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Ea Hānau Cultural Council is a Council of Kūpuna (elders) and Mākua (parent-age) practitioners of traditional Indigenous Kānaka Maoli birthing customs. Our work includes the perpetuation of traditional knowledge, community problem-solving, and protection of hānau (birth) practices from extinction.

Ho'opae Pono Peace Project builds peace and strength in Hawai'i and in the world through the practice of Indigenous Kanaka Maoli peace processes and concepts, providing direct cultural peace support in communities, families and activism, including cultural conflict help, facilitation, wellness support, and networking.

Malama Na pua o Haumea is a native Hawaiian birthing arts organization, leading efforts to revitalize traditional native Hawaiian healing and reproductive rites. We perpetuate ceremony and healing knowledge to increase the Mana, kuleana, and connection of Wāhine in Hawaii, while practicing traditions related to hānau (birth).

Introduction

The ability of birthing people to freely choose who will attend them in birth in Hawaii has been a major human rights issue over the past century. This escalated following the 2019 passage of HRS457J, a restrictive law that criminalizes the unlicensed practice of "Midwifery", which it defines as any type of "care" or "advice" given to a birthing person, even by relatives[1]. Further escalation occurred when a traditional birth attendant exemption expired in 2023, drastically limiting the legal attendant choices of birthing people[2].

This law is set to sunset (expire) in July 2025, but the Hawaii State legislature is actively engaged in making it permanent via a complicated bill known as HB1194[3], which addresses some of the problems in HRS457J, but further restricts care in other important ways. HB1194 has already gone through most of the legislature, sometimes without public hearing. It is expected to go to a conference vote and may become law soon.[3]

Historic context. The course of this measure has in itself been a human and civil rights concern that highlights over a century of colonial oppression and deliberate extinguishment of Indigenous hānau (birth) practices, as well as repression of the birth traditions of immigrant cultures[4] and disenfranchisement of the native population. This reflects the experiences of numerous other Indigenous peoples, Black people, and other United States minorities[5] with whom we have been in active communication. Hawai'i's experience is by no means unique, but it is part and parcel of the repression of birth-related reproductive freedom experienced throughout the United States. Immediately following the invasion of the Kingdom of Hawai'i in 1893, Indigenous Kanaka Maoli healing practices, including cultural midwifery, were criminalized[6], stigmatized and forced underground. This coincided with repression of midwives in the United States, particularly Black midwives in the rural South[7]. Over the course of the 20th Century, licensure was used to quietly extinguish healing practices in the Territory of Hawaii; for example, licensure for traditional lāʻau lapaʻau (Indigenous herbalists) required a written test with the names of traditional herbs in Latin[6]. Licensure for midwives meanwhile has never included Kānaka Maoli at all, and the program was discontinued when it became so stringent that no one could qualify (this also coincided with Japanese travel restrictions in WWI, which precluded licensed midwives, nearly all of whom were Japanese, from attending births)[8]. Underground midwives were prevalent but increasingly denigrated and sometimes persecuted,[9] creating a climate of fear and distrust.

Medical trade organizations such as the Hawaii Chapter of the American College of Obstetrics and Gynecology (ACOG) and the Hawaii Medical Association (HMA) have added major systemic heft to this, aligning with legislators in vociferously condemning unlicensed midwifery as dangerous and irresponsible[i], without any proof of actual danger. This same alliance between government and medical industry organizations, utilizing the same methodology, has been a

common theme since the 1800's in the persecution of midwives in both post-takeover Hawai'i and in Black and Indigenous communities throughout the Continental United States[11].

