro International. 2006. Encuesta Nacional de Salud y Demografía 2005-2006. Tegucigalpa, Honduras: SS, INE y Macro International (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR189/FR189.pdf)	2005 -2006	202
Saudi Arabia	13.0	Khawaja M, Choueiry N, Jurdi R. "Hospital-based Caesarean section in the Arab region: an overview". Eastern Mediterranean health journal. 2009;15(2):458–69 (Accessed February 10, 2010. Available at: http://www.emro.who.int/emhj/1502/15_2_2009_0458_0469.pdf)	2002	591
Namibia	12.7	Ministry of Health and Social Services (MoHSS) [Namibia] and Macro International Inc. 2008. Namibia Demographic and Health Survey 2006-07. Windhoek, Namibia and Calverton, Maryland, USA: MoHSS and Macro International Inc. (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR204/FR204.pdf)	2006-2007	59
Montenegro	12.0	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	115
Moldova, Republic of	11.9	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	45
Guatemala	11.4	Betrán AP, Merialdi M, Lauer JA, Bing-Shun W, Thomas J, Van Look P, Wagner M. Rates of caesarean section: analysis of global, regional and national estimates. Paediatric and Perinatal Epidemiology 2007; 21:00 98-113.	2002	453
Kuwait	11.2	Alnesef Y, Al-Rashoud RH, Farid SM. Kuwait Family Health Survey 1996. Ministry D71 of Health, Kuwait, 2000.	1996	52
Kazakhstan	11.0	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	304
Cape Verde	10.7	Instituto Nacional de Estatística (INE) [Cabo Verde], Ministério da Saúde, e Macro International 2008. Segundo Inquérito Demográfico e de Saúde Reprodutiva, Cabo Verde, IDSR-II, 2005. Calverton, Maryland, USA: INE (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR203/FR203.pdf)	2005	12

United Arab Emirates	10.0	World Health Organization. The world health report 2005. Basic Indicators (Accessed at December 10, 2009. Available at: http://www.who.int/whr/2005/annex/indicators_country_p-z.pdf)	1995	63
Viet Nam	9.9	Committee for Population, Family and Children [Vietnam], and ORC Macro. 2003. Vietnam Demographic and Health Survey 2002. Calverton, Maryland, USA: Committee for Population, Family and Children and ORC Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR139/08Chapter08.pdf)	2002	1494
Philippines	9.5	National Statistics Office (NSO) [Philippines], and ICF Macro. 2009. National Demographic and Health Survey 2008. Calverton, Maryland: National Statistics Office and ICF Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR224/FR224.pdf)	2008	2236
India	8.5	International Institute for Population Sciences (IIPS) and Macro International. 2007. National Family Health Survey (NFHS-3), 2005–06: India: Volume I. Mumbai: IIPS (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FRIND3/08Chapter08.pdf)	2005 -2006	26913
Tunisia	8.0	World Health Organization. The world health report 2005. Basic Indicators (Accessed at December 10, 2009. Available at: http://www.who.int/whr/2005/annex/indicators_country_p-z.pdf)	2000	164
Swaziland	7.9	Central Statistical Office (CSO) [Swaziland], and Macro International Inc. 2008. Swaziland Demographic and Health Survey 2006-07. Mbabane, Swaziland: Central Statistical Office and Macro International Inc. (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR202/FR202.pdf)	2006-2007	35
Azerbaijan	7.6	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	166
Bangladesh	7.5	National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International 2009. Bangladesh Demographic and Health Survey 2007. Dhaka, Bangladesh and Calverton, Maryland, USA:National Institute of Population Research and Training, Mitra and Associates, and Macro International (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR207/FR207%5BApril-10-2009%5D.pdf)	2007	3430
Libyan Arab Jamahiriya	7.5	Betrán AP, Merialdi M, Lauer JA, Bing-Shun W, Thomas J, Van Look P, Wagner M. Rates of caesarean section: analysis of global, regional and national estimates. Paediatric and Perinatal Epidemiology 2007; 21:00 98-113.	1995	147
Pakistan	7.3	National Institute of Population Studies (NIPS) [Pakistan], and Macro International Inc. 2008. Pakistan Demographic and Health Survey 2006-07. Islamabad, Pakistan: National Institute of Population Studies and Macro International Inc. (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR200/FR200.pdf)	2006-2007	5337
Ghana	6.9	Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF Macro. 2009. Ghana Demographic and Health Survey 2008. Accra, Ghana: GSS, GHS, and ICF Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR221/FR221.pdf)	2008	757
Indonesia	6.8	Statistics Indonesia (Badan Pusat Statistik—BPS) and Macro International. 2008. Indonesia Demographic and Health Survey 2007. Calverton, Maryland, USA: BPS and Macro International (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR218/FR218%5BApril-09-2009%5D.pdf)	2007	4220

Oman	6.6	Sulaiman AJM, Al-Riyami A, Farid SM. Oman Family Health Survey 1995. Ministry of Health, Muscat, 2000.	1995	61
Cote d´Lvoire	6.4	Institut National de la Statistique (INS) et Ministère de la Lutte contre le Sida [Côte d'Ivoire] et ORC Macro. 2006. Enquête sur les Indicateurs du Sida, Côte d'Ivoire 2005. Calverton, Maryland, U.S.A. : INS et ORC Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/AIS5/AIS5.pdf)	2005	722
Uzbekistan	6.3	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	553
Algeria	6.0	World Health Organization. The world health report 2005. Basic Indicators (Accessed at December 10, 2009. Available at: http://www.who.int/whr/2005/annex/indicators_country_a-f.pdf)	2000	714
Kyrgyzstan	5.8	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	120
Gabon	5.6	Direction Générale de la Statistique et des Études Économiques (DGSEE) [Gabon] et ORC Macro. 2001. Enquête Démographique et de Santé Gabon 2000. Calverton, Maryland : Direction Générale de la Satistique et des Études Économiques, et Fonds des Nations Unie (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR122/08chapitre08.pdf)	2000	40
Morocco	5.4	Ministère de la Santé [Maroc], ORC Macro, et Ligue des États Arabes. 2005. Enquête sur la Population et la Santé Familiale (EPSF) 2003-2004. Calverton, Maryland, USA : Ministère de la Santé et ORC Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR155/08Chapitre08.pdf)	2003-2004	646
Comoros	5.3	Mondoha, Kassim A., Juan Schoemaker et Monique Ban'ère. 1997. Enquête Démographique et de Santé, Comores 1996. Calverton, Maryland : Centre National de Documentation et de Recherche Scientifique et Macro International Inc. (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR79/07Chapitre7.pdf)	1996	21
Lesotho	5.1	Ministry of Health and Social Welfare (MOHSW) [Lesotho], Bureau of Statistics (BOS) [Lesotho], and ORC Macro. 2005. Lesotho Demographic and Health Survey 2004. Calverton, Maryland: MOH, BOS, and ORC Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR171/09Chapter09.pdf)	2004	59
Mongolia	5.0	World Health Organization. The world health report 2005. Basic Indicators (Accessed at December 10, 2009. Available at: http://www.who.int/whr/2005/annex/indicators_country_g-o.pdf)	2000	50
Zimbabwe	4.8	Central Statistical Office (CSO) [Zimbabwe] and Macro International Inc. 2007. Zimbabwe Demographic and Health Survey 2005-06. Calverton, Maryland: CSO and Macro International Inc. (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR186/FR186.pdf)	2005-2006	378
Congo Democratic Republic	4.0	Ministère du Plan et Macro International. 2008. Enquête Démographique et de Santé, République Démocratique du Congo 2007. Calverton, Maryland, U.S.A. : Ministère du Plan et Macro International (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR208/FR208.pdf)	2007	2886

Kenya	4.0	Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro. 2004. Kenya Demographic and Health Survey 2003. Calverton, Maryland: CBS, MOH, and ORC Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR151/09Chapter09.pdf)	2003	1506
Turkmenistan	3.8	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2007	111
Sudan	3.7	Betrán AP, Merialdi M, Lauer JA, Bing-Shun W, Thomas J, Van Look P, Wagner M. Rates of caesarean section: analysis of global, regional and national estimates. Paediatric and Perinatal Epidemiology 2007; 21:00 98-113.	1993	1296
Benin	3.6	Institut National de la Statistique et de l'Analyse Économique (INSAE) [Bénin] et Macro International Inc. 2007 : Enquête Démographique et de Santé (EDSB-III) - Bénin 2006. Calverton, Maryland, USA : Institut National de la Statistique et de l'Analyse Économique et Macro International Inc. (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR197/08Chapitre08.pdf)	2006	342
Liberia	3.5	Liberia Institute of Statistics and Geo-Information Services (LISGIS) [Liberia], Ministry of Health and Social Welfare [Liberia], National AIDS Control Program [Liberia], and Macro International Inc. 2008. Liberia Demographic and Health Survey 2007. Monrovia, Liberia: Liberia Institute of Statistics and Geo-Information Services (LISGIS) and Macro International Inc. (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR201/FR201.pdf)	2007	145
Senegal	3.3	Ndiaye, Salif, et Mohamed Ayad. 2006. Enquête Démographique et de Santé au Sénégal 2005. Calverton, Maryland, USA : Centre de Recherche pour le Développement Humain [Sénégal] et ORC Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR177/08Chapitre08.pdf)	2005	470
Mauritania	3.2	Office National de la Statistique (ONS) [Mauritanie] et ORC Macro. 2001. Enquête Démographique et de Santé Mauritanie 2000-2001. Calverton, Maryland, USA : ONS et ORC Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR127/07Chapter7.pdf)	2000-2001	108
United Republic of Tanzania	3.2	National Bureau of Statistics (NBS) [Tanzania] and ORC Macro. 2005. Tanzania Demographic and Health Survey 2004-05. Dar es Salaam, Tanzania: National Bureau of Statistics and ORC Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR173/09Chapter09.pdf)	2006	1771
Malawi	3.1	National Statistical Office (NSO) [Malawi], and ORC Macro. 2005. Malawi Demographic and Health Survey 2004. Calverton, Maryland: NSO and ORC Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR175/09Chapter09.pdf)	2004	599
Uganda	3.1	Uganda Bureau of Statistics (UBOS) and Macro International Inc. 2007. Uganda Demographic and Health Survey 2006. Calverton, Maryland, USA: UBOS and Macro International Inc. (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR194/FR194.pdf)	2006	1466
Haiti	3.0	Cayemittes, Michel, Marie Florence Placide, Soumaïla Mariko, Bernard Barrère, Blaise Sévère, Canez Alexandre. 2007. Enquête Mortalité, Morbidité et Utilisation des Services, Haïti, 2005-2006. Calverton, Maryland, USA : Ministère de la Santé Publique et de la Population, Institut Haïtien de l'Enfance et Macro International Inc. (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR192/FR192.pdf)	2005-2006	273

