Proposed Revisions to the Rules and Regulations Governing the Practice of Licensed Lay Midwifery in Arkansas

Public Comments Received

October 13, 2017

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Arkansas Department of Health
Proposed Revisions to the Rules and Regulations Governing the Practice of
Licensed Lay Midwifery in Arkansas

Public Comments Received

A public hearing was conducted on September 21st, 2017 at 10:00 a.m. in the Arkansas Department of Health's auditorium, located at 4815 W. Markham, Little Rock, Arkansas. Oral comments were received during this meeting. During the public comment period, comments were also received via email. All comments and responses are documented below:

Transcript from Public Hearing – Moderated by Reginald Rogers:

MODERATOR ROGERS: Good morning, everyone. Welcome to the Arkansas Department of Health. We are in the Dr. Joseph Bates Auditorium, 4015 West Markham Street, here in Little Rock, Arkansas. And we are here for the public hearing regarding proposed changes, proposed amendments to the Lay Midwives Rules and Regulations. My name is Reginald Rogers, and I will serve as moderator this morning.

And we do have sign-up sheets in the back, and you can be put on the list if you want to make comments, verbal comments concerning the proposed changes to the Lay Midwives Rules and Regulations. If you have written comments, also, those are most welcome, and please present those to us, and the wonderful, vivacious court reporter, Ms. Petre, will be kind to take those and she will be assembling a transcript and she will attach it to the transcript.

We do ask that you state your name if you make verbal comments, and that's for the transcript. We want to make a good and accurate recording, and all comments are welcome.

And at some point, we will conclude the public hearing. I will leave the mike available. We have mikes stationed there, and kind, wonderful people from our fantastic, wonderful communications section that are always so willing to help, and they will assist you in getting a microphone, because we want all comments to be heard and taken down by the court reporter.

This is a process that Dr. Zohoori has handled for, it's getting on three years now. So, it has been a long process. And thanks so much to the Midwife Advisory Board for their patience and kind understanding through this process and willing to work with us and with the department concerning these rules and regs. And I see several members present from the Midwife Advisory Board.

This is part of the Administrative Procedures process in Arkansas, which, as you know, is a long process, but one that allows the public to give input, and then at some point we take it to the Arkansas legislature. The Arkansas Department of Health Rules and Regulations go before two legislative committees, the Rules Committee and the Public Health Committee. And that would be the next step after the public comment time concludes this morning.

The time is now 10:02 a.m. Again, does anyone have any comments they would like to make? Feel free to take a microphone and make those comments and share those with the audience. And I will leave the mike open for several minutes. Thank you for attending.

AUDIENCE: Are you calling people from the list?

MODERATOR ROGERS: Whichever way they want to do it. Has anyone signed up on the list?

Dr. ZOHOORI: Yes, they have. People have signed up.

MODERATOR ROGERS: Okay.

DR. ZOHOORI: We can just call from the list.

MODERATOR ROGERS: Yes. If they will just hand me the list, and I will see if they would like to come up at this time.

(WHEREUPON, the list was provided.)

MODERATOR ROGERS: Oh, great.

DR. ZOHOORI: And they just state whether they wish to talk or not.

MODERATOR ROGERS: Okay. So, I have the list with me. And Christina Grace indicated that she may want to make comments. And, Christina, I will have you go to the mike there, and they will assist you. Thank you so much for coming, and take however much time as you need.

MS. GRACE: All right. Thank you. I have...

MODERATOR ROGERS: Please state your name again.

MS. GRACE: Oh. I'm Christina Grace, and that is in my speech here. I was informed by my midwife once I got here that the new regulations are better than the current regulations. So, that may come out in my speech. But anyway, I would like to start off.

How would you feel if you went to the doctor with a back ache and the first thing the doctor said to you was, "Have you ever been tested for HIV?" You politely tell him or her that you tested negative while in the military, and then married a virgin to whom you have always been faithful, they have always been faithful to you, so you know you are not at risk. The doctor then says, "Well, you really need to be tested." "I appreciate your concern", you reply, "but that is not why I am here. I came to see you about this pain in my back." The doctor then tells you he will not treat you for your back problem until you agree to be tested for HIV. This would probably be very upsetting to you, because it is precisely what is happening to pregnant women every day at Health Departments and other medical facilities across Arkansas.

Hi, my name is Christina Grace, and I appreciate the opportunity to speak before this Board about the new Midwifery Draft Rules and Regulations. I' sorry, I'm very nervous, you can probably tell from my voice.

I'm not a health professional, but I am a mother. And I can tell you that since I have had children, their well-being has been at the forefront of my mind in nearly every decision I make. For many reasons, before we even married, my husband and I decided that home birth was the best decision for our family.

Twenty years ago with my first child,I went to the Health Department afterseeing my midwife, I had a horrendous experience,I refused the PAP smear, and she apparently had it out for meafter

that. Herbedside manner was very gruff and she started making veiled threats about taking my child. So, I finally consented. I started bleeding and it worried me since I was 32weeks gestation. But when I shared with her my concern, she rudely said, "Yeah. I scraped you kind of hard." I left with tears running down my face and cried so hard all night I thought I would go into labor.

I felt like I had been sexuallyassaulted. Apparently, though, she stillwasn't satisfied, and told me she would not release me to have a home birth unless I came in weekly until I went into labor.

Fast forward 20 years to today, I assumed things had changed. As you can tell, I'm onceagain pregnant. I have been seeing a very competent midwife and recently had my first consultation at the local Health Department. I'm no longer a naïve 19-year-old that doesn't know how to stand up for myself. I politely answeredtheir battery of intrusive questions, such as, do I have sex with women, do I have sex with transgenders, am I a prostitute, et cetera. I consented to blood work to determine that I am free of any STDs, I consented to an ultrasound. I explained that my midwife had performed a glucose and Group B streptest, had my iron levels tested, but I declined a PAP smear. And you know what, I was once again refused continuing prenatal careand told that the nurse practitioner would not sign for me to have a home birth unlessI consented to a PAPsmear.

Aside from the recent research froma leading OB/GYN showing that PAP smearscan lead to more harm than good, a PAP smearis, in fact, a cancer screening, and I'm not seeking a cancer screening, I'm seeking prenatal care to determine that my baby and I are prepared for a homebirth.

I'm a healthy 39-year-old woman with no medical issues. I have not had even one surgery, I eat right, exercise, drink plenty of water, and take high qualityprenatal vitamins. I have never smoked, drank alcohol, or taken any illegaldrugs. I was a virgin when I married, and have been monogamous with my husband, who has also been monogamous with me, and he has no sexual diseases. I have had ten healthy pregnancies and ten healthy births with absolutely no complications. You would think I would be a perfect candidatefor home birth. And unfortunately,I'm considered high risk because of my age and the number of babies I have birthed and the fact that two of my babies have beenover ten pounds. I have never had gestational diabetes, I just have large babies. Obviously, as you can tell, I'm big, simply the way I was designed, since all mybabies have been between eight and a half and ten and a halfpounds.

So, first thing I'm asking you today is reconsider labeling women high risks who have no health problems and no past birthing complications.

Response: ADH relies on evidence and guidelines provided by the American College of Obstetricians and Gynecologists (ACOG) and the Centers for Disease Control and Prevention (CDC). The scope of practice for LLM in Arkansas is to provide care for women who are at low risk for complications (Section 104.1). The ADH considers a high risk pregnancy as one that threatens the health or life of the mother or fetus. Pregnancies may be considered high risk because of a condition that exists before the onset of pregnancy or because of risk of complication developing as pregnancy progresses.

Risk factors for high-risk pregnancy include but are not limited to:
Multiple gestation, young or advanced maternal age, obesity, history of cesarean delivery, and certain pre-existing health conditions. Comprehensive risk assessments (302.01) are performed to ensure that clients have no medical contraindications to home birth.

Secondly, the current regulations are that we can't refusePAP smears and pelvic exams. So, I appreciate that it has been -- that we are able to decline that now, seeing that the PAP test risk has gone largely unnoticed foryears, and it's time for doctors to realizeit's okay for women to deny access to their most intimate areas.

Response: Correct, the revised rules allow women to sign an informed refusal for certain test, procedures and treatments, depending on the level of education and certification of their LLM.

Thirdly, I would like -- personally, at some point, I would like to see that mandatory risk assessments -- well, mandatory risk assessments equalmandatory medical treatment, which is not anAmerican concept. No one in America should have the authority to force another human beingto seek or accept medical treatment against their will.

Yes, pregnancy and childbirth carry risks. Risks, unfortunately, and even tragedy are part of the human experience. But if you truly believe in freedom,it should extend to the pregnant womanin allowing her to make the decisions she deems best for her and her child.

Response: A comprehensive risk assessment is required by these Rules and Regulations so that the expected low-risk status of the client can be determined.

And so, I would like to close by saying it would be ideal if the obstetrical community didn't see midwifes as competition and could, instead, work with them as colleagues, it would ensure that mothers and their babies have the best chance for asafe and healthy birth. Thank you.

MODERATOR ROGERS: Thank you somuch, Christina. Those comments will be entered into the record and the transcriptfor today's public hearing. Next, I believewe have Ida. Thank you so much.

Again, this is public hearingregarding Proposed Revisions to the Rules and Regulations Governing the Practice of Lay Midwifery in Arkansas.

MS. DARRAGH: Hi, my name is Ida Darragh. And I will have writtencomments to turn in. I'm speaking in support of the revisions to the Arkansas Midwives Rulesand Regulations. Please include my commentsin the public hearing being held on September 21st.

I have been a midwife in Arkansassince 1980, and received the first licenseissued by the Department of Health on March8th, 1985. I remain licensed since that date and have served on the Midwives AdvisoryBoard several times in the last32 years. I also serve as the Executive Director of the North American Registry of Midwives, which issues the credential, Certified Professional Midwife, and I'm also the Executive Director of the Arkansas Childbirth Institute,a state nonprofit that provides supportfor continuing education for midwives,student midwives, doulas, and childbirth professionals inArkansas.

I served on the original committeethat drafted the rules and regs after licensure was established, and have served on each of the committees that proposed revisionsto the Midwives Advisory Board since 1985. Following the previous revision in 2007,the Midwives Advisory Board began meeting with the Department of Health LiaisonCommittee over the two issues that were discussedbut not accepted in the 2007 revisions. Those were the limited use of emergency medications and the option for licensed midwives to attend VBACs (Vaginal

Birth After Cesarean) in out-of-hospitalsettings. You can see how long these issues have been before us, and how many years we have talked about these.

By 2012, it was determined that the ADH said that licensed midwives could not be allowed to carry emergency medicationsto treat postpartum hemorrhage without a change to thelicensure statute. However, the discussion about adding VBAC to the listof permitted conditions continued to be onthe discussion agenda based on the good results in states that do allow VBAC with licensed midwives. VBAC continues to be one of the highest interest among the public in the state, and the voice supporting VBAC has been loud and clear in the years leadingup to thecurrent revision. Although VBACis still not allowed in the current revision,I can guarantee you that consumerswill continue to push for inclusion in the next revision. It's not an issue that willgo away; indeed, the consumer voice will continue togrow.

Although there continues to be a lotof work needed to remedy the deficienciesin the proposed regulations, good progresshas been made in acknowledging the right of the consumer to make informed choices in her healthcare. For that reason, I do support the current draft of revision to the regulations, and encourage the Boardof Health to support these regulationsthrough the remainder of the process. I also urge the Board of Health to continue to listento the public on issues related to their birth choices as we continue the processof developing good regulations for midwivesand their clients.

Again, I speak in support of the 2017 revision to the Arkansas Rulesand Regulations. Thank you.

Response: Thank you for your support of these revisions. We also appreciate your tireless work on the Midwife Advisory Board and your advice and guidance during the revision process.

ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

With this in mind, ADH is convening a committee to study and make recommendations to the ADH regarding steps that can be taken towards the reduction of unnecessary elective cesarean deliveries, and removing barriers to access to TOLAC and VBAC in Arkansas. We look forward to the deliberations and the recommendations of this Committee so that we can collaboratively improve the 'system of care' for all women in Arkansas.

MODERATOR ROGERS: Thank you, Ms. Darragh. And your comments will be added to the transcript of this hearing.

(WHEREUPON, Exhibit One was marked for identification.)

MODERATOR ROGERS: Next, I believewe have Mary Alexander. I will takethose comments. Thank you. State your name.

MS. ALEXANDER: I'm Mary Alexander, I'm a licensed midwife. I am also the chairfor the Midwives Advisory Board and co-chairfor the Arkansas Association of Midwives. And I'm here for the Arkansas Associationof Midwives. The AAM has reviewed the proposed draft rules and regulations for Arkansas licensed midwives and support the recommended changes. We would like to see this draft document replace our current regulations as soon as possible. We feel it updates the standard of care givenby Arkansas midwives and attempts to reflect national norms in giving respect to women's rights and making decisions for themselves regarding their healthcare and that of their children.

However, there is still much to be done, especially in the area of respectfor clients making their own healthcare decisions without fear of losing their healthcare practitioner of choice. I hope we will begin soon to continue to update and upgrade these regulations to become aneven better example of trust and respect for consumers rights. Thank you.

Response: Thank you for your support of these revisions. We also appreciate your tireless work on the Midwife Advisory Board and your advice and guidance during the revision process.

MODERATOR ROGERS: Thank you, Ms. Alexander.

(WHEREUPON, Exhibit Two was markedfor identification.)

MODERATOR ROGERS: And I believe nextwe have Shea Childs. Ms. Alexander isalso presenting her written comments. Thank you. And those will be added to the record. Please state yourname.

MS. CHILDS: Hello, I'm Shea Childs,and I am a licensed midwife. Ladies and gentlemen, I am speaking out in supportof the revision to the Arkansas MidwivesRules and Regulations. Please include my comments, in the public hearingtoday.

I'm a licensed midwife from Hot Springs. I have been serving families sincemy apprenticeship in 2007, and was licensedby the state in 2011. I received my CPM credential from NARM that same year and the Midwifery Bridge Certificate recognized by the US-MERA organizations in April of this year. I have also served on the Midwifery Advisory Board as secretary since 2015,and have been active in the LiaisonCommittee working through the current revisionsfor the last few years here with the Department of Health. I have missed y'all, by the way.

I'm steadfast in my belief that women have the right to choose their healthcare provider, the right to make informed decisions about their care, including which tests and procedures they arecomfortable with, and which risks they may be willingto accept in order to birth where they wish, with the provider theyhave chosen. Because the current revisions have includeda process for pregnant women to review evidence-based best practicesregarding their pregnancies through Informed Consent, as well as Informed Refusal for those things they find intrusive or unacceptable, I'm in support of these current revisions. I would like it noted, however, that the process should be ongoing and consistently striving toward improvement.

The discussion revolving aroundhome VBAC as an option to birthing women has been kicked down the road for several yearsnow. Cesarean sections at one of the two hospitals in my home county are reportedto be at 47 percent, which then force repeat C-sections on these women in the form of an administrative VBAC ban. Frankly, this should be investigated as criminalaction, in my

opinion. Performing surgery on half of all laboring women in a community,there, simply cannot be a medical reason for half of all labors to end in C-section. These mothers are at the mercy of a systemthat does not recognize the inherentrisks involved in C-section, the surgeryitself, that then inevitably lead to multiple surgeries for purely administrativereasons. It's a public health crisis that needs tobe investigated and rectified. These risks associated with repeat abdominal surgeryare many. A number of states have reached agreement outlining conditions to be met that are acceptable risks for motherswho have had a previous C-section to havea trial of labor at home with subsequent births. It will take serious commitment and deserves real discussion, but should be on the table until this option is availablefor Arkansas families. Thank you for yourtime.

Response: Thank you for your support of these revisions. We also appreciate your tireless work on the Midwife Advisory Board and your advice and guidance during the revision process.

ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

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MODERATOR ROGERS: Thank you, Ms. Childs. And your written comments willalso be added to therecord.

(WHEREUPON, Exhibit Number Threewas marked foridentification.)

MODERATOR ROGERS: Deb Phillips? Please state your name.

MS. PHILLIPS: I'm Deb Phillips. I've been a midwife since 1982, I've been a licensed midwife since 1985, and I've had a license eversince then. I haveattended 1,081 births withno stillbirths. So, I practice evidence-based midwifery, and it pretty much works. I have been a midwife on the Midwifery Advisory Board, all the same stuff Ida said, and chair of the Board,and co-chair of the ArkansasMidwifery Association, and I am a member of the Midwives Alliance of North America, and I hold my CPM Certificate and myBridge Certificate.

So, I have been a member of the Liason Committee, who has been working on these regs, actually every time that therehas been a change to the regs, which has not been many times. I am in support of these current regulations because I do feel that they are an advancement for the women, butI feel that the state has a long way to goto make midwifery safer and more acceptableto those who desire

out-of-hospitalbirthing: Emergency drugs should be allowed for the midwives to carry, as it is in mostevery other state thatlicenses midwives.

Response: The ADH appreciates the concern expressed regarding allowing LLMs to carry and administer emergency drugs. However, this issue will not be addressed in the proposed revisions to the Rules and Regulations at this time.

Vaginal Birth After Cesareans are attended by most other midwives in the country. Also, women who want to have VBACs are havingunattended home births -- how safe is that -- because of the VBAC banon midwives.

Response: There are two relevant questions to be answered in the decision of whether the Rules and Regulations should allow, or not, vaginal birth after cesarean (VBAC) in home settings in Arkansas.

The first question is: "Is VBAC less risky than an elective repeat cesarean section?" and the answer to that question is "Yes". The American College of Obstetricians and Gynecologists (ACOG) corroborates that in the ACOG Clinical Management Guideline (reaffirmed 2013) and ACOG Practice Bulletin (Number 115, 2010)) as does the Arkansas Department of Health (ADH). However, to make that statement out of context and without taking into consideration the full picture gives the wrong impression of the risks—and this is also affirmed by ACOG.

VBAC is the outcome of a process, and that process is "trial of labor after cesarean", or TOLAC. To be counted as a VBAC, one needs to have successfully gone through TOLAC. According to ACOG, anywhere from 20- 40% of TOLACs fail to proceed to VBAC (depending on what studies one looks at). Also, most maternal morbidity that occurs during TOLAC occurs when repeat cesarean delivery becomes necessary. In those situations, the outcome is not VBAC. Because high-risk individuals and needed cesarean deliveries are filtered out during TOLAC, VBAC becomes associated with fewer complications and a failed TOLAC is associated with more complications than an elective repeat cesarean delivery. Consequently, risk for maternal morbidity is inversely related to a woman's probability of achieving VBAC. Therefore, to say simply that "VBAC is less risky than an elective repeat cesarean section" without also counting the failed TOLACs, leaves out the risk borne by the 20-40% of women who do not make it through TOLAC to VBAC.

The second relevant question is: "Is VBAC safe at home within the Arkansas setting?". Clearly, for some individuals who successfully go through TOLAC, VBAC at home may be a safe option. However, as mentioned before, 20-40% of TOLACs do fail (often unexpectedly) and a cesarean section is needed. In a lot of cases, that is an emergency situation and the immediate access to services can sometimes determine the difference between life and death for mother and baby.

Having said this, ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We recommend that hospitals, maternity care providers, health care and

professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

With this in mind, ADH is convening a committee to study and make recommendations to the ADH regarding steps that can be taken towards the reduction of unnecessary elective cesarean deliveries, and removing barriers to access to TOLAC and VBAC in Arkansas. We look forward to the deliberations and the recommendations of this Committee so that we can collaboratively improve the 'system of care' for all women in Arkansas.

A mother should not fear losing her midwiferycare because she does not want a vaginal examby a stranger. A mother should not fear losing her midwifery care because she does not want to subject her developing baby to an ultrasound.

Response: ADH recognizes a woman's right to refuse medical tests or procedures. The LLM must inform the client of all tests, procedures, treatments, medications, or referrals specified in Section 300 of the Rules and Regulations. With the proposed revisions to the Rules and Regulations, LLMs who maintain specific credentials (Section 104) have within their scope of practice the authority to continue care for women who choose to decline certain tests or procedures.

These new regs bring Arkansas up to standards around the country in many issues, while failing in others. I do supportthem because I see them as an advancement,but hope that we continue to work on themmany more years. Thankyou.

Response: Thank you for your support of these revisions. We also appreciate your tireless work on the Midwife Advisory Board and your advice and guidance during the revision process.

MODERATOR ROGERS:Thank you, Ms. Phillips, and your comments will be added to therecord.

(WHEREUPON, Exhibit Number Four was marked for identification.)

MODERATOR ROGERS: At this time,I believe that completes the listed personson our sheet.

MS. JACOB: Is thisworking?

MODERATOR ROGERS: I think it should be working. State your name. It works.

MS. JACOB: Okay. Hi, I'm KimJacob.

MODERATOR ROGERS: Oh, okay. I saw your name there.

MS. JACOB: Yeah. I just didn't write it onthere.

MODERATOR ROGERS: Okay.

MS. JACOB: Anyway, my name isKim Jacob, and I have been licensed in Arkansas as a midwife since 2005. I've alsoserved on the Midwives Advisory Board asa chairperson, and other roles, and onthe Liaison Committee. I am also a CPM, and got my Bridge. Yes, that's right. So, I just wanted

to say that I'm in approval of these revisions to the regulations. I think they are an improvement, for sure, over theold ones. I do expect that we have a continued conversation to continue improving the regs, including a provision for home birthVBAC. But, anyway, that's what I have.

Response: Thank you for your support of these revisions. We also appreciate your tireless work on the Midwife Advisory Board and your advice and guidance during the revision process.

ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

With this in mind, ADH is convening a committee to study and make recommendations to the ADH regarding steps that can be taken towards the reduction of unnecessary elective cesarean deliveries, and removing barriers to access to TOLAC and VBAC in Arkansas. We look forward to the deliberations and the recommendations of this Committee so that we can collaboratively improve the 'system of care' for all women in Arkansas.

MODERATOR ROGERS: Thank you, Ms. Jacob. And your comments will be added to the record.

MS. JACOB: Okay.

(WHEREUPON, Exhibit Number Fivewas marked foridentification.)

MODERATOR ROGERS: Is there anyoneat this time that would like to add verbal comments? Of course, you are alwayswelcome at this time to submit your written comments now. Thank you. And please step up to the mike -- and can we lower that for her? State your name.

MS. CAMERON: My name isChelsea Cameron, I'm one of the newest members of the MAB.I was only able to attend the last few meetings before these revisions went to be made into our newest regulations. I represent a consumer position on the MAB, even though I personally, which is kindof ironic, I personally cannot be a consumerof midwifery care here in Arkansas due to the VBAC ban.

I have stated a lot in the meetingswhy I believe VBAC needs tobe allowed. But I would just like to highlight, out of 28 states that license and regulate midwives, seven, including Arkansas, do notallow licensed midwives to attend home VBACs. I would like to know why Arkansas continuesto side with the minority of states that license midwives.

We have talked about the risks of VBAC, the main one being uterine rupture,which studies have shown, and I will submitmy references for cross check. The risk of uterine rupture in VBAC is about half of a percent, 0.5 percent, yet Arkansas,by allowing licensed midwives and homebirths, have already allowed other obstetrical emergencies, such as cord prolapse,which carries a higher rate of occurrence than uterine rupture and a higher riskof neonatal fatality, to be allowed. So, we are

already allowing obstetricalemergencies that could happen in any birth, we are already allowing more risky situationsthan a VBAC. So, today I would like to see previous cesarean added to the Informed Consent refusal. Thank you.

Response: We appreciate your tireless work on the Midwife Advisory Board and your advice and guidance during the revision process, even if for a relatively short time. Your voice as a consumer is an important one.

There are two relevant questions to be answered in the decision of whether the Rules and Regulations should allow, or not, vaginal birth after cesarean (VBAC) in home settings in Arkansas.

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The second relevant question is: "Is VBAC safe at home within the Arkansas setting?". Clearly, for some individuals who successfully go through TOLAC, VBAC at home may be a safe option. However, as mentioned before, 20-40% of TOLACs do fail (often unexpectedly) and a cesarean section is needed. In a lot of cases, that is an emergency situation and the immediate access to services can sometimes determine the difference between life and death for mother and baby. It is the charge of ADH to set Rules and Regulations that protect the health and well-being of all Arkansans at the population level. We recognize that some individuals bear less of a risk than others, but the Rules and Regulations are designed to minimize risk at the population level.

Having said this, ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to

care stating: "We recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

With this in mind, ADH is convening a committee to study and make recommendations to the ADH regarding steps that can be taken towards the reduction of unnecessary elective cesarean deliveries, and removing barriers to access to TOLAC and VBAC in Arkansas. We look forward to the deliberations and the recommendations of this Committee so that we can collaboratively improve the 'system of care' for all women in Arkansas.

(WHEREUPON, Exhibit Number Sixwas marked foridentification.)

MODERATOR ROGERS: Anyone else whowould like to make comments at this time, you are more than welcome. We want to hear all comments. Thank you. Anyone else?

We would like to get as many commentsas we can. We want everyone to share allof their thoughts on these proposed rules. A lot of time and effort has been put into this by the Midwife Advisory Board and the Department of Health staff. So, I knowthey want to be totally transparent and want to hear about all of this. Of course, this is just another step in theAdministrative Procedures process and will go before the legislative committees which will be another opportunity for people to expresstheir views, and then, if it's successful,I believe at a review, then it will comeback to the full Board of Health for a final review at some point. So, this isjust another important step inthis Administrative Proceduresprocess.

I'm looking around the room. I don't see any more listed speakers, and I don't see any hands raised or anyone headed to the mike. Yes?

MS. DARRAGH: I just have a question. Is there a possibility of any revisions before it goes to the legislative committees, or does that not happen?

MODERATOR ROGERS: Well, if there were substantial changes, and I would meet with General Counsel who is in the backthere, Robert Breck, and we would review that and decide where we go, if therewere substantial changes that developed out of the comments in the public hearingtoday, and see what our next stepswould be. So, we will just have to review after we lookat everything that occurred this morning and see if there were substantialchanges.

MS. ALEXANDER: But we would beinformed if that were to happen?

MODERATOR ROGERS: Oh, you willalways be informed. We believe infull transparency, with the help of our wonderful CommunicationsDepartment. So, we want to keep you informed at all times. And wehave a -- I'm glad you brought that up, because we have a great new website, public website, and we want to tout that to everyone. I believe it ismuch friendlier. Would you agree, Doctor?

DOCTOR DiCARLO: Yes.

MODERATOR ROGERS: Doctor DiCarloagrees it is much friendlier. So, please go to our public Department of Health website, and we would put any proposed changes on that website.

MS. ALEXANDER: Speaking of your new website, you list us as lay midwives,not licensed lay midwives, there. And really, women look us up, we get a lot of referrals from that website, women look us up as "Midwives". So, it should be"Midwives, comma, licensed lay".

MODERATOR ROGERS: I believe thatis duly noted by the communicationsdirector. So, she is right there. That is duly noted. Good point.

Any other comments or suggestions, recommendations? I noticed we have several distinguished guests inthe audience. We will turn it over to Doctor Zohoori,if that's fine withyou.

DOCTOR ZOHOORI: Actually -- isthis working? I really don't have -- is this working?

MODERATOR ROGERS:Yes.

DOCTOR ZOHOORI: Okay. Most ofthe comments that I was going to make,pretty much everybody here has already heardmy comments onspecific issues. But I just wanted to express, also, my thanks for the positive comments that were expressed, and the support that the Midwife Advisory Board has provided throughout this process, it has been a tremendous help to havethat discussion back and forth and yoursupport. A number of people -- we have received a number of written comments, as well,over the past few days that I have looked through, and several people are insupport, and there are several, also, that have specific issues that they have broughtup that we will look at verycarefully.

Some people have shared theirpersonal experiences, as Ms. Grace has, andwe appreciate that. I think those personal experiences are very important. You know, personal experiences are particularly important to the people who experiencethem.

When they are good experiences, they are really good, and when they are bad, they are painful, and weappreciate that. And our, efforts in this process has been to try and minimize those painful experiences as much as possible and to increase the positive experiences. Because birth is a very happy experience and it should be experiencedas such. And so, that has been our goal throughout this process.

One of the things I just wanted topoint out is that, you know, while the individual experiences are very important and we do appreciate them, we, as an agency, arealso charged with public health. So, we have to consider the individual experiences of people versus the public health aspectsof the rules and regulations that are put in place. And our challenge is always to weigh those two. You know, our individual experiences can vary. The same set of circumstances might produce a different individual experience in one personversus somebody else. And those kindsof variations will always happen at the individual level. What we are trying to do is to try and minimize the public health burden of any issue in the state. So, we would very carefully, as we study all of these comments, continue to weigh these two, and read them very carefully and make sure that we balance these two issues across each other.