The major points that we would like to highlight as needing attention by the United States in relation to the issues brought forth in the third UPR cycle are:

Collusion between State and Business Actors. As the State of Palestine pointed out in the Third Cycle (26.153, A/HRC/46/15/Add.1 - Para.16, supported by U.S.), policies, legislation, regulations and enforcement measures should prevent and address the heightened risk of business involvement in abuses in conflicts, not contribute to them. Clear examples of collusion between medical industry representatives and governmental bodies have been a feature of repressive legislation that endangers the lives and reproductive rights of birthing people in Hawai'i and other Indigenous nations occupied by the United States. Some examples we have recently experienced:

- Widespread repetition by legislators and administrators of hearsay anecdotes (which we know from firsthand accounts by people present at births in question to contain numerous falsehoods) shared by medical professionals representing industry interests in closed-door meetings[5].
- Clear examples of business/government collusion, such as the recent (4/1/25 hearing) reference by the Hawaii Medical Association (HMA) to the testimony of the Department of Commerce and Consumer Affairs (DCCA) *prior* to DCCA testimony being publicly released[2]. This contributed to the rollback of protections of the choices of birthing people that were included in a previous hearing.[3]
- Adoption by DCCA of language for the Scope of midwifery licensure from the Midwives Alliance of Hawaii (a non-Indigenous trade organization seeking a monopoly on the title "midwife" and practice of midwifery under rigid medical standards that cannot be achieved by local practitioners), without input from others or passing through the Midwives Advisory Committee (MAC) required by State law. This same language also appeared in HB 1194 itself, making it clear that both lawmakers and administrators have been extensively colluding with industry representatives with no public oversight.

The United States should:

- Examine the effects of State/business collusion in the field of healthcare where reproductive and human rights are affected, and utilize its authority and influence to prevent harm.
- Enact laws and policies that firmly protect reproductive choice, specifically including in the area of traditional birthing choice.

Structural Discrimination. As Pakistan suggested in the third UPR cycle (A/HRC/46/15/Add.1 - Para.7, supported by the US), an action plan to address structural discrimination, including timelines and milestones, is strongly recommended. Structural discrimination has been a major theme in the systemic repression of birthing traditions throughout Hawaii and forced medicalization of cultures[11].
It is important to understand that since the illegal US takeover of Hawaii over a century ago, continual structural discrimination within health practices has resulted in the near-decimation of traditional health systems, forcing Indigenous and other cultural practitioners into extinction or token systems in which they do not fit, and their communities cannot openly access them. In this case, the repression of traditional midwifery has resulted in criminalized, underground status of midwives of many cultures, which in turn has meant:

- maternal avoidance of hospitals, due to stigma and fear of systemic repercussions such as removal of children via child welfare systems (known for racial bias[12]), as well as obstetric trauma[13]. We traditional practitioners have ample firsthand knowledge of this, as it is very common and can be very dangerous. Many of the complications systemically blamed by medical trade representatives on traditional midwives are actually late transfers due to maternal reluctance as a result of stigma of unsanctioned birth practices and prior obstetric trauma. In our conversations with these medical representatives, we have agreed on this point; where we differ, however, are 1) their blame of these late transfers on midwives, as opposed to our perspective that does not involve the forcing of birthing people against their will (as even if we morally supported this, we have no means to do so, unlike in hospital settings where force and systemic pressure is available and normalized) and 2) their focus is on torte relief and practitioner repercussion, while our priority is preventing harm via lack of access to traditional care[10].
- lack of communication or healthy relationship between medical personnel and both midwives and parents. The continual attacks on traditional birthing practices by medical industry representatives has resulted in distrust and severe communication impediments. Parents often will not disclose circumstances about their birth, and can be driven to avoid medical care altogether. Criminalization makes communication between underground midwives and doctors impossible, meaning that critical information cannot be shared.

The United States should:

- Enact comprehensive state and federal legislation prohibiting discrimination in healthcare, specifically inclusive of traditional cultural midwifery.
- Repeal state bans on traditional midwifery practice. Emphasis should be on the free choice of all birthing people to select any attendant they choose to touch their bodies, and autonomous determination of that relationship by the birthing person, including practices, scope, gifts, and any other aspects of the relationship between them.