Zambia	3.0	Central Statistical Office (CSO), Ministry of Health (MOH), Tropical Diseases Research Centre (TDRC), University of Zambia, and Macro International Inc. 2009. Zambia Demographic and Health Survey 2007. Calverton, Maryland, USA: CSO and Macro International Inc. (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR211/FR211%5Brevised-05-12-2009%5D.pdf)	2007	542
Rwanda	2.9	Institut National de la Statistique du Rwanda (INSR) and ORC Macro. 2006. Rwanda Demographic and Health Survey 2005. Calverton, Maryland, U.S.A.: INSR and ORC Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR183/08Chapter08.pdf)	2005	403
Eritrea	2.7	National Statistics and Evaluation Office (NSEO) [Eritrea] and ORC Macro. 2003. Eritrea Demographic and Health Survey 2002. Calverton, Maryland, USA: National Statistics and Evaluation Office and ORC Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR137/09Chapter09.pdf)	2002	182
Nepal	2.7	Ministry of Health and Population (MOHP) [Nepal], New ERA, and Macro International Inc. 2007. Nepal Demographic and Health Survey 2006. Kathmandu, Nepal: Ministry of Health and Population, New ERA, and Macro International Inc. (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR191/FR191.pdf)	2006	732
Tajikistan	2.1	World Health Organization. European Regional Office Health for all database (Accessed March 10, 2010. Available at: http://data.euro.who.int/hfadb)	2006	193
Cameroon	2.0	Institut National de la Statistique (INS) et ORC Macro. 2004. Enquête Démographique et de Santé du Cameroun 2004. Calverton, Maryland, USA : INS et ORC Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR163/08chapitre08.pdf)	2004	704
Togo	2.0	Anipah, Kodjo, Gora Mboup, Afi Mawuéna Ouro-Gnao, Bassanté Boukpessi, Pierre Adadé Messan, et Rissy Salami-Odjo. 1999. Enquete Démographique et de Santé, Togo 1998. CAlverton, Maryland USA: Direction de la Statistique et Macro Internation Inc. (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR101/09Chapter09.pdf)	1998	213
Central African Republic	1.9	Ndamobissi, Robert, Gora Mboup et Edwige Opportune Nguélébé. 1995. Enquête Démographique et de Santé, République Centrafrieaine 1994-95. Calverton, Maryland, U.S.A. : Direction des Statistiques Démographiques et Sociales et Macro International Inc. (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR67/10Chapitre10.pdf)	1994-1995	154
Mozambique	1.9	Instituto Nacional de Estatistica da Maputo, Moçambique, Ministerio da Saude da Maputo, Moçambique and ORC Macro/DHS Program (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR161/FR161.pdf)	2003	876
Cambodia	1.8	National Institute of Public Health, National Institute of Statistics [Cambodia] and ORC Macro. 2006. Cambodia Demographic and Health Survey 2005. Phnom Penh, Cambodia and Calverton, Maryland, USA: National Institute of Public Health, National Institute of Statistics and ORC Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR185/FR185%5BNov-11-2008%5D.pdf)	2005	361

Nigeria	1.8	National Population Commission (NPC) [Nigeria] and ICF Macro. 2009. Nigeria Demographic and Health Survey 2008. Abuja, Nigeria: National Population Commission and ICF Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR222/FR222.pdf)	2008	6028
Guinea	1.7	Direction Nationale de la Statistique (DNS) (Guinée) et ORC Macro. 2006. Enquête Démographique et de Santé, Guinée 2005. Calverton, Maryland, U.S.A. : DNS et ORC Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR162/08Chapter08.pdf)	2005	392
Mali	1.6	Cellule de Planification et de Statistique du Ministère de la Santé (CPS/MS), Direction Nationale de la Statistique et de l'Informatique du Ministère de l'Économie, de l'Industrie et du Commerce (DNSI/MEIC) et Macro International Inc. 2007. Enquête Démographique et de Santé du Mali 2006. Calverton, Maryland, USA : CPS/DNSI et Macro International Inc. (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR199/FR199.pdf)	2006	542
Sierra Leone	1.5	Statistics Sierra Leone (SSL) and ICF Macro. 2009. Sierra Leone Demographic and Health Survey 2008. Calverton, Maryland, USA: Statistics Sierra Leone (SSL) and ICF Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR225/FR225.pdf)	2008	223
Yemen	1.4	Central Statistical Organization (CSO) [Yemen] and Macro International Inc. (MI). 1998 Yemen Demographic and Maternal and Child Health Survey 1997 (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR94/08Chapter08.pdf)	1997	846
Ethiopia	1.0	Central Statistical Agency [Ethiopia] and ORC Macro. 2006. Ethiopia Demographic and Health Survey 2005. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR179/FR179.pdf)	2005	3093
Madagascar	1.0	Mariko, Soumaïla et Victor Rabeza. 2005. Enquête de Base sur la Santé de la Reproduction et la Survie des Enfants dans les zones d'intervention USAID, à Madagascar - EBSRSE 2003-2004. Calverton, Maryland, USA : INSTAT et ORC Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR158/08Chapitre08.pdf)	2003-2004	687
Niger	1.0	Institut National de la Statistique (INS) et Macro International Inc. 2007. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2006. Calverton, Maryland, USA : INS et Macro International Inc. (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR193/08Chapitre08.pdf)	2006	791
Burkina Faso	0.7	Institut National de la Statistique et de la Démographie (INSD) et ORC Macro. 2004. Enquête Démographique et de Santé du Burkina Faso 2003. Calverton, Maryland, USA : INSD et ORC Macro (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR154/08Chapitre8.pdf)	2003	721
Chad	0.4	Ouagadjio, Bandoumal, Kostelngar Nodjimadji, Tchobkréo Bagamla, Riradjim Madnodji, Joël Sibaye Tokindang, Ningam Ngakoutou, Joël Nodjimbatem Ngoniri, Caman Bédaou, Donato Koyalta, Bernard Barrère, Monique Barrère. 2004. Enquête Démographique et de Santé T (Accessed December 10, 2009. Available at: http://www.measuredhs.com/pubs/pdf/FR170/09Chapitre09.pdf)	2004	498

*The cesarean section was adjusted by the percentage of births attended by skilled health personnel (77.0%) (World Health Organization. World Health Statistics 2007. Accessed December 14, 2009. Available at: http://www.who.int/whosis/whostat2007.pdf)

**The cesarean section was adjusted by the percentage of births attended by skilled health personnel (74.0%) (World Health Organization. World Health Statistics 2007. Accessed December 14, 2009. Available at: http://www.who.int/whosis/whostat2007.pdf)

†The cesarean section was adjusted by the percentage of births attended by skilled health personnel (71.0%) (World Health Organization. World Health Statistics 2007. Accessed December 14, 2009. Available at: http://www.who.int/whosis/whostat2007.pdf)

‡The cesarean section was adjusted by the percentage of births attended by skilled health personnel (67.0%) (World Health Organization. World Health Statistics 2007. Accessed December 14, 2009. Available at: http://www.who.int/whosis/whostat2007.pdf)

From:
Robin Minton, Constituent District 23

To:
Senator Josh Green, Chair Committee on Health; Members, Senate Committee on Health

Senator Roz Baker, Chair Committee on Commerce and Consumer Protection; Members, Senate Committee on Commerce and Consumer Protection

Senator Clayton Hee, Chair Committee on Judiciary and Labor; Members, Senate Committee on Judiciary and Labor

Hearing: February 10, 2014, 1:30 pm, Room 229

Re: SB 2569 and SB 2569 SD 1, Relating to Home Birth

As a mother of four respectful and informed home births, I am writing to strongly oppose SB2569 and SB2569 SD1. I feel that women are capable of discussing their decisions with their doctor or midwife, educating themselves on the risks and benefits of the place they choose to deliver their children and making an informed decision that is safe for themselves. Every woman should have the right to make this decision for herself, and home birth is a desired and safe option for many women.
SB2569 and SB2569 SD1 violate women's rights and their medical confidentiality, takes away their choices and leaves them without options.
I strongly encourage you to oppose these two bills.

Mahalo,
Robin Minton

SB2569 AND SB2569 SD1

Comparison of Birth Outcomes as a Non-medical Event

abstract

Birth outcomes for mother and child are alarming in the United States. While the US spends more money in the world on prenatal care, it ranks among the highest for both maternal and fetal mortality rates in industrialized countries. The use of ultrasound and drugs has been proven to be ineffective and dangerous, yet, a strong component of this country's 26 billion dollar industry. Holland's people believe that in humans, pregnancy and parturition are normal events, which require careful observation and care, and only if specifically indicated is medical intervention necessary. The basic philosophy of the Dutch system is that the midwife or general practitioner takes care of normal pregnancies (82%). Giving birth at home was shown in present day studies to be a safe choice and important to the Dutch society that the homebirth option remains available to women. The more educated the woman was in the studies, the more that homebirth was chosen. Homebirth with traditional midwives has always had the best statistics and safest outcomes as shown with the statistics in this article. The truth is birth is a sacred and powerful experience. Most problems would be avoided if a prepared healthy mother and baby were left to birth with the support of the family and midwife. Women of all colors and ages are equally capable of birthing naturally at home where it is safest. How many more birth practitioners will be taught to use drugs and machines that are not safe to mother and baby?