We do agree, also, that we think that these rules are an improvement over what we have had, thanks, also, again to the patience of the Midwife Advisory Board and their advice and counsel during this time. We have had a number of very interesting back-and-forthdiscussions through whichI think we both learned about each other and our perspectives. And I think that's all reflected inhere.

That's really all I needto say. I think we will definitely look at these very carefully, all the comments that have been sent in, both as written, as oral – and your oral presentations, and we will consider all the -- any changes that might need to be made. Thank you very much.

MODERATOR ROGERS: Thank you, Ms. Darragh?

MS. DARRAGH: Are any of the comments that were sent in writing for the public hearing going to be available to the public?

MODERATOR ROGERS: Yes, they can be. We can send those to you or make a note to send the public comments to the Midwife Advisory Board. Any other comments?

The time is 10:31 a.m. And with your indulgence, I would like to leave this meeting open until 10:45 a.m., just to in an abundance of caution and make sure that everyone that could get here has opportunity to arrive here and make comments. We, again, are fully transparent and we want everyone to share with us their experiences and comments regarding these proposed rules and regs. So, at this time I will just leave the mike here, and you are welcome to stay or go as you see fit. But we will conclude formally at 10:45 a.m.

I notice, again, we have several distinguished guests, Doctor Lowrey is here and others. We appreciatetheirattendance. They are always mostwelcome.

So, today's date is Thursday,September 21st, it's 10:32 a.m., concerning the Proposed Revisions to the Lay Midwifery Rules, and we are going to go into recess until 10:45 a.m.

(WHEREUPON, a break was taken.)

MODERATOR ROGERS: Welcome back. It's 10:45 a.m. We are considering the Proposed Revisions to the Licensed Lay Midwifery Rules at thispublic hearing. It's Thursday, September 21st, 2017 at the Arkansas Department of Health, 4815 West Markham Street. My name isReginald Rogers, one of the attorneys for the Arkansas Department of Health. We were in recess to see if anyoneelse would appear or have any other comments or suggestions. And I'm looking around the room. Does anyone have anything further to add or share with us, or has anyone else arrived that didn't have an opportunity to speak earlier? And I'm looking around, seeing, going once, going twice, three times. All right. Time is 10:46 a.m.

Well, seeing that there are nofurther comments, we thank you for yourattendance and your interest in this very important issue. The licensed lay midwives serve a very important function in our society, and we thank you for your attendance this morning. So, this concludes thepublic hearing of the licensed laymidwifery proposed revisions. Thank you. The time is 10:46 a.m.

(WHEREUPON, at 10:46 a.m., the taking of the above-entitled proceeding was concluded.)

Written Comments Received during Public Comment Period (8/21/2017 – 9/21/2017):

1. Name: **Aly Kirkpatrick (email received 8/21/17)**

Comment:

a. To Whom it May Concern: I received the below message at 9:04 am this morning. It states "Please submit written comments no later than 8:00 am on September 21, 2017 via email ."
As I did not receive this message before 8:00 am, it was not possible for me to respond within the time restraint.

Response: The notification of public hearing was sent via email to all persons on the interested parties list on August 21, 2017. This comment was received prior to the deadline mentioned above.

b. If I had received it in time I would have urged you to remove the prohibition of lay midwives from attending VBAC mothers. As a former ICAN leader who worked with dozens of women and from my personal experience as a VBAC mother I know without a doubt that prohibiting midwives from attending does not prevent mothers from having homebirths after cesarean. What this prohibition does do is limit options for women and create situations that are less safe from them to birth within.

In many areas of Arkansas having a hospital attended VBAC is not a reasonable option. Women run into situations every day where their local hospital will not allow it, and they do not know they have the right of informed refusal. They are bullied or manipulated by doctors who say they would do it, but their insurance will not allow them to. Many women do consent to unnecessary repeat cesareans as they believe (whether it is true or not) they have no options. Some women choose to drive for hours to a supportive provider and hospital. Other women birth at home, unattended. While we could debate the safety of homebirth after cesarean, the fact remains that it can and does happen.

Response: There are two relevant questions to be answered in the decision of whether the Rules and Regulations should allow, or not, vaginal birth after cesarean (VBAC) in home settings in Arkansas.

The first question is: "Is VBAC less risky than an elective repeat cesarean section?" and the answer to that question is "Yes". The American College of Obstetricians and Gynecologists (ACOG) corroborates that in the ACOG Clinical Management Guideline (reaffirmed 2013) and ACOG Practice Bulletin (Number 115, 2010)) as does the Arkansas Department of Health (ADH). However, to make that statement out of context and without taking into consideration the full picture gives the wrong impression of the risks—and this is also affirmed by ACOG.

VBAC is the outcome of a process, and that process is "trial of labor after cesarean", or TOLAC. To be counted as a VBAC, one needs to have successfully gone through TOLAC. According to ACOG, anywhere from 20- 40% of TOLACs fail to proceed to VBAC (depending on what studies one looks at). Also, most maternal morbidity that occurs during TOLAC occurs when repeat cesarean delivery becomes necessary. In those situations, the outcome is not VBAC. Because high-risk individuals and needed cesarean deliveries are filtered out during TOLAC, VBAC becomes associated with fewer complications and a failed TOLAC is associated with more complications than an elective repeat cesarean delivery. Consequently, risk for maternal morbidity is inversely related to a woman's probability of achieving VBAC. Therefore, to say simply that "VBAC is less risky than an

elective repeat cesarean section" without also counting the failed TOLACs, leaves out the risk borne by the 20-40% of women who do not make it through TOLAC to VBAC.

The second relevant question is: "Is VBAC safe at home within the Arkansas setting?". Clearly, for some individuals who successfully go through TOLAC, VBAC at home may be a safe option. However, as mentioned before, 20-40% of TOLACs do fail (often unexpectedly) and a cesarean section is needed. In a lot of cases, that is an emergency situation and the immediate access to services can sometimes determine the difference between life and death for mother and baby. It is the charge of ADH to set Rules and Regulations that protect the health and well-being of all Arkansans at the population level. We recognize that some individuals bear less of a risk than others, but the Rules and Regulations are designed to minimize risk at the population level.

Having said this, ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

With this in mind, ADH is convening a committee to study and make recommendations to the ADH regarding steps that can be taken towards the reduction of unnecessary elective cesarean deliveries, and removing barriers to access to TOLAC and VBAC in Arkansas. We look forward to the deliberations and the recommendations of this Committee so that we can collaboratively improve the 'system of care' for all women in Arkansas.

2. Name: **Tanya Smith (email received 8/23/17)**

Comment: The postal mail address left off the city, state, and zip code for public comments. I imagine most people will email, but there may be some who want to send via the post office.

Response: The original email sent to all interested parties contained the complete mailing address.

3. Name: **Christina Boyd (email received 8/23/17)**

Comment: My name is Christina Boyd. I currently live in Rector, Arkansas. I have two children. My first child was born via csection in Illinois. After my cesarean I was told I was a good candidate for VBAC. I moved to Paragould, Arkansas while pregnant with my second child. All of the local hospitals had VBAC bans. I was told that if I went into labor and went to one of the local hospitals, that I would have to sign an Against Medical Advice (AMA) form if I did not want to have a cesarean section. I ended up having an unassisted vaginal birth in my home.

Response: There are two relevant questions to be answered in the decision of whether the Rules and Regulations should allow, or not, vaginal birth after cesarean (VBAC) in home settings in Arkansas.

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ADH also recognizes the right of women to choose their health care providers. However, implicit in the choice to go with any particular licensed health care provider is the expectation that the provider will work within their scope of practice. These Rules and Regulations simply set out the scope of practice for Licensed Lay Midwives in Arkansas.

4. Name: **Paula Hill, CNM, APN (email received 9/7/17)**

Comment: I have been performing the required risk assessments for the licensed midwives in Northwest Arkansas for over 15 years. I am well aware of the careful screening that the midwives do under the regulations, and I find the rules to be completely appropriate for their practice.

I appreciate the work that has been put into revising the regulations and I support the proposed changes.

Response: Thank you for your support of these revisions and your service to the LLM community and their clients.

5. Name: **Alexandria Howland (email received 9/12/17)**

Comment: *Clients who test positive for Group B Strep in the urinary tract at any time in the current pregnancy (regardless of repeated testing that is negative for Group B Strep). Vaginal/rectal testing for Group B Strep is not indicated when the urine testing is positive for Group B Strep in the current pregnancy.*

a. Did the ADH consider that women may test positive at certain times during a pregnancy and negative at other times? If that was a consideration then what justification does the ADH rely on when formulating a rule that will terminate her relationship with her licensed midwife if she tests positive at week 12 and negative at week 37? In that situation, how does mother go about getting her midwife back at week 37. Since the ACOG and the American Pregnancy Association both recommend women be tested between 35 and 37 weeks why do the Arkansas Midwifery Rules differ?

Response: A client with a positive Group B Streptococcus (GBS) test is not precluded from LLM care. Conditions that preclude midwifery care are listed in section 303.01, 305.01, 307.01 and 309.01. The only GBS situation that precludes midwifery care is "Unknown GBS status prior to sixteen (16) hours of ruptured membranes, when delivery is not imminent" (305.01.12), which requires immediate transport to the planned hospital.

The ADH practice of universal screening at 35-37 weeks of gestation and intrapartum antibiotic prophylaxis was developed using CDC guidelines, is endorsed by ACOG and the American Academy of Pediatrics (AAP), and serves as the basis of this prevention strategy and rules and regulations.

b. The rules go on to state that care must be transferred. What negative impact will that have on the care of the mother and fetus? What is ADH's justification for a rule that creates a break in continuity of care for a mother and unborn child?

Response: Transfer of care is inherently possible for many conditions that may arise during the antepartum, intrapartum, postpartum and newborn periods. The conditions that warrant consultation, referral or transfer are addressed in the proposed rules and are necessary to reduce the risks to the health and life of mother or baby.

In order to minimize the impact of transferring care to another provider or to a hospital the proposed rules address the requirements for LLMs to utilize the Disclosure Form to discuss certain information to prepare mothers for the care that LLMs may and may not provide. More specifically the rule's Section 302.07 Antepartum Preparation for Home

Birth, #4.b. Obtaining Intrapartum and Postpartum Medications for Mothers, addresses the requirement for GBS prophylaxis.

The LLM is further required to inform the mother if her certification and licensure permit her to continue to provide care to the mother that refuses recommended tests, procedures, treatment, referral or medication (Section 104 Scope of Practice, 8.a).

Clients who test positive for Group B Streptococcus may continue care with an LLM if a physician/certified nurse midwife (CNM) consultation or referral is made. The client must be examined by a physician or CNM currently practicing obstetrics. A plan of care for the condition must be established, and execution of the plan must be documented. This does not preclude midwifery care, but does seek to ensure that Centers for Disease Control and Prevention (CDC) approved GBS prophylaxis is available during the woman's labor.

c. Since many Obstetricians will not take a client past the 30th week of pregnancy what does the ADH suggest mothers do who are unable to find obstetrical care because of the Midwifery Rules?

Response: The Rules and Regulations require that a comprehensive risk assessment be performed by a physician or certified nurse midwife (CNM) currently practicing obstetrics or an ADH clinician at or near the time care is initiated with the licensed lay midwife (LLM) and at or near the 36th week of gestation (Section 302.01). These risk assessments often allow the LLM client to develop a relationship with a medical provider other than the LLM who can provide care in the event that a condition develops that requires a transfer from LLM care.

d. And lastly is it safer for a mother to go without Obstetrical care rather than continue care with a licensed midwife when positive for Group B Strep?

Response: Clients who test positive for Group B Streptococcus may continue care with an LLM if a physician/certified nurse midwife (CNM) consultation or referral is made. The client must be examined by a physician or CNM currently practicing obstetrics. A plan of care for the condition must be established, and execution of the plan must be documented. This does not preclude midwifery care, but does seek to ensure that Centers for Disease Control and Prevention (CDC) approved GBS prophylaxis is available during the woman's labor.

6. Name: ICAN of Central Arkansas (email received 9/12/17)

Comment: The International Cesarean Awareness Network (ICAN) Arkansas Chapters are writing to formally request a 20 day extension of the public comment period regarding the proposed changes to the Licensed Lay Midwife rules and regulations in accordance with the Administrative Procedures Act. This is an important issue to our state and national membership.

Response: Even though the email gave no reason for this request, we have considered it and, while we appreciate the importance of the issue to the women of Arkansas, we see no reason for extending the comment period. We have provided the legally required notice and comment period, and the revised rules themselves have been available on our website for a number of months. We will be very happy to entertain any comments received during

this period, or at the public hearing on Thursday, September 21, at 10:00 a.m. at the Arkansas Department of Health auditorium.

The Arkansas Administrative Procedures Act allows for at least a thirty-day comment period. There is not a valid reason for an extension of that time period.

7. Name: Shoaf Camp (email received 9/15/17)

Comment: I am a doula, a home birth mother, and a student midwife. I currently live in Kansas, but am from Arkansas. I would love to move back to my home state and practice midwifery when I am finished with my training.

a. However, in reading the guidelines for home birth, it sounds like women under midwifery care with a licensed midwife who is trained in pregnancy, birth, and postpartum in the low risk population must see a Health Department nurse during their pregnancy. A Health Department Nurse who is not necessarily trained in maternity. This is outrageous to me as both a home birthing mother and as a student midwife.

Response: A comprehensive risk assessment is required by the Rules and Regulations Governing the Practice of Licensed Lay Midwifery in Arkansas (Rules and Regulations) so that the expected low-risk status of the client can be determined. There is no requirement that an Arkansas Department of Health (ADH) clinician perform the risk assessment. Women may also choose to see any physician or certified nurse midwife currently practicing obstetrics for risk assessments (Section 302.02).

b. I have heard horror stories of women being bullied into Pap smears as well being told they cannot have a home birth if they do not submit to a vaginal exam. This is assault. This is forcing a woman, using pregnancy as the excuse, to be assaulted sexually by a stranger to be approved to give birth in the place that she chooses. I found the information below:

One legal definition, which is used by the United States Armed Forces is found in the United States Uniform Code of Military Justice [Title 10, Subtitle A, Chapter 47X, Section 920, Article 120], defines rape as:

(a) Rape. — Any person subject to this chapter who commits a sexual act upon another person by —

(1) using unlawful force against that other person;

(2) using force causing or likely to cause death or grievous bodily harm to any person;

(3) threatening or placing that other person in fear that any person will be subjected to death, grievous bodily harm, or kidnapping;

(4) first rendering that other person unconscious; or

(5) administering to that other person by force or threat of force, or without the knowledge or consent of that person, a drug, intoxicant, or other similar substance and thereby substantially impairing the ability of that other person to appraise or control conduct;

is guilty of rape and shall be punished as a court-martial may direct.[9]

Also, this definition of rape from the FBI: "the FBI's Uniform Crime Report (UCR) definitions are used when collating national crime statistics from states across the US. The UCR's definition of rape was changed on January 1, 2013 to remove the requirement of force against a female and to include a wider range of types of penetration.[1] The new definition reads:

Penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim."

So, now we see that rape is defined both as penetration, no matter how slight, without consent. Also, that rape is a sexual act upon another person while threatening that any person may be subjected to grievous bodily harm. A woman who is planning a home birth might believe that a hospital birth will subject herself or her unborn child to grievous bodily harm.

These unnecessary vaginal exams may be the cause that Arkansas has women choosing to birth without a qualified birth professional (either unassisted or with an unlicensed midwife). These regulations are not protecting the health of women in any way or that of their unborn children.

Consent given under coercion is NOT consent. Leveraging a home birth against a forced vaginal exam is NOT consent. This is ASSAULT condoned by the state government. This is RAPE condoned by state regulations. Please work towards new regulations where a healthy, safe birth may happen at home without forcing women to undergo assault and rape at the hands of strangers.

Response: ADH recognizes a woman's right to refuse medical tests or procedures. The LLM must inform the client of all tests, procedures, treatments, medications, or referrals specified in Section 300 of the Rules and Regulations. With the proposed revisions to the Rules and Regulations, LLMs who maintain specific credentials (Section 104) have within their scope of practice the authority to continue care for women who choose to decline certain tests or procedures.

ADH also recognizes the right of women to choose their health care providers. However, implicit in the choice to go with any particular licensed health care provider is the expectation that the provider will work within their scope of practice. These Rules and Regulations simply set out the scope of practice for Licensed Lay Midwives in Arkansas.

Neither the Arkansas Board of Health nor ADH has the authority to regulate the practice of medicine or advance practice nursing and cannot direct the individual clinical practice of any physician, CNM or nurse practitioner. Individual medical providers determine what exams and/or tests are necessary for a comprehensive risk assessment based on individual or agency policies, protocols and practice guidelines. Any perceived violations of policies, protocols or guidelines should be reported to the relevant agency or authorities by any client experiencing them.

8. Name: Bethany Ellen Smith (email received 9/15/17)

Comment: Hi, I have something to contribute to the issue that informed pregnant people face in our state, more and more, and that is evidently about to get even worse, if legislators have their way.

I'd like you forward this and/or to read this aloud to any legislators you have a chance to speak at, regarding the abhorrent and baseless hurdles that the State of Arkansas currently puts pregnant people through, who want their rights bodily autonomy and informed consent to be respected by their care providers, instead of having birth done TO them.

"I am seeking midwifery care for my next pregnancy in Arkansas, where I live. I have a three and a half year old son who was born in my midwife's bathtub in 2014, and had a daughter who was stillborn this summer. These are both normal birth outcomes, as sad as the second one was. The way my second birth

unfolded was NOT normal, mainly because of the way I was treated when I had to transfer to a hospital at the first sign of fetal distress after my water broke at 37+4.

I was coerced, abused and neglected, per standard Sparks hospital SOP, during my second child's birth, after she died suddenly en utero, in June, and I had to go to a hospital just in case there was something wrong with me. There was not. We suffered an unexplained and instant massive placental abruption, with no preliminary symptoms, and my excellent midwife knew what was happening, despite never having seen it in 35 years of practice. The causes of this condition are usually massive trauma, via domestic violence or automobile accidents. I was not asked about trauma of any kind at the hospital, ever, but I was asked by the surgeon, Dr. Jeanmarie Householder, after she offered me an elective C-section for no medical reason, and without any discussion of risks or benefits or future pregnancies, what "supplements" I took.

A single dose of cramp bark was blamed for my child's death, in my records. I was not asked how much was used, how long it had been taken, nor why it was used. I took 5ml when my water broke, and have never taken any before or since. There is zero evidence that cramp bark is related in any way to placental abruptions - but that surgeon looked me in the face and rolled her eyes when I told her about it. Silly hippies, ya know? Barns and stuff.

My son was born in the water with a fantastic midwife, so I know exactly what was taken from me by that hospital and it's asinine, harmful, and non-evidence-based "policy" to totally ignore my bodily autonomy and right to informed consent in favor of staff convenience and avoidance of litigation. They can be sued for doing too little, but they'll never lose a case where they did too much, for no reason, just to cover their own asses. My "care" at the hospital was laughable, disrespectful, and non-evidence-based, even when they KNEW they had no baby to "save." Dr. Householder is beholden the interests of hospital board of directors, NOT to her patients wellbeing, despite having a modicum of authority to address the abuses she is required to preside over in a daily basis.

I genuinely feel lucky that I escaped punitive surgery, and I was then given drugs against my will and without my consent that could have seriously harmed myself and my nursing son, because NO ONE EVER THOUGHT TO ASK ME ABOUT WHAT I WANTED before doing things to my body. They really did try, some of the nurses - it was just such a foreign concept to consult me about my own body that they couldn't remember to do it. Over and over and over. Until I couldn't keep track anymore.

I was treated like an idiot by the obviously exasperated surgeon, because I wanted to be an active participant in my own birth, to simply give birth, instead of having birth done to me, and I was sedated asap so that I would stop inconveniencing the staff with my silly demands to be treated with basic human respect.

I can't remember half of my dead daughter's birth because of what they did to me, and my records are an absolute joke of inaccuracy. My child's sudden death HAD to be horrible, but her birth didn't. The hospital policy made sure that it was, anyway. And I get to feel lucky that it wasn't worse.

I KNEW what they would try to do to me when I went there, telling them that my fetus was dead, only to be totally ignored and treated like a pork chop - they "had" to catheterize and restick me before they would even run a Doppler to verify what I was telling them, and even after they released me from the theatre table restraints after doing so, they REFUSED to believe that I could possibly know anything about what was going on in my own body, instead choosing to treat me as though I couldn't possibly understand what was happening and just needed to take drugs to "relax." I repeatedly told them I did not

want pain medication, and yet was condescended to because "it doesn't matter now," and tricked into consenting to opiates and tranquilizers within half an hour. I was literally told that the pain medicine I agreed to a tiny dose of, in order to get the nurses to stop harassing me, was not an opiate, when I specifically asked. When it was pushed, the walls started swimming and I could barely speak to tell my husband what was happening. It was contraindicated for nursing mothers, as it is dangerous for nursing children. They gave me more of it AFTER they saw my child nursing. The initial dose was so heavy that I don't remember consenting to the Ativan, but apparently I did, according to a trusted friend who witnessed this birth.

They put Cytotec (not labeled for obsteteric use and contraindicated in cases where uterine rupture chance is heightened, like during massive abruption) in my mouth, and only told me what it was after I asked. I had to spit it at them while holding my dead daughter when I remembered how dangerous it is in my particular situation. It's just what all women are given after birth, evidently, so that's what I was going to get, without even being told. The only medication that was medically indicated, of the dozen or so that I was given without my consent or knowledge, was the blood pressure stabilizer I was given, to correct the spike that occurred when I entered the ambulance, for obvious reasons. The surgeon attempted to convince me that I must have been suffering from undiagnosed preeclampsia, which I had not symptoms of before entering the hospital after my baby had died.

My midwife was denied entry to the ambulance- despite their lack of any kind of monitoring equipment and her portable Doppler that she waved at them, begging to come. They did not believe me when I told them exactly when her heart stopped - they had no way to verify a heart tone, and she died in the driveway while explained to them, over and over, what a midwife is, and why I don't live at my midwife's birth cottage.

They were required to strap me flat on my back to a gurney for the ten minute ride to the hospital, where gurney pushers laughed about who would take credit for "this one." I've never been in more pain in my life than I was in that truck and those hallways, because of their non-evidence-based POLICIES. They were not allowed to give me a bottle of water, because of their non-evidence-based polices that are not even in line with the ACOG. My midwife was treated like garbage by anyone who knew who she was, there. She wasn't even allowed to hold my hand, despite being the only person in the room who actually knew what I needed.

I was laughed at when I told the nurses that it was time to help catch, in the bathroom, while they just kept telling me to lie down on the bed for them - in the most difficult and painful position to birth in. They seriously had no idea how to help me birth beyond drugging me and telling me to lie on my back, and seemed to truly believe baby would not come until I did. They just ran around yelling while I birthed my baby as normally as I could, in spite of them - as if I was doing something wrong by just birthing my own damn baby. I could barely catch her under the influence of the large doses of mind altering drugs they had forced me to take, and I wouldn't have been able to if she had come five minutes later. That's when the memory gaps started and I couldn't remember what I was saying for an entire sentence.

I slept that night not caring where my son was, because of what they did to me. That was his first ever night away from me.

They think this is normal. They think this is just how birth is. That totally debasing and humiliating and harassing and frightening and coercing birthing people, ignoring what they say, and treating them like indigent infants is just part of leaving dignity behind during childbirth.

It is not. That was likely the closest thing to a normal birth those nurses have ever seen - and all it did was confirm for them what they already knew - that midwives kill babies and mothers can't be trusted to make their own choices. According to my records, my OK CPM is "unlicensed," and I need to be "educated about labor and delivery," (not birthing, of course - that's too active a verb), but that I am "not interested." This is what will be added to statistics in Arkansas, regarding midwifery clients. More about how we are just silly children who need to be ALLOWED certain things, within limits, regarding their own bodies and lives. I am water cooler fodder about how stupid women who seek respect during pregnancy and birth are.

They gave us a box of prayers and polyester baby clothes and instructions not to cry, after they stole my placenta and told me that my child died BECAUSE I sought respectful care, instead of what they do, to begin with. That if I I'd just been at the hospital before any symptoms appeared, like I "should have been," she could have been cut out of me and all would be well. Because what I need doesn't matter, clearly.

Placental abruptions cannot even be diagnosed until after birth, let alone prevented or stopped, regardless of birth environment or technology. My sister in law lost a baby at term, the same way, IN THAT SAME HOSPITAL, where she was "supposed to be."

The new rules making access to respectful care via midwives, instead of the non-evidence-based and often disrespectful and infantilizing "care" provided by surgeons even harder for us to access will do zero things except require us to travel or see unlicensed midwives for our care - for the crime of wanting to be treated like adults with sound minds, even when pregnant.

It looks like I'll be sticking with my highly experienced and skilled OK midwife, regardless of where we live in AR, for my next pregnancy, despite my desire to access a little bit more diagnostic technology next time, just in case. I cannot afford private insurance, and do not qualify for Medicaid unless I am pregnant - a Medicaid that covers ZERO percent of the care I wanted while pregnant and birthing. Medicaid covered the incorrectly documented hospital debacle that left me broken. The hospital hasn't called me since I had to pull my own ports to get out, after hours of being told I could go home and they'd get me ready to leave. My midwife did my postpartum care, and will not allow me to finish paying her fee. My hospital records indicate "emotional support given," as if it was just one more prescription from the surgeon.

It is unconscionable that I am not "allowed" total autonomy over my own body when pregnant, in my own state. I will NOT be subject to "mandatory" vaginal exams, for any reason. The only thing mandatory about my pregnancy and birth is that I am the boss of my own body, period. Strange old men have zero right to make rules about what I can and cannot choose for my own vagina.

You are not allowed to not allow me to make my own decisions about my own body and my own fetus. Ever. Period. If you are seriously thinking that I might not be up to the responsibly of managing this basic human right to bodily autonomy and informed consent, and making intelligent decisions for myself, without consulting YOU first, how on earth do you believe I am capable of parenting children? Any remote decision making regarding any of this that begins with the idea of what we are going to "allow" adult people to do with their own lives and bodies is fundamentally flawed, and will do nothing but endanger us and our babies because we cannot access the care we need because of your fear of women having too much power over their own lives.

Asking obstetricians if their DIRECT COMPETITION should be something that should be ALLOWED to access easily is exactly like asking Walmart if a Costco is SAFE to build down the street, and if we should trust shoppers to be able to choose between them. And Walmart doesn't tie people to tables and drug them against their will."

Response: ADH recognizes a woman's right to refuse medical tests or procedures. The LLM must inform the client of all tests, procedures, treatments, medications, or referrals specified in Section 300 of the Rules and Regulations. With the proposed revisions to the Rules and Regulations, LLMs who maintain specific credentials (Section 104) have within their scope of practice the authority to continue care for women who choose to decline certain tests or procedures.

ADH also recognizes the right of women to choose their health care providers. However, implicit in the choice to go with any particular licensed health care provider is the expectation that the provider will work within their scope of practice. These Rules and Regulations simply set out the scope of practice for Licensed Lay Midwives in Arkansas.

Neither the Arkansas Board of Health nor ADH has the authority to regulate the practice of medicine or advance practice nursing and cannot direct the individual clinical practice of any physician, certified nurse midwife (CNM) or nurse practitioner. Individual medical providers determine what exams and/or tests are necessary for a comprehensive risk assessment based on individual or agency policies, protocols and practice guidelines. Any perceived violations of policies, protocols or guidelines should be reported to the relevant agency or authorities by any client experiencing them.

9. Name: ICAN of Central Arkansas (email received 9/18/17)

Comment: On behalf of the three Arkansas Chapters of the International Cesarean Awareness Network and our membership, we would like to voice our support for removing previous cesarean delivery from the restrictions in the Arkansas midwifery regulations.

Response: Please see response regarding VBAC lower down in this comment.

a. We support an informed consent process to return ownership of decision making to consumers.

Response: Thank you for your support of the informed refusal (consent) process included in these revisions.

b. ICAN recognizes that midwifery-model care provides woman-centered care with as good or better outcomes than medical-model care. This includes both hospital-based and out-of-hospital based midwives. Because of this, ICAN supports efforts to increase availability of midwifery care for all women, regardless of where they plan to give birth.