Equitable access to healthcare. As Poland highlighted (n- Para.12), equitable access to healthcare needs to be protected and expanded in the United States. Angola similarly pointed out the need to make health-care services accessible to vulnerable people not supported by the current health system (A/HRC/46/15/Add.1 - Para.12). Acts of repression of cultural birthing traditions of any kind, including repression of access to chosen midwives from outside of any given culture who may be able to serve that community, are a severe limitation to healthcare access. Considering the lack of access that many Hawaii communities - and other Indigenous peoples - already face, resulting in the highest rates of maternal mortality in the United States[17], placing barriers of criminalization between birthing people and their attendants is a major human rights violation. For example:

- lack of overall rural health access. In some areas, a hospital is over an hour's drive, and no community health services are realistically accessible. Many families do not have working vehicles or access to other transportation. Evacuation births (in which pregnant people are sent, generally alone, to a faraway hospital where they must stay for weeks prior to giving birth, often resulting in trauma, obstetric abuse and mental health crises)[18] are the standard in several areas. Unassisted births (statistically the most dangerous without cultural preparation) are common, as are births in vehicles while trying to access care. Denying knowledgeable midwife care under these circumstances endangers both birthing people and infants severely.
- outright denial of medical care, such as has been experienced by birthing people receiving letters from Mālama i ke Ola, the primary affordable medical clinic on Maui, overtly denying all prenatal and other maternal care if the pregnant person has chosen a home birth, and forcing patients to sign a form stating that they will have a hospital birth, in order to receive prenatal care. There is no realistic medical alternative to this care on Maui. While clinic representatives state that these overtly coercive letters have been discontinued, conflicting accounts exist, and parents report to us that the sentiment and pressure persists.

What the United States should do:

- Expand rather than limit maternal care services of all kinds, particularly those strongly desired and utilized by birthing people themselves. Expand transportation options available to birthing people, and emergency services, particularly in rural areas.
- Create laws based on what is actually happening, such as high maternal death rates associated with trauma, colonial repression, chronic disempowerment and lack of access to maternal health care of all kinds, rather than hypothetical harm (what "could" happen) that has never been shown to exist, and rare, complex, multi-causal situations that cannot be shown to be prevented by the proposed law.

Division. As Kenya pointed out (A/HRC/46/15/Add.1 - Para.6), there is an urgent need to heal the systemic gap between Indigenous and non-Indigenous peoples and ways of being, in order to reduce structural and institutional discrimination. There is no reason that traditional midwives and medical institutions should not be working together for the good of birthing people, except that the former is being actively persecuted to the point of legal elimination by the latter. This creates real danger, including the very conditions that medical industry representatives are incorrectly accusing traditional midwives of creating, such as late hospital transport, which is typically due to maternal fear of systemic repercussions related to the stigma of engaging with traditional midwifery. Forcing
traditional cultural practitioners underground is neither safe nor effective; this goes for cultures who are Indigenous to other lands as well.

What the US should do:

- Prioritize Indigenous and other BIPOC cultural voices in maternity care.
- Facilitate relationship building and mutual respect between traditional birth practitioners and medical practitioners, as opposed to holding modern medical perspectives as superior to cultural systems.
- Take steps to decolonize and deoccupy Hawai'i and other peoples seeking self-determination in accordance with The United Nations Charter. The forcible US Annexation of Hawai'i in 1898 is fraught with unresolved legal problems, as is Statehood in 1959, which did not meet the international criteria for referendum, as no choice but US integration was offered on the ballot. Hawai'i meets the UN criteria for a Non-self governing Territory as well as the international criteria as an occupied state. The problems we are experiencing in Indigenous midwifery and other areas of cultural practice are a direct result of colonization and occupation. While we acknowledge that this is potentially a very long and complex process, it is extremely important in long-term solutions for human rights of all kinds, including birth-related reproductive justice, for this process to begin as soon as possible. We recommend that the United States take actionable steps toward peacefully withdrawing from Hawai'i and other overseas territories, beginning with cleaning up its messes such as all fuel and chemical spills, ceasing military leases, and protecting and restoring rights taken from the original occupants by State repression, including the reproductive freedom of Indigenous (and all) birthing people to freely choose who attends them.

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