Introduction

The real question about safety is not whether you want a pleasant birth at home or a safe birth in the hospital? It is, "Do you want to give birth at home and run the miniscule risk of an emergency that might (but not necessarily would) be handled better in the hospital, or do you want to give birth in the hospital and run the considerably increased risk of infection, the certainty of additional stress, and the near certainty of having unnecessary (and potentially risky) interventions?" Henri Goer

Worldwide many are looking for solutions to this rising maternal and infant mortality rate, the lack of obstetricians willing to work, and the medicalization of birth. Examining the reasons why the United States has a high infant and mortality rate, when more money is spent on prenatal care and showing birth as a normal ceremony of life wil be examined. Why have so many OB's abandoned the work? Why have the insurance rates risen? What is the solution to remedying this grave situation? Traditional birthing has been shown to be the safest place to birth because traditional midwives use the least interventions. Each intervention carries risks that affect both the mother and child and eventually the society. Examining these risks associated with these "medical interventions" will be shown in this paper. The concept that birth in a natural event and there is no need for medication, instruments pulling out a baby and in almost all cases a cesarean avoided, will be explored. Midwives have always worked with birth as a sacred event of life, the bringing of a new family member into the clan. Truthful education is the most important factor in overcoming this catastrophe in the United States that is spreading around the world.
This paper will further examine what is happening in the medical world and the consequences that are afflicted on the baby, the mother and society.

Methods

This paper shows data that compares 370 of the births of the approximately 600 births that I have attended as a traditional midwife. They speak for themselves and truly they speak for the women that made them statistics. This is an average representation of all my births. The population includes women of diverse ethnic backgrounds, ages, and locations (city, town or rural), incidence of transport, maternal and infant mortality, tears, cesareans (due to transport), PPD (postpartum depression), induction of labor, breastfeeding success and length longer than 6 months, 1 yr, and premature labor with birth

outcome will be shown. This data came from my personal statistics that I kept and the last five years where I was able to obtain from the MANA (Midwifery Alliance of North America) database as I am also a CPM (certified professional midwife).

I did an extensive literature search to examine the well-known statistics from the Netherlands. The Dutch statistics shown address the issue of low-risk deliveries (82% of pregnancies) in the Netherlands, taking place in the home or hospital setting with the midwifery model of care. The settings vary where the birth took place, at home, birthing center. Data was gathered on perinatal mortality and morbidity rates, safe and satisfying care, and methods of delivery. The data in this report are entirely observational. It is important again to realize that you cannot have a randomized trial with the different birthing settings as the dependent variables are widely influenced. Measuring the quality of care that women received during pregnancy is not easy. Since mortality is so low with low-risk birthing women, to measure for maximal outcome with minimal intervention became the measure.

Finally the last statistics were found in a variety of articles. These are the statistics that are kept in the United States. They are not well kept and it took a lot of work to find what I could.

RESULTS

Variable	Clare	Dutch mid/hos	Dutch mid/home	US
Location				
rural	23.2%			
town	69.7%			
city	7.0%			

Ethnicity

native Am./Hi	11.0%
asian	4.0%
African Am	3.6%
Caucasian	81.7%

Age

Varaiable Required parameters are missing or incorrect.

	Dutch	Dutch mid/hospital	US mid/home
15-19	8.3%		
20-30	61.0%		
31-35	31.0%		
36-45	8.3%		

Econonic

Upper	4.6%
Middle	54.0%
Lower`	41.4%

Relationship status

married/partners	82.0%
single moms	18.0%

MMR	0
IMR	0

Breastfeeding

Breastfeeding>6 mo.	369
Breastfeeding>12 mo.	369

Induction of labor	0

Epidurals	0			67%
Medications in Labor	0	20%	7.9%	67%
Ultrasound Use	0			100%
C-sections	0			30%
Transports				
small town	1			
rural	2			
city	2			
middle income white)				
2nd degree tears	3	19, town, nat. Am, lower 31, town, white, lower 35, asian, rural, lower)		
PPT	1	(25yrs white, middle, town)		
Premature births	2	(25, white, lower, town, 35, white, middle, rural)		

DISCUSSION

The effects of modern technology and drugs on infant and maternal mortality and morbidity including PPD (postpartum depression), infections, long-term sequelae, and the economic

ramifications on society are discussed. Homebirth practices, the practices in the Netherlands, traditional midwives, and the United States are examined. The direct practices of midwives and traditional midwives will be discussed so that it will become clear why traditional midwives statistics are always going to be the best.

The Netherlands

The midwifery model of care in the Netherlands is a unidisciplinary team approach amongst the homebirth midwives, hospital midwives and obstetricians. This approach has a low infant and maternal mortality and is a model of care that is being used as an example to other countries. There is a mutual respect between the midwives, obstetricians, general practioneers, nurses and aids as they work together to create good birthing experiences for the Dutch women. Cooperation not confrontation is the motto in the Netherlands amongst all that are involved in birth. (Oppenheimer,93) (The system reflects the feeling of the people by showing that litigation there is very low. With their rates of perinatal mortality so low (well below the 10 per 1000) they have virtually lost all their usefulness for measuring quality of care in the western world. This is why they now measure maximum outcome with minimum intervention. (Wiegers,96) Giving birth at home was shown to be a safe choice and it appears to be important to the Dutch society that the homebirth option remains available to women. The more educated the woman was, the more that homebirth was chosen.

England recently has stated that they want to use Holland's birthing model and by 2009 wants a third of their births back at home. They too also stressed the need for good relationships between maternity teams including midwives, obstetricians, anesthetists, pediatricians and support staff. At present women are given a choice of where to give birth, including at home, in units led by midwives and in units led by consultants. (Block,07)

This recent change in England in returning to homebirth is a direct result of the homebirth movement in Holland and finding a solution to the similar problems that the United States has today concerning birth outcomes for both mother and baby. These studies are the most comprehensive of medical midwifery done.

There have been effective and well-done long-term studies to examine the birthing system in Holland. This Dutch system is being studies all over the world because of the consistent high level of homebirths. Some say that it is hard to use the data of safety with homebirth statistics with infant mortality. Therefore it is important to clarify the meaning of perinatal mortality. This period includes the labor and first week of the life of the baby. Both WHO (World Health Organization) and FIGO (International Federation of Gynecology and Obstetrics) in Europe recommend perinatal mortality to be associated with birth weight of 1000g or above. Because many countries do not yet follow these recommendations, it is impossible to get accurate comparison of perinatal mortality in comparisons with other countries. (Eskes,92)

It is important again to realize that you cannot have a randomized trial with the different birthing settings as the dependent variables are widely influenced. These influences are the various population-characteristics of each group of women per the obstetric caregiver and also the birth weight per case. Although some would argue that the socio-economic level of the Dutch population affected the low mortality rate, the Dutch studies did not find a relationship between the economic population and the mortality rate. The analysis shows that at least 25-33% infant mortality could be avoided. (Eskes,1992) This was because there was a strong cooperation between each level of healthcare providers the organizational structure amongst the homebirth midwives, the hospital midwives and the OB/GYN's.

It is noted that OB's intervened more often than homebirth midwives in the birthing process. It is also noted that transportation was another factor in healthy outcomes. The

nulliparous women outcome showed little difference between home and hospital deliveries. In the hospital births there were more interventions with regard to longer than 12 hours of ruptured membranes, more sedation of mothers, more problems with the newborns, and more worries maternal worries concerning their children. In the parous women there were more postpartum hemorrhage, blood transfusions, placental retention, episiotomies, perineal lacerations, inadequate progress medication in third stage of labor and rates of referral during labor for the women birthing in the hospital. (Weigers,96)

The Society for Obstetrics and Gynecology in close cooperation with the organization of midwives, the Medical Health Inspection and the Hospital Administrative Systems are part of a country-wide data base (LVR). The LVR data base has recorded hospital deliveries since 1982 and the midwives joined this program in 1985. Approximately 70% of all hospitals participate with this system, which makes for a great database. (Eskes,92)

Birth in the United States

Mortality Rates

The United States has both a high infant and mortality rate. The leading causes of the pregnancy related mortality are hemorrhage, embolism, pregnancy induced hypertension, infection, and cardiomyopathy. The United Stated ranked 27th in the world for infant mortality with a rate more than twice that of the lowest ranked country. In 2002 the infant mortality rate increased for the first time in 40 years. Major causes of infant mortality are prematurity, low birth weight, congenital abnormalities, respiratory distress syndrome, sudden infant death syndrome, infections and injury. There is also a shift in an increase in the number of infants

weighing less than 750 grams, a increase occurred to women between 20-34 years of age and ethnic disparity is increasing. (Fuddy,06) The problem is compounding with the fact that many obstetricians are quitting and the graduating classes of OB/Gyn's are choosing to just work GYN. This is also resulting in a highly litigious profession. These are the norms in most hospitals births in the United States, including drugs, ultrasounds and doppler use. The medications are administered by a licensed professional, medications in labor may vary widely. Each method has a desired or not so desired effect, one on the mother the other on the baby and used for induction, augmentation, stopping labor, or for pain in labor. Oxygen and IV hydration are also medications used in the labor process. **All medications require continuous fetal monitoring of uterine activity and fetalb heart tones. Complications include: fetal distress, hyperstimulation, uterine rupture, fetal hypoxia, and possible fetal and maternal death.(Vaugh,07)**