Response: ADH also recognizes the right of women to choose their health care providers. However, implicit in the choice to go with any particular licensed health care provider is the expectation that the provider will work within their scope of practice. These Rules and Regulations simply set out the scope of practice for Licensed Lay Midwives in Arkansas.

c. With regard to women with a previous cesarean or cesareans, research is clear that planning a vaginal birth after cesarean (VBAC) is a safe option for many. The risks incurred by a woman planning a VBAC are essentially the same as any laboring woman. Midwives are trained to respond to rare, if life-threatening complications and this training is sufficient for the client desiring a VBAC. A spontaneous,

physiological labor typically results in a VBAC and does not represent a special procedure. Given that one- third of all women will undergo a surgical delivery, the population of women who may consider VBAC for a subsequent pregnancy is large and expected to continue to increase. Since finding support for a VBAC within the hospital system is difficult or even impossible in many communities, out-of-hospital care for women desiring a VBAC is essential to any serious effort to reduce the cesarean rate and its associated maternal and fetal consequences.

ICAN categorically opposes any proposed licensure or regulation of midwives that in any way restricts the access of women desiring midwife support for a planned VBAC. We believe such restrictions are short-sighted and will ultimately damage both midwives and the women they serve. Such restrictions consign a significant number of women to unnecessary repeat surgery, increasing maternal and fetal morbidity and mortality. Statute limitations on VBAC are never acceptable and criminalizing midwives who attend primary VBACs is never progress. There are no mitigating circumstances or rationalizations that justify these restrictions. Support is always available for any efforts to educate and promote VBAC as a safe option for most women with a previous cesarean, consistent with our Mission Statement: To improve maternal-child health by preventing unnecessary cesareans through education, providing support for cesarean recovery, and promoting Vaginal Birth After Cesarean (VBAC).

Response: There are two relevant questions to be answered in the decision of whether the Rules and Regulations should allow, or not, vaginal birth after cesarean (VBAC) in home settings in Arkansas.

The first question is: "Is VBAC less risky than an elective repeat cesarean section?" and the answer to that question is "Yes". The American College of Obstetricians and Gynecologists (ACOG) corroborates that in the ACOG Clinical Management Guideline (reaffirmed 2013) and ACOG Practice Bulletin (Number 115, 2010)) as does the Arkansas Department of Health (ADH). However, to make that statement out of context and without taking into consideration the full picture gives the wrong impression of the risks—and this is also affirmed by ACOG.

VBAC is the outcome of a process, and that process is "trial of labor after cesarean", or TOLAC. To be counted as a VBAC, one needs to have successfully gone through TOLAC. According to ACOG, anywhere from 20- 40% of TOLACs fail to proceed to VBAC (depending on what studies one looks at). Also, most maternal morbidity that occurs during TOLAC occurs when repeat cesarean delivery becomes necessary. In those situations, the outcome is not VBAC. Because high-risk individuals and needed cesarean deliveries are filtered out during TOLAC, VBAC becomes associated with fewer complications and a failed TOLAC is associated with more complications than an elective repeat cesarean delivery. Consequently, risk for maternal morbidity is inversely related to a woman's probability of achieving VBAC. Therefore, to say simply that "VBAC is less risky than an elective repeat cesarean section" without also counting the failed TOLACs, leaves out the risk borne by the 20-40% of women who do not make it through TOLAC to VBAC.

The second relevant question is: "Is VBAC safe at home within the Arkansas setting?". Clearly, for some individuals who successfully go through TOLAC, VBAC at home may be a safe option. However, as mentioned before, 20-40% of TOLACs do fail (often unexpectedly) and a cesarean section is needed. In a lot of cases, that is an emergency

situation and the immediate access to services can sometimes determine the difference between life and death for mother and baby.

Having said this, ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

With this in mind, ADH is convening a committee to study and make recommendations to the ADH regarding steps that can be taken towards the reduction of unnecessary elective cesarean deliveries, and removing barriers to access to TOLAC and VBAC in Arkansas. We look forward to the deliberations and the recommendations of this Committee so that we can collaboratively improve the 'system of care' for all women in Arkansas.

d. What studies has ADH based the decision to prohibit the controversial issue of VBAC with a licensed lay midwife?

Response: ADH relies on evidence and guidelines provided by the American College of Obstetricians and Gynecologists (ACOG).

e. Of the 22 states that regulate homebirth/midwifery and permit VBAC in their regulations, how many did the state contact for information on the success of their programs prior to making a decision regarding VBAC with a licensed lay midwife in Arkansas?

Response: According to our analysis of the latest data, there are only 21 states in the country that legally allow VBAC at home with a midwife. We did not consult individually with any other states. We did review charts regarding the availability and conditions for VBAC in other states prepared by the Midwives Alliance of North America, as well as individual Rules and Regulations from these states. Decisions were made by our clinical staff based on evidence-based guidelines and recommendations, while taking into consideration the specific circumstances in Arkansas.

10. Name: Jennifer Nelson (email received 9/19/17)

Comment: I have always hoped to have a natural unmediated childbirth with a midwife. My first baby was breach requiring a transfer to a hospital for a c-section and my second was a hospital VBAC, feeing this was my only option for a natural birth. I interviewed and had consult appointments with several "VBAC friendly doctors", hospitals and nurses prior to becoming pregnant to get the best compromise for my ideal birth experience. I arrived at the hospital and everything my doctor and I discussed for the previous several months did not matter. The nursing staff fought me every step of the way, trying to force me to stay in the bed, being hostile, loud, harsh and demanding, refusing to let me have even water or taking hours to get me a cup of ice chips. The doctor lost my trust immediately saying he was not the one I should have had a consult with but rather the hospital administration and lawyers. I had to get administrators involved and nearly left the hospital with very limited options while in active labor. The hospital put my baby and myself at risk, stalling my labor with unnecessary stress. Hospitals and doctors are fabulous for what they are trained for, medical emergencies and an abnormal

birth experience (including my c-section) but a natural birth with a relaxing and birth promoting atmosphere are not. I will not go back to a hospital for a natural birth and limited options in the state of Arkansas will force me to either go out of state or have an unassisted home birth.

Please consider allowing midwifes at birth centers and home births help women have the natural birth experience they are looking for. The alternative is not have the experienced midwife and attempting an unassisted birth or traveling long distances while in labor.

Thank you for taking the time to read a bit about my experience and hopes for the future.

Response: There are two relevant questions to be answered in the decision of whether the Rules and Regulations should allow, or not, vaginal birth after cesarean (VBAC) in home settings in Arkansas.

The first question is: "Is VBAC less risky than an elective repeat cesarean section?" and the answer to that question is "Yes". The American College of Obstetricians and Gynecologists (ACOG) corroborates that in the ACOG Clinical Management Guideline (reaffirmed 2013) and ACOG Practice Bulletin (Number 115, 2010)) as does the Arkansas Department of Health (ADH). However, to make that statement out of context and without taking into consideration the full picture gives the wrong impression of the risks—and this is also affirmed by ACOG.

VBAC is the outcome of a process, and that process is "trial of labor after cesarean", or TOLAC. To be counted as a VBAC, one needs to have successfully gone through TOLAC. According to ACOG, anywhere from 20- 40% of TOLACs fail to proceed to VBAC (depending on what studies one looks at). Also, most maternal morbidity that occurs during TOLAC occurs when repeat cesarean delivery becomes necessary. In those situations, the outcome is not VBAC. Because high-risk individuals and needed cesarean deliveries are filtered out during TOLAC, VBAC becomes associated with fewer complications and a failed TOLAC is associated with more complications than an elective repeat cesarean delivery. Consequently, risk for maternal morbidity is inversely related to a woman's probability of achieving VBAC. Therefore, to say simply that "VBAC is less risky than an elective repeat cesarean section" without also counting the failed TOLACs, leaves out the risk borne by the 20-40% of women who do not make it through TOLAC to VBAC.

The second relevant question is: "Is VBAC safe at home within the Arkansas setting?". Clearly, for some individuals who successfully go through TOLAC, VBAC at home may be a safe option. However, as mentioned before, 20-40% of TOLACs do fail (often unexpectedly) and a cesarean section is needed. In a lot of cases, that is an emergency situation and the immediate access to services can sometimes determine the difference between life and death for mother and baby. It is the charge of ADH to set Rules and Regulations that protect the health and well-being of all Arkansans at the population level. We recognize that some individuals bear less of a risk than others, but the Rules and Regulations are designed to minimize risk at the population level.

Having said this, ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We recommend that hospitals, maternity care providers, health care and professional liability

insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

With this in mind, ADH is convening a committee to study and make recommendations to the ADH regarding steps that can be taken towards the reduction of unnecessary elective cesarean deliveries, and removing barriers to access to TOLAC and VBAC in Arkansas. We look forward to the deliberations and the recommendations of this Committee so that we can collaboratively improve the 'system of care' for all women in Arkansas.

11. Name: Tanya Smith (email received 9/19/17)

Comment: As a member of the Midwifery Advisory Board (MAB), I have invested many years in the proposed changes to the Licensed Lay Midwife rules and regulations along with Arkansas midwives and the health department. There are many great updates in this draft, many of which ADH and the MAB readily agreed to include and/or edit. This draft is the result of years of collaboration between ADH and the MAB. In my representation of consumers on the MAB, I fully support the recognition of patient autonomy and the inclusion of informed consent and refusal in this draft of the rules and regulations. I believe this to be a significant step forward and anticipate Arkansas midwifery consumers to be very happy with this aspect of the rules and regulations.

Response: Thank you for your support of these revisions. We also appreciate your tireless work on the Midwife Advisory Board and your advice and guidance during the revision process.

The proposed draft is not without controversy despite the fantastic collaboration that occurred during this process. The most significant controversial issue is the continued exclusion of women who have a history of cesarean from care with a LLM. Arkansas has a history of failing to ensure access to vaginal birth after cesarean (VBAC) in the hospital and at home. Women are rejecting unnecessary cesareans and facing many barriers in the process. Some are trying to fight hospitals that have official policies banning a trial of labor after a cesarean. Others are traveling from far corners of the state to Little Rock to give birth, sometimes over 100 miles. Women are angry that options for normal birth after cesarean are limited in Arkansas, including their inability to hire the midwifery care provider of their choice because of the restrictions in the midwifery regulations.

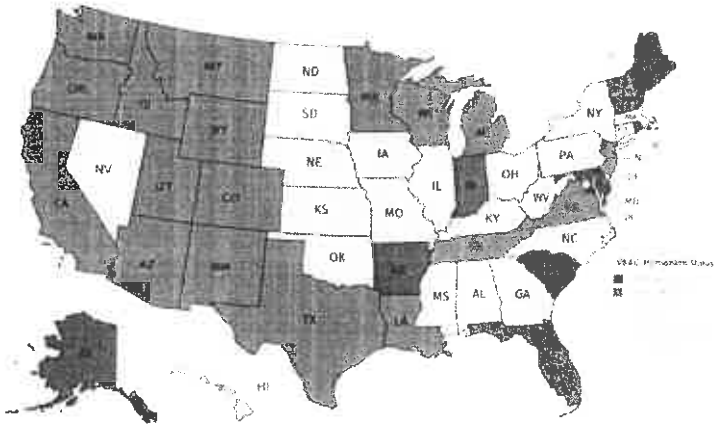
Response: Please see response regarding VBAC lower down in this comment.

According to most studies, a trial of labor after previous cesarean carries about a 0.5% risk of uterine rupture. Uterine rupture is an important consideration for any woman considering VBAC. Arkansas is one of very few states that exclude VBAC from homebirth. In fact, we are only one of SEVEN states (that license and regulate midwives) to prohibit VBAC. VBAC is accessible in ALL surrounding states (see image below for details). Midwives in unregulated states are unrestricted and accept clients with a history of cesarean. You will also notice that THREE of our surrounding states include access to VBAC with a homebirth midwife in their regulations.

Response: According to our analysis of the latest data, among our surrounding states, only Texas and Tennessee legally allow VBAC at home with a midwife.

Some obstetrical emergencies, such as prolapsed cord, are a statistically higher risk and yet they are accepted risks associated with homebirth. Why is a *less* risky aspect of birth not permitted when higher risk scenarios are accepted?

Response: A prolapsed umbilical cord is a rare (<0.2%) condition that can occur in a healthy pregnancy without any pre-existing risk factors. It is a diagnosis that is made at delivery and cannot be predicted. Therefore, a prolapsed cord is not a condition that the Rules and Regulations can preclude from LLM care.



The National Institutes of Health (NIH, 2010) expressed concerns about barriers to access a trial of labor after cesarean:

"We are concerned about the barriers that women face in gaining access to clinicians and facilities that are able and willing to offer trial of labor. Given the low level of evidence for the requirement for "immediately available" surgical and anesthesia personnel in current guidelines, [emphasis mine] we recommend that the American College of Obstetricians and Gynecologists and the American Society of Anesthesiologists reassess this requirement with specific reference to other obstetric complications of comparable risk, [emphasis mine] risk stratification, and in light of limited physician and nursing resources."

ACOG has yet to remove the low level "immediately available" recommendation.

Further, the NIH charged policymakers to lead the way to improving access to care stating:

"We recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor.

We are concerned that medical-legal considerations add to, and in many instances exacerbate, these barriers to trial of labor. Policymakers, providers, and other stakeholders must collaborate in developing and implementating [sic] appropriate strategies to mitigate the chilling effect the medical-legal environment has on access to care." [emphasis mine] (NIH, 2010)

According to informal surveys conducted by the International Cesarean Awareness Network in 2008, VBAC is banned in nearly 50% of Arkansas hospitals either by official policy or a lack of providers willing to attend VBAC. Since then, there has been very little change in Arkansas despite NIH recommendations to improve access to trial of labor after cesarean.

The NIH consensus addressed risk magnitude as well. Dr. George Macones presented an important abstract at the NIH consensus. It is important to consider in its entirety, but I wanted to highlight this section:

"Beauty, and risk, are in the eyes of the beholder. Short-term maternal complication rates (uterine rupture) are similar to other procedures in obstetrics and medicine overall. Short-term neonatal risks are possibly increased with VBAC, although close in magnitude to complications observed with any vaginal delivery. The effect of multiple repeat cesareans on maternal health can be profound, mainly

due to complications of multiple surgeries and issues related to abnormal placentation." (Macones, 2010)

As you can see, consumers are *not* asking the Board of Health to take egregious risks by removing this exclusion to midwifery services. Sincerely, no one loves and desires to protect the baby more than the expectant mother. VBAC and repeat cesarean both carry risks and benefits. Women are the ones who endure these risks and they should be the ones who choose which manner of delivery and birth location is acceptable to them even if that choice includes homebirth after previous cesarean. Thank you again for your thoughtful attention to this very important controversial issue.

Response: There are two relevant questions to be answered in the decision of whether the Rules and Regulations should allow, or not, vaginal birth after cesarean (VBAC) in home settings in Arkansas.

The first question is: "Is VBAC less risky than an elective repeat cesarean section?" and the answer to that question is "Yes". The American College of Obstetricians and Gynecologists (ACOG) corroborates that in the ACOG Clinical Management Guideline (reaffirmed 2013) and ACOG Practice Bulletin (Number 115, 2010)) as does the Arkansas Department of Health (ADH). However, to make that statement out of context and without taking into consideration the full picture gives the wrong impression of the risks—and this is also affirmed by ACOG.

VBAC is the outcome of a process, and that process is "trial of labor after cesarean", or TOLAC. To be counted as a VBAC, one needs to have successfully gone through TOLAC. According to ACOG, anywhere from 20- 40% of TOLACs fail to proceed to VBAC (depending on what studies one looks at). Also, most maternal morbidity that occurs during TOLAC occurs when repeat cesarean delivery becomes necessary. In those situations, the outcome is not VBAC. Because high-risk individuals and needed cesarean deliveries are filtered out during TOLAC, VBAC becomes associated with fewer complications and a failed TOLAC is associated with more complications than an elective repeat cesarean delivery. Consequently, risk for maternal morbidity is inversely related to a woman's probability of achieving VBAC. Therefore, to say simply that "VBAC is less risky than an elective repeat cesarean section" without also counting the failed TOLACs, leaves out the risk borne by the 20-40% of women who do not make it through TOLAC to VBAC.

The second relevant question is: "Is VBAC safe at home within the Arkansas setting?". Clearly, for some individuals who successfully go through TOLAC, VBAC at home may be a safe option. However, as mentioned before, 20-40% of TOLACs do fail (often unexpectedly) and a cesarean section is needed. In a lot of cases, that is an emergency situation and the immediate access to services can sometimes determine the difference between life and death for mother and baby. It is the charge of ADH to set Rules and Regulations that protect the health and well-being of all Arkansans at the population level. We recognize that some individuals bear less of a risk than others, but the Rules and Regulations are designed to minimize risk at the population level.

Having said this, ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

With this in mind, ADH is convening a committee to study and make recommendations to the ADH regarding steps that can be taken towards the reduction of unnecessary elective cesarean deliveries, and removing barriers to access to TOLAC and VBAC in Arkansas. We look forward to the deliberations and the recommendations of this Committee so that we can collaboratively improve the 'system of care' for all women in Arkansas.

12. Name: Mariah Harder Reescano (email received 9/19/17)

Comment: My name is Mariah Reescano and I live in N. Little Rock, Arkansas. I have three children. The first was delivered by cesarean but the second & third were delivered by VBAC (Vaginal Birth After Cesarean). As you work to update the Rules and Regulations regarding the practice of Licensed Lay Midwifery, I am writing to ask that you please remove VBAC from the list of prohibited births in the regulations that govern midwives. I strongly believe that families should have the right to choose to have a VBAC birth at home with a licensed midwife. I feel that by utilizing an Informed Consent process, this practice (common in many states) could safely and compassionately occur in Arkansas. My Cesarean delivery was an incredibly traumatic experience. While pregnant with my second child, I was dismayed to find that my only non-hospital option was to have an unattended home birth, an option that for most women is not an option at all. In addition, many hospitals in Arkansas do not allow mothers who have had a cesarean delivery to even attempt a VBAC. As I researched the risks and benefits of a VBAC vs repeat Cesarean, the VBAC was, to me, clearly the better, safer, option. Therefore, I could not understand why a trained and licensed midwife would be prohibited from serving a mother who wanted a VBAC. I ask that you allow women in Arkansas the right to have a choice in birth options for themselves and their families. I ask that you allow me the right to choose a home birth with a Licensed Lay Midwife.

Thank you for your time and attention to this important matter and for the work that you do to make home births a safe and available option for the women in our state.

Response: ADH recognizes a woman's right to refuse medical tests or procedures. The LLM must inform the client of all tests, procedures, treatments, medications, or referrals specified in Section 300 of the Rules and Regulations. With the proposed revisions to the Rules and Regulations, LLMs who maintain specific credentials (Section 104) have within their scope of practice the authority to continue care for women who choose to decline certain tests or procedures.

There are two relevant questions to be answered in the decision of whether the Rules and Regulations should allow, or not, vaginal birth after cesarean (VBAC) in home settings in Arkansas.

The first question is: "Is VBAC less risky than an elective repeat cesarean section?" and the answer to that question is "Yes". The American College of Obstetricians and Gynecologists (ACOG) corroborates that in the ACOG Clinical Management Guideline (reaffirmed 2013) and ACOG Practice Bulletin (Number 115, 2010)) as does the Arkansas Department of Health (ADH). However, to make that statement out of context and without taking into consideration the full picture gives the wrong impression of the risks—and this is also affirmed by ACOG.

VBAC is the outcome of a process, and that process is "trial of labor after cesarean", or TOLAC. To be counted as a VBAC, one needs to have successfully gone through TOLAC.

According to ACOG, anywhere from 20- 40% of TOLACs fail to proceed to VBAC (depending on what studies one looks at). Also, most maternal morbidity that occurs during TOLAC occurs when repeat cesarean delivery becomes necessary. In those situations, the outcome is not VBAC. Because high-risk individuals and needed cesarean deliveries are filtered out during TOLAC, VBAC becomes associated with fewer complications and a failed TOLAC is associated with more complications than an elective repeat cesarean delivery. Consequently, risk for maternal morbidity is inversely related to a woman's probability of achieving VBAC. Therefore, to say simply that "VBAC is less risky than an elective repeat cesarean section" without also counting the failed TOLACs, leaves out the risk borne by the 20-40% of women who do not make it through TOLAC to VBAC.

The second relevant question is: "Is VBAC safe at home within the Arkansas setting?". Clearly, for some individuals who successfully go through TOLAC, VBAC at home may be a safe option. However, as mentioned before, 20-40% of TOLACs do fail (often unexpectedly) and a cesarean section is needed. In a lot of cases, that is an emergency situation and the immediate access to services can sometimes determine the difference between life and death for mother and baby. It is the charge of ADH to set Rules and Regulations that protect the health and well-being of all Arkansans at the population level. We recognize that some individuals bear less of a risk than others, but the Rules and Regulations are designed to minimize risk at the population level.

Having said this, ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

With this in mind, ADH is convening a committee to study and make recommendations to the ADH regarding steps that can be taken towards the reduction of unnecessary elective cesarean deliveries, and removing barriers to access to TOLAC and VBAC in Arkansas. We look forward to the deliberations and the recommendations of this Committee so that we can collaboratively improve the 'system of care' for all women in Arkansas.

13. Name: Megan Williams (email received 9/19/17)

Comment: a. I cannot believe you are trying to coerce women into antibiotics and out of the care of their preferred midwife based on a test that can change from week to week. Because let's be honest: your hope is by forcing women positive for group b strep to seek the care of an OBGYN instead of a midwife that they will be coerced into antibiotics during their labor by hospital staff (likely using scare tactics or "implied consent" to treat the laboring woman). What happens if she declines antibiotics at the hospital? Why couldn't she have just delivered with her midwife at home or at the birthing center? What are you seeking to accomplish by doing this? If a woman wants antibiotics for strep b, she can choose to switch medical providers without the state forcing her to.

Response: The ADH recognizes a patient's right to choose their care provider and their desire for a continuous relationship with their preferred provider. The ADH seeks to ensure that all clients receive high quality care and believes that integration of consultation and referral does not represent a break in the continuity of care.

b. Group B Strep Prophylaxis Indications. CDC approved Group B Strep intrapartum prophylaxis (per ADH approved guidelines) must be obtained for the clients listed below (A-D). Clients who refuse antibiotics will be transferred from midwifery care to a physician for hospital care unless a physician agrees to supervise the LLM care of the client. The plan of care agreed to by the physician and the LLM must be documented and submitted as an incident report to ADH.

What happens when the mother refuses, which is her right to do so, and is left without any care? If something goes wrong is the department going to take responsibility?

> **Response: A client with a positive Group B Streptococcus (GBS) test is not precluded from LLM care. Conditions that preclude midwifery care are listed in section 303.01, 305.01, 307.01 and 309.01. The only GBS situation that precludes midwifery care is "Unknown GBS status prior to sixteen (16) hours of ruptured membranes, when delivery is not imminent" (305.01.12), which requires immediate transport to the planned hospital.**
>
> **Clients who test positive for Group B Streptococcus may continue care with an LLM if a physician/certified nurse midwife (CNM) consultation or referral is made. The client must be examined by a physician or CNM currently practicing obstetrics. A plan of care for the condition must be established, and execution of the plan must be documented. This does not preclude midwifery care, but does seek to ensure that Centers for Disease Control and Prevention (CDC) approved GBS prophylaxis is available during the woman's labor.**

c. Aren't you opening up MWs to civil liability by mandating them to abandon a client? A client could sue them for patient abandonment. If the MW stays with the client then she is in violation of the rules and is now exposed to administrative liability correct?

> **Response: Patient autonomy allows for the right refuse treatment. This has no bearing on civil liability. If the licensed lay midwife (LLM) is unable to adhere to the plan of care due to a patient's refusal of antibiotics, then arrangements should be made for a physician to supervise the LLM care of the client or the client must be transferred to a physician for hospital care (Section 303.03).**

d. Clients who test positive for Group B Strep in the urinary tract at any time in the current pregnancy (regardless of repeated testing that is negative for Group B Strep). Vaginal/rectal testing for Group B Strep is not indicated when the urine testing is positive for Group B Strep in the current pregnancy.

> **Response: Neonates born to women who have heavy GBS colonization, such as with GBC Bacteriuria, are at increased risk for neonatal infection. (ACOG Committee Opinion 485, Reaffirmed 2016). If a client is found to have a GBS positive urine culture or have previously given birth to a neonate with early-onset GBS disease, then intrapartum antibiotic prophylaxis is indicated per CDC guidelines.**

e. A woman may test positive at certain times and negative at others isn't that right? Therefore, it is important for all pregnant women to be tested for group B strep between 35 to 37 weeks of every pregnancy correct? This is according to ACOG and the American Pregnancy Association. Based on this recommendation wouldn't it make more sense to say if the client tested positive at any time between 35-37 weeks?

Response: The goal of the rules and regulations as related to Group B Streptococcus is to prevent GBS disease in Newborns. The ADH practice of universal screening at 35-37 weeks of gestation and intrapartum antibiotic prophylaxis was developed using CDC guidelines, is endorsed by ACOG and the American Academy of Pediatrics (AAP), and serves as the basis of this prevention strategy and rules and regulations.

f. What is the point in transferring care if the client declines antibiotics with the midwife won't she decline antibiotics at the hospital?

I hope you will consider the ramifications of this proposal.

Response: A client with a positive Group B Streptococcus (GBS) test is not precluded from LLM care. Conditions that preclude midwifery care are listed in section 303.01, 305.01, 307.01 and 309.01. The only GBS situation that precludes midwifery care is "Unknown GBS status prior to sixteen (16) hours of ruptured membranes, when delivery is not imminent" (305.01.12), which requires immediate transport to the planned hospital.

Clients who test positive for Group B Streptococcus may continue care with an LLM if a physician/certified nurse midwife (CNM) consultation or referral is made. The client must be examined by a physician or CNM currently practicing obstetrics. A plan of care for the condition must be established, and execution of the plan must be documented. This does not preclude midwifery care, but does seek to ensure that Centers for Disease Control and Prevention (CDC) approved GBS prophylaxis is available during the woman's labor.

14. Name: Halee Burchfield (email received 9/19/17)

Comment: Five years ago I became pregnant with my first child and after studying all of my options I determined that the best course of action for my family would be to hire a midwife and plan a home birth. I was fortunate that I had access to friends who could tell me of their experience both of hospital and home births, and I was fortunate that I had access to a skilled midwife.

Throughout the course of the last five years I have become increasingly interested and invested in the culture of birth here in Arkansas as well as the outcomes. I am encouraged that the ADH and MAB have worked to update outdated regulations and I am discouraged that these regulations do not go far enough toward bringing Arkansas into the modern era of best practices.

I have no desire to hold up the passing of these regulations but I emphatically want to see changes continue that will be for the betterment of our citizens.

a. For instance: it is unconscionable that the would require in these regulations discriminatory practices like not allowing women to opt out of testing that is undesired. That women are subjected to having to seek out care from outside providers; twice, and possibly three times! That women are told that they must submit to state sanctioned vaginal exams by strangers is not only a violation of rights, but it isn't even good medicine.

Will the state be requiring that women who have chosen an obstetrician to submit to vaginal exams? The department was made aware at liaison committee meetings that women were being coerced into vaginal exams at local health clinic visits which are mandated in the rules, I myself testified to this. What formal action has been taken to address this problem?

Does the department acknowledge a competent adult as the right to refuse medical treatment? Does the department acknowledge that these regulations are discriminatory?
How does the department reconcile mandatory clinic visits with the right to refuse medical treatment?

Response: ADH recognizes a woman's right to refuse medical tests or procedures. The LLM must inform the client of all tests, procedures, treatments, medications, or referrals specified in Section 300 of the Rules and Regulations. With the proposed revisions to the Rules and Regulations, LLMs who maintain specific credentials (Section 104) have within their scope of practice the authority to continue care for women who choose to decline certain tests or procedures.

Neither the Arkansas Board of Health nor ADH has the authority to regulate the practice of medicine or advance practice nursing and cannot direct the individual clinical practice of any physician, CNM or nurse practitioner. Individual medical providers determine what exams and/or tests are necessary for a comprehensive risk assessment based on individual or agency policies, protocols and practice guidelines. Any perceived violations of policies, protocols or guidelines should be reported to the relevant agency or authorities by any client experiencing them.

Regarding the reporting to the ADH of alleged forced vaginal exams, no specific ADH employees were named in these reports. However, meetings and discussion were conducted by ADH with relevant supervisors to inform and educate clinical staff regarding the right of clients to refuse any tests or examinations. In addition, changes have been made to the ADH report form that outlines the findings of the risk assessment and the new forms are being processed and are expected to go into effect in November.