Inductions

Induction Drugs

Induction drugs are becoming another norm of US hospital births. Commonly used Drugs for Induction are Dinoprostines (PGE2 gel, Cervidil, Prepidil), Misoprostal (Cytotec) Not FDA approved for cervical ripening, Cochrane libraries suggests not to use misoprostal due to lack of studies and propensity for hyperstimulation Oxytocin (Pitocin) IV, Subuchal, IM: for stimulation of uterus. These drugs again effect both mother and baby. **Women whose labors are induced for non-medical reasons are more likely to suffer from intrapartum fever and are more likely to be instrumental or operative intervention to deliver their babies. Labor induction increases the rate of fetal distress, shoulder dystocia, jaundice requiring phototherapy and breathing difficulties with baby, requiring intensive care. (Suarez,93)**

The major adverse effects of Cytotec in labor are hyperstimulation of the uterus which may progress to uterine tetany, marked impairment of uteroplacental blood flow, uterine rupture (requiring surgical repair, hysterectomy) and amniotic

fluid embolism. (Ewigman,93) The risk of uterine rupture increases with advancing gestational ages and with prior uterine surgery, including Cesarean delivery. The other affects that can be associated with this drug is pelvic pain, shock, maternal and fetal death, uterine rupture, meconium staining of amniotic fluid, cesarean delivery due to uterine hyperstimulation and frequently gastrointestinal adverse events of diarrhea and abdominal pain. There should be a concern that with a decade of cesarean section rates in the United States above 20 percent, a significant proportion of American women of childbearing age have a scarred uterus. Misoprostol may increase the risk of uterine rupture in the patient with a scarred uterus. Carefully controlled studies of the risks and benefits of misoprostol are necessary before its widespread use in this setting. (Wagner,99) Misoprostol has become a welcome drug for many doctors. They can induce mothers first thing in the morning and have babies born by five. It is effective at low dosages and it is cheap. (Wagner,99)

Misoprostal (Cytotec) Not FDA approved for cervical ripening, Cochrane libraries suggests not to use misoprostal due to lack of studies and propensity for hyperstimulation of the uterus.(Vaugh,07) In **fact the toxic dose of Cytotec in humans has not been determined and the functional maturation of the child when Cytotec is used for cervical ripening or induction of labor have not been established. (Wagner,99) With Pitocin and misoprostol there is continuous electronic fetal monitoring. Cesarean cause 3 times more maternal death rate than a vaginal hospital delivery and there is a significantly associated with increased risk of postpartum maternal death. (Fuddy,07) These are due to anesthesia, puerperal infection, and venous thromboembolism. In other reviews of published randomized controlled trials (RCT) of misoprostol induction, show how dangerous this drug is and the fact that it has never been approved and is readily used to induce labor throughout the United States. (Wagner,99) The studies leave wide open serious concerns about risks of another induction drug being used on mothers and children.**

Ultrasounds

The use of Doppler or ultrasound pictures has never been proven safe. Before the use of this type of technology, x-rays were used for 40 more years when x-rays were known to cause cancer for babies and moms. Ultrasound waves are known to effect tissues by causing heating of the area. The rise of temperature in the gas create wide range of chemical products, some of which are potentially dangerous. Studies raise these concerns concerning ultrasound: cell abnormalities persisted for several generations by ultrasound exposure, damage to the myelin sheath (nervous system) that covers nerves, a 22% reduction in the rate of cell division and doubling of the rate of apoptosis in the cells of the small intestine and loss of brain cells in the developing fetus that leads to mental impairment.(Beech,99)

Five or more Doppler ultrasounds were 30% more likely to develop intrauterine growth retardation, premature ovulation, preterm labor or miscarriage, low birth weight rates, poorer condition at birth, and delayed speech development. It has been shown not to help psychologically with women who terminated their pregnancies because their babies were shown to be already dead from ultrasounds. (Beech,99) More than 85% of women with low-risk labors had electronic fetal monitoring, despite the fact that it does not provide a benefit, and puts women at risk for an instrumental delivery. (Ewigman, 93) The largest study of its kind to date states that routine ultrasound does not benefit mothers or babies in terms of pregnancy outcome. (Ewigman,93) It did not reduce the number of infant or maternal deaths and it did not lead to better care for the newborn. The only thing it did was expose the families to increased cost and risk. Not only are ultrasounds affecting the fetus but a study in Helsinki showed that the physiotherapists who used ultrasound equipment for 20 hours a week had a significant increase of spontaneous abortion.(Beech,99)

Epidurals

Epidurals give a woman a pain free birth but interfere with the mental state and deprive the woman of feeling their baby birth through her body. Absorption of this drug is in the maternal circulation and occurs in 10-15 minutes regardless of site of injection, this medication cross the placenta.. It drugs both the mom and the baby and increases the chance of cesarean section, significantly increases longer labors, has a higher use of Pitocin, more forcep deliveries and thirty percent of the women will have chronic headaches and chronic back pain where injection was given.(Vaugh,07) Epidurals effect the tone of the uterus and the muscle (uterus) is unable to hold the baby in the correct position. This results in a 2 cm. greater dimension of the head coming through. Most women in the United States deliver infants in hospitals where epidural analgesia or intravenous narcotics are the only pain-relief options. **All medications require continuous fetal monitoring of uterine activity and fetal heart tones. Complications include: fetal distress, hyperstimulation, uterine rupture, fetal hypoxia, and possible fetal and maternal death. (Vaugh,07)**

Pain Relieving Drugs

The inducting drugs create painful contractions and most women will then use pain-relieving drugs. These include Demerol (meperidine), Stadol (butorphanol), and Nubain (nalbuphine) all of which cross the placenta and affect the respiratory and physiological function of the newborn. They have serious respiratory-depressant effects on the baby. Births where these drugs were given one to three hours before birth required more resuscitation at birth.(Vaughn,07)

Cesareans

One-third of women in the US now have cesareans, putting them at risk of infection, hemorrhage requiring transfusion, surgical injury and a variety of complications. Babies delivered by are more likely to have lacerations, respiratory complications and require intensive care. Bonding is interrupted in a big way.

PPD (Postpartum Depression)

The affects of birth being treated as a medical procedure is directly linked to postpartum depression. Few women are spared episiotomies or pelvic floor tearing. Perineal and pelvic floor morbidity was greatest among women receiving median episiotomy versus those remaining intact or sustaining spontaneous perineal tears. Median episiotomy was causally related to third- and fourth-degree tears. Those using episiotomy at the highest rates were more likely use other interventions as well. These other interventions were use of forceps or vacuum extractors along with induction drugs. Effects of childbirth on the muscles, nerves, and connective tissue of the pelvic floor, review the evidence to support an association between childbirth and anal incontinence, urinary incontinence, and pelvic organ prolapse; and present recommendations for the prevention of these sequelae.

Finally, episiotomy has not been shown to reduce severe lacerations or prevent pelvic relaxation, and use of this procedure should be limited. The incision substantially increases maternal blood loss, the average depth of posterior perineal injury, the risk of anal sphincter damage and its attendant long-term morbidity (at least for midline episiotomy), the risk of improper perineal wound healing, and the amount of pain in the first several postpartum days. Few women are spared episiotomies or pelvic floor tearing. Perineal and pelvic floor morbidity was greatest among women receiving median episiotomy versus those remaining intact or sustaining spontaneous perineal tears. Median episiotomy was causally related to third- and fourth-degree tears. A further result of this trauma is pelvic organ prolapse, the most common woman's health disorder of the developed world. It is estimated that more than half of birthing women have pelvic floor prolapse. (Kent, 07) The affects are pain, sexual lost, bowel and bladder dysfunction, chronic pain and emotional devastation. This pain remains for months and many times years. Sexual relations are strained between partners, taking a bowel movement is painful and many

times a pandora's box of sexual abuse is open. Whether a woman had a past history of abuse or not, in most hospital births in America, the women are being sexually, physically, emotionally and spiritually abused. This is clearly related to being stressed out.

Postpartum depression and worries new mothers have are a direct reflection on the parenting skills she will have. Stress is known to have a great effect on disease. The effects mirror the success rate of breastfeeding, which reflects on the healthy outcome of the child. Sleep deprivation, which is often a result of depression, pain from tears and c-sections often contributes to depressive symptoms in approximately 40-60% of patients. (Giedke,2001). With the continuity of care that is given in the midwifery model of care with homebirths proper support and healing is done in the postpartum period. Almost all homebirth mothers nurse their babies for at least two years. The bonding time is continuously interrupted by medicalized birth. This time affects the maternal/child bonding, breastfeeding and long term emotional aspects for both mother, baby, family and society.

In my private practice, the one severe case of postpartum depression was a woman whose birth was almost picture perfect. From the outside if one was to look at her birth outcome and statistics and followed her for the first six weeks postpartum it would be ideal. No tears, a 6 hour labor, great partner and breastfeeding was success and easy. Three months postpartum I received a call from her husband saying that this woman was not eating or wanting to feed her baby. She was talking about past sexual abuse that had recently been reawaken in her. For several weeks we helped her to eat, feed her baby, assured her that she would heal and support her. We used methods of massage, nutrition, acupuncture and herbs. Although it took time she and her baby remained bonded and breastfeeding continued for two more years.

Social-emotional/economic consequences.

The birth process is known to be an important process for both mom and baby and again deeply affects the family, community and society at large. It is the beginning of life, the foundation. Native Peoples know when a child is born drugged or with affects of alcohol, it is known to affect that child's life.(Kuerschner,00) When a mother has drugs, tears, or surgery it also affects the state of her emotional state and that of her baby. Drugs used in labor are effecting the baby in utero and all cross the placenta. Birth is a monumental time in a woman's life and sets the stage for her and her baby's health and well-being later in life. This use of drugs in birth is also affecting both the mother and the baby, affecting their relationship and bonding process.
The economic ramifications are huge for society. It is estimated that birth in the United States is a 26 billion dollar business. Although a doctor will have insurance to cover her/him, the emotional stress on them from lawsuits has a great impact on them. A dead baby is estimated to cost at least 5 million dollars and a baby with disabilities due to malpractice considerably more.

Solutions

Natural birth/Solutions to modern day birthing crisis

Traditional midwives have been helping women birth since the beginning of time. Our ways have not changed. We know that birthing is natural and a woman has the ability to birth simply and safely. We have never relied on machines, drugs and the modern technology to help with birth. Traditional midwives past and present do not use forms of ultrasound or drugs. We know that birth is ceremony of life and do not view it as a medical procedure.

Present day there is a lot of fear about birthing. Prenatal work includes physical, emotional, and spiritual work. This work is for

both the midwife and the woman. The emotional work the midwife does with each woman is to help her know she is strong and beautiful. She needs to know this and when she feels this it goes through to her baby. It is simple. It is love. It builds confidence in her birthing process and then she creates her birth story Listening to the mother and baby is also done with our hands. When I do my work with the women I use my hands along with my other senses. When a pregnant woman relaxes with her baby and becomes part of that energy, the woman knows how to birth. It is instinctive. With this relaxation in birth, endorphins kick in at an amazingly high level. So the energy changes, it is now an extremely intense opening experience. It is amazing. This amazing journey is so instinctive in women, the nidwife guides the mother and baby do what they know how to do best, birth naturally. Both are treated with the utmost of respect. These new mothers-to-be are our friends; we know them and their babies well. The mother and child control their birth. They work together and the body, mind and spirit of both release the correct dosage of hormones that work for them. They are in control; nothing is done to them that interrupt their birthing ceremony.

These days midwives work is harder because society works hard to implant fear in the birthing mother. Most women that have birthed in the hospitals have a lot of work to undo because of past traumatic birth experiences. It is important that women have a positive birth experience for both mother and baby. The child will soon breathe and grow.

This first breath the baby takes is important. When the room is filled with love and support that is the first breath the baby breathes that in. The baby comes out and up to the breast. The baby and the mom are clear headed. They are totally tuned into each other. The baby and mom, skin on skin, will bond in the most primal way. The work that they did to get skin to skin was an amazing journey, now the baby rests with the mom in her arms. Their bodies keeping each other warm and secure. They finally get to see each other and the love deepens. The baby knows the familiar smell of the mother and already knows how to

suck. As any animal knows when they crawl to their mother, they smell, lick and then suck. The mom and baby do what moms and babies do best, nurse. Mothers and babies already are connected to each other. Let them bond with no interruptions. . Everything with birthing is respected this way. The child bonds with important family that will help him or her throughout life. The baby knows security and knows that he/she is safe. No one will allow any abuse to this baby, such as circumcision, which was done for many years to the baby boys. The baby will remain intact in mind, body and spirit getting prepared to face today's world.

Traditional midwives believe that the idea of pain with childbirth needs to be buried. Birth is about opening up your body and feeling the sweet baby come through the body. This is the most important part of the birthing ceremony. We must remember that birth has just recently become a medical procedure for so many, instead of an incredible journey that women and babies are blessed to be a part of. Many of the modalities that are used in modern birth are scaring women today and understandably so. The relationship between a mother and her choice of practitioner; whether it be a doctor or midwife; is all important as it allows birthing mother is able to open up and share this wonderful journey.

Members of the home birth movement have chosen their alternative form of care not through faulty understanding of medical principles, but as a result of active and reasoned disagreement with them. Bonny O'Connor

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Induced labour, cae

Testimony from Marie Rangel for SB2569 and SB2569 SD1

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor

Hearing date: 2-10-14 1:30pm room 229

RE: SB2569 and SB2569 SD1 Relating to Home Birth

Oppose

Home birth is safe, if not safer than hospital birth. Please study all birth options, hospital and home to decide what is safe. Become educated. Take time to learn about home birth and the differences between midwifery and medical models of birthing practices.

We all want safe and quality care. This isn't what this bill will provide for us. Instead it restricts the rights of our families to deliver our babies in places we feel most comfortable and with the professionals of our choosing. It is not legislatures right to decide where and how we can birth.

The home birth community is united and wants to include all practitioners who can provide support for all different types of birthing options we the community are asking for.

Let the home birth community form their own advisory counsel with all birth practitioners represented. Let them form standards acceptable for all birth practitioners and our community.

My own experience of giving birth to two of my children at home was one of peace, safety, love and superb care. I want the choice to home birth my next child.

Mahalo,
Marie Rangel

February 10, 2014
Monday
1:30 PM
Conference Room 229
State Capitol

To: Senator Josh Green, Chair - Committee on Health
Senator Rosalyn Baker, Chair - Committee on Commerce and Consumer Protection
Senator Clayton Hee, Chair - Committee on Judiciary and Labor

From: Al Katz, MD, MPH

Re: SB 2065/SB2065SD1, Relating to Health

Position: Strongly support licensure, patient safety rules/regulations, informed consent, data collection, and establishment of a board to ensure Home Birth Safety in Hawaii as per Hawaii ACOG testimony

Dear Senators Green, Baker, Hee and members of the Committees on Health, Commerce and Consumer Protection, and Judiciary and Labor:

Home births are unfortunately much riskier than births which occur in hospital.
The most recent and largest study to date reveals that there is a four-fold increased risk of neonatal death associated with home birth. In addition, there is a seven-fold increased risk of neonatal death for first time mothers who deliver at home and a ten – fold increased risk for pregnancies more than 41 weeks gestation.

Currently, there is no licensure, and therefore no patient safety rules and regulations regarding home birth.

I urge you to support the Home Birth Safety bill. This bill will ensure that home birth providers have had formal obstetrics education to care for mothers and infants, follow patient safety regulations such as no high-risk pregnancy deliveries at home, adequately inform their patients regarding their educational background and the possible risks of home birth, and require the timely completion of birth certificates and other data for all planned home births.

Thank you for the opportunity to submit this testimony on this very important women’s health issue.

IN OPPOSITION TO SB2569 AND SB2569 SD1, Relating to Home Birth

Regular Session of 2014
Hearing on Monday, February 10, 2014 at 1:30 p.m. in Room 229

For: Honorable Chair and Vice Chair and members of Health Committee, Commerce and Consumer Protection Committee and Judiciary and Labor Committee

To whom it may concern,

My name is Josuna Kinsey, I am 7 years old, nice and healthy, and I was a home birth, so was my older sister and younger brother, they are also nice and healthy. My older sister(Anabel)is 8 years old, and my younger brother(Matteo)is 1 years old, he's really active. Why I like home birthing is because at home there's lots of peace and your baby gets to be born in a sunny and natural place. Another reason why home birthing is good is because the mom knows all the midwifes there. My mom would of have had to have a caesarean sections, she hated having a surgery for her tumor when she was younger. Usually home births are relaxing, so everything turns out fine, but me, not EVERYTHING was fine, but my shoulders got stuck. Thankfully the midwife knew exactly what to do so I was born fine. It should be people's choice. Please keep home birthing legal, thank you.

Sincerely,
Josuna Kinsey

Astrid Drolson, PO Box 405, Kilauea, HI 96754 – Kaua'i

Aloha Senators,

I OPPOSE both SB2569 and SB2569 SD1 strongly.

Please Excuse me for testifying against both bill in one, I could not find a special place for the SD1 version

I believe that its intentions are meant well, and I thank you for your efforts, it gives us all a chance to address this but the initial version of the bill SB 2569 its poorly written and clearly showsthat the home-birthing professionals did not have a word on this bill.
This Version is non acceptable

The second versionSD1 is way better but drafted after one of the worsted Midwife Bills and I truly believe Hawaii can and should do better than that.

We need to protect the Midwife Care in Hawaii and if we can even improve it and empower all midwifes for better care and service they can offer.

We have a chance to create outstanding midwife care in Hawaii with this Bill for Woman that wish to do a home birth.

Kauai for examples has no midwifes in hospital, and if they want one they have to hire one, but they cant not birth in a hospital with them, in a hospital the midwife it self becomes a Doula, even though our most professional home birthing midwifes here on the island are nurse midwifes. Just want to mention I support Nurse Midwifes that do hospital and or that do home birth as well as all direct entry midwifes.
I would love to see support of developing Birthing Centers run by midwifes next to hospitals to offer the best of both worlds and community midwifes as well as a closer work together between hospital birth professionals, all kind of midwifes, and also doulas and all the other professions that are connected.. (that other topic)

Please understand these are the same professions but also both (hospital & home environment) are its own special areas of expertise and knowledge for midwifes and that are supposed to work and support each other.

Why is the board under the medical advisory? there are other solutions to this, and that's done only in two other states. Its a conflict of interest. There are other solutions, and much to discuss and I do not think we can work though this with amendments. We need to prepare better together and draft a Bill. We have the chance to be a leader in Hawaii and make a great step

into birthing save and peaceful new generations on baby.

Some suggested restrictions are not based on evidence or best evidence. For example - It denies women who have had a previous cesarean delivery access to midwives and out-of-hospital care, forcing them to give birth in hospitals whose policies dictate surgical delivery for all women with a previous cesarean, whether it's medically indicated or not. It is possible to have vaginal birth after a C-Section. Many
I decided to have a home birth myself and I want to do it again, and it was a very empowering experience, I felt very save because I knew that my midwife would transfer me to the hospital anytime if i wasn't. I did labor a long time, and needed that time what could have been in a hospital setting more problematic as they like to get you along. In the privacy with my family and friends I was able to become the primal me and let my body do the work Birth is a very private moment, and if you don't feel save, you might can open up at all. for soe woman like me its better to have a home birth, and I was open of cause to go to the hospital if we had to. I met all the OB/Gym and rotated them as I also made prenatal in the hospitals. I did not feel i needed that for the sake of the prenatal, since i felt in very good care with my midwife, but I wanted to get to know all the OB/gyn docs in case I had to go in the hospital. My birth went smooth and I loved it, and I recommend home birth to any low-risk woman that feel compelled to it, it takes guts and strength to do it.