Regarding 'mandatory clinic visits', the Rules and Regulations require that a comprehensive risk assessment be performed by a physician or certified nurse midwife (CNM) currently practicing obstetrics or an ADH clinician at or near the time care is initiated with the licensed lay midwife (LLM) and at or near the 36th week of gestation (Section 302.01). These risk assessments are required by these Rules and Regulations so that the expected low-risk status of the client can be determined. They also often allow the LLM client to develop a relationship with a medical provider other than the LLM who can provide care in the event that a condition develops that requires a transfer from LLM care. Depending on the level of training and certification of the LLM, the client is able to continue under the care of an LLM with appropriate informed refusal of certain tests and procedures that are part of the clinic visit, but not the clinic visit itself.

b. Another point of non evidence based practice and the state interfering in a discriminatory manner is by the requiring of antibiotics for midwifery clients who have tested positive for Group B Strep at anytime during their pregnancy. Will the state be subjecting hospital birthing clients to these same standards?

Response: Clients who test positive for Group B Streptococcus may continue care with an LLM if a physician/certified nurse midwife (CNM) consultation or referral is made. The client must be examined by a physician or CNM currently practicing obstetrics. A plan of care for the condition must be established, and execution of the plan must be documented. This does not preclude midwifery care, but does seek to ensure that Centers for Disease

Control and Prevention (CDC) approved GBS prophylaxis is available during the woman's labor.

c. Another important point of contention is the continued banning of women who have had previous surgical births from being attended by a midwife. In a state which has such high cesarean rate, one would think the state would be seeking to address this. Many hospitals in this state, despite being against evidence based medicine and ACOG have banned vaginal birth after cesarean. Then the state bans the use of midwife, forcing women into repeated, unnecessary, unwanted and dangerous surgeries. According to most studies, a trial of labor after previous cesarean carries about a 0.5% risk of uterine rupture. Uterine rupture is an important consideration for any woman considering VBAC. Arkansas is one of very few states that exclude VBAC from homebirth. In fact, we are only one of SEVEN states (that license and regulate midwives) to prohibit VBAC. VBAC is accessible in ALL surrounding states. Midwives in unregulated states are unrestricted and accept clients with a history of cesarean. You will also notice that THREE of our surrounding states include access to VBAC with a homebirth midwife in their regulations. Some obstetrical emergencies, such as prolapsed cord, are a statistically higher risk and yet they are accepted risks associated with homebirth. Why is a less risky aspect of birth not permitted when higher risk scenarios are accepted?
Is the state willing to regulate hospitals and force them to accept VBAC women if it is going to disallow them from seeking care from a licensed midwife?
Does the state recognize that rules like this make birth more risky for everyone by effectively informing women that they should not be honest with their care providers and that they should withhold information, or that they will be driving birth underground to unlicensed midwives?

Response: According to our analysis of the latest data, among our surrounding states, only Texas and Tennessee legally allow VBAC at home with a midwife.

A prolapsed umbilical cord is a rare (<0.2%) condition that can and does occur in a healthy pregnancy without any pre-existing risk factors. It is a diagnosis that is made at delivery and cannot be predicted. Therefore, a prolapsed cord is not a condition that the Rules and Regulations can preclude from LLM care.

There are two relevant questions to be answered in the decision of whether the Rules and Regulations should allow, or not, vaginal birth after cesarean (VBAC) in home settings in Arkansas.

The first question is: "Is VBAC less risky than an elective repeat cesarean section?" and the answer to that question is "Yes". The American College of Obstetricians and Gynecologists (ACOG) corroborates that in the ACOG Clinical Management Guideline (reaffirmed 2013) and ACOG Practice Bulletin (Number 115, 2010)) as does the Arkansas Department of Health (ADH). However, to make that statement out of context and without taking into consideration the full picture gives the wrong impression of the risks—and this is also affirmed by ACOG.

VBAC is the outcome of a process, and that process is "trial of labor after cesarean", or TOLAC. To be counted as a VBAC, one needs to have successfully gone through TOLAC. According to ACOG, anywhere from 20- 40% of TOLACs fail to proceed to VBAC (depending on what studies one looks at). Also, most maternal morbidity that occurs during TOLAC occurs when repeat cesarean delivery becomes necessary. In those situations, the outcome is not VBAC. Because high-risk individuals and needed cesarean deliveries are filtered out during TOLAC, VBAC becomes associated with fewer complications and a failed TOLAC is associated with more complications than an elective repeat cesarean

delivery. Consequently, risk for maternal morbidity is inversely related to a woman's probability of achieving VBAC. Therefore, to say simply that "VBAC is less risky than an elective repeat cesarean section" without also counting the failed TOLACs, leaves out the risk borne by the 20-40% of women who do not make it through TOLAC to VBAC.

The second relevant question is: "Is VBAC safe at home within the Arkansas setting?". Clearly, for some individuals who successfully go through TOLAC, VBAC at home may be a safe option. However, as mentioned before, 20-40% of TOLACs do fail (often unexpectedly) and a cesarean section is needed. In a lot of cases, that is an emergency situation and the immediate access to services can sometimes determine the difference between life and death for mother and baby. It is the charge of ADH to set Rules and Regulations that protect the health and well-being of all Arkansans at the population level. We recognize that some individuals bear less of a risk than others, but the Rules and Regulations are designed to minimize risk at the population level.

Having said this, ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

With this in mind, ADH is convening a committee to study and make recommendations to the ADH regarding steps that can be taken towards the reduction of unnecessary elective cesarean deliveries, and removing barriers to access to TOLAC and VBAC in Arkansas. We look forward to the deliberations and the recommendations of this Committee so that we can collaboratively improve the 'system of care' for all women in Arkansas.

d. I am concerned about ACT 759 of 2013 which amended statute 25-12-201 that says any proposed rule or rules change must be accompanied by a Financial Impact Statement (FIS) which realistically states the new or increased cost of obligation of the proposed rule or rule change on private government. These regulations state that mothers cannot exercise constitutional rights to decline medical treatment like antibiotics for group b strep, and moms must now go to the doctor or emergency room to have a baby. Will the state being paying for these increased costs?

In the case of VBAC - if the mother wants to avoid surgical birth but is forced back to a hospital and has another cesarean will the state be paying for her increased and undesired costs?

Response: The current rules require LLMs to follow the CDC guidelines for the treatment of GBS. And therefore an increase in the rate of transfers to physicians, CNMs, and hospitals is not anticipated. The proposed rules more clearly state how the LLM is to apply the CDC guidelines to the management of mothers who test positive for GBS and those with unknown GBS status. The proposed rules if adopted will permit mothers to remain in the care of the LLM who meets required criteria for licensure and certification in the event the mother refuses treatment for GBS; this is an expanded scope of practice that is not permitted under the current LLM rules.

e. My final point of contention is the continued description of midwives as "licensed lay midwives" this is an insulting and incorrect labeling of educated professionals. Frankly, it makes the state look further

inept. Certified Professional Midwives are highly educated individuals, trained in the scope of practice of birth. To call them "lay" is to incorrectly insinuate that they are not educated. Something that the state should know is not accurate based upon licensure in and of itself as well as the training that they must receive and tests that must be passed to receive licensure. Update the terminology.

Response: Arkansas Code §17-85-101, et seq. states that: "This chapter shall be known as the "Licensed Lay Midwife Act". Arkansas Code §17-85-107(a) " The State Board of Health is empowered to license lay midwives in this state pursuant to regulations established by the board to include, but not be limited to :

(1) The qualifications for licensure;
(2) Standards of practice for prenatal, intrapartum, and postpartum care of mother and baby;
(3) Physician supervision, physician consultation, licensed nurse-midwife supervision or consultation, or physician and hospital backup;
(4) Grievance procedures; and
(5) Recordkeeping and reporting.

Furthermore, it should be noted that not all of the licensed lay midwives in Arkansas have completed the credential requirements of a "Certified Professional Midwife" so it would not be accurate to make this change at this time.

Thank you again for your thoughtful attention to this very important controversial issue.

15. Name: Halee Burchfield (email received 9/19/17)

Comment: I would like this article included in its entirety for the public comment, this article is about Arizona, but one could replace almost every instance of the word Arizona with Arkansas and the article would ring true for our situation here.

http://birthmonopoly.com/arizona-birth-monopoly-mandatory-surgery-or-forced-vaginal-exams/

SEE ATTACHMENT No. 2 (page 89) for complete article.

Response: ADH recognizes a woman's right to refuse medical tests or procedures. The LLM must inform the client of all tests, procedures, treatments, medications, or referrals specified in Section 300 of the Rules and Regulations. With the proposed revisions to the Rules and Regulations, LLMs who maintain specific credentials (Section 104) have within their scope of practice the authority to continue care for women who choose to decline certain tests or procedures.

ADH also recognizes the right of women to choose their health care providers. However, implicit in the choice to go with any particular licensed health care provider is the expectation that the provider will work within their scope of practice. These Rules and Regulations simply set out the scope of practice for Licensed Lay Midwives in Arkansas.

16. Name: ICAN of Central Arkansas (email received 9/19/17),
(In reply to the ADH response to their initial comment (see #6 above))

Comment: It was our understanding that a reason was not required of an organization with at least 25 members. However, we are not requesting it for no reason. It has come to our attention that some our members never received notification of the public comment period despite requesting to be added to the list. In fact, one of our members just found out last night at our monthly meeting that the deadline was this week. We would like more time to make sure ALL of our members are aware the public comment period is open.

Response: The notice was sent on 8/21/2017 to every person whose name and email address we had on our list. We have provided the legally required notice and comment period, and the revised rules themselves have been available on our website for a number of months. We will be very happy to entertain any comments received during this period, or at the public hearing on Thursday, September 21, at 10:00 a.m. at the Arkansas Department of Health auditorium.

The Arkansas Administrative Procedures Act allows for at least a thirty-day comment period. There is not a valid reason for an extension of that time period.

17. Name: Brittany Oaks (email received 9/19/17)

Comment: Please provide a copy of the notice of rulemaking that ADH sent to any appropriate trade, industry or professional publications as required by Ark. Code Ann. 25-15-204 (amended by Act 759 of 2013). Interested trade groups and organizations include the American College of Nurse Midwives, Midwives Alliance of North America (MANA), the North American Registry of Midwives (NARM), and the Midwifery Accreditation Council (MEAC). This is not a definitive list so please respond with the date and the name of the representative you sent the notice to whether included in the above list or not.

Response: The code requires that notice be published "In a newspaper of general daily circulation" and "when appropriate, in those trade, industry, or professional publications that the agency may select..." ADH published the notice in the Democrat Gazette, and it was published by the Secretary of State on the internet, as required. The notice was not published in any national trade industry or professional publications.

The ADH also sent notifications to any individual and/or organization that requested to be included on a list of interested parties, including the following:
Becky Fay, CNM – President of the Arkansas Chapter of the American College of Nurse Midwives
Brenda May, BSN, RN – President of the Arkansas Nurses Association
Karen J. Whatley, JD - Executive Director of the Arkansas State Medical Board
John Kirtley – Executive Director of the Arkansas Board of Pharmacy
Curtis Lowery, MD – Director, UAMS ANGELS Program
ICAN of Central Arkansas
Sue Tedford, MNSc, APRN – Executive Director, Arkansas State Board of Nursing
All licensed lay midwives (active license status as of 8/21/2017)
All lay midwife apprentices (active permit status as of 8/21/2017)
All interested parties who had requested to be notified

Please see Attachment 1 (page 88) for a copy of the notice sent out by ADH.

18. Name: Kimberly Anderson (email received 9/19/17)

Comment: My name is Kimberly Anderson, and I'm a mother of a 3 year old born by cesarean and a 1 year old born vaginally. 3 years ago my son Benjamin was born through an emergent cesarean following what I now know was an unnecessary induction of labor by artificial rupture of membranes. I lost my care provider over the decision, and was forced to see a different provider instead of the midwife that I had originally selected for my prenatal care- this person had no knowledge of me or my case prior to our meeting that day. I cannot go in to all of the details here for sake of time and the sacredness of my family's story, but I will say that that was one of the most difficult experiences of my life. Both my autonomy of choice and choice over my body were taken away that day. I was coerced, misled, and naked, and violated. I suffered anxiety and PTSD for which I spent months in therapy. To this day, I have anxiety even walking into a hospital.

The ACOG states that Pregnancy is not an exception to the principle that a decisionally capable patient has the right to refuse treatment, even treatment needed to maintain life. Therefore, a decisionally capable pregnant woman's decision to refuse recommended medical or surgical interventions should be respected. Would you all not agree that this also applies to the right to choose her care provider? By continuing to ignore the wishes of the consumers and Midwives Advisory Board to allow home VBAC, you're effectively revoking a pregnant woman's choice over her body and her medical care directly against the guidelines ACOG.

I'm not upset that I had a cesarean, I'm upset at the way that I was treated. Revoking my ability to choose my provider and where and with whom I birth my baby violates me all over again. ADH, you can do better. You must do better. Remove the home VBAC ban.

I have 2 questions, but first a quote from George Macones' presentation at the NIH consensus on VBAC in 2010.

"Beauty, and risk, are in the eyes of the beholder. Short term complication rates (uterine rupture) are similar to other procedures in obstetrics and medicine overall. Short-term neonatal risks are possibly increased with VBAC, although close in magnitude to complications observed with any vaginal delivery. The effect of multiple repeat cesareans on maternal health can be profound, mainly due to complications of multiple surgeries and issues related to abnormal placentation."

Given the dangers of repeat cesarean and the low risk of VBAC at home, why does ADH continue to prohibit this option?

Are you aware that every state surrounding Arkansas allows midwives to attend VBACs? What is it that all of these states have learned about home VBACs that we haven't? Why are we the only state in our area of the country that does not allow for home VBACS?

Response: According to our analysis of the latest data, among our surrounding states, only Texas and Tennessee legally allow VBAC at home with a midwife.

There are two relevant questions to be answered in the decision of whether the Rules and Regulations should allow, or not, vaginal birth after cesarean (VBAC) in home settings in Arkansas.

The first question is: "Is VBAC less risky than an elective repeat cesarean section?" and the answer to that question is "Yes". The American College of Obstetricians and Gynecologists (ACOG) corroborates that in the ACOG Clinical Management Guideline (reaffirmed 2013) and ACOG Practice Bulletin (Number 115, 2010)) as does the Arkansas Department of Health (ADH). However, to make that statement out of context and without taking into consideration the full picture gives the wrong impression of the risks—and this is also affirmed by ACOG.

VBAC is the outcome of a process, and that process is "trial of labor after cesarean", or TOLAC. To be counted as a VBAC, one needs to have successfully gone through TOLAC. According to ACOG, anywhere from 20- 40% of TOLACs fail to proceed to VBAC (depending on what studies one looks at). Also, most maternal morbidity that occurs during TOLAC occurs when repeat cesarean delivery becomes necessary. In those situations, the outcome is not VBAC. Because high-risk individuals and needed cesarean deliveries are filtered out during TOLAC, VBAC becomes associated with fewer complications and a failed TOLAC is associated with more complications than an elective repeat cesarean delivery. Consequently, risk for maternal morbidity is inversely related to a woman's probability of achieving VBAC. Therefore, to say simply that "VBAC is less risky than an elective repeat cesarean section" without also counting the failed TOLACs, leaves out the risk borne by the 20-40% of women who do not make it through TOLAC to VBAC.

The second relevant question is: "Is VBAC safe at home within the Arkansas setting?". Clearly, for some individuals who successfully go through TOLAC, VBAC at home may be a safe option. However, as mentioned before, 20-40% of TOLACs do fail (often unexpectedly) and a cesarean section is needed. In a lot of cases, that is an emergency situation and the immediate access to services can sometimes determine the difference between life and death for mother and baby. It is the charge of ADH to set Rules and Regulations that protect the health and well-being of all Arkansans at the population level. We recognize that some individuals bear less of a risk than others, but the Rules and Regulations are designed to minimize risk at the population level.

Having said this, ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

With this in mind, ADH is convening a committee to study and make recommendations to the ADH regarding steps that can be taken towards the reduction of unnecessary elective cesarean deliveries, and removing barriers to access to TOLAC and VBAC in Arkansas. We look forward to the deliberations and the recommendations of this Committee so that we can collaboratively improve the 'system of care' for all women in Arkansas.

ADH also recognizes the right of women to choose their health care providers. However, implicit in the choice to go with any particular licensed health care provider is the expectation that the provider will work within their scope of practice. These Rules and Regulations simply set out the scope of practice for Licensed Lay Midwives in Arkansas.

19. Name: Janna Aughenbaugh (email received 9/19/17)

Comment: Good evening! My name is Janna, and I have had two midwife-attended homebirths in Arkansas. The welcoming of my children into this world was a wonderful experience, and one that provided the safest delivery and highest level of care for my two babies. The ADH midwifery rules deeply affects me and my family. Let me be extremely clear. Unless I have a medical reason to do so, I will birth at home. Restricting my right to choose and restricting my chosen care providers unnecessarily will only harm me and my babies, as I would have less choice in my care provider. I would choose to birth unassisted instead choosing to birth in a hospital when not medically necessary.

The ADH draft midwifery rules includes the following definition:
LABOR SUPPORT ATTENDANT An individual who is present, at the request of the client, to provide emotional or physical support for the client and her family.

a. Is a Labor Support Attendant the same as a Doula? Why doesn't the department use the term Doula? Did the ADH consult with a representative from DONA when crafting the rules pertaining to Labor Support Attendants? If the answer to the preceding question is no please state why DONA was not consulted. Is a Labor Support Attendant the same as a "support person" in 106 of the rules, section A? Is a Labor Support Attendant paid or unpaid?

> **Response: There is currently no legal recognition or regulation for the practice of doulas in Arkansas. The ADH staff overseeing the licensure and regulation of LLMs in Arkansas recognizes the supportive roles of others who are commonly present for labor. It is necessary to define the role of each assistant or support person in relation to the Arkansas rules for LLMs, and for the LLMs to be aware of and note any care provided, since it is the LLMs who are ultimately accountable for the care of the client. Section 106, #2 states: The LLM shall monitor and document the care and procedures performed by any LLM assistant or labor support attendant in the client's medical record.**

b. Section 106, C. states, "The LLM is accountable for documenting the presence during labor and birth of any unlicensed labor/birth assistant (support person) engaged by the client."

- Does "engaged" mean someone who was hired and if so by whom?
- Is the client the pregnant mother?
- Can a "client" be a father or other family member or friend?
- Which labor/birth assistants are licensed?

> **Response: This comment refers to Section 106 Item C, which must be from an earlier draft of the proposed rules. The latest draft dated 3/8/2017 does not include item C in Section 106; it does include the definitions for Client, Labor Support Attendant and LLM Assistant (Section 103. DEFINITIONS, included below).**
>
> **103.09. CLIENT - A pregnant woman, a postpartum woman for a minimum of thirty (30) days, or her healthy newborn for the first fourteen (14) days of life who is the recipient of LLM services.**
> **103.12. LABOR SUPPORT ATTENDANT - An individual who is present at the request of the client to provide emotional or physical support for the client and her family.**

103.13. LLM ASSISTANT - An individual who is present at the request of the LLM at any point during the course of midwifery care of the client to provide services under LLM supervision.

c. Please provide a definition for the following: "Labor Support Attendant", "Support Person", and "Unlicensed Labor/Birth Assistant".

Response: "Labor Support Attendant" definition is in Section 103.12 of the revised Rules and Regulations (copied above). The terms "Support Person", and "Unlicensed Labor/Birth Assistant" are not used in the latest version of the revised Rules and Regulations.

The purpose of Section 106 is to state the rules for LLMs who engage an assistant to complement their work and describes the LLM tasks that may be delegated to an assistant and the LLM tasks that may not be delegated. Section 106 rules identify the role of the LLM as distinct and separate from the supportive role of those providing assistance or support, and Arkansas Registered Nurses who may participate in the care of the mother during labor and birth.

Please provide the names of the Labor Support Attendants the ADH consulted with when crafting this rule.

Please provide the names of the Un-Licensed Labor Support Attendants the ADH consulted with when crafting this rule.

Please provide the names of the Support Persons the ADH consulted with when crafting this rule.

Please provide the list of best scientific, technical or economic data that the ADH relied on when drafting the requirement of a licensed lay midwife to document the presence of private parties, not subject to the Midwifery rules, present at a birth in a private home as required by Ark. Code Ann. §25-15-204.

- Please note which data in particular demonstrated a need for this rule.
- Please state the consequences of the rule and the alternatives the ADH considered.

One could reasonably presume that anyone who is present in the family's home for a birth is there by request of the family and thus providing support; Is it the contention of the ADH that the names of all adults in the private home of a laboring woman should be documented and presented to the ADH?

Response: The ADH did not consult the specific individuals indicated above. The proposed rules were developed by the staff of the ADH Women's Health Section working with members of the Midwife Advisory Committee; this committee is comprised of Licensed Lay Midwives and consumers of LLM services. This rule is not based on specific scientific, technical or economic data, and it is not the intention of the Rules and Regulations that all persons in the private home of a laboring woman should be documented and presented to the ADH. The intention is to convey that the Rules hold the LLM, who is the ultimate person responsible for the care provided, to be aware of, supervise, and document any relevant care provided to the client by others.

20. Name: Joel Boyd (email received 9/20/17)

Comment: My wife and I are parents of two wonderful children. Our first was born by cesarean, and my second was born via VBAC. Achieving a VBAC was not easy for my wife. We were going to a doctor in Jonesboro, Arkansas and even though her first OBGYN told her she was a good candidate for a VBAC, when she moved to Jonesboro she was continually told that she should schedule a C-section. Doesn't ACOG recommend that mothers should have a choice to have a trial of labor after cesarean? We ended up being so uncomfortable in dealing with the doctors that we ended up staying home for the birth of our second child. While risky, it was a beautiful and wonderful experience and we will have our next child, whenever that is, at home again. Please change the law to allow midwives to see patients at home who have had a previous cesarean. The odds are in the favor of a successful birth. Going to a hospital just further increases the chance of high hospital involvement and more of a change that a repeat cesarean will occur.

Response: There are two relevant questions to be answered in the decision of whether the Rules and Regulations should allow, or not, vaginal birth after cesarean (VBAC) in home settings in Arkansas.

The first question is: "Is VBAC less risky than an elective repeat cesarean section?" and the answer to that question is "Yes". The American College of Obstetricians and Gynecologists (ACOG) corroborates that in the ACOG Clinical Management Guideline (reaffirmed 2013) and ACOG Practice Bulletin (Number 115, 2010)) as does the Arkansas Department of Health (ADH). However, to make that statement out of context and without taking into consideration the full picture gives the wrong impression of the risks—and this is also affirmed by ACOG.

VBAC is the outcome of a process, and that process is "trial of labor after cesarean", or TOLAC. To be counted as a VBAC, one needs to have successfully gone through TOLAC. According to ACOG, anywhere from 20- 40% of TOLACs fail to proceed to VBAC (depending on what studies one looks at). Also, most maternal morbidity that occurs during TOLAC occurs when repeat cesarean delivery becomes necessary. In those situations, the outcome is not VBAC. Because high-risk individuals and needed cesarean deliveries are filtered out during TOLAC, VBAC becomes associated with fewer complications and a failed TOLAC is associated with more complications than an elective repeat cesarean delivery. Consequently, risk for maternal morbidity is inversely related to a woman's probability of achieving VBAC. Therefore, to say simply that "VBAC is less risky than an elective repeat cesarean section" without also counting the failed TOLACs, leaves out the risk borne by the 20-40% of women who do not make it through TOLAC to VBAC.

The second relevant question is: "Is VBAC safe at home within the Arkansas setting?". Clearly, for some individuals who successfully go through TOLAC, VBAC at home may be a safe option. However, as mentioned before, 20-40% of TOLACs do fail (often unexpectedly) and a cesarean section is needed. In a lot of cases, that is an emergency situation and the immediate access to services can sometimes determine the difference between life and death for mother and baby. It is the charge of ADH to set Rules and Regulations that protect the health and well-being of all Arkansans at the population level. We recognize that some individuals bear less of a risk than others, but the Rules and Regulations are designed to minimize risk at the population level.

Having said this, ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas.

The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

With this in mind, ADH is convening a committee to study and make recommendations to the ADH regarding steps that can be taken towards the reduction of unnecessary elective cesarean deliveries, and removing barriers to access to TOLAC and VBAC in Arkansas. We look forward to the deliberations and the recommendations of this Committee so that we can collaboratively improve the 'system of care' for all women in Arkansas.

21. Name: Brunilda Anderson (email received 9/20/17)

Comment: I am writing to show my support for women who have had prior cesareans. My daughter had a cesarean, and she was able to have an unmedicated natural birth without complications for her second child. I am writing to show support for her. She would like to have a home birth, whenever she is pregnant again, and I believe the option for her to birth at home, is her choice, and her choice alone. Please allow licensed midwives to treat and assist women who have had previous cesareans for home births. Thank you!

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22. Name: Jason Frater (email received 9/20/17)

Comment: It is somewhat disconcerting that midwives consider there is herd immunity, a fallacious and unscientific matter undermines your profession. You may wish to consider this factual information http://myeclinik.com/harvard-trained-immunologist-demolishes-california-pro-mass-vaccination-legislation/?utm_campaign=shareaholic&utm_medium=facebook&utm_source=socialnetwork

Response: The comment is noted. However, under the proposed revisions, licensed lay midwives are, in fact, encouraged to be vaccinated and not to rely on herd immunity. Nevertheless, no vaccines are required for licensure (Section 108).

23. Name: Sandra Davis (email received 9/20/17)

Comment: You are requesting/demanding that midwives be vaccinated with dangerous poisons in the name of herd immunity. Please educate yourselves.

HERD IMMUNITY FROM VACCINES is scientifically IMPOSSIBLE

Includes multiple links to articles discussing vaccinations.

Response: The comment is noted. However, under the proposed revisions, licensed lay midwives are, in fact, encouraged to be vaccinated and not to rely on herd immunity. Nevertheless, no vaccines are required for licensure (Section 108).

24. Name: Gabrielle Thrailkill, CPM, LLM (email received 9/20/17)

Comment: Good Morning! I am emailing my approval of the rules and regulations governing Arkansas Midwives. I am unable to be at the Public Meeting. I am a Licensed Lay Midwife in Arkansas and Texas. I am registered and practice in Oklahoma, as well. I live in DeQueen, AR. Thank you.

Response: Thank you for your support of these revisions.

25. Name: Janna Aughenbaugh (email received 9/20/17)

Comment: Hello, I noticed that in your proposed midwifery rules, you encourage midwives to be vaccinated with the dtap/tdap. Are you aware that this vaccination lessons symptoms, but does not prevent infection or the transmission of infection? In other words, a midwife could have pertussis but due to this vaccination not know it and unknowingly pass the disease on to her clients. This is a horrible recommendation and should be thrown out. Please do your part to protect newborn babies and their mothers by getting rid of this recommendation. Vaccination and midwifery have nothing to do with each other.

Response: Proposed vaccination of providers against pertussis is intended to prevent symptomatic illness among LLMs. Symptomatic illness caused by pertussis among adults may be mild, and pertussis may be overlooked as the cause, which contributes to its spread.

It is true that vaccination against pertussis may not totally prevent the spread of pertussis bacteria to others. This is because the pertussis vaccine will not prevent a vaccinated person from being exposed to the bacteria and developing a brief infection before the immunity stimulated by the vaccine is able to stop the infection and prevent the development of illness. This is similar to other vaccines, as this is how vaccines work. With pertussis specifically, a vaccinated person may briefly carry the pertussis bacteria in their nose and throat, and during that time, they can spread it to others. However, the risk of spreading the pertussis bacteria to others is much less if the carrier has been vaccinated than if they were unvaccinated and develop illness.

In other words, an unvaccinated person with pertussis is much more likely to spread pertussis bacteria-- in greater amounts and for longer periods of time--compared to a vaccinated person. There are many studies that show that unvaccinated persons spread pertussis more easily than vaccinated persons. Therefore, unvaccinated persons pose a higher risk to the people they are in close contact with. Tdap vaccination among health care providers, parents, and caregivers has been proven to prevent the majority of pertussis in infants, which is the group most vulnerable to severe illness and death from pertussis.

26. Name: Amy Ward (email received 9/20/17)

Comment: I am writing to show my support for women who have had prior cesareans. My friend had a cesarean, and she was able to have an unmedicated natural birth without complications for her second child. I am writing to show support for her. She would like to have a home birth, whenever she is pregnant again, and I believe the option for her to birth at home, is her choice, and her choice alone. Please allow licensed midwives to treat and assist women who have had previous cesareans for home births. Thank you!

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Having said this, ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

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27. Name: Ida Darragh, CPM, LLM (email received 9/20/17)

Comment: I am speaking in support of the revision to the Arkansas Midwives Rules and Regulations. Please include my comments in the public hearing being held on Sept 21, 2017.

I have been a midwife in Arkansas since 1980, and received the first license issued by the Department of Health on March 8, 1985. I have remained licensed since that date, and have served on the Midwifery Advisory Board several times during the past 32 years. I also serve as the Executive Director of the

North American Registry of Midwives, which issues the credential, Certified Professional Midwife. I am also the Executive Director of the Arkansas Childbirth Institute, a state non-profit that provides support for continuing education for midwives, student midwives, doulas, and childbirth professionals in Arkansas.

I served on the original committee that drafted the Rules and Regs after licensure was established, and have served on each of the committees that proposed revisions to the Midwives Advisory Board since 1985. Following the previous revision in 2007, the Midwives Advisory Board began meeting with the ADH Liaison Committee over the two issues that were discussed but not accepted in the 2007 revisions: the limited use of emergency medications and the option for licensed midwives to attend VBACs (Vaginal Birth After Cesarean) in out-of-hospital settings. By 2012, it was determined by the ADH that licensed midwives could not be allowed to carry and administer a specific list of emergency medications to treat postpartum hemorrhage without a change in the licensure statute. However, the discussion about adding VBAC to the list of permitted conditions continued to be on the discussion agenda based on the good results obtained in states that do allow VBAC with licensed midwives. VBAC continues to be one of the issues of **highest interest** among the public in the state, and the public voice supporting VBAC has been loud and clear in the years leading up to this current revision. Although VBAC is still not allowed in the current revision, I can guarantee you that the consumers will continue to push for inclusion in the next revision. It is not an issue that will go away; indeed, the consumer voice will continue to grow.

Although there continues to be a lot of work needed to remedy the deficiencies in the proposed regulations, **good progress has been made in acknowledging the right of the consumer to make informed choices in her health care.** For that reason, I do support the current draft of revisions to the regulations, and encourage the Board of Health to support these regulations through the remainder of the process. I also urge the Board of Health to continue to listen to the public on issues related to their birth choices as we continue the process of developing good regulations for midwives and their clients.

Again, I speak in support of the 2017 revision to the Arkansas Rules and Regulations

Response: These comments were also presented verbally at the public hearing. Please see response to this comment as part of the public hearing verbal comments.

28. Name: Mari Nitaska-Jordan (email received 9/20/17)

Comment: I am a 33 year old mother to a daughter who could not receive midwifery service because of limited insurance coverage. I ended up having an unnecessary cesarean on Easter Sunday 4 hours before the 24 hour mark simply because of doctors decision on my slow progress. It still bothers me today that I could not have midwifery service and home birth as I initially desired. I strongly believe the hospital could not accommodate me as a patient to its fullest especially because of the fact that I went in the night before Easter Sunday. The doctor on call even said not to have the baby that night because she was going to church in the morning. The hospital setting does not offer the personable atmosphere and comfort a midwife can. I feel that I was treated as just a patient number whatever they were seeing that day. Giving birth should be an option where the mother can feel comfort and confidence in delivering in which I could not have at all. Please do your part to support more mothers and future mothers who are seeking full potential in midwifery services and its better access.

Response: Thank you for your comment and sharing your experience. These revised Rules and Regulations are intended to increase LLM training and certification and to allow greater number of qualified women to receive care from an LLM.

29. Name: Chelsea Cameron, RN (email received 9/20/17)

Comment: As a member of the Midwifery Advisory Board (MAB), I have an invested interest in the proposed changes to the Licensed Lay Midwife rules and regulations along with Arkansas midwives and the health department. There are many great updates in this draft, many of which ADH and the MAB readily agreed to include and/or edit. This draft is the result of years of collaboration between ADH and the MAB. In my representation of consumers on the MAB, I fully support the recognition of patient autonomy and the inclusion of informed consent and refusal in this draft of the rules and regulations. I believe this to be a significant step forward and anticipate Arkansas midwifery consumers to be very happy with this aspect of the rules and regulations.

Response: Thank you for your support of these revisions. We also appreciate your tireless work on the Midwife Advisory Board and your advice and guidance during the revision process.

The proposed draft is not without controversy despite the fantastic collaboration that occurred during this process. The most significant controversial issue is the continued exclusion of women who have a history of cesarean from care with a LLM. Arkansas has a history of failing to ensure access to vaginal birth after cesarean (VBAC) in the hospital and at home. Women are rejecting unnecessary cesareans and facing many barriers in the process. Some are trying to fight hospitals that have official policies banning a trial of labor after a cesarean. Others are traveling from far corners of the state to Little Rock to give birth, sometimes over 100 miles. Families who feel an out of hospital VBAC birth is best for them are only left with the option of traveling to a boarder state or having an unassisted home birth. Women are angry that options for normal birth after cesarean are limited in Arkansas, including their inability to hire the midwifery care provider of their choice because of the restrictions in the midwifery regulations.
According to most studies, a trial of labor after previous cesarean carries about a 0.5% risk of uterine rupture. Uterine rupture is an important consideration for any woman considering VBAC.

Response: Please see response re VBAC lower down in this comment.

Arkansas is one of very few states that exclude VBAC from homebirth. In fact, we are only one of SEVEN states (that license and regulate midwives) to prohibit VBAC. VBAC is accessible in ALL surrounding states (see image below for details). Midwives in unregulated states are unrestricted and accept clients with a history of cesarean. You will also notice that THREE of our surrounding states include access to VBAC with a homebirth midwife in their regulations.

Response: According to our analysis of the latest data, among our surrounding states, only Texas and Tennessee legally allow VBAC at home with a midwife.

Some obstetrical emergencies, such as prolapsed cord, are a statistically higher risk and yet they are accepted risks associated with homebirth. Why is a *less* risky aspect of birth not permitted when higher risk scenarios are accepted?

Response: A prolapsed umbilical cord is a rare (<0.2%) condition that can and does occur in a healthy pregnancy without any pre-existing risk factors. It is a diagnosis that is made at delivery and cannot be predicted. Therefore, a prolapsed cord is not a condition that the Rules and Regulations can preclude from LLM care.

The National Institutes of Health (NIH, 2010) expressed concerns about barriers to access a trial of labor after cesarean:

"We are concerned about the barriers that women face in gaining access to clinicians and facilities that are able and willing to offer trial of labor. Given the low level of evidence for the requirement for "immediately available" surgical and anesthesia personnel in current guidelines, [emphasis mine] we recommend that the American College of Obstetricians and Gynecologists and the American Society of Anesthesiologists reassess this requirement with specific reference to other obstetric complications of comparable risk, [emphasis mine] risk stratification, and in light of limited physician and nursing resources."

ACOG has yet to remove the low level "immediately available" recommendation.

Further, the NIH charged policymakers to lead the way to improving access to care stating:

"We recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor.

We are concerned that medical-legal considerations add to, and in many instances exacerbate, these barriers to trial of labor. Policymakers, providers, and other stakeholders must collaborate in developing and implementating [sic] appropriate strategies to mitigate the chilling effect the medical-legal environment has on access to care." [emphasis mine] (NIH, 2010)

According to informal surveys conducted by the International Cesarean Awareness Network in 2008, VBAC is banned in nearly 50% of Arkansas hospitals either by official policy or a lack of providers willing to attend VBAC. Since then, there has been very little change in Arkansas despite NIH recommendations to improve access to trial of labor after cesarean.

The NIH consensus addressed risk magnitude as well. Dr. George Macones presented an important abstract at the NIH consensus. It is important to consider in its entirety, but I wanted to highlight this section:

"Beauty, and risk, are in the eyes of the beholder. Short-term maternal complication rates (uterine rupture) are similar to other procedures in obstetrics and medicine overall. Short-term neonatal risks are possibly increased with VBAC, although close in magnitude to complications observed with any vaginal delivery. The effect of multiple repeat cesareans on maternal health can be profound, mainly due to complications of multiple surgeries and issues related to abnormal placentation." (Macones, 2010)

As you can see, consumers are *not* asking the Board of Health to take egregious risks by removing previous cesarean exclusion to midwifery services. Sincerely, no one loves and desires to protect the baby more than the expectant mother. VBAC and repeat cesarean both carry risks and benefits. Women are the ones who endure these risks and they should be the ones who choose which manner of delivery and birth location is acceptable to them even if that choice includes homebirth after previous cesarean. Thank you again for your thoughtful attention to this very important controversial issue.

Response: There are two relevant questions to be answered in the decision of whether the Rules and Regulations should allow, or not, vaginal birth after cesarean (VBAC) in home settings in Arkansas.

The first question is: "Is VBAC less risky than an elective repeat cesarean section?" and the answer to that question is "Yes". The American College of Obstetricians and Gynecologists (ACOG) corroborates that in the ACOG Clinical Management Guideline (reaffirmed 2013) and ACOG Practice Bulletin (Number 115, 2010)) as does the Arkansas Department of Health (ADH). However, to make that statement out of context and without taking into consideration the full picture gives the wrong impression of the risks—and this is also affirmed by ACOG.

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ADH recognizes a woman's right to refuse medical tests or procedures. The LLM must inform the client of all tests, procedures, treatments, medications, or referrals specified in Section 300 of the Rules and Regulations. With the proposed revisions to the Rules and Regulations, LLMs who maintain specific credentials (Section 104) have within their scope of practice the authority to continue care for women who choose to decline certain tests or procedures.

ADH also recognizes the right of women to choose their health care providers. However, implicit in the choice to go with any particular licensed health care provider is the expectation that the provider will work within their scope of practice. These Rules and Regulations simply set out the scope of practice for Licensed Lay Midwives in Arkansas.

30. Name: Stephanie Dorr (email received 9/20/17)

Comment: I would like to provide you some information regarding the forced vaccinations program they are promoting around the world. Have you heard of informed consent? Created after Nazi Germany? Did you know that it took only 50 physicians in Germany to create the eugenics program? Did you also know that the 1986 vaccine immunity law violates our 7th Amendment? I would ask as a representative of the people that you educate yourself regarding the truth about vaccinations before you force the public (human beings) in our great state into an ideology that violates our first and seventh amendment rights and Nuremberg laws.

Know your ingredients:
https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf
Know your side effects: https://www.fda.gov/BiologicsBloodVaccines/Vaccines/ApprovedProducts
Know your risks: https://www.cdc.gov/vaccines/pubs/pinkbook/hepb.html
https://www.ncbi.nlm.nih.gov/books/NBK220067/
This law violates our 7th Amendment – 7TH Amendment to the constitution states: In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury, shall be otherwise re-examined in any Court of the United States, then according to the rules of the common law.
YOU HAVE NO RIGHT TO A "JURY" TRIAL IF ANYONE HAS A SIDE EFFECT FROM VACCINATIONS!
1983: A healthy-born child according to the CDC vaccination schedule [2] receives 6 vaccines in the first 15 months of life. The autism rate is 1:10,000.
2017: A healthy-born child according to the CDC vaccination schedule [3] receives 23 vaccines in the first 15 months of life. The autism rate is 1:68.
1986: Law created to give vaccine manufacturers immunity.
Notice a correlation but not a causation here? This correlation does not causation statement is integrated within the medical community and states that vaccines are never the cause of anything. Can you honestly with a straight face say this to be true?

CDCs study that claims vaccines do not cause Autism. The guy who wrote the study is a fugitive for defrauding the CDC.
https://oig.hhs.gov/fraud/fugitives/profiles.asp
OIG Fugitive: Poul Thorsen

- From approximately February 2004 until February 2010, Poul Thorsen executed a scheme to steal grant money awarded by the Centers for Disease Control and Prevention (CDC). CDC had awarded grant money to Denmark for research involving infant disabilities, autism, genetic disorders, and fetal alcohol syndrome. CDC awarded the grant to fund studies of the relationship between autism and the exposure to vaccines, the relationship between cerebral palsy and infection during pregnancy, and the relationship between developmental outcomes and fetal alcohol exposure.
- Thorsen worked as a visiting scientist at CDC, Division of Birth Defects and Developmental Disabilities, before the grant was awarded.
- The initial grant was awarded to the Danish Medical Research Council. In approximately 2007, a second grant was awarded to the Danish Agency for Science, Technology, and Innovation. Both agencies are governmental agencies in Denmark. The research was done by the Aarhaus University and Odense University Hospital in Denmark.
- Thorsen allegedly diverted over $1 million of the CDC grant money to his own personal bank account. Thorsen submitted fraudulent invoices on CDC letterhead to medical facilities assisting in the research for reimbursement of work allegedly covered by the grants. The invoices were addressed to Aarhaus University and Sahlgrenska University Hospital. The fact that the invoices were on CDC letterhead made it appear that CDC was requesting the money from Aarhaus University and Sahlgrenska University Hospital although the bank account listed on the invoices belonged to Thorsen.
- In April 2011, Thorsen was indicted on 22 counts of Wire Fraud and Money Laundering.
- According to bank account records, Thorsen purchased a home in Atlanta, a Harley Davidson motorcycle, an Audi automobile, and a Honda SUV with funds that he received from the CDC grants.
- Thorsen is currently in Denmark and is awaiting extradition to the United States.

I hope you find this an interesting read regarding eugenics:
https://highschoolbioethics.georgetown.edu/units/cases/unit4_5.html
I am assuming you are a smart! Which do you believe in more, science or the constitution and the Bill or Rights of our great country?

> **Response: Under the proposed revisions, licensed lay midwives are encouraged to be vaccinated, but no vaccines are required for licensure (Section 108). Licensed lay midwifes are required to educate their clients on the need for updated immunizations (section 306.02.3). However, these Rules and Regulations do not require the LLM client or her child to receive any vaccination.**

31. Name: Amy Van Hooser (email received 9/20/17)

Comment: My name is Amy and I live in Little Rock. I am the mother of 4 boys, all born out of a hospital. 2 in Michigan, 2 here in my home in Little Rock. I'm reaching out in regards to the current and pending regulations regarding homebirth in Arkansas. Currently the laws seem very dated and obstructive to those of us choosing to birth at home.

I support a family's right to make personal medical decisions, including to birth their child at home. My family has personally benefited from birthing at home. My first 2 boys were born at home with midwives in Michigan. There I was able to refuse tests I didn't feel necessary. I also had friends there who birthed at home after a cesarean, with twins, and with baby in breech position. Mothers birthing at home isn't new, hospitals are.

I was surprised when I became pregnant in Arkansas to hear I had to see a Dr for 2 "risk assessments" during my pregnancy. Then when I called several Drs offices they wouldn't take me. I cried, feeling unsure where to turn or how to meet the requirements while still being able to birth where I wanted. I was then told I could go to the health dept or visit the one CNM seeing home birth mothers here. At that time I was able to see the CNM, who I don't believe is seeing mothers here anymore. I was irritated again when I was told there were certain tests I was required to take that I was able to opt out of in Michigan.

- What happens when the mother refuses, which is her right to do so, and is left without any care? If something goes wrong is the department going to take responsibility?
- You say that the department isn't violating the enabling statute of the board of health which says they shall not interfere with a citizen's choice of practitioner or healer because the client cannot expect the midwife to perform outside of her scope of practice correct?

I know mothers who have moved out of Arkansas because of the birth restrictions. Others who travel out of the state to birth so they can have the birth they want. Or some choose to birth alone to avoid current regulations.

Women are being discriminated against in Arkansas. They are being told who can attend their births, what tests and drugs they "must" take, and not allowed true informed consent. I implore you to put mother's choices back in their hands!

Response: A comprehensive risk assessment is required by the Rules and Regulations Governing the Practice of Licensed Lay Midwifery in Arkansas (Rules and Regulations) so that the expected low-risk status of the client can be determined. There is no requirement that an Arkansas Department of Health (ADH) clinician perform the risk assessment. Women may also choose to see any physician or certified nurse midwife currently practicing obstetrics for risk assessments (Section 302.02).

Neither the Arkansas Board of Health nor ADH has the authority to regulate the practice of medicine or advance practice nursing and cannot direct the individual clinical practice of any physician, CNM or nurse practitioner. Individual medical providers determine what exams and/or tests are necessary for a comprehensive risk assessment based on individual or agency policies, protocols and practice guidelines.

ADH recognizes a woman's right to refuse medical tests or procedures. The LLM must inform the client of all tests, procedures, treatments, medications, or referrals specified in Section 300 of the Rules and Regulations. With the proposed revisions to the Rules and Regulations, LLMs who maintain specific credentials (Section 104) have within their scope of practice the authority to continue care for women who choose to decline certain tests or procedures.

ADH also recognizes the right of women to choose their health care providers. However, implicit in the choice to go with any particular licensed health care provider is the expectation that the provider will work within their scope of practice. These Rules and Regulations simply set out the scope of practice for Licensed Lay Midwives in Arkansas.

32. Name: Amanda McKay (email received 9/20/17)

Comment:

a. These required risk assessments are redundant. The midwives already do these reviews and assessments. These licensed and/or certified midwives have enough education and experience to take care of prenatal, birth, and post natal care independently. So why do you need to hold their hand or more likely keep them under the thumb of physicians or ADH clinicians? Where is your evidence, where is the study, that shows these redundant assessments already being done by our professional midwives add any benefit and do not cause harm? Especially if the woman does not want these extra tests or procedures, then there is ever more reason not to be forced to do these extra assessments.

Response: As dictated by Arkansas Code A.C.A. 17-85-101 "Licensed Lay Midwife Act", the LLM may provide midwifery care to a woman who is at low risk for development of medical complications. The ADH recognizes each woman's right regarding medical decisions, including the option for home birth; however, home birth is not without risk. (ACOG Committee Opinion 696 April 2017). The purpose of risk assessment is to ensure that a client has no potentially serious medical condition and contraindications to home birth. (302.01)

b. Along the same lines, why is it not sufficient for the midwife to interpret the blood sugar testing themselves without having to report it to a "physician CNM or ADH clinician within 10 days," or be able to assess risk after 42 weeks 0/7days gestation? This shows you do not trust midwives to make these decisions, why? These midwives have many more contact hours and much more knowledge of the pregnant clients medical history and her wishes than a person reviewing a chart and making patient contact for a matter of minutes. So why is the midwives professional opinion given less weight and where is your evidence that they should not be able to make these decisions along with the client themselves? Isn't that how you would go about making a medical decision for yourself, with you and your own care provider, not a second one dictated to you that the state must have the opinion of and who has decision making power over you given by the state?

Response: Arkansas Code A.C.A. 17-85-101 "Licensed Lay Midwife Act" requires that the practice of Licensed Lay Midwifery be under the supervision of a physician. The current and proposed Rules and Regulations for the Practice of Lay Midwifery require the risk assessments in consideration for the required physician supervision. A comprehensive risk assessment is required so that the expected low-risk status of the client, as required by Arkansas Code A.C.A. 17-85-101 "Licensed Lay Midwife Act", can be determined. It is not within the training or the scope of practice of an LLM to perform or interpret the results of many of the tests required, or to make medical diagnoses or to manage the treatment of medical or obstetric complications.

With these revised Rules and Regulations, with the exception of a limited number of situations, the decision-making power regarding the continuation of care is with the client and her LLM, based on the results of required tests.

c. "104.4 "...the LLM must inform the client of the requirements" should read "the LLM must inform the client of the recommended" tests, procedures, treatments ,medications, or referrals.." etc. and the phrase at the end "...and refusal is strongly discouraged." should be omitted.

Response: The tests, procedures and treatments in the Rules and Regulations are required. With the proposed revisions to the Rules and Regulations, LLMs who maintain specific credentials (Section 104) have within their scope of practice the authority to continue care for women who choose to decline certain tests or procedures

d. A phrase like "the pros and cons or possible benefits, and/or side-effect of each 'test, procedure, treatment, medication or referral,' should be presented and/or discussed so the client can make a fully educated and personal decision."

Response: This is covered in the initial Disclosure Statement signed by the client and LLM at the initiation of care, as well as in the Informed Refusal form when applicable.

e. A woman should not lose her care provider because she refuses a particular test or treatment. These regulations do not support a woman's full right to informed refusal.

Response: ADH recognizes a woman's right to refuse medical tests or procedures. The LLM must inform the client of all tests, procedures, treatments, medications, or referrals specified in Section 300 of the Rules and Regulations. With the proposed revisions to the Rules and Regulations, LLMs who maintain specific credentials (Section 104) have within their scope of practice the authority to continue care for women who choose to decline certain tests or procedures

f. Please provide the studies/evidence you used to make the decision that the following conditions preclude midwifery care: Previous Cesarean delivery, Multiple Gestation, and Pregnancy that extends beyond 42 weeks 0/7days gestational age.

It is very important that the "evidence based information" used to come to these regulations be made publicly known especially to the clients to which they are being applied. Clients must be able to inform themselves and make these decisions themselves and not be dictated to and patronized.

"Pregnancy is not an exception to the principle that a decisionally capable patient has the right to refuse treatment, even treatment needed to maintain life. Therefore, a decisionally capable pregnant woman's decision to refuse recommended medical or surgical interventions should be respected." - ACOG

Please seriously consider these comments and provide the answers to these questions.

Response: ADH relies on evidence and guidelines provided by the American College of Obstetricians and Gynecologists (ACOG) and the Centers for Disease Control and Prevention (CDC). The scope of practice for LLM in Arkansas is to provide care for women who are at low risk for complications (Section 104.1). The ADH considers a high risk pregnancy as one that threatens the health or life of the mother or fetus. Pregnancies may be considered high risk because of a condition that exists before the onset of pregnancy or because of risk of complication developing as pregnancy progresses.

Risk factors for high-risk pregnancy include but are not limited to:

Multiple gestation, young or advanced maternal age, obesity, history of cesarean delivery, and certain pre-existing health conditions. Comprehensive risk assessments (302.01) are performed to ensure that clients have no medical contraindications to home birth.

33. Name: Hannah Lee (email received 9/20/17)

Comment: My name is Hannah Lee and I currently live in Conway. I am writing to you today regarding the regulations currently being revised by the Arkansas Department of Health regarding home birth and midwife care in Arkansas.

a. I write to you as a woman who has had a birth in a local hospital, as well as two births at home with a licensed midwife. My experiences with both hospital and home birth make me passionate about birth choices. But, also knowing several women who have had a cesarean birth and have sought Vaginal Birth after Cesarean (VBAC), only to be told it is illegal in Arkansas fuels my interest.

Response: There are two relevant questions to be answered in the decision of whether the Rules and Regulations should allow, or not, vaginal birth after cesarean (VBAC) in home settings in Arkansas.

The first question is: "Is VBAC less risky than an elective repeat cesarean section?" and the answer to that question is "Yes". The American College of Obstetricians and Gynecologists (ACOG) corroborates that in the ACOG Clinical Management Guideline (reaffirmed 2013) and ACOG Practice Bulletin (Number 115, 2010)) as does the Arkansas Department of Health (ADH). However, to make that statement out of context and without taking into consideration the full picture gives the wrong impression of the risks—and this is also affirmed by ACOG.

VBAC is the outcome of a process, and that process is "trial of labor after cesarean", or TOLAC. To be counted as a VBAC, one needs to have successfully gone through TOLAC. According to ACOG, anywhere from 20- 40% of TOLACs fail to proceed to VBAC (depending on what studies one looks at). Also, most maternal morbidity that occurs during TOLAC occurs when repeat cesarean delivery becomes necessary. In those situations, the outcome is not VBAC. Because high-risk individuals and needed cesarean deliveries are filtered out during TOLAC, VBAC becomes associated with fewer complications and a failed TOLAC is associated with more complications than an elective repeat cesarean delivery. Consequently, risk for maternal morbidity is inversely related to a woman's probability of achieving VBAC. Therefore, to say simply that "VBAC is less risky than an elective repeat cesarean section" without also counting the failed TOLACs, leaves out the risk borne by the 20-40% of women who do not make it through TOLAC to VBAC.

The second relevant question is: "Is VBAC safe at home within the Arkansas setting?". Clearly, for some individuals who successfully go through TOLAC, VBAC at home may be a safe option. However, as mentioned before, 20-40% of TOLACs do fail (often unexpectedly) and a cesarean section is needed. In a lot of cases, that is an emergency situation and the immediate access to services can sometimes determine the difference between life and death for mother and baby. It is the charge of ADH to set Rules and Regulations that protect the health and well-being of all Arkansans at the population level. We recognize that some individuals bear less of a risk than others, but the Rules and Regulations are designed to minimize risk at the population level.

Having said this, ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We recommend that hospitals, maternity care providers, health care and professional liability

insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

With this in mind, ADH is convening a committee to study and make recommendations to the ADH regarding steps that can be taken towards the reduction of unnecessary elective cesarean deliveries, and removing barriers to access to TOLAC and VBAC in Arkansas. We look forward to the deliberations and the recommendations of this Committee so that we can collaboratively improve the 'system of care' for all women in Arkansas.

b. Having personally looked at a draft of these regulations, I am alarmed and frustrated. They are grossly overreaching, over restrictive and essentially take away a patient's right to informed consent and refusal. These regulations would require a woman to transfer care at any point of gestation at the suggestion of an ADH clinician. This could leave women without a care provider during her due date, as many providers will not accept a new patient after a certain point. Other issues include not allowing informed refusal for tests and treatments that a woman could decline if birthing in a hospital.

Response: With the proposed revisions to the Rules and Regulations, LLMs who maintain specific credentials (Section 104) have within their scope of practice the authority to continue care for women who choose to decline certain tests or procedures This is in fact less restrictive than the current rules that do not allow informed refusal under any circumstances.

c. Many of these tests or treatments are not standard in countries with better baby/mother birthing outcomes than the USA, like treating GBS+ women with antibiotics in labor. Yet, if a GBS+ mother declines IV antibiotics in labor, under the new regs, she would have to be transferred to a hospital immediately. Even if the birth is imminent. Even though evidence doesn't show catastrophic consequences for declining. Even though it should be her right to say what does and does not happen to her body during labor.

Response: A client with a positive Group B Streptococcus (GBS) test is not precluded from LLM care. Conditions that preclude midwifery care are listed in section 303.01, 305.01, 307.01 and 309.01. The only GBS situation that precludes midwifery care is "Unknown GBS status prior to sixteen (16) hours of ruptured membranes, when delivery is not imminent" (305.01.12), which requires immediate transport to the planned hospital.

Clients who test positive for Group B Streptococcus may continue care with an LLM if a physician/certified nurse midwife (CNM) consultation or referral is made. The client must be examined by a physician or CNM currently practicing obstetrics. A plan of care for the condition must be established, and execution of the plan must be documented. This does not preclude midwifery care, but does seek to ensure that Centers for Disease Control and Prevention (CDC) approved GBS prophylaxis is available during the woman's labor.

The goal of the rules and regulations as related to Group B Streptococcus is to prevent GBS disease in Newborns. The ADH practice of universal screening at 35-37 weeks of gestation and intrapartum antibiotic prophylaxis was developed using CDC guidelines, is endorsed by ACOG and the American Academy of Pediatrics (AAP), and serves as the basis of this prevention strategy and rules and regulations.

Neonates born to women who have heavy GBS colonization, such as with GBC Bacteriuria, are at increased risk for neonatal infection. (ACOG Committee Opinion 485, Reaffirmed 2016). If a client is found to have a GBS positive urine culture or have previously given

birth to a neonate with early-onset GBS disease, then intrapartum antibiotic prophylaxis is indicated per CDC guidelines.

The ADH recognizes a patient's right to choose their care provider and their desire for a continuous relationship with their preferred provider. The ADH seeks to ensure that all clients receive high quality care and believes that integration of consultation and referral does not represent a break in the continuity of care.

d. Having experienced a hospital birth, I had an OB who did NOT follow the standard of informed consent and refusal during my pregnancy and birth, which led me into a higher risk birth with more intervention than may have been necessary if I had been fully informed and had a care provider that worked with me. This led me to seek two home births with a midwife that worked with me to stay healthy and low risk. This led to low intervention births and a much healthier mom and baby in the end. I don't say this to imply that all OBGYNs are poor healthcare providers or that homebirth is superior. Simply that the freedom for me to learn, be informed and make my own medical choices regarding the healthcare provider that was right for me, my baby and my family was instrumental in a safe birth for me and my children.

When I was coming to the end of my first trimester with my third pregnancy, I was starting to feel hopeful I would get to keep that baby. My second pregnancy had ended in miscarriage just months earlier, which led to much emotional turmoil in my subsequent pregnancies. I had cramping and bleeding throughout the first trimester, which was terrifying.

When it was time for my risk assessment, I talked to my midwife about declining internal exams and testing because I didn't want to risk more cramping and bleeding unless there was a measurable benefit and cause. My midwife agreed that I should be able to decline.

I took a copy of the regulations with me, which stated I simply needed a pap smear and std testing within the last year, which I had on file at the health department.

Yet, I was told no.

I was told consent or you will be "risked out." The regulations weren't followed simply because the nurse practitioner had such power given to her by the regulations themselves. The nurse practitioner told me she would not sign my risk assessment form if I did not consent, which would mean losing my midwife. I cannot describe the emotional turmoil this caused me.

I've since been told I should have simply held my ground and reported her.