I am training to become a birth Doula, and in the long run a midwife, which is not easy in USA unlike the country that I come from that has a very straight forward program - but I am here.. I am training to serve families to have a smooth & empowering birth experience as possible at home or in the hospital. I am supporting the mom in whatever she feels is save and good for her. Since my own birth my hearts desire to help other families rose strongly

Hospital birth is wonderful when needed and/or desired and its is own area expertise as home-birth, the truly traditional way is. Any responsible midwife always will sent their clients into a hospital if any signs of concerns showing that a home birth may not appropriate for mom and baby.

Home-Birth midwifes deserves to be respected and not be creating rules for by a board that does not practice home birth. If you look at the board that is suggested <u>only maybe</u> 0-4 of 13***** would have some or expertise in home-birthing. This is not equal or fair or any good for anyone. Also I do believe that working on a regulation, legalization and empowering for Direct Entry Midwifes & and home-birth service provider can make a difference in the state, and help to make it all saver while letting the woman have their freedom to make educated decisions about their birth.

The Home-birth- Professionals should be encourage and supported to create their version and work together with hospital professionals to make the process of transferring home birth moms to the hospital smoother and how this network and communication and education can become

more effective for the well being of all.

Also rethinking how we can create a system to educate our own midwifes for home & Hospital birth, CNM, CPM, CM and have ongoing education.

Home-birth & Hospital Birth professional can learn from each other and with that make birth for anyone better.
I truly believe we are all in one boat ! Because we all want the best outcome at birth for Mom & Baby.

I truly belie this topic goes very deep, and we need more education & balance of experiences around it
at least for the people that write the bill.

I follow this bill and watch what happens, pleas support the moms of Hawaii.

I thank all of you that took on this, I know the intentions are in the right place,
so lets do whats right and create a great Midwife Bill for Hawaii.

Sincerely!

Astrid Drolson,

PS:

in addition to my own research, opinion, experience and write-up I like to share with you some statements I agree with and give you more details in the technical concerns:

- The bill is micromanaging the board of midwives. The BOARD is suppose to create, change, amend any rules and regulations, not the bill. And if it is in the bill, then there is not a good chance in amending it for the future changes that may need to happen due to the fact that it must undergo a long legislative process. Besides, midwives shouldn't be regulated by legislators anyway. The national boards that certify midwives do that already!!! (ACNM, NACPM, NARM, MANA)
- The midwifery board as stated in this bill is made up of 3 midwives and 3 obstetricians plus 1 un-named body, total of 7. Let the homebirth community form their own board/advisory counsel made up of birth practitioners (CPM, CNM,ND,TM,DEM,OB,Family MD) to gather data & form appropriate standards acceptable to all birth practitioners and the community.

- Women's rights/rites and choices in choosing when, how, with whom and where to give birth through their own bodies are at stake in this bill through regulating midwives who care for the childbearing women. And criminalizing midwives for supporting women.
- Those who had to undergo a previous caesarian surgery are limited and removed of the chance to choose a vaginal birth in the future. Research again states the more vaginal birth you have after a caesarian, the more adaptable and increase in successful vaginal births.
- Home-birth is safe, if not safer than hospital births. All birth place options should be made available, free of choice. There are recent studies, statistics, research that shares this fact. http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12172/pdf
- .Midwifery model of care is different than the Medical model of care and Senator Green is proposing/pushing a medical model onto midwives and to comprise the midwifery board in a medical model. This would defeat the intended purpose of the existence of midwives and midwifery model of care.

To: Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor
Hearing date 2-10-14 1:30pm rm 229
RE: SB2569 and SB2569 SD1 Relating to Home Birth
Oppose

Hawaii Homebirth Midwifery Testimony for bills SB2569 AND SB2569 SD1
by Nancy Gibbs
2014Feb9

When I first heard of this bill (SB 2569 and shortly after SB2569 SD1), I thought I wouldn't have any right to submit testimony since I'm not a resident of Hawaii. Then it occurred to me that – even though I'm not a permanent resident – I absolutely have a right as well as an obligation to speak for my fellow women. I'm not just speaking for those of child-bearing age, but also for any women who will live in Hawaii in the future. I'd be remiss if I didn't speak up.

You see, my Husband is in the military, so we're stationed here in Hawaii for only a few years. And it just so happens I'll be giving birth here on Oahu in a few months. So now these bills, which I initially thought wouldn't really affect me, will have direct and very personal consequences.

I oppose these bills because for pregnancy and childbirth, the medical model of care and the midwifery model of care are completely different. To have persons who are trained in the medical model oversee those trained in midwifery is ludicrous – the models just don't match.

I oppose these bills because women's autonomy in pregnancy and childbirth is of utmost importance. Autonomy is our right. Women are informed and educated about themselves and we have every right who to choose for our caregivers.

I oppose these bills because restricting and dictating care (including attendants and location) does NOT improve care, safety, nor outcomes of pregnancy and childbirth. Restricting and dictating choices of care serves only to punish and infantilize women for THEIR OWN CHOICES, as well as reducing their safety and their quality of care. Making behaviors difficult/illegal does not stop the behaviors.

Please do NOT pass these bills (SB2569 and SB2569 SD1)!

Respectfully and Passionately,
Nancy Gibbs

From: Madir Scolpini
To: HTHTestimony
Subject: I am opposing both both SB2569 & SB2569 SD1, mahalo for considering this.
Date: Sunday, February 09, 2014 11:01:18 AM

Aloha, I am a Maui resident since 1989, I am a Therapist on Somatic Trauma healing therapies, I work with families and their newborns.
I strongly support and advocate for natural home births whenever possible, unless health issues surface.
In my work I witnessed the many health issues that can surface in not necessary medicated births.

Women have it programmed in their body how to birth, the safer and the more empowered they feel the easier and so safer the birth process will be.
We need strongly to support Women and family to feel safe and make choices accordingly to their choices.
This Bill will limit greatly their choices, as the qualifications required for home births are too hard to achieve financially and time wise for the many gifted Mid-wives we have on these Islands.

Thanks for listening and consider in depth this important issue.

Antonella Scolpini-Heisel.

TO:

COMMITTEE ON HEALTH
Senator Josh Green, Chair
Senator Rosalyn H. Baker, Vice Chair

COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
Senator Rosalyn H. Baker, Chair
Senator Brian T. Taniguchi, Vice Chair

COMMITTEE ON JUDICIARY AND LABOR
Senator Clayton Hee, Chair
Senator Maile S.L. Shimabukuro, Vice Chair

DATE: Monday, February 10, 2014
TIME: 1:30PM
PLACE: Conference Room 229
State Capitol 415 South Beretania Street

From: STEPHANIE AUSTIN
495 AWALAU RD., HAIKU, HI 96708

RE: SB 2569 and SB2569 SDI RELATING TO HOME BIRTH

Submitted in OPPOSITION TO BOTH BILLS.

Both SB2569 and SB2569 SD1, seeking to provide regulation of home birth providers and suggest establishing an "advisory board" to the Hawaii Board of Medicine, which under the DCCA regulates **physicians**. Currently, both Nurses, including Certified Nurse Midwives and Naturopathic Doctors, have their **own independent Boards under the DCCA.** It is difficult to dismiss those who call this "the doctor's bill"…..

When Marion Higa, our former State Auditor reviewed regulation of midwives in 1999, she found that, under state law, regulation of Certified Professional Midwives (and lay midwifes) is warranted. She also found that midwives regulated by the American College of Nurse-midwives (ACNM who are certified by the American Midwifery Certification Board (who Certified Nurse Midwives and a category called "Certified Midwives" –each requiring a college degree and more, AND CERTIFIED PROFESSION MIDWIVES, certified by the North American Registry of Midwives (NARM) should BOTH BE INCLUDED, and regulated by their own board directly under the DCCA. The majority of midwives attending home births in Hawaii are Certified Professional Midwives. Both Bills refer to educational and training requirements for midwives established by American Midwifery Certification board, which eliminates Certified Professional Midwives. (Marion Higa also states that HB 3123 included the finding that: The five industrialized Nations with the lowest infant mortality rates have 70

percent of all births attended by midwives; and that: Certified professional midwife credentials are based on widely recognized core competencies for midwifery and represent national midwifery educational and certification standards of practice.

Both SB2569 and SB2569 SDI eliminate reference The North American Registry of Midwives (NARM) as a source of certification.

REFERENCE: Report No 99-14, March j1999, Marion M. Higa, State Auditor

There are many other problems, such as the physician-weighted makeup of an "advisory" board, reference to highly disputed statistics, excessive specific rulemaking, reporting requirements in violation of existing HIPPA regulations, among others.

Then, there are the findings from the **Centers for Disease control, NCHS Date Brief, Number 84, January 2012: Home Births in the United States: 1990=2009:**

U.S. home births increased by 29% from 2004 to 2009.

Home births have a lower risk profile than hospital births.

The percentage of home births that were preterm was 6%, compared with 12% for hospital births

The percentage of home births that were low birth weight was 4%, compared with 8% for hospital births.

Less than 1% of home births were multiple deliveries, compared with 3.5% of hospital births.

The lower risk profile of home births suggests that home birth attendants are selecting low-risk women as candidates for home birth

Please do not try to "fix" either of these deeply flawed bills.

There are models both from Idaho and from Oregon which, given a year's time, can be the source of a truly good bill for Hawaii, providing for the greater safety and well being of mothers and infants, without further alienating those who share this same goal.

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	elwenfreitas@gmail.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Sunday, February 09, 2014 11:06:11 AM

SB2569

Submitted on: 2/9/2014

Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Elwen Freitas	Individual	Oppose	No

Comments: I STRONGLY OPPOSE both SB2569 and the proposed SB2569 SD1. I testify as a husband and father of a wife and daughter who had a happy and healthy home birth experience. I strongly oppose SB2569 in both forms for three main reasons. First, the bill infringes on a consumer's freedom of choice. Hospitals and physicians have a reputation for overzealously advocating for sometimes unnecessary cesarean sections on mothers with a "history of disorders, diagnoses, conditions, or symptoms" that are listed in the bill. This "cesarean-by-default" mantra is what leads many pregnant mothers with said medical history to a home birth. A home birth provides these women with a natural and healthy birthing experience with minimal medical intervention. Second, the qualifications for licensure may provide an undue burden on experienced midwives that may not meet the CPM requirement. Years of experience in a home birth setting are invaluable in comparison to an education requirement. More importantly, the education requirement would likely force an experienced midwife to either seek certification - which may be costly - or give up their profession. Consequently, this could potentially limit the number of midwives available to tend to home births. Third, this bill is essentially a "knee-jerk reaction" to an unfortunate incident. Licensure is not necessarily a bad thing. However, this bill should also consider and include the input of experienced midwives and the home birth community. Thank you for your time and consideration. Very truly yours, Elwen A. Freitas, Esq.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	rachelnina1@yahoo.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Sunday, February 09, 2014 11:06:36 AM

SB2569

Submitted on: 2/9/2014

Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
rachel geringer	Individual	Oppose	No

Comments: Honorable state legislate, please do not pass bills SB2569 AND SB2569 SD1. I strongly oppose both bills. Home birthing is NOT a medical procedure, it is my right as a woman to chose how to birth my child. This is my body, my baby, my choice. PLEASE, i beg you, not to pass these bills! Rachel Geringer

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RE: SB2569 and SB2569 SD1 Relating to Home Birth

Dear Honorable Chair and Committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor,

I am writing to strongly oppose SB2569 and SB2569 SD1 Relating to Home Birth. As someone who was both born at home and birthed my baby at home, I am outraged at the attempts to deny women the autonomy to make an educated choice about the best place to birth their babies. Birth is not solely a medical act; it is a ceremony that is incredibly spiritual and deeply personal. Each woman should have the right to choose to birth where she is able to create the birth story that she envisions.

The notion that all hospital births, or births with a medical doctor in attendance, are ALWAYS safer is simply not true. I chose to have a home birth because my husband and I believed this was the route that would lead to a safe and natural delivery of our baby. There are traditional midwives who have incredible statistics in terms of their rates of safely delivered babies and natural vaginal births. It is essential that it remain legal for families to do their own research and seek out the option that best meets their birth plan, including the right to birth babies at home with a traditional midwife. The majority of births attended by highly skilled traditional midwife are safe.

You will actually be creating a more dangerous dynamic if you enact SB2569 and/or SB2569 SD1 because more families who would typically seek the services of a traditional midwife will attempt unattended births. In addition, you will create a stigma and fear of transferring to the hospital in the rare occurrences when this is necessary.

Please do not enact SB2569 and SB2569 SD1. Where to birth is a choice that must remain legal for women. Thank you for keeping an open mind and heart as you consider the ethics of birthing that will have innumerable repercussions for our communities and families.

Sincerely,

Leona Kassel

February 7, 2014

Senate Committees on Health, CPN, & Judiciary

Subj: SB 2569 and the proposed SD 1, Relating to Homebirth

My name is Ramona Hussey, and I am opposed to S.B. 2569 and to the proposed revision, SD 1.

First, I do not understand the rush to criminalize midwifery and homebirth. Where are the numbers to show that there is an actual problem?

- How many births occur in Hawaii each year?
- How many in a hospital?
- How many at home?
- How many deaths (and separately, serious complications) occur in each place? (For example, the bill claims that "*multiple, preventable, neonatal deaths have occurred in Hawaii*", but gives no figures for either birth location. Does that mean 100% of those *preventable deaths* were in hospital births? Or 50% of them? And how many of those '*serious neurological problems'* occurred in hospitals versus homes?

Why are no numbers provided? Is it because there is not actually a problem with homebirths? That is the logical conclusion.

Women have been giving birth at home for centuries. Actually, women have given birth at home for all eternity…hospital births have not even been the norm for a full hundred years yet! Yet humans have been birthing their babies for over 100,000 years.

I was born at home…. My mother was born at home… Her mother was born at home. Her mother's mother was born at home…. I could go on. Indefinitely. All three of my children were born at home. In Hawaii with midwives assisting. All of my two sister's children were born at home. I guess you could say, we are a homebirth family. And we strongly believe homebirth should always be an option for birthing mothers.

I chose a homebirth for myself and my family because I wanted the safest, sanest place to give birth for my child. I did not wish the medical interventions which were (and still are) standard practice in hospitals. I am convinced those interventions cause more harm to the child than they solve.

Senator Green's 30 page bill is would essentially prohibit homebirth in Hawaii. I cannot imagine a practitioner willing to submit to such a rigid and punishing scheme of regulation. For example, any practitioner (midwife, naturopath, or family practice physician) would have to submit to a completely medical-oriented board of governance,

would be severely restricted in what births they can perform, would have grueling amounts of reporting to do, could lose their license over every little dispute about their practice (3 pages of reasons to lose their license), would have to report every time they deviate from the Board's rules, must file an "intent to deliver at home" (does this sound like freedom to give birth at home?), must file a yearly "complete data practice summary".

Specific problems with the bill as proposed by Sen. Josh Green include:

- the licensing board consists of medical personnel only (13 members, all but one must be medical personnel)
- only midwives will be licensed who are highly medically- oriented because graduate degrees AND post-graduate training is required (do doctors who deliver in a hospital even meet those requirements?)
- "informed consent" means providing such information about the dangers of homebirth that women are scared away from the possibility - midwives would have to lie and say homebirth means greater risk of death of the baby: Sec 8 (5)
- Every year, midwives would have to renew all the requirements for a license (do doctors handling hospital births have this onerous requirement?
- The bill forbids homebirths except in medically defined "low-risk pregnancies" (homebirth not allowed if twins, breech births, previous C-sections, etc.)
- Mandatory transfers to hospitals pursuant to a medical model of birth are required for many circumstances
- Any homebirth provider would be held to strict & unusual standards of personal conduct (3 pages of violations, including possession of a controlled substance, violating professional trust or confidence, and more)

New proposal – SB 2569, SD 1 Proposed

I also oppose this bill because although it is somewhat more midwife-friendly (it allows 3 of the 5 Board members to be midwives, doesn't require a nursing degree, and allows some use of birthing supplies such as oxygen, anesthetics & fluids), and does away with some of most punitive and restrictive measures, it still seriously medicalizes and over-regulates homebirth.

Altho there has been little time to review the proposed revision, these are some of the problems I see right off:

- Still forbids many homebirths which could be done with a trained, experienced midwife (No twins, more than 1 C-section, overweight women, any history of

various conditions, including thyroid problems, sleep apnea (!), even a history of drug use in younger years)

- Requires homebirth providers to document and report many, many things that a woman may want to keep private (previous “complicated pregnancies”, premature labors, C sections, prior miscarriages, underlying genetic disorders, etc.)

- Forces homebirth providers to tell clients how dangerous homebirth is (in ‘informed consent’ section)

- Absolutely requires transport to hospital in certain situations, including ‘abnormal heart tones’, breech birth, and many other circumstances where it may not be necessary

- Does not leave an entry-way for lay midwives to begin to practice (altho it ‘waives’ requirements for those ALREADY practicing for 5 years with 75 births)

While I would be willing to consider a bill which provides for a safer homebirth experience, this bill is not the vehicle for making homebirth safer. Any such bill would need to come out of a community coalition of birthing mothers and homebirth providers. I am asking you to shelve BOTH of these two proposals until a community group can come together to develop a law which truly protects birthing mothers, their babies, and professional midwives.

Thank you for your consideration of my concerns.

Aloha,

Ramona Hussey
2315 Liloa Rise
Honolulu, HI 96822
Ramona@lava.net
(808) 699-6167

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	madirscolpini@yahoo.com
Subject:	Submitted testimony for SB2569 on Feb 10, 2014 13:30PM
Date:	Sunday, February 09, 2014 11:12:33 AM

SB2569

Submitted on: 2/9/2014

Testimony for HTH/CPN/JDL on Feb 10, 2014 13:30PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Antonella Scolpini	Individual	Oppose	No

Comments: Aloha, I am a Maui resident since 1989, I am a Therapist on Somatic Trauma healing therapies, I work with families and their newborns. I strongly support and advocate for natural home births whenever possible, unless health issues surface. In my work I witnessed the many health issues that can surface in not necessary medicated births. Women have it programmed in their body how to birth, the safer and the more empowered they feel the easier and so safer the birth process will be. We need strongly to support Women and family to feel safe and make choices accordingly to their choices. This Bill SB2569 will limit greatly their choices, as the qualifications required for home births are too hard to achieve financially and time wise for the many gifted Mid-wives we have on these Islands. Similarly families need to have the freedom of choice for modalities that support their health the best way they choose, hence I also oppose the Bill SB2569 SD1 Thanks for listening and consider in depth this important issue. Antonella Scolpini-Heisel.

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In **OPPOSITION** of
S.B. 2569 and S.B. 2569 SD1 – Relating to Home Birth

Senate Committees on Health, Commerce and Consumer Protection, and Judiciary and Labor
Monday, February 10, 2014 1:30pm Conference Room 229

Honorable Chairs Green, Baker, Hee, and Members of the Committees:

Mahalo for the opportunity to submit testimony in **OPPOSITION** to S.B. 2569 and S.B. 2569 SD1. For the purposes of my written testimony, I will focus my points of opposition with regards to S.B. 2569 SD1. I am in opposition to the bill for, but not limited to, the following reasons:

First, S.B. 2569 SD1 sets out to do more than, and will impact more than, the stated purpose of the bill. If the purpose of the bill is to "improve home birth safety," and there is existing scientific literature quantifying how home births are as safe, or even safer than, a hospital birth, then the purpose of this bill is moot. If the legislature is not convinced by existing scientific literature establishing how safe planned home births actually are, then allow more time for investigation and research to be conducted to your satisfaction.