I was being told I had to choose between "consent" and keeping my midwife, who had provided me with fantastic care and support OR being risked out and forced to begin the process of obtaining pregnancy Medicaid and seeing the same practitioner who was coercing me into an exam and testing I did not want or need, all to ensure my midwife was accepting only low risk clients. This is how the regulations, in reality, police the women seeking midwifery care, rather than regulating the midwives themselves.

In short, ADH has no business making medical decisions for me, or any other birthing woman. These decisions can safely and reasonably made by the midwives who are licensed by ADH and their clients. Creating regulations that are so restrictive may force women to have an unattended birth, force them to seek unlicensed midwives, force them to submit to repeat surgery (during which they are more likely to

die than if they were allowed to attempt VBAC) or forced to give birth in a neighboring state where VBAC is legal.

Response: ADH recognizes a woman's right to refuse medical tests or procedures. The LLM must inform the client of all tests, procedures, treatments, medications, or referrals specified in Section 300 of the Rules and Regulations. With the proposed revisions to the Rules and Regulations, LLMs who maintain specific credentials (Section 104) have within their scope of practice the authority to continue care for women who choose to decline certain tests or procedures.

ADH also recognizes the right of women to choose their health care providers. However, implicit in the choice to go with any particular licensed health care provider is the expectation that the provider will work within their scope of practice. These Rules and Regulations simply set out the scope of practice for Licensed Lay Midwives in Arkansas.

A comprehensive risk assessment is required by the Rules and Regulations Governing the Practice of Licensed Lay Midwifery in Arkansas (Rules and Regulations) so that the expected low-risk status of the client can be determined. There is no requirement that an Arkansas Department of Health (ADH) clinician perform the risk assessment. Women may also choose to see any physician or certified nurse midwife currently practicing obstetrics for risk assessments (Section 302.02).

Neither the Arkansas Board of Health nor ADH has the authority to regulate the practice of medicine or advance practice nursing and cannot direct the individual clinical practice of any physician, CNM or nurse practitioner. Individual medical providers determine what exams and/or tests are necessary for a comprehensive risk assessment based on individual or agency policies, protocols and practice guidelines.

34. Name: Arkansas Birth Matters (email received 9/20/17)

Comment: Greetings, We are concerned that the rights of childbearing women in Arkansas to choose their place of birth is being significantly compromised. The Arkansas Department of Health (ADH) is proposing increasingly restrictive midwifery rules on Arkansas families. Arkansas already has some of the most restrictive midwifery rules in the country.

a. The ADH has outlined a number of medical procedures and tests to which they will soon mandate mothers consent to as a condition of being cared for by a midwife rather than a physician. If the mother does not consent, then she will lose her midwife. It will not matter how far along the mother is in her pregnancy. Many obstetricians will not accept pregnant patients in the third trimester and some are unable to take any new patients. If these mothers cannot find a doctor, they may experience a gap in maternity care, go without any maternity care for the duration of their pregnancy, or hire an unlicensed midwife.

Response: ADH recognizes a woman's right to refuse medical tests or procedures. The LLM must inform the client of all tests, procedures, treatments, medications, or referrals specified in Section 300 of the Rules and Regulations. With the proposed revisions to the Rules and Regulations, LLMs who maintain specific credentials (Section 104) have within their scope of practice the authority to continue care for women who choose to decline

certain tests or procedures. This is, in fact, less restrictive that the current Rules and Regulations.

b. Mothers who have had a previous cesarean are currently prohibited from hiring a midwife under Arkansas' regulations. These mothers will likely deliver in a hospital with a policy that requires she have another surgical birth. A woman who has a cesarean birth is three times more likely to die as a result and minority women are four times more likely to die.

Response: There are two relevant questions to be answered in the decision of whether the Rules and Regulations should allow, or not, vaginal birth after cesarean (VBAC) in home settings in Arkansas.

The first question is: "Is VBAC less risky than an elective repeat cesarean section?" and the answer to that question is "Yes". The American College of Obstetricians and Gynecologists (ACOG) corroborates that in the ACOG Clinical Management Guideline (reaffirmed 2013) and ACOG Practice Bulletin (Number 115, 2010)) as does the Arkansas Department of Health (ADH). However, to make that statement out of context and without taking into consideration the full picture gives the wrong impression of the risks—and this is also affirmed by ACOG.

VBAC is the outcome of a process, and that process is "trial of labor after cesarean", or TOLAC. To be counted as a VBAC, one needs to have successfully gone through TOLAC. According to ACOG, anywhere from 20- 40% of TOLACs fail to proceed to VBAC (depending on what studies one looks at). Also, most maternal morbidity that occurs during TOLAC occurs when repeat cesarean delivery becomes necessary. In those situations, the outcome is not VBAC. Because high-risk individuals and needed cesarean deliveries are filtered out during TOLAC, VBAC becomes associated with fewer complications and a failed TOLAC is associated with more complications than an elective repeat cesarean delivery. Consequently, risk for maternal morbidity is inversely related to a woman's probability of achieving VBAC. Therefore, to say simply that "VBAC is less risky than an elective repeat cesarean section" without also counting the failed TOLACs, leaves out the risk borne by the 20-40% of women who do not make it through TOLAC to VBAC.

The second relevant question is: "Is VBAC safe at home within the Arkansas setting?". Clearly, for some individuals who successfully go through TOLAC, VBAC at home may be a safe option. However, as mentioned before, 20-40% of TOLACs do fail (often unexpectedly) and a cesarean section is needed. In a lot of cases, that is an emergency situation and the immediate access to services can sometimes determine the difference between life and death for mother and baby. It is the charge of ADH to set Rules and Regulations that protect the health and well-being of all Arkansans at the population level. We recognize that some individuals bear less of a risk than others, but the Rules and Regulations are designed to minimize risk at the population level.

Having said this, ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We recommend that hospitals, maternity care providers, health care and professional liability

insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

With this in mind, ADH is convening a committee to study and make recommendations to the ADH regarding steps that can be taken towards the reduction of unnecessary elective cesarean deliveries, and removing barriers to access to TOLAC and VBAC in Arkansas. We look forward to the deliberations and the recommendations of this Committee so that we can collaboratively improve the 'system of care' for all women in Arkansas.

c. Consent by coercion is not consent at all. The decision to assess the risks versus the benefits of a particular type of birth must be left to the person who is assuming that risk. It is not for the state government or any other person to decide. Case law supports the fact that pregnant women have an absolute right to refuse medical treatment and advice.

Response: ADH recognizes a woman's right to refuse medical tests or procedures. The LLM must inform the client of all tests, procedures, treatments, medications, or referrals specified in Section 300 of the Rules and Regulations. With the proposed revisions to the Rules and Regulations, LLMs who maintain specific credentials (Section 104) have within their scope of practice the authority to continue care for women who choose to decline certain tests or procedures.
ADH also recognizes the right of women to choose their health care providers. However, implicit in the choice to go with any particular licensed health care provider is the expectation that the provider will work within their scope of practice. These Rules and Regulations simply set out the scope of practice for Licensed Lay Midwives in Arkansas.

d. We believe that it is a basic human right to be able to choose where and with whom you birth. We believe that current and proposed restrictions violate the enabling statute of the Board of Health which states that the Board shall not interfere with a person's right to choose their health care provider. ACA §20-7-109.

We call on the ADH to enact midwifery rules that do not violate State and Federal law: All women shall be able to choose where and with whom they give birth as protected by Arkansas law, including those who have a history of previous cesarean delivery.

Midwives shall have the legal freedom to work within their full scope of practice without regulation by another profession. The Midwifery Model of Care is separate and distinct from the Medical Model.

Women shall retain the right to accept or reject any intervention or procedure during pregnancy, birth, and postpartum care. Therefore, rights to informed refusal shall be included in any forthcoming regulations. We call on the ADH to make an immediate review of the rules and regulations governing homebirth in Arkansas with the objective of ensuring that all women have equal access to homebirth services and that the state government supports homebirth as a credible option for all.

Response: ADH recognizes a woman's right to refuse medical tests or procedures. The LLM must inform the client of all tests, procedures, treatments, medications, or referrals specified in Section 300 of the Rules and Regulations. With the proposed revisions to the Rules and Regulations, LLMs who maintain specific credentials (Section 104) have within their scope of practice the authority to continue care for women who choose to decline certain tests or procedures.

ADH also recognizes the right of women to choose their health care providers. However, implicit in the choice to go with any particular licensed health care provider is the expectation that the provider will work within their scope of practice. These Rules and Regulations simply set out the scope of practice for Licensed Lay Midwives in Arkansas.

d. There are two files attached. They are to be printed and included in the public comment. The petition, signatures and comments are all to be included

Response: The signatures and comments attached to this letter are included as "Attachment 3" (page 92). Since these were not originally sent to the ADH as part of the official public comment period and in response to the latest version of the revised Rules and Regulations, we have not responded to them individually. Additionally, there was a separate list attached to this comment that included 1,547 names along with their location and date signed. No individual comments were included in that list.

35. Name: Steven Smith (email received 9/20/17)

Comment: My name is Steven Smith and I live in Benton, Arkansas. I am writing to support families in Arkansas who are currently restricted from having a homebirth with a licensed midwife. My wife and I have three children. The first birth was traumatic for both of us, but my wife experienced much greater emotional and physical trauma than I did. She had a VBAC in a state that permitted licensed midwives to attend a homebirth after a cesarean.

When we moved to Arkansas, this safe option was unavailable to us due to the current restrictions in the midwifery regulations. Planning another hospital birth after previous birth trauma led to significant anxiety for my wife. We find it ridiculous that Arkansas does not recognize the rights of families to make their own medical decisions when choosing to birth at home.

This issue is not only a women's rights issue. Men care about the safety of their wives and babies, too. Please remove VBAC from the restrictions in the current regulations. An informed consent process can be implemented to ensure women are fully informed of the rare complications associated with VBAC. Further, VBAC can be made a safe option with the addition of guidelines for these scenarios.

Response: There are two relevant questions to be answered in the decision of whether the Rules and Regulations should allow, or not, vaginal birth after cesarean (VBAC) in home settings in Arkansas.

The first question is: "Is VBAC less risky than an elective repeat cesarean section?" and the answer to that question is "Yes". The American College of Obstetricians and Gynecologists (ACOG) corroborates that in the ACOG Clinical Management Guideline (reaffirmed 2013) and ACOG Practice Bulletin (Number 115, 2010)) as does the Arkansas Department of Health (ADH). However, to make that statement out of context and without taking into consideration the full picture gives the wrong impression of the risks—and this is also affirmed by ACOG.

VBAC is the outcome of a process, and that process is "trial of labor after cesarean", or TOLAC. To be counted as a VBAC, one needs to have successfully gone through TOLAC. According to ACOG, anywhere from 20- 40% of TOLACs fail to proceed to VBAC (depending on what studies one looks at). Also, most maternal morbidity that occurs during TOLAC occurs when repeat cesarean delivery becomes necessary. In those situations, the outcome is not VBAC. Because high-risk individuals and needed cesarean deliveries are

filtered out during TOLAC, VBAC becomes associated with fewer complications and a failed TOLAC is associated with more complications than an elective repeat cesarean delivery. Consequently, risk for maternal morbidity is inversely related to a woman's probability of achieving VBAC. Therefore, to say simply that "VBAC is less risky than an elective repeat cesarean section" without also counting the failed TOLACs, leaves out the risk borne by the 20-40% of women who do not make it through TOLAC to VBAC.

The second relevant question is: "Is VBAC safe at home within the Arkansas setting?". Clearly, for some individuals who successfully go through TOLAC, VBAC at home may be a safe option. However, as mentioned before, 20-40% of TOLACs do fail (often unexpectedly) and a cesarean section is needed. In a lot of cases, that is an emergency situation and the immediate access to services can sometimes determine the difference between life and death for mother and baby. It is the charge of ADH to set Rules and Regulations that protect the health and well-being of all Arkansans at the population level. We recognize that some individuals bear less of a risk than others, but the Rules and Regulations are designed to minimize risk at the population level.

Having said this, ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

With this in mind, ADH is convening a committee to study and make recommendations to the ADH regarding steps that can be taken towards the reduction of unnecessary elective cesarean deliveries, and removing barriers to access to TOLAC and VBAC in Arkansas. We look forward to the deliberations and the recommendations of this Committee so that we can collaboratively improve the 'system of care' for all women in Arkansas

36. Name: Jennifer Briley (email received 9/20/17)

Comment: My name is Jennifer Briley. I am a 30 year old mother to three children, living in Sebastian County. I am writing you in regards to the current review of midwifery regulations in the state of Arkansas.

I would like to ask you to consider changing the current stance on two topics as they are written within the regulations regarding midwifery care. These two components of your regulations include the responsibility of a midwife should her patient choose to opt out of testing and the policies that govern midwifes attended vaginal birth after ceserean.

a. As a resident of Arkansas, an American citizen, and a mom it should always be within my right to have both knowledge and capable help when the Lord blesses me with a child to be able to safely deliver him into this world. In both cases of my pregnancies, I have been stripped of an opportunity to choose a midwife here in the state. The first pregnancy was a twin pregnancy and I was denied the ability to choose a midwife although in the next state over, truthful event after truthful event yields that I could have safely delivered those children out of a hospital. However, I was left in less than capable hands and followed medical advisement and my twins were extracted via ceserean.

When the Lord once again blessed me with child, because of the first pregnancy ending in cesarean, I was forced to once again choose a surgeon over a skilled midwife. After 9 months of "maternal care," also known as propaganda on how unsafe the whole process of vaginal birth would be, my husband and I were scared and vulnerable and the pregnancy ended again in another unnecessary and unwanted cesarean. The second left me with scars much deeper than the one on my uterus. It's a poor testimony from those who first promise to do no harm. The most upsetting part to me, is that I really was not even given an option. I could choose from a surgeon or another surgeon to do handle my pregnancy. But the safest and best option for me and my baby was a skilled, capable midwife. I know there are several in my area who qualify as such.

Response: There are two relevant questions to be answered in the decision of whether the Rules and Regulations should allow, or not, vaginal birth after cesarean (VBAC) in home settings in Arkansas.

The first question is: "Is VBAC less risky than an elective repeat cesarean section?" and the answer to that question is "Yes". The American College of Obstetricians and Gynecologists (ACOG) corroborates that in the ACOG Clinical Management Guideline (reaffirmed 2013) and ACOG Practice Bulletin (Number 115, 2010)) as does the Arkansas Department of Health (ADH). However, to make that statement out of context and without taking into consideration the full picture gives the wrong impression of the risks—and this is also affirmed by ACOG.

VBAC is the outcome of a process, and that process is "trial of labor after cesarean", or TOLAC. To be counted as a VBAC, one needs to have successfully gone through TOLAC. According to ACOG, anywhere from 20- 40% of TOLACs fail to proceed to VBAC (depending on what studies one looks at). Also, most maternal morbidity that occurs during TOLAC occurs when repeat cesarean delivery becomes necessary. In those situations, the outcome is not VBAC. Because high-risk individuals and needed cesarean deliveries are filtered out during TOLAC, VBAC becomes associated with fewer complications and a failed TOLAC is associated with more complications than an elective repeat cesarean delivery. Consequently, risk for maternal morbidity is inversely related to a woman's probability of achieving VBAC. Therefore, to say simply that "VBAC is less risky than an elective repeat cesarean section" without also counting the failed TOLACs, leaves out the risk borne by the 20-40% of women who do not make it through TOLAC to VBAC.

The second relevant question is: "Is VBAC safe at home within the Arkansas setting?". Clearly, for some individuals who successfully go through TOLAC, VBAC at home may be a safe option. However, as mentioned before, 20-40% of TOLACs do fail (often unexpectedly) and a cesarean section is needed. In a lot of cases, that is an emergency situation and the immediate access to services can sometimes determine the difference between life and death for mother and baby. It is the charge of ADH to set Rules and Regulations that protect the health and well-being of all Arkansans at the population level. We recognize that some individuals bear less of a risk than others, but the Rules and Regulations are designed to minimize risk at the population level.

Having said this, ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We recommend that hospitals, maternity care providers, health care and professional liability

insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

With this in mind, ADH is convening a committee to study and make recommendations to the ADH regarding steps that can be taken towards the reduction of unnecessary elective cesarean deliveries, and removing barriers to access to TOLAC and VBAC in Arkansas. We look forward to the deliberations and the recommendations of this Committee so that we can collaboratively improve the 'system of care' for all women in Arkansas

b. The other issue of needed attention is allowing women to choose proceedures and tests done to them and remain under the care of their midwife. In no other area, be it a field of medicine, business, or social setting, would it be exceptable for a person to be treated (truthfully bullied) as such! We aren't children, nor are we slaves, and we should not be demanded to submit to the Department of Health's recommended screenings or proceedures. Threatening to remove our choosen care provider if we do not submit is a form of blackmail. It is forced compliance and removes my personal freedoms as an American, and even greater, as an Arkansan.

I have used strong language in the writing of this message because this is a topic that I feel very strongly about. It not only affects my future and my children's future, but it effects the entire generation of women who are birthing now and will birth in the near future in our Natural State. Please consider these requests for the sake of mothers and babies that are your neighbors and loved ones. I understand that not everyone desires to use a midwife but I no longer desire to use a surgeon and I currently do not have a choice. A freedom has been taken away from me and countless others. The steps you take today in regards to midwifery regulations are either a step towards restoring our rightfully granted freedom as Americans, or a step in solidifying our oppression and our hurt.

Response: ADH recognizes a woman's right to refuse medical tests or procedures. The LLM must inform the client of all tests, procedures, treatments, medications, or referrals specified in Section 300 of the Rules and Regulations. With the proposed revisions to the Rules and Regulations, LLMs who maintain specific credentials (Section 104) have within their scope of practice the authority to continue care for women who choose to decline certain tests or procedures.

ADH also recognizes the right of women to choose their health care providers. However, implicit in the choice to go with any particular licensed health care provider is the expectation that the provider will work within their scope of practice. These Rules and Regulations simply set out the scope of practice for Licensed Lay Midwives in Arkansas.

37. Name: Sarah Davis (email received 9/20/17)

Comment: My name is Sarah and I am a mother of seven. My first pregnancy ended in a unnecessary traumatic cesarean after having a healthy uncomplicated pregnancy.

a. I very much wanted to have my second baby at home, but Midwifery Regulations did not allow for a midwife to attend a VBAC (vaginal birth after cesarean). I was lead to believe I would be given a chance to VBAC with my third child only to be told at my 36 week appointment the hospital would not allow it. Knowing I didn't want to be forced into another unnecessary surgery, my husband and I decided an unassisted home birth was our only chance at a natural birth. We were successful and have since delivered four more children at home. It would be much safer for women like myself to have a midwife attend our births. Twenty-two other states allow it. So should Arkansas.

Response: According to our analysis of the latest data, there are only 21 states in the country that legally allow VBAC at home with a midwife.

b. Earlier this year, I saw an OBGYN at 16 weeks and I was forced into a pelvic exam as well as blood testing I didn't want. This shouldn't happen to anyone. I was told the doctor would not see me if said tests were not completed. Once the doctor came in I was told I would be allowed to try for a VBAC only if a specific doctor was on-call and the chances of that occurring would only be around 25 percent. This is not acceptable care. Women should be offered an out-of-hospital choice. I would very much like to see the regulations change and be able to have a midwife with me during delivery if we are blessed with more children. I feel it's very important for women to have the right choose the way they want to birth.

Response: There are two relevant questions to be answered in the decision of whether the Rules and Regulations should allow, or not, vaginal birth after cesarean (VBAC) in home settings in Arkansas.

The first question is: "Is VBAC less risky than an elective repeat cesarean section?" and the answer to that question is "Yes". The American College of Obstetricians and Gynecologists (ACOG) corroborates that in the ACOG Clinical Management Guideline (reaffirmed 2013) and ACOG Practice Bulletin (Number 115, 2010)) as does the Arkansas Department of Health (ADH). However, to make that statement out of context and without taking into consideration the full picture gives the wrong impression of the risks—and this is also affirmed by ACOG.

VBAC is the outcome of a process, and that process is "trial of labor after cesarean", or TOLAC. To be counted as a VBAC, one needs to have successfully gone through TOLAC. According to ACOG, anywhere from 20- 40% of TOLACs fail to proceed to VBAC (depending on what studies one looks at). Also, most maternal morbidity that occurs during TOLAC occurs when repeat cesarean delivery becomes necessary. In those situations, the outcome is not VBAC. Because high-risk individuals and needed cesarean deliveries are filtered out during TOLAC, VBAC becomes associated with fewer complications and a failed TOLAC is associated with more complications than an elective repeat cesarean delivery. Consequently, risk for maternal morbidity is inversely related to a woman's probability of achieving VBAC. Therefore, to say simply that "VBAC is less risky than an elective repeat cesarean section" without also counting the failed TOLACs, leaves out the risk borne by the 20-40% of women who do not make it through TOLAC to VBAC.

The second relevant question is: "Is VBAC safe at home within the Arkansas setting?". Clearly, for some individuals who successfully go through TOLAC, VBAC at home may be a safe option. However, as mentioned before, 20-40% of TOLACs do fail (often unexpectedly) and a cesarean section is needed. In a lot of cases, that is an emergency situation and the immediate access to services can sometimes determine the difference between life and death for mother and baby. It is the charge of ADH to set Rules and Regulations that protect the health and well-being of all Arkansans at the population level. We recognize that some individuals bear less of a risk than others, but the Rules and Regulations are designed to minimize risk at the population level.

Having said this, ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We

recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

With this in mind, ADH is convening a committee to study and make recommendations to the ADH regarding steps that can be taken towards the reduction of unnecessary elective cesarean deliveries, and removing barriers to access to TOLAC and VBAC in Arkansas. We look forward to the deliberations and the recommendations of this Committee so that we can collaboratively improve the 'system of care' for all women in Arkansas.

38. Name: Shea Childs, LLM, CPM (email received 9/20/17)

Comment: I am speaking out in support of the revision to the Arkansas Midwives Rules and Regulations. Please include my comments in the public hearing being held on September 21, 2017.

I am a licensed midwife from Hot Springs. I have been serving families since my apprenticeship in 2007 and was licensed by the state in 2011. I received my CPM credential from NARM that same year and the Midwifery Bridge Certificate recognized by the US-MERA organizations in April of this year. I have also served on the Midwifery Advisory Board as Secretary since 2015 and have been active in the Liaison Committee working through the current revisions for the last few years with the Department of Health.

I am steadfast in my belief that women have the right to choose their healthcare provider, the right to make informed decisions about their care, including which tests and procedures they are comfortable with and which risks they may be willing to accept in order to birth where they wish, with the provider they have chosen. Because the current revisions have included a process for pregnant women to review evidence-based best practices regarding their pregnancies through Informed Consent as well as Informed Refusal for those things they find intrusive or unacceptable, I am in support of these current revisions. I would like it noted however, that the process should be ongoing and consistently striving toward improvement.

The discussion revolving around home VBAC as an option to birthing mothers has been kicked down the road for several years now. Cesarean sections at one of the two hospitals in my home county are reported to be 47%, which then force repeat c-sections on those women in the form of an administrative VBAC ban. Frankly, this should be investigated as criminal action, performing surgery on half of laboring mothers in a community. There simply cannot be medical reason for half of all labors to end in c-section. These mothers are at the mercy of a system that does not recognize the inherent risks involved in c-section that inevitably lead to multiple surgeries for purely administrative reasons. It is a public health crisis that needs to be investigated and rectified. The risks associated with repeat abdominal surgery are many. A number of states have reached agreement, outlining conditions to be met that are acceptable risks for mothers who have had a previous c-section to have a trial of labor at home with subsequent births. It will take serious commitment and deserves real discussion, but should be on the table until this option is available for Arkansas families.

Response: Thank you for your support of these revisions. We also appreciate your tireless work on the Midwife Advisory Board and your advice and guidance during the revision process.

ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National

Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

With this in mind, ADH is convening a committee to study and make recommendations to the ADH regarding steps that can be taken towards the reduction of unnecessary elective cesarean deliveries, and removing barriers to access to TOLAC and VBAC in Arkansas. We look forward to the deliberations and the recommendations of this Committee so that we can collaboratively improve the 'system of care' for all women in Arkansas.

39. Name: Erin Casey Lachowsky (email received 9/21/17)

Comment: I am writing to urge you to make changes to the Licensed Lay Midwife rules and regulations which currently prohibit LLMs from attending VBAC home births in the state of Arkansas. I am appalled that in this age there are still regulations which are not evidenced based which restrict a woman's right to make her own medical choices. Despite the National Institute of Health recommending that most women are candidates for VBAC and should be given the option of a trial of labor, *half* of hospitals in Arkansas, especially in rural communities, do not "allow" a woman to choose VBAC as an option for herself. Women who hope to have a VBAC but are not given the option due to hospital policy are often left feeling patronized, angry, and worried about their upcoming births. These women could be safely attended by LLMs in most circumstances thereby undergoing a much easier birth process and recovery. I know women who have driven almost two hours *while in labor* in order to be attended by a provider who would be supportive of their choices during labor and birth. That doing so is so often her only option for making her own birth choices is both insulting and demeaning to the laboring mother. Furthermore, women who are wanting a VBAC by definition already have at least one child: to force a woman to choose a painful, debilitating surgery with a long recovery time when she must go home to parent not only the new baby, this time, but also another older child is gross neglect of the larger picture of her well being. And yet that is the default recommendation---requirement, even---of half of Arkansas hospitals. Women need more options and deserve more options. Please give the women of Arkansas the right to choose their provider, the setting of their birth, and the manner of their birth to the fullest extent. Please allow licensed midwives to practice within their competency while still referring women to hospitals when complications arise. I'm sure that regulations are meant to protect women and babies from harm, but a woman is the BEST judge of risks to herself and her baby, and no one in the world is more invested in making those decisions carefully, thoughtfully, and correctly than *she* is.

Response: There are two relevant questions to be answered in the decision of whether the Rules and Regulations should allow, or not, vaginal birth after cesarean (VBAC) in home settings in Arkansas.

The first question is: "Is VBAC less risky than an elective repeat cesarean section?" and the answer to that question is "Yes". The American College of Obstetricians and Gynecologists (ACOG) corroborates that in the ACOG Clinical Management Guideline (reaffirmed 2013) and ACOG Practice Bulletin (Number 115, 2010)) as does the Arkansas Department of Health (ADH). However, to make that statement out of context and without

taking into consideration the full picture gives the wrong impression of the risks—and this is also affirmed by ACOG.

VBAC is the outcome of a process, and that process is "trial of labor after cesarean", or TOLAC. To be counted as a VBAC, one needs to have successfully gone through TOLAC. According to ACOG, anywhere from 20- 40% of TOLACs fail to proceed to VBAC (depending on what studies one looks at). Also, most maternal morbidity that occurs during TOLAC occurs when repeat cesarean delivery becomes necessary. In those situations, the outcome is not VBAC. Because high-risk individuals and needed cesarean deliveries are filtered out during TOLAC, VBAC becomes associated with fewer complications and a failed TOLAC is associated with more complications than an elective repeat cesarean delivery. Consequently, risk for maternal morbidity is inversely related to a woman's probability of achieving VBAC. Therefore, to say simply that "VBAC is less risky than an elective repeat cesarean section" without also counting the failed TOLACs, leaves out the risk borne by the 20-40% of women who do not make it through TOLAC to VBAC.

The second relevant question is: "Is VBAC safe at home within the Arkansas setting?". Clearly, for some individuals who successfully go through TOLAC, VBAC at home may be a safe option. However, as mentioned before, 20-40% of TOLACs do fail (often unexpectedly) and a cesarean section is needed. In a lot of cases, that is an emergency situation and the immediate access to services can sometimes determine the difference between life and death for mother and baby. It is the charge of ADH to set Rules and Regulations that protect the health and well-being of all Arkansans at the population level. We recognize that some individuals bear less of a risk than others, but the Rules and Regulations are designed to minimize risk at the population level.

Having said this, ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

With this in mind, ADH is convening a committee to study and make recommendations to the ADH regarding steps that can be taken towards the reduction of unnecessary elective cesarean deliveries, and removing barriers to access to TOLAC and VBAC in Arkansas. We look forward to the deliberations and the recommendations of this Committee so that we can collaboratively improve the 'system of care' for all women in Arkansas

ADH recognizes a woman's right to refuse medical tests or procedures. The LLM must inform the client of all tests, procedures, treatments, medications, or referrals specified in Section 300 of the Rules and Regulations. With the proposed revisions to the Rules and Regulations, LLMs who maintain specific credentials (Section 104) have within their scope of practice the authority to continue care for women who choose to decline certain tests or procedures.

ADH also recognizes the right of women to choose their health care providers. However, implicit in the choice to go with any particular licensed health care provider is the expectation that the provider will work within their scope of practice. These Rules and Regulations simply set out the scope of practice for Licensed Lay Midwives in Arkansas.

40. Name: Kesha Chiappinelli (email received 9/21/17)

Comment: Attached is a screenshot of an email that the American College of Nurse Midwives (ACNM) disseminated June 9, 2017.

Response: We are not clear on the relevance of these screenshots. One is simply a listing, from USDHHS (2011) of "Excess Health Risks Associated with Not Breastfeeding Among Full-Term Infants", and the other is presumably a partial screenshot of just the 'From' and 'Date' fields of an email, with no indication of the subject, recipients or contents of the email. Therefore, we cannot comment on this.

Comment: Please state what date the ADH first notified ACNM of the draft Midwifery rules.

Response: The President of the Arkansas Chapter of ACNM was notified on August 21, 2017, along with everyone else who had requested a notification.

Comment: Pursuant to A.C.A. 25-15-204, interested trade groups and organizations are to be sent an ADH notice about rulemaking so that it can be published by the organization. The ADH has notified ACNM despite the fact that Nurse Midwives are not subject to the ADH Midwifery rules. Please list what other interested trade organizations the ADH notified and when. Please provide a copy of the notice the ADH sent to each group.

Response: The code requires that notice be published "In a newspaper of general daily circulation" and "when appropriate, in those trade, industry, or professional publications that the agency may select..." ADH published the notice in the Democrat Gazette, and it was published by the Secretary of State on the internet, as required. The notice was not published in any national trade industry or professional publications.

The ADH also sent notifications to:
Becky Fay, CNM – President of the Arkansas Chapter of the American College of Nurse Midwives
Brenda May, BSN, RN – President of the Arkansas Nurses Association
Karen J. Whatley, JD - Executive Director of the Arkansas State Medical Board
John Kirtley – Executive Director of the Arkansas Board of Pharmacy
Curtis Lowery, MD – Director, UAMS ANGELS Program
ICAN of Central Arkansas
Sue Tedford, MNSc, APRN – Executive Director, Arkansas State Board of Nursing
All licensed lay midwives (active license status as of 8/21/2017)
All lay midwife apprentices (active permit status as of 8/21/2017)
All members of the Arkansas Midwifery Advisory Board (MAB)
All interested parties who had requested to be notified

Please see Attachment 1 (page 88) for a copy of the notice sent out by ADH.

Comment: Was NARM (North American Registry of Midwives) notified?
Was MANA (Midwives Alliance of North America) notified?
Was MEAC (Midwifery Education and Accreditation Council) notified?
If none of the above agencies were notified please state the reason for that decision?

Response: No, we did not notify national organizations. However, Ms. Ida Darragh, the Executive Director of NARM is a member of the Arkansas Midwifery Advisory Board (MAB) and was involved in every step of the revisions to the rules.

Comment: Does the ADH regulate nurse midwives? If the answer is no then please state why ACNM was notified of Midwifery rule making here in Arkansas.

Response: No, ADH does not regulate nurse midwives. A notice was sent to the President of the Arkansas Chapter of the American College of Nurse Midwives (ACNM) because she had asked to be notified.

Comment: If ACNM is the only trade group/interested organization the ADH notified of rulemaking please explain why a medical group should be notified to the exclusion of any groups that support midwifery among non-nurses.

Response: A notice was sent to the President of the Arkansas Chapter of the American College of Nurse Midwives (ACNM) because she had asked to be notified.

41. Name: Maria Chowdhury, LLM, CPM (email received 9/21/17)

Comment: I am speaking in support of the revision to the Arkansas Midwives Rules and Regulations. Please include my comments in the public hearing being held on Sept 21, 2017.

I am an Arkansas Licensed Midwife, since 2004. We have seen lots of discussion about the scope of practice for licensed midwives. In my opinion, we are making strides in the right direction, but have not yet arrived at our full potential as a profession. I want to continue the discussion about adding VBAC to the list of permitted conditions that are allowed with licensed midwives. VBAC continues to be the highest interest among the public in the state, and the public voice supporting VBAC is loud and clear about this topic. Although VBAC is still not allowed in the current revision, this controversial issue will continue with more and more, consumer and midwifery support.

There is still a lot of work ahead to address the deficiencies in the proposed regulations, good progress has been made in acknowledging the rights of the consumer to make informed choices in her health care. For this reason, I personally and professionally affirm a woman's right to choose what provider, tests, procedures she wants, or does not want. I support the 2017 revision to the Arkansas Rules and Regulations.

Furthermore, I implore the Board of Health to continue to listen to the public on issues related to their birth choices as we continue the process of developing good regulations for midwives and their clients.

Response: Thank you for your support of these revisions.

There are two relevant questions to be answered in the decision of whether the Rules and Regulations should allow, or not, vaginal birth after cesarean (VBAC) in home settings in Arkansas.

The first question is: "Is VBAC less risky than an elective repeat cesarean section?" and the answer to that question is "Yes". The American College of Obstetricians and Gynecologists (ACOG) corroborates that in the ACOG Clinical Management Guideline

(reaffirmed 2013) and ACOG Practice Bulletin (Number 115, 2010)) as does the Arkansas Department of Health (ADH). However, to make that statement out of context and without taking into consideration the full picture gives the wrong impression of the risks—and this is also affirmed by ACOG.

VBAC is the outcome of a process, and that process is "trial of labor after cesarean", or TOLAC. To be counted as a VBAC, one needs to have successfully gone through TOLAC. According to ACOG, anywhere from 20- 40% of TOLACs fail to proceed to VBAC (depending on what studies one looks at). Also, most maternal morbidity that occurs during TOLAC occurs when repeat cesarean delivery becomes necessary. In those situations, the outcome is not VBAC. Because high-risk individuals and needed cesarean deliveries are filtered out during TOLAC, VBAC becomes associated with fewer complications and a failed TOLAC is associated with more complications than an elective repeat cesarean delivery. Consequently, risk for maternal morbidity is inversely related to a woman's probability of achieving VBAC. Therefore, to say simply that "VBAC is less risky than an elective repeat cesarean section" without also counting the failed TOLACs, leaves out the risk borne by the 20-40% of women who do not make it through TOLAC to VBAC.

The second relevant question is: "Is VBAC safe at home within the Arkansas setting?". Clearly, for some individuals who successfully go through TOLAC, VBAC at home may be a safe option. However, as mentioned before, 20-40% of TOLACs do fail (often unexpectedly) and a cesarean section is needed. In a lot of cases, that is an emergency situation and the immediate access to services can sometimes determine the difference between life and death for mother and baby. It is the charge of ADH to set Rules and Regulations that protect the health and well-being of all Arkansans at the population level. We recognize that some individuals bear less of a risk than others, but the Rules and Regulations are designed to minimize risk at the population level.

Having said this, ADH recognizes, as do ACOG and many other professional bodies, that elective cesarean sections and lack of access to safe VBACs is a major problem in Arkansas. The National Institutes of Health (NIH) Consensus Statement (2010), cited by some of the comments, charged policymakers to lead the way to improving access to care stating: "We recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor."

With this in mind, ADH is convening a committee to study and make recommendations to the ADH regarding steps that can be taken towards the reduction of unnecessary elective cesarean deliveries, and removing barriers to access to TOLAC and VBAC in Arkansas. We look forward to the deliberations and the recommendations of this Committee so that we can collaboratively improve the 'system of care' for all women in Arkansas.

ADH recognizes a woman's right to refuse medical tests or procedures. The LLM must inform the client of all tests, procedures, treatments, medications, or referrals specified in Section 300 of the Rules and Regulations. With the proposed revisions to the Rules and Regulations, LLMs who maintain specific credentials (Section 104) have within their scope of practice the authority to continue care for women who choose to decline certain tests or procedures.

ADH also recognizes the right of women to choose their health care providers. However, implicit in the choice to go with any particular licensed health care provider is the

expectation that the provider will work within their scope of practice. These Rules and Regulations simply set out the scope of practice for Licensed Lay Midwives in Arkansas.

NO OTHER COMMENTS WERE RECEIVED BY CLOSE OF BUSINESS SEPTEMBER, 21, 2017.

EXHIBIT 1

Comments for Public hearing on the Arkansas Midwives Rules and Regulations
September 20, 2017

From: Ida Darragh
4322 Country Club
Blvd Little Rock, AR
72207

To the Arkansas Department of Health:

I am speaking in support of the revision to the Arkansas Midwives Rules and Regulations. Please include my comments in the public hearing being held on Sept 21, 2017.

I have been a midwife in Arkansas since 1980, and received the first license issued by the Department of Health on March 8, 1985. I have remained licensed since that date, and have served on the Midwifery Advisory Board several times during the past 32 years. I also serve as the Executive Director of the North American Registry of Midwives, which issues the credential, Certified Professional Midwife. I am also the Executive Director of the Arkansas Childbirth Institute, a state non-profit that provides support for continuing education for midwives, student midwives, doulas, and childbirth professionals in A r k a n s a s .

I served on the original committee that drafted the Rules and Regs after licensure was established, and have served on each of the committees that proposed revisions to the Midwives Advisory Board since 1985. Following the previous revision in 2007, the Midwives Advisory Board began meeting with the ADH Liaison Committee over the two issues that were discussed but not accepted in the 2007 revisions: the limited use of emergency medications and the option for licensed midwives to attend VBACs (Vaginal Birth After Cesarean) in out-of- hospital settings. By 2012, it was determined by the ADH that licensed midwives could not be allowed to carry and administer a specific list of emergency medications to treat postpartum hemorrhage without a change in the licensure statute. However, the discussion about adding VBAC to the list of permitted conditions continued to be on the discussion agenda based on the good results obtained in states that do allow VBAC with licensed midwives. VBAC continues to be one of the issues of **highest interest** among the public in the state, and the public voice supporting VBAC has been loud and clear in the years leading up to this current revision.
Although VBAC is still not allowed in the current revision, I can guarantee you that the consumers will continue to push for inclusion in the next revision. It is not an issue that will go away; indeed, the consumer voice will continue to grow.

Although there continues to be a lot of work needed to remedy the deficiencies in the proposed regulations, **good progress has been made in acknowledging the right of the consumer to make informed choices in her health care.** For that reason, I do support the current draft of revisions to the regulations, and encourage the Board of Health to support these regulations through the remainder of the process. I also urge the Board of Health to continue to listen to the public on issues related to their birth choices as we continue the process of developing good regulations for midwives and their clients.

Again, I speak in support of the 2017 revision to the Arkansas Rules and Regulations

Sincerely,

Ida Darragh

Midwife licensed by the state of Arkansas

Certified Professional Midwife

EXHIBIT 2

Arkansas Association of Midwives 109 South Martin Street
Little Rock, AR 72205 501-663-2850

September 20, 2017

Bradley Planey, M.S., M.A. Branch
Chief
Family Health Branch
Arkansas Department of Health 4815
W. Markham St. Slot-16 Little Rock,
AR 72205-3867

To Whom It May Concern:

The Arkansas Association of Midwives has reviewed the proposed draft of Rules and Regulations for Arkansas licensed midwives and support the recommended changes. We would like to see this draft document replace our current regulations as soon as possible. We fill it updates the standard of care given by Arkansas midwives and attempts to reflect national norms in giving respect to women's rights in making decisions for themselves regarding their health care, and that of their children.

However, there is still much to be done; especially in the area of respect for clients making their own health care decisions without fear of losing the health care practitioner of their choice. I hope we will begin soon in continuing to update and upgrade these regulations to become an even better example of trust and respect for consumers rights.

Sincerely,

Mary R. Alexander

Mary R. Alexander, Co-Chair Arkansas
Association of Midwives

EXHIBIT
2

EXHIBIT 3

Shea Childs, LM, CPM
112 Edgewood St.

Hot Springs, AR 71901
501-282-9057 call

866-706-0747 fax

natural state midwife services

September I 5, 2017

Arkansas Department of Health
Women's Health Section

Ladies and Gentlemen,
I am speaking out in support of the revision to the Arkansas Midwives Rules and Regulations. Please include my comments in the public hearing being held on September 21. 2017.

I am a licensed midwife from Hot Springs. I have been serving families since my apprenticeship in 2007 and was licensed by the state in 2011. I received my CPM credential from NARM that same year and the Midwifery Bridge Certificate recognized by the US-MERA organizations in April of this year. I have also served on the Midwifery Advisory Board as Secretary since 2015 and have been active in the Liaison Committee working through the current revisions for the last few years with the Department of Health.

I am steadfast in my belief that women have the right to choose their healthcare provider, the right to make informed decisions about their care, including which tests and procedures they are comfortable with and which risks they may be willing to accept in order to birth where they wish, with the provider they have chosen. Because the current revisions have included a process for pregnant women to review evidence-based best practices regarding their pregnancies through Informed Consent as well as Informed Refusal for those things they find intrusive or unacceptable, I am in support of these current revisions. I would like it noted however, that the process should be ongoing and consistently striving toward improvement.

The discussion revolving around home VBAC as an option to birthing mothers has been kicked down the road for several years now. Cesarean sections at one of the two hospitals in my home county are reported to be 47%, which then force repeat C-sections on those women in the form of an administrative VBAC ban. Frankly, this should be investigated as criminal action, performing surgery on half of laboring mothers in a community. There simply cannot be medical reason for half of all labors to end in c-section. These mothers are at the mercy of a system that does not recognize the inherent risks involved in c-section that inevitably lead to multiple surgeries for purely administrative reasons. It is a public health crisis that needs to be investigated and rectified. The risks associated with repeat abdominal surgery are many. A number of states have reached agreement, outlining conditions to be met that are acceptable risks for mothers who have had a previous c-section to have a trial of labor at home with subsequent births. It will take serious commitment and deserves real discussion, but should be on the table until this option is available for Arkansas families.

Thank you for your time,
Shea Childs

Licensed Midwife

Certified Professional Midwife
501-282-9057

EXHIBIT 3

PENGAD 800-631-6989

EXHIBIT 4

Deborah R. Phillips, CPM

Midwife Licensed by the State of Arkansas
6 Edenwood Lane
North Little Rock, AR 72116
501-833-3322 fax 501-350-1520
ARmidwife2@aol.com
ARmidwife.com

September 20, 2017

I would like to have my written words entered into the record in support of the revisions being proposed to the Arkansas Midwives Rules and Regulations. Please include my comments in the public hearing being held September 21, 2017.

I have been a midwife since 1982. I have been a licensed midwife since 1985. have had a license in Arkansas since that date. I have attended 1081 births and have never had a stillbirth. I practice evidence based midwifery. I have been a member of the Midwifery Advisory Board many times and the Chair of the Board twice. I am a member of the Midwives Alliance of North America. I hold my CPM certificate and also my Bridge Certificate.

I have been a member of the liaison committee every time there has been a rules and regulations change for midwives in Arkansas. I am in support of the current regulations changes but feel that the state has a long way to go to make midwifery safer and more accessible to those who desire out of hospital birthing. Emergency drugs are carried by most other midwives in the country. Vaginal Births After Cesareans are attended by most other midwives in the country. Women who want to have VBACs are having unattended home births because of the VBAC ban for Arkansas midwives. A mother should not fear losing her midwifery care because she does not want a vaginal exam by a stranger. A mother should not fear losing her midwifery care because she does not want to subject her developing baby to an ultrasound.

These new regs bring Arkansas up to standard around the country in many issues while failing in others. I do support them because as a midwife I see this as the first improvement in regs since we first became licensed.

Sincerely,

[redacted]
EXHIBIT

Deb Phillips

Kim Jacob
HOMEBIRTH SERVICES

9.20.21

Re: Public Hearing in regards to the revision of the regulations governing the practice of licensed midwives.

To Whom It May Concern:

My name is Kim Jacob. I have been a licensed midwife in Arkansas since 2005. I also hold the CPM credential.

I am in approval of the current revision to the regulations governing the practice of Arkansas licensed midwives. This revision is an improvement to the old regulations. That being said, I expect a continued conversation on making more changes in the near future, including a provision for allowing home vbac. I stand firm in a woman's right to choose what provider, tests and procedures she wants or does not want.

Sincerely,

Kim Jacob, LM, CPM

EXHIBIT
5

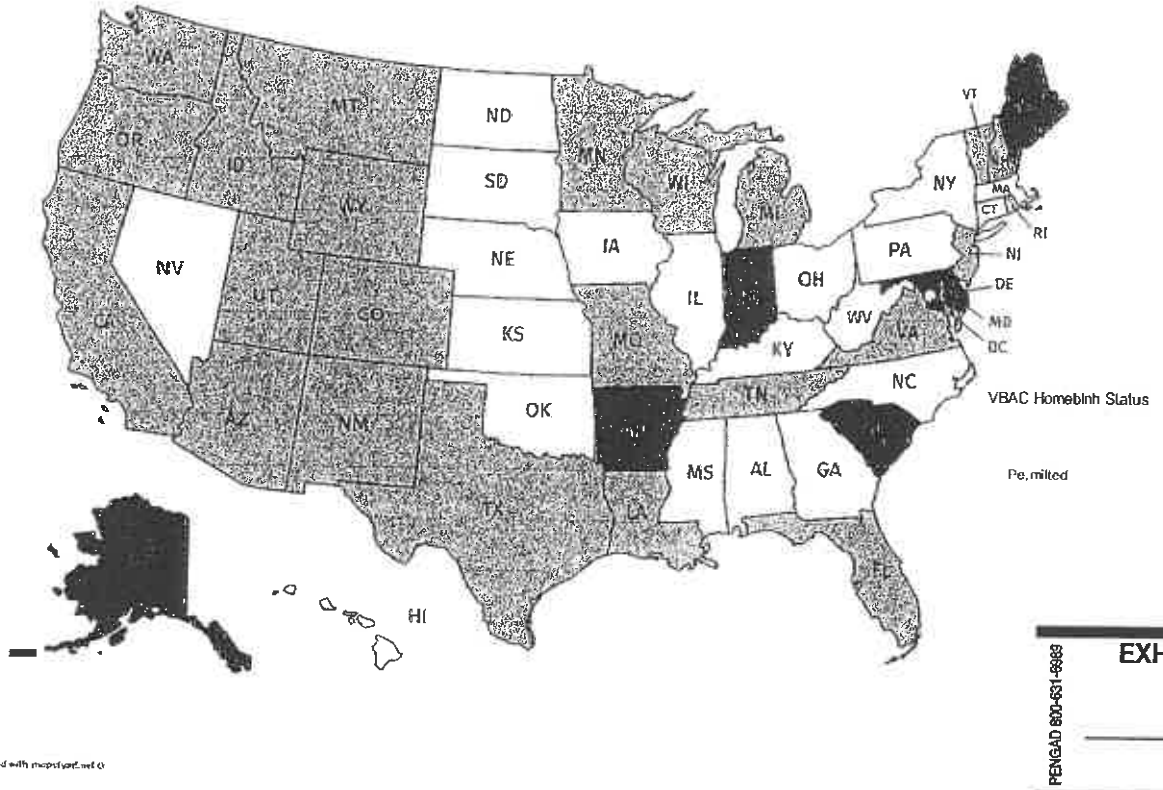
Kim Jacob LM, CPM 131 Sunny Gap Rd. Conway, AR 72032 Phone: 501-514-1277 Fax: 866-551-1024

Email: kimjacobmidwife@gmail.com

Website: www.kimjacobconwaymidwife.com

Chelsea Cameron

VBAC Homebirth Status by State



A comparison of uterine rupture to similar obstetrical emergency:

Table 1.	
Uterine Rupture[1]	**Umbilical Cord Prolapse[2]**
7-8 out of every 1000 VBAC attempts	14-62 out of every 1000 labors

The next table shows **the risk of a baby dying as a result of one of these emergencies:**

Table 2.	
Uterine Rupture	**Umbilical Cord Prolapse**
60 out of every 1000 uterine ruptures will result in a baby's death	91 out of every 1000 babies with cord prolapsed result in a baby's death

Additional information:

According to AGOG, the VBAC success rate is 60-80%.[3] VBAC success is comparable to the rate of vaginal birth nationwide. However, the uterine rupture rate is only less than

0.5%.[4] There are other factors that affect VBAC success. VBAC failure is not solely due to uterine rupture.

Arkansas cesarean rate in 2014 (most recent CDC data) 32.1%[5] Arkansas VBAC rate in 2014 6.4% (ranked LAST in the nation)[6] United States VBAC rate in 2014 11.3%[7]

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ATTACHMENT 1

NOTICE OF PUBLIC HEARING

The Arkansas Department of Health Women's Health Section will hold a public hearing on Thursday, September 21 at 10:00 a.m. in the Auditorium of the Arkansas Department of Health, 4815 West Markham Street, Little Rock, AR, to allow interested persons to comment on the proposed adoption of revisions to the Rules and Regulations Governing the Practice of Licensed Lay Midwifery in Arkansas promulgated pursuant to Arkansas Code Ann. §§17-85-101 et seq. and Arkansas Code Ann. §§20-7-109.

Copies of the proposed revisions are available for public inspection and copying at the Arkansas Department of Health, Women's Health Section, Freeway Medical Tower, Suite 401, 5800 West Tenth Street, Little Rock, Arkansas 72204. The proposed revisions are also available for inspection online through the Arkansas Department of Health website: http://www.healthy.arkansas.gov/ "Proposed Rules & Regulations" link.

The public may submit written comments regarding the proposed amendments to: Women's Health Section Chief, Arkansas Department of Health, 4815 W. Markham St, Slot-16, Little Rock, Arkansas 72205-3867 or by email to WomensHealth@arkansas.gov no later than 8:00 a.m. on September 21, 2017.

ATTACHMENT 2
Article submitted by Halee Burchfield

Arizona Birth Monopoly: Mandatory Surgery or Forced Vaginal Exams

by Kristen Pascucci | Jun 30, 2014 | Blog |

While some states are working hard to make maternity care safer, less expensive, and more humane, Arizona is going backwards, fast, led by its state Department of Health Services. New interpretation of existing state regulations that go into effect on July 1 impose strict "one-size-fits-all" mandates on pregnant Arizona women, that violate their privacy and include things like periodic vaginal exams throughout pregnancy and labor. These regulations are just the latest skirmish in an ongoing tug-of-war between Arizona and its women about private family decisions related to childbirth. This comes after a long process last year updating regulations related to home birth, and a failed legislative attempt earlier this year to restrict those rights.

What's so ironic about these mandates is that they are expressly for women who choose midwives for their care—that is, the group of women that tends to be lower risk, and informed about and engaged in their healthcare. These women have thoughtfully chosen midwives for a wellness model of high-quality, individualized care, and many of them are paying out of pocket for this kind of expertise.

But now, the midwives who care for them will be required to transfer to the care of an obstetrician—someone in a separate but complementary profession—any woman who declines any of the state-mandated tests or exams. This begs the question: does the state view obstetricians as better at coercing women into vaginal exams? Or are doctors expected to physically force women to open their legs?

Imagine you're a woman with a history of sexual abuse (that's 1 in 5 women). Imagine you find these exams during labor to be incredibly painful. Imagine you've had an emergency delivery in the past because of a dangerous infection caused by an unnecessary vaginal exam.

Your history, humanity, and health circumstances don't matter here.

And whether you are physically forced, or coerced by the threat of losing your trusted care provider, isn't the point. The point is that every woman has the right to decide if and when a hand goes in her vagina. Full stop.

Enforced consent is not informed consent

The state says these regulations are about safety, but science and common sense don't support that. It's not as if women are wantonly refusing necessary testing and treatments at the expense of health—it's that unnecessary testing and treatments carry real health risks, as well as expense. For example, many care providers don't even perform vaginal exams because of the increased risk of infection they impose on the mother and baby. They assess dilation, if necessary, using non-invasive techniques. By mandating vaginal exams, however, the Arizona regulations don't allow either care providers or the women they serve to choose for an alternative–or to opt out of a measurement that simply may not be that useful in a labor that is progressing.

Regardless of its intent, the state's imposition of prescribed treatment ignores a fundamental right of all U.S. citizens: the right to informed consent. In treating patients, all healthcare providers have the obligation to present all of the information about and alternatives to any suggested treatment, and all patients have the unequivocal right to say "no" to any treatment.

Coercion nullifies informed consent. Violations of healthcare rights can be considered malpractice or even assault. When a state promotes and enforces violations of civil rights, there might even be grounds for a constitutional challenge.

Reality for Arizona Women

So what other options do Arizona women have as of July 1? For many women in Arizona, there are two options only: if not at home with licensed midwives under the direction of the state, then in their local hospital with an obstetrician, subject to those policies and routine procedures. **Let's take a quick look at the for-profit institutions where the state is directing the dollars of its growing families.**

If you've ever had a Cesarean, you're looking at mandatory surgery in about half of Arizona's hospitals—against national health policy. Due to liability concerns, they don't even allow women to attempt a vaginal birth if

they've had surgery in the past, even though, very generally speaking, each subsequent surgery increases risk to mother and baby, while each subsequent vaginal birth lowers risks. Human rights, legal rights, and ethical guidelines support a woman's right to choose the method by which she gives birth and to refuse surgery. Unfortunately, that right is all but meaningless against unwilling care providers in a facility with unsupportive policies.

For low-risk women, care in some Arizona hospitals mirrors what many U.S. hospitals provide: routine practices shown by current science to be of no benefit or harmful to pregnant women and their babies, things like prohibiting food and drink in labor, restricting women to bed, and over-reliance on machines to monitor labor—machines that the U.S. Preventive Services Task Force issued a recommendation against almost 20 years ago, partially due to their *99% false-positive rate*, which increases complications for moms without improving health outcomes for babies.

In fact, here's what some women said in June 2014 about their actual hospital and obstetrician experiences in Arizona. These statements cover a range of outdated and even harmful protocols, poor treatment, and serious violations of their rights. It's safe to assume that these are not stand-alone stories, either, since many of them refer to facility policies that apply to all women:

I was not allowed to eat during my labors. With my first and second, they didn't let me get out of bed or tell they were going to give me an episiotomy. During my second labor, the nurse gave me Pitocin in my IV before telling what she was doing. – Y., Mesa, AZ

[My induction] was horrible and I was under these conditions for well over two days. My back pain from being in the bed on my back for that long was horrible and by the time I was dilated enough to push I was nearly too exhausted because I hadn't eaten in days. Horrible horrible. Not to mention I couldn't sleep in that position and every time I tried to turn to my side the nurses came in and yelled at me because it moved the monitors. So no sleep and no food for days… Then I was supposed to push. It was such a bad experience that I waited years before having another baby. – S., Tucson, AZ

I was coerced into having an induction with my first baby. My Doctor told me that if I didn't induce on my due date with my first baby then he couldn't be responsible if something bad happened to her because he couldn't get to the hospital in time. Also was not allowed to eat anything during labor. Also was stitched up way too tight after I tore by this same doctor. – L., Scottsdale, AZ

I have only had one baby in the hospital. It was my first. Liberties were taken. I wanted a natural birth without IVs and such but I was told that I had to have them. I asked for water and was not allowed to have any as well. Pitocin was given to me without my consent as well. I did not have a great experience and had some complications. – C., Prescott, AZ

This one hospital boasted about their fancy bathtub for moms in labor. When I was in labor, they told me it was being serviced or something. When my doctor came in, he asked if I wanted to use it, they said I couldn't, he said unhook her and let her take a shower than. Come to find out they were liars and didn't like having to use the tub. My doctor also stopped them from giving me Pitocin after my baby was delivered. – J., Gilbert, AZ

My first 4 pregnancies, there was no medical indication at all but I was still strapped in to be monitored. They wouldn't let me use the ball or even stand or anything. There was no reason for it and sadly I didn't know my rights then. – A., Chandler, AZ

Certainly, there are some wonderful hospital options in Arizona, too, and women have every right to choose them. But not all women have wonderful hospital options—in fact, some have bad and dangerous hospital options—and they have every right to choose something else. Each woman must make that determination, weighing her individual circumstances and the merits of the local options available to her.

The state cannot and should not make those choices for her.

What's this really about?

If the state were concerned about safety, it would go after the for-profit institutions where the vast majority of women give birth, facing mandatory surgery policies, outdated protocols, and providers who impose these things on women against their constitutionally based rights. Interestingly, the very people who represent those for-

profit institutions exert real influence on the current efforts in Arizona to control what goes on outside of hospitals.

But this isn't about safety. And the state said as much during a recent meeting, when it was questioned about the specifics of some of the mandates. Let me say that again: this is not about safety. It is about compliance.

It is about compliance for a group of women who have opted out of the traditional hospital system, and into a model of care that system can't comprehend. This model of care, midwifery, is all about supporting women in giving birth on their own steam, supporting them in making their own decisions about their bodies and babies, and only interfering when necessary. That's something our outdated traditional system—where women are still told what they are "allowed" and "not allowed" to do—is not set up for.