Second, mothers and their families should have the right to choose where to give birth, and with whom they want to give birth with. This bill will infringe on one's freedom of choice. Looking to the scientific literature that researched actual causes of neonatal deaths, many of the causes listed are not related to one choosing a home birth. Instead, one of the main causes of neonatal deaths is low birth weight.

Third, this bill is divisive because some forms of midwifery and home birth practices are excluded and would be criminalized under this bill. In other states and countries where midwives are regulated or illegal, and not allowed to attend home births, this does not improve safety outcomes nor prevent neonatal deaths.

Mahalo nui for taking the time to read my testimony in **OPPOSITION** to S.B. 2569 SD1.

Sincerely,

Sharde Mersberg Freitas, MPH
Mother and Wife
J.D. Candidate 2014
shardem@hawaii.edu

Sandra M.Christensen

291 Elelupe Road

Honolulu, Hawai'i 96821

808.396.5353

February 10, 2014

RE: SB2569 AND SB2569 SD1 RELATING TO HOME BIRTH

TO: The Honorable Chair and committee members of Health, Committee on Commerce and Consumer Protection and Judiciary and Labor:

I am strongly OPPOSED to this proposed bill that infringes upon a persons basic right to *freedom of choice*!

Mandating that a woman must give birth in a hospital with an attending physician because it is *more* safe than an at home birth attended by a mid-wife does *not* correlate with current statistics. The United States is among the *highest* in infant death rates in all developed countries. *Traditionally* all of Western Europe requires only a midwife in attendance for births. So giving birth in a hospital is actually a *non-traditional* way to have a baby. And the statistics prove that the *traditional* way to give birth, i.e. with a midwife, is **safer** than the *non-traditional* physician attended hospital birth.

Maggie Fox of NBC News presented on February 3, 2014, "The United States may be one of the richest countries in the world, but has a very high rate of infant mortality compared to other wealthy countries — and compared even to some not-so-rich countries. The Organization for Economic Cooperation and Development (OECD) consistently finds the U.S. near the bottom of its list of 34-member countries on this measure." Fox states, "Save the Children organization found in a report released in April 2012 that more newborns die in the U.S. than in 68 other countries, including Egypt, Turkey and Peru."

In a 2009 article by Marian F. MacDorman and T.J. Mathews for the Center for Disease Control and Prevention state that “Infant mortality is an important indicator of the health of a nation, and the recent stagnation (since 2000) in the U.S. infant mortality rate has generated concern among researchers and policy makers.” In a study of 10 select European countries that included Austria, Denmark, England and Wales, Finland, Northern Ireland, Norway, Poland, Scotland and Sweden “infants born at 37 weeks of gestation or more, the United States' infant mortality rate was highest among the countries studied.”

In a November 2012 *Parenting* magazine article, “best and worst places to give birth” by Lisa Selin Davis she states, “We have given up the ecstasy of childbirth for a sterile, safe, vacant experience.” A momentous time in a woman's life is taken, and replaced with technology. Davis continues, “The best places to give birth are those where attendants honor the pain and help women through it, giving them the opportunity to have the kind of birth they want. “

This bill does not protect a persons right but rather restricts their rights. Please oppose this bill.

Best regards

Sandra M. Christensen

To: The Honorable Josh Green, Chair, Committee on Health
The Honorable Roz Baker, Vice Chair, Committee on Water & Land

The Honorable Roz Baker, Chair, Committee on Commerce and Consumer Protection
The Honorable Brian Taniguchi, Vice Chair, Committee on Commerce and Consumer Protection

The Honorable Clayton Hee, Chair, Committee on Judiciary and Labor
The Honorable Maile Shimabukuro, Vice Chair, Committee on Judiciary and Labor

Members, Senate Committee on Health
Members, Senate Committee on Commerce and Consumer
Members, Senate Committee on Judiciary and Labor

From: Jennifer Noelani Ahia
Date: February 10th, 2014
Hrg: Senate Committee on Health/Senate Committee on Commerce and Consumer Protection/Senate Committee on Judiciary and Labor;
Mon. February 10th 2014 at 1:30 p.m. in Rm 229
Re: SB 2569 and SB2569 SD1, Relating to Home Birth – **In Opposition**

Thank you for the opportunity to offer testimony in opposition of SB 2569 and SB 2569 SD1, both of which attempt to regulate midwifery in the State of Hawaii.

Here are some reasons why **I OPPOSE** SB2569 and SB2569 SD1:

• Both bills take away choices for women when it comes to their reproductive health.
• SB2569 threatens women's health and would all but make midwifery and home birth illegal in the state of Hawaii, forcing mothers who choose to home birth to potentially go underground in finding illegal care providers which may pose a risk to herself and her baby. The bill also infringes on patients' rights and violates their right to medical privacy.
• Home birth with a trained midwife is SAFE. This bill uses false data to support it's claim. It refers to a two to three fold increase in neonatal mortality and that is cited from a study that has been refuted. Here are studies addressing that particular study, along with others that support home birth with a trained midwife to be just as safe as a hospital birth. (1,2,3,4,5)
• I am not opposed to regulation – however the regulations in SB2569 don't make sense and neither bill promotes the health of mothers or their babies.
• These bills do NOT take into account cultural practices in home birth. It must be viewed in the context of a cultural, traditional, spiritual belief and practice, which is protected by law.
• The Home Birth Safety Board is also based on a medical model, and it does not reflect the culture and practice of home birth. It doesn't even reflect the participants of home birth practice. The Home Birth Safety Board should be autonomous from the Hawaii Medical Board. There should be a Home Birth Providers Board overseen directly by the DCCA .
• The Home Birth Safety Board to be comprised of the home birth providers primarily, with some OB/MD representation but certainly not the majority or even half.
• It is the right of every birthing mother to choose where, with whom, and how she feels best to birth their child, in accordance with self-determination and privacy and in the context of cultural, traditional, spiritual or personal beliefs. This bill currently proposes to

violate a woman's bodily autonomy and a woman's right to choose.
Suggestions:
Write a new bill next legislative session that addresses the concerns stated above and include home birth providers and key stakeholders in the birthing community when drafting new legislation. Amending SB2569 OR SB2569 SD1 is NOT an option. Both bills are too flawed to correct given the time constraints of the legislature. A complete overhaul of these bills must ensue. There are many suggestions for a new bill, please let's work together to create it.
Thank you for your time. I appreciate the opportunity to testify.

Aloha,

Jennifer Noelani Ahia L.Ac., MSTOM

Sources:

1. "Home Birth versus Hospital Birth: Questioning the Quality of the Evidence on Safety" article published in Birth (Volume 30, Issue 1, pages 57-63, March 2003) "In contrast, the Midwives Association of Washington State press release stated that 'Childbearing women and health policy makers should be made aware that the study contains numerous flaws and limitations...this study alone should not be used to make decisions that could restrict women's choice of birth place or access to birth attendants with expertise in home birth'" (http://onlinelibrary.wiley.com/.../j.1523-536X.../abstract)
2. Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong, Medscape Ob/Gyn & Women's Health 4/1/2011 (http://cfpcwp.com/.../Medscape-Wax-Critique-Michal...)
3. Hawaii Health Data Warehouse - Vital Statistics Hawaii (http://www.hhdw.org/cms/index.php?page=vital-statistics)
4. BMJ 2005;330;1416 Outcomes of planned home birth with certified professional midwives; large prospective study in North America
5. BJOG, 2009 Aug; 116(9):1177-84 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births
6. The Myth of a Safer Hospital Birth for Low Risk Pregnancies (http://www.greenmedinfo.com/.../myth-safer-hsopital-birth...)
"Study validity questioned" in The American Journal of Obstetrics & Gynecology (volume 204, Issue 4, page e14, April 2011) (http://ajog.org/article/S0002-9378(10)01107-5/fulltext)
7. Home birth metaanalysis: does it meet AJOG's reporting requirements? (http://ajog.org/article/S0002-9378(11)00074-3/fulltext)
8. International data demonstrate home birth safety. (http://www.ncbi.nlm.nih.gov/pubmed/21458614)
9. "Home birth triples the neonatal death rate": public communication of bad science? (http://www.ajog.org/article/S0002-9378(11)00075-5/abstract)
10. http://www.ncbi.nlm.nih.gov/pubmed/23769011
11. http://www.bmj.com/content/330/7505/1416
12. Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009 http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12172/pdf

In opposition to SB2569 and SB2569 SD1, Relating to Homebirth

From: Ben Kinsey

To whom it may concern:

I strongly oppose SB2569 and SB2569 SD1, Relating to Homebirth.

I find it deeply offensive that this bill makes no exemptions for religious or cultural practitioners. As such this bill directly violates my freedom of religion to choose a traditional homebirth, a traditional cultural practice that goes back 10's of 1000's of years. The government knows nothing about homebirth with respect to my traditional practice, so how DARE can this government presume to have the expertise necessary to regulate it?

All three of my children were born at home attended by skilled and capable midwives and doulas. We asked our kids how they would feel if their births at home had been outlawed. They were understandably horrified. Our midwives are heros! They should not be criminalized! I understand this bill even threatens jail time! Hasn't our society finally evolved beyond the witchhunts against women?

The medical system is a fantastic CHOICE for most people. But don't force all of us to opt into a medical birth (even a medical homebirth) if we don't want it. There are religious exemptions for vaccines! How can my kids' homebirth be any less important to my traditional and religious practice than vaccines?

This Bill is an absurd overreach of governmental power and it MUST not pass.

Sincerely,

Ben Kinsey