Realistically speaking, women are not going to leave the midwives they trust because of these regulations. Arizona women will continue to make their own informed decisions, and their midwives will be put in the position of putting their hands inside their clients at the behest of the state, or lose their licenses. And while this is an attack on midwives, it is, moreso, an attack on women.

It is a clear message from the state of Arizona that they do not see women as having the same rights as all American citizens, that they do not believe women are capable of making intelligent healthcare decisions, that they don't think women have the right of deciding who they contract for that healthcare, and that they do not respect women as best representing their own babies.

And the state is willing to put its hands into their vaginas to enforce those beliefs.

Arizona women are now standing in the gap for all women, in rejecting these regulations on their bodies and their family decisions—and an invasion of their sexual organs. It is my hope that they will stand for themselves, their babies, and their midwives with a message back to the state that compliance, in this case, is not an option. I hope they demand from the state reasonable regulation that is supported by evidence and common sense, and fully respects women giving birth as the #1 stakeholders in this deal.

Arizona women, this woman stands with you.

**********END OF ARTICLE**********

ATTACHMENT 3
Petition Signatures and Comments
Submitted by Arkansas Birth Matters

Name	Location	Date	Comment
Tessie Coble-Mix	Morrilton, AR	2016-10-25	Women should have the right to give birth with the health care provider she sees fit. Doctor, midwife, home or hospital.
Ashley Moss	Perryville, AR	2016-10-25	Everyone deserves a choice to choose whats right for them
Rachel Green	Clarksville, AR	2016-10-25	Women deserve options! Midwives offer attentive care for low risk pregnancies, resulting in fewer interventions and quicker postpartum recovery. A woman has a right to choose where and with whom she births.
Halee Burchfield	Conway, AR	2016-10-25	"Pregnancy is not an exception to the principle that a decisionally capable patient has the right to refuse treatment, even treatment needed to maintain life. Therefore, a decisionally capable pregnant woman's decision to refuse recommended medical or surgical interventions should be respected."
Jessica Trauger	Fulton, AR	2016-10-25	I'm signing because I support midwives in the state of Arkansas. I believe that women should have the right to choose how they will give birth. I had a midwife with all 6 of my babies and would not chose anything different.
Jennifer Keith	SPRINGDALE, AR	2016-10-25	Women deserve the right to make an informed decision as to their provider and the care they receive during their pregnancy.
Megan Bernhardt	Damascus, AR	2016-10-25	It's a human right to choose a provider. Informed consent is important! Coercion is not okay.
Kayla McDonald	Fairfield Bay, AR	2016-10-25	I'm a mother who was lucky enough to have a doctor who let me labor naturally, despite showing signs that I'd need a cesarean section. And I birthed my daughter vaginally, despite the "odds". Everyone woman deserves a chance. And VBACs ARE a viable option.
Elizabeth Durrett	Little Rock, AR	2016-10-25	I believe we need to have the right to choose where and with whom we birth! My own rights to medical access or not if I so please!
Mekelle Daniel	Benton, AR	2016-10-25	I do think it is in the best interest for the ADH to put such restictions on both women and midwives. The woman should have the power to make those informed decisions herself, just as she would in a hospital.
Cindy Shaw	Little Rock, AR	2016-10-25	I support a woman's right to know what is best for her body and her baby. The Freedom to choose her provider and where and how she gives birth should be hers alone.
Angela Stone Adcock	Magnolia, AR	2016-10-25	I want to make choices about my own body.
Rachel Rogers	Hot Springs, AR	2016-10-25	No woman should be forced to give up her choice in care provider, *just because* she refuses a medical procedure from her care provider. Women are able to refuse such procedures while under the care of an OB/GYN, and not lose their care, so this is LITERALLY

			forcing midwives out of business. It's LITERALLY forcing women to be without maternity care. How is that right?
Jennifer Briley	Mansfield, AR	2016-10-25	I am signing because this is me! Every one talks about how women need equal rights but this most basic right has been denied to me TWICE! NO MORE
Ida Darragh	Little Rock, AR	2016-10-25	Mothers need the right to refuse or decline certain medical procedures and still continue to see their midwife.
Ebony Blevins	Little Rock, AR	2016-10-25	I'm signing because women deserve fewer restrictions when deciding to utilize the services of a midwife to assist with the birth of their child(ren).
Lacy Berry	Greenwood, AR	2016-10-25	I'm signing because coerced consent is not consent. Being bullied into consent is not consent. Birth is the only natural thing left on this planet and it does not belong in the hands of politicians. It belongs to the women whose bodies grew their baby for 10 months. To the women who will labor to give that child life. And every woman and newborn baby deserves a safe, unregulated birth experience!
Jdean Butler	Little Rock, AR	2016-10-25	I believe everyone has a right to what kind of birth they want!
Karen Tucker	Siloam Springs, AR	2016-10-25	Bodily autonomy applies to every body.
Diana Nash	Leslie, AR	2016-10-25	I believe midwives provide safe maternity cate and women should be able to give birth where and with whom they choose.
Steven Smith	Benton, AR	2016-10-25	Men care about women's birthing rights.
Lisa Ray	Conway, AR	2016-10-25	Women and families need to be trusted to make healthcare decisions and have options!
Jason Daniel	Benton, AR	2016-10-26	I believe in freedom.
Jen Olewinski	Bellwood, MN	2016-10-26	I'm sighing because after having a successful vbac with an amazing midwife team in minneapolis, I will not be alllowed that experience here after moving to Arkansas. I feel a women should be able to make choices on her care and body, and assume any risks she feels are worth it for having a baby with the provider she feels most comfortable with.
Cindy Sharp	New Caney, TX	2016-10-26	I believe every woman has the right to choose where she wants to have her baby and with whom.
Judith Davis	Mountain View, AR	2016-10-26	Women should have a Right to Choose how they birth. I have been a nurse for 45 years and 20 years of that was in high risk labor and delivery. I support Home Birth and Midwives. Does this not conflict with the Patient Bill of Rights?
Brittany Maine	Parks, AR	2016-10-26	It's my right to choose where I want to give birth to my child
Jessica Dulac	Conway, AR	2016-10-26	I believe it's a families right to choose

Liz Coker	Cabot, AR	2016-10-26	It should be a choice that no woman shouldn't have to compromise on
Jody Wells	North Little Rock, AR	2016-10-26	I'm signing because these rights can save lives!
Wanda Delacerda	Morrilton, AR	2016-10-26	Women should have choice.
Mari Nitasaka-Jordan	Jonesboro, AR	2016-10-26	I am signing this petition because my insurance did not cover midwifery and I had no choice but to have a ob-gyn whom I did not like (I felt like I was treated as just another one) and ended up having cesarean (again, just another one). It's important for pregnant women to make a choice without feeling pressured just simply because of the profitable medical system. Life is more than that.
Temeka Smith	Jacksonville, AR	2016-10-26	I believe in birthing freedoms. I also believe it is important for the mother to have a choice in what she wants, after all it is her body. We need to keep the tradition of old world birthing alive
Shanon Moody	Hot Springs National Park, AR	2016-10-26	I had the pleasure and privilege to have two home births. Both with incredibly wonderful midwives! I support this way of birth if it is able for the mom and Baby. :)
Tanya Smith	Benton, AR	2016-10-26	This is important to me because the state had made my medical decisions for me in advance and I cannot hire the care provider of my choice in Arkansas. A cesarean scar does not erase my ability to make my own medical decisions.
Khepri Williams	Houston, TX	2016-10-26	My wife is a midwife!!!
Casondra Witham	Hot Springs Village, AR	2016-10-26	When I have a child, I want the option of having an at-home birth with a midwife.
Heather Ryan	Enola, AR	2016-10-26	All women should have the right to choose a midwife for their pregnancy and birth.
Debbie Jones	Little Rock, AR	2016-10-26	i support homebirth.
Hannah Lee	Conway, AR	2016-10-26	Families deserve the right to informed consent and informed refusal. ADH needs to keep their actions in check and stay within the bounds and accordance of law. This isn't just an issue for those who desire to homebirth. This is a women's issue. This is a family issue. This is a basic human rights issue. I would be able to decline procedures or tests with informed refusal if under the care of a doctor. Therefore,I should have the same right under a midwife. Further, a doctor would never have the mandated oversight of someone else in a competing profession that could discontinue care with a patient at any point. Midwives, who are in fact licensed by the state, should have the same autonony.
Abigail Nichols	Little Rock, AR	2016-10-26	I support women's right to access midwifery care and choose for themselves where and how they would like to receive care and give birth

Felicia Bumbalough	Tilly, AR	2016-10-26	Im a student midwife
Bailey Fitzpatrick	Cabot, AR	2016-10-26	Because women's rights.....
Jennifer Clark	Bentonville, AR	2016-10-26	The access to the kind of prenatal care and medical decisions of women should not be unduely coerced or infringed.
Rebecka Ockay	Searcy, AR	2016-10-26	Women have a right to choices in prenatal care and during delivery of their baby, just like everyone has a right to choices in their care for every other healthcare specialty. You don't lose autonomy over your body simply because you are in labor. By limiting the midwife, you are limiting the mother's safety and autonomy.
Amanda McKay	Conway, AR	2016-10-26	We keep our right to birth where and with what medical practicioner we choose and the choice of medical proceedure we do or do not want. These proposed regulations not only strip mother's of decision making for their own birth but coerce women when they are in a vulnerable state and can lead them to have unattended births. We must have informed refusals.
Kristina Brazeal	Conway, AR	2016-10-26	I'm signing because I am currently pregnant with my second child amd intend to have a home birth, as I did with my first, as long as this pregnancy remains healthy. I am signing because I am already seeing the restrictions being added to my midwife's abilities to work with me if I refuse procedures that I have been made fully aware of the intent and risks involved. With my last pregnancy, I was able to decline STD testing (both my husband and I are completely monogamous and there is absolute zero chance either of us have come in contact with, let alone contracted an STD) as well as GBS testing, after being made fully aware of the intent of the tests and risks involved if I declined. Now, to protect her and be able to stay with a licensed midwife, I have to comply to these tests that I DO NOT WISH TO HAVE. I feel that my rights have been violated and the injustice of forcing a woman to comply to your medical standards, yet arguing in favor of a woman choosing to abort her baby is just wrong. My body, my baby,
Katie Kelley	Fayetteville, AR	2016-10-26	this shouldn't even be something we have to fight for...
Christina Winton	Horatio, AR	2016-10-26	I'm signing because I have a right to informed consent and refusals. I have a right to choose my care provider, I have a right to birth when and where I choose, and I have the right to midwives to are free to practice safely within the scope of their CPM training including VBAC & medications.
Christina Boyd	Oak Park, IL	2016-10-26	I want to have access to birth in my own home with a midwife even though it is a VBAC, as it is reasonably safe to do so
Lindsay Kegley	Gravette, AR	2016-10-26	Consent implies choice. Stripping away choice, strips away rights. This is a humn rights issue. A womens rights issue. A medical rights issue. AN infants rights issue.
Deb Phillips	North Little Rock, AR	2016-10-26	Women should be able to exercise the medical rights and still keep their midwife in attendance for their birth.

Brittani Balentine	Lincoln, AR	2016-10-26	I'm signing because it's important that women have options to be able to birth however they feel most comfortable, and placing regulations on it like there are now leave women feeling powerless and without options, which is just not right.
Della Hale	Conway, AR	2016-10-26	So many women need options for their birth! It's time we realized birth does matter!
Duafe Arkansas	Jacksonville, FL	2016-10-26	It's our right to choose. Pregnant women are not being "treated" for an illness when having a baby. It's birth not brain surgery. Something we've been able to do with or without a Doctor or even a Midwife for that matter, since... forever. Unless a pregnant mother is ill and fragile during gestation, then a medical doctor (OBGYN) should be the only choice for the safety of the mother and baby. We have a right to our OWN options otherwise.
Ashley Pickering	Cave City, AR	2016-10-26	Every woman deserves the right to refuse any medical treatment. This is just basic human rights. Informed consent and the right to refuse...
Freedom G	Murfreesboro, AR	2016-10-26	I've had 1 cesarean and 3 subsequent successful VBACs and yet legally I am still denied the right to a midwife and a homebirth, should I have more children in the future. This needs to be changed.
Barbara Keding	Royal, AR	2016-10-26	I'm signing because I prefer to be able to accept or reject any intervention or procedure during pregnancy, birth or postpartum care!
Meg Byers	Benton, AR	2016-10-26	I'm signing because I believe women have the right to make their own decisions regarding the care they receive during pregnancy.
Jennifer Wang	Rogers, AR	2016-10-26	I enjoyed my midwife care and though I've been medically risked out I wanted to make that choice with my husband.
Leslie Rawlings	Little Rock, AR	2016-10-26	Two of my children were born at home in the 1980's, and it was a wonderful experience for our family.
Tiffini Beyerlein	Little Rock, AR	2016-10-26	I am signing this petition because I believe in a woman's right to choose how she gives birth.
Claudia Stone	Sherwood, AR	2016-10-26	Im signing because... Human Rights.
Tasha Weeks	Powhatan, AR	2016-10-26	I had a home birth and it was the most wonderful experience. I want others to have the same opportunity.
Monica Arnold	Little Rock, AR	2016-10-26	Having had a home birth with a midwife, it was such an amazing experience that I could not imagine doing it any other way. If that right is stripped from me it would make me reconsider having more children which is a sad corner to be pushed into.
Rachel Meynders	Centerton, AR	2016-10-26	I fully support the right for mothers to choose.
Sally Howell	Benton, AR	2016-10-26	I am a home birth mama of 2 and 1 on the way. I should have complete control over where and with whom I birth my children. This is not for the government to decide.

Jeanne Bailey	Maumelle, AR	2016-10-26	Every woman has the right to choose her birth plan
Marilyn De Leon	Orlando, FL	2016-10-26	Women have a right to choose where they want to give birth and with who #
Suerene Freeman	Hackett, AR	2016-10-26	I am signing because the decision of where and how to birth should be given to the mother and father of the child not the government.
Byron Lawrence	Little Rock, AR	2016-10-26	Women's Rights...
Haley Kirachner	Searcy, AR	2016-10-26	Women should have options and evidence based practice shows better outcomes for births with a midwife involved
Andrea S	Little Rock, AR	2016-10-26	It matters
Bethany Vaupel	Conway, AR	2016-10-26	No woman should be forced by law into a procedure which may not be necessary, or denied medical care during pregnancy.
Jessica Turcotte	Bella Vista, AR	2016-10-26	Because the government doesn't know my (or everyone's) mental and physical health history and should have no input when it comes to making important medical decisions concerning MY body. Period. Mothers should be able to inform themselves and make a decision about where the best place to birth (for them) is - be that home, hospital, or birthing center.
Darla Benedict	Rogers, AR	2016-10-26	It's the right thing to do.
Jessica Klakring	Newport News, VA	2016-10-26	I believe women, such as myself, should have the right to choose which care I receive during my pregnancy without it being the governments business of who and why.
Lori Lynn Tucker	Bentonville, AR	2016-10-26	I'm signing because I believe in a woman's right to choose where and with whom she decides to give birth. Midwife or doctor, home, birth center, or hospital, she should have option. Thank you for your time!
Jammie Bonds	Perry, AR	2016-10-26	Government and state should stay out of personal decisions regarding birth.
Rikki Cobb	Conway, AR	2016-10-26	I don't think the government should have a say on where a woman chooses to give birth. It is a personal thing and shouldn't be taken into question unless there is a serious medical concern.
Christa Harbor	Conway, AR	2016-10-26	Parents should have the right to choose how they want to bring their child into this world
Cari Harmon	Heber Springs, AR	2016-10-26	I used a midwife in Texas when I had my son. The quality of care and care from midwives cannot be matched by OB/GYNs.
Amanda Hanberg	Bentonville, AR	2016-10-26	I'm signing because this should all be in place already.
Daulton Brewer	Hope, AR	2016-10-26	Weather conventional medicine is willing to admit it or not, home birth is one of the safest ways for a woman to have her baby. In addition to the fact that statistically home births are more successful with healthy mother and healthy baby as the end result than

			conventional medical facilities and hospitals, also burning in the home give us the mother and father more control the treatment of themselves and their child, which let's face it, is not that great in a conventional medical facility or hospital...unless of course the mother and father demand it from the staff, which leads to arguments and attitudes, which is not a comfortable situation for anybody. Not to mention--lest we forget--it cost a helluva lot less!!!
Elene Murray	Alexander, AR	2016-10-26	The government should not take individual rights away
karen ault	North Little Rock, AR	2016-10-26	Women should have the right to birth the way they want! Homebirth vbac!!
Stephanie McEntire	Coalgate, OK	2016-10-26	I believe in home birth and a woman's right to bring forth her baby in the manor in which she sees fit. I had an incredible homebirth experience and it's my wish that other woman who desire this experience have the right to pursue it.
Chelsea Cameron	Alexander, AR	2016-10-26	A scar on my uterus does not affect my ability to assess risk and benefits. Home birth after cesarean (hbac) is the right path for my family after much research. That will be the plan whether ADH allows it or not, even if I have to move out of state. How can hbac be safely attended by licensed midwives in Texas, Missouri, and Tennessee? But not in Arkansas.
Vicki Hobby	Rogers, AR	2016-10-26	I have delivered 5 healthy babies at home with the assistance of a licensed midwife. I am strongly opposed to further laws and restrictions being placed on midwives and their patients.
Ashley Smith	Sherwood, AR	2016-10-26	I have had very pleasant home births and would highly encourage other women to use a midwife. We need less government dictating our rights.
Kim Godfrey	Little Rock, AR	2016-10-26	I believe a woman should have the choice to give birth wherever SHE WANTS!
Lauren Marks	Little Rock, AR	2016-10-26	I'm signing and sharing this petition because women should have a right to give birth in a space in which they are comfortable. And a space that occupies peace and love. Midwifery is not new or some trend. Midwives have the knowledge needed for prenatal care and to successfully bring a baby Earthside.
Abrianna Kremer	DeLand, FL	2016-10-26	Women have the right to choose where and how they birth their babies.
Charlene Winston	Pine Bluff, AR	2016-10-26	It should be a woman's option to have her baby out side of the hospital.
bonnie stribling	Russellville, AR	2016-10-26	I'm signing because I believe.
Francis Bassett	Fayetteville, AR	2016-10-26	its our right!
Lauren Carter	Monticello, AR	2016-10-26	Women should have rights. My home birth was healthier and more natural than 95% of other women I know.

kimberly anderson	little rock, AR	2016-10-26	I'm signing because I want Arkansas to lead the way in upholding women's rights to choose where and with whom they birth. Our rights as birthing women should not be limited, especially by regulations that violate state and federal laws. I'm signing for myself, but even more importantly I'm signing for my daughter so that she may be able to grow up and enjoy more birthing freedoms than I do.
Amy Van Hooser	Little Rock, AR	2016-10-26	As a mother of 4 boys born at home I support families making the best birth choices for them!
Erin Larkin	Little Rock, AR	2016-10-26	I was very lucky to have two midwife assisted births in Arkansas, and enjoyed excellent care. In my experience, closing midwives and their patients out of the health system endangers both the mothers and child. Arkansas is already so restrictive and closed on this matter , I am extremely concerned what this will mean for maternal Healthcare in our state. While pregnant with my last child, I had to travel to Texas late in my third trimester. I contacted a friend who works in health care to help me come up with a contingency plan for early labor in Texas. I was surprised to find out that I she had had a midwife assisted birth in the hospital there, and that the restrictions were quite different just a state away. It would be extremely regressive for Arkansas maternal care to get even more restrictive.
Amanda Beck	Vancouver, WA	2016-10-26	Consent by coercion is NOT consent! Women have rights that are not immediately taken away upon becoming pregnant. To treat pregnant women as second class citizens (or worse), to require unreasonable obstacles that only apply to one class of person, is not only unfair but unconstitutional.
Kayla House	Batesville, AR	2016-10-26	We should have the right to choose over our health our baby. My last birth was a homebirth and so wonderful. IF I ever had to had a C-section I would want the option to deliver naturally at home for the next child.
April Fatula	Searcy, AR	2016-10-26	"We believe that it is a basic human right to be able to choose where and with whom you birth."
Rebecca Rosser	Fayetteville, AR	2016-10-27	Women are capable of making their own informed health care choices!
gina Petersen	Garfield, AR	2016-10-27	I've had 3 healthy home births and they were far superior to the two hospital births. Keep home birth options available! It's a human right!
Mandy Blount	Conway, AR	2016-10-27	I delivered all 4 of my babies at home with an excellent midwife and want other women to be able to experience the joy and peace of homebirth.
Lindsey Sherrin	Sherwood, AR	2016-10-27	I'm signing because every family deserves the right to choose the birth path that they believe is right for them.
michelle scoggins	Little Rock, AR	2016-10-27	AR women should have the right to choose how they receive skilled prenatal & delivery care.

Amy Cowan	Gravette, AR	2016-10-27	Women should have a choice when it comes to birthing and coercion is not consent.
chloe snook	Bentonville, AR	2016-10-27	I have had two successful amazing home births with a wonderful Arkansas midwife, and I appreciated the freedom to refuse unnecessary blood work, "just for fun mostly" ultrasounds, and vaccines for philosophical and religious reasons.
Amy Jackson	Gravette, AR	2016-10-27	I don't need a government to tell me or other women how and where to give birth and to tell me who will or will not be present. Frankly, it's not the states business.
Amanda Wylie	Greenwood, AR	2016-10-27	After having several beautiful home births I had a c-section for a cord prolapse. Now I can't use an Arkansas midwife and am forced to go to another state for my second v-bac home birth!
C Blockett	Little Rock, AR	2016-10-27	Because women SHOULD have a right to have their child with at home...
Stacy Pierce	Greenbrier, AR	2016-10-27	I had three beautiful midwife assisted births, two of which were at home. Compared to one physician assisted birth, they were by far the best. Every woman should be able to choose where and with whom she gives birth.
Margie Riley	Alma, AR	2016-10-27	I've attended hundreds or maybe thousands of vbac's with women in my job as an RN in L&D from December of 1984 until June of 2016. I believe from my experience that vbac's are completely safe and more safe than a scheduled repeat c/s. I've only seen one uterine rupture in my 30+ years and she was NOT a vbac!!
marj anderson	conway, AR	2016-10-27	I care about midwifery in Arkansas.
Betty Helms	Leslie, AR	2016-10-27	A woman or parents should have a choice. This is America and their is proof that it helps the bonding for all. In this day and time we need parents to be restored to the miracle of their child coming in to this world needing them. It's the natural way life was first experienced and the medical coast are a major burden. Good mid wife's are more able to stay right with the birth and not be called off to another patient. I believe it is much better care for the mother and the baby and it includes the father if it's what the couple want.
Jan McCabe	Texarkana, TX	2016-10-27	I support Health Freedom, education and responsibility which often means home birth with a midwife.
Odell Goodman-EL	Miami, FL	2016-10-27	I agree with the cause
Mylinda Cheatham	Rogers, AR	2016-10-27	You should be able to choose.
Camellia May	Houston, TX	2016-10-28	As a native Arkansawyer and a midwife, I live and practice in Texas instead of my home state due to the restrictive laws that prevent me from safely practicing as I've been trained to do. Please make laws that allow families to have safe licensed midwifery care in Arkansas.
Sarah Palmer	Russellville, AR	2016-10-28	I feel it is the right of every woman to be able to decide how, with whom, and where she chooses to give birth to her child.

Brittany Umholtz	Little Rock, AR	2016-10-28	Regardless of where, how, or with whom a woman chooses to give birth, she should have all the options open to her. Being told by a doctor who isn't her care provider that he can take away her rights to bodily autonomy at any point if he wants leaves women in fear and anxious their entire pregnancies and labors. When a doctor holds that power over women and midwives, who are his direct competition, it leaves women with the hard choice of leaving the state to give birth, having an unassisted birth, or being forced into a situation that may cause flashbacks and trigger PTSD.
Sharon Umholtz	Mabelvale, AR	2016-10-28	It's the right thing to do. Our body, Our child, Our choice.
Miranda B	Fayetteville, AR	2016-10-28	This is something near and dear to my heart. I have seen so many women who were "bullied" into tests and procedures they did not consent to during their pregnancies but especially during labor. As a result of what I witnessed, I knew at a young age that I would want a home birth away from those pressures and unnecessary interventions. I am an extremely analytical person, so research began long before I actually considered getting pregnant. I decided what things I would do and what I would consent to during pregnancy to ensure that both myself and future children would be healthy and safe. Even though I have a supportive and experienced midwife, the regulations imposed on her, affect my body and my ability to decide what I do and do not want tremendously. If I "decline" things I deem unnecessary, she would have to turn me away. With each pregnancy I have felt obligated to "comply" with "routine" practices that simply weren't necessary for my situation. While I understand why most of the test and procedures are
Jessica Reeves	Easley, SC	2016-10-28	It's your bodyYour rightYour human rightMy ancestors never had so many laws and we shouldn't eitherWe as humans know our bodiesKnow what we can or cannot doHaving the support to be able to do what we want from help of coursel am protected by my freedom of speech by the first amendment of the Bill of Rights.That's the law.Obey it.The ninth Amendment of the United States of America in the Constitution let's me have my protected rights.Read the Bill Of Rightsl order the judge to do so as the laws of the Constitution.
Venetia Trussell	Fayetteville, AR	2016-10-28	Enough of our rights are being stomped on by the government.
Katherine Bottoms	Hackett, AR	2016-10-28	Every woman has the right to the maternity care and birth of her choice.
Kendra Morgan	Carrollton, TX	2016-10-28	Birth is a private affair.
Claire EYES	Pukekohe, New Zealand	2016-10-28	All women and families deserve the right to choose or at least have an informed choice of where the safest ooption is for them to birth. This should be based on research & best practice.
Sara Wince	King George, VA	2016-10-28	I sincerely wish the government and the medical community would start to recognize that childbirth is not an illness, and that 98% of the time a woman has a better chance of avoiding intervention that could lead to harm when birthing outside of the medical model of care. Women were not meant to be strapped down, drugged up, and "delivered". The midwife model of care is sufficient, and

			even more proficient than many Ob practices in our country, and they have just as much experience with childbirth as any other provider- in fact they have more. The procedures and tests shouldn't be imposed unless medically necessary- something a midwife CAN determine. Please, please, please let women make their own educated decisions based on what is best for them. Please allow midwives to continue to practice fully within their scope of practice, which also means well past 41 weeks gestation. Some women go to 44-45 weeks before delivering a healthy, normal baby. It's not rocket science. Stop interfering with something that sho
vanessa littleton	Camden, AR	2016-10-28	Every woman has a right to choose where she should be able to have their baby.....we woman should be able to be in the comfort of our own home.
Kim Jacob	Conway, AR	2016-10-28	I'm a midwife serving families in AR. These issues matter to us. Women have certain rights about childbearing that shouldn't be threatened by such paternalistic points of view. We have excellent outcomes and should be allowed more autonomy, not less.
Karen Hrencecin	Bentonville, AR	2016-10-28	This is very important for women in this state!
Rachel Stabler	Rogers, AR	2016-10-28	Women deserve to be able to chose! Pregnancy is a condition. It isn't a medical emergency for most women. It is something that each woman and her providers should be able to decide upon individually.
Jorden Ochoa	Hubert, NC	2016-10-28	Forced medical care is unconstitutional
Mandie Smith	Maumelle, AR	2016-10-28	I had an awesome home birth experience with a Certified Nurse Midwife twelve years ago. Women should be able to choose the way they want to give birth. My midwife took care of me better than any OBGYN had ever done.
Randall Irelan	Conway, AR	2016-10-28	Woman should have choices and midwifery is a valid choice. I agree with the points outlined in this petition.
Alexandra Welky	Conway, AR	2016-10-28	I trust midwives, and the ADH should too!
Jolie Delatorre	Springdale, AR	2016-10-28	I had a c-section in 1992 and 2 natural births after that. I was told in 2006 that I could not have a VBAC. No doctor would allow me that option. There was no medical reason for me to have another c-section but I was denied a natural birth.
louis sanford	Marion, AR	2016-10-28	I think home births are awesome. I think hospital births are awesome. I think ADH needs to ASS OUT!
Judy Johnston	Fairfield Bay, AR	2016-10-28	Stay out of women's bodies!
Hannah Burleson	Clinton, AR	2016-10-28	I believe women should have the freedom to choose to give birth the way they want, being empowered and respected in that decision!

Henry Carraro	Little Rock, AR	2016-10-28	I am signing this petition because the hospitals in Arkansas and are a virtual ceespool of infectious diseases and should be avoided at all costs.
Adina Mitchell Jones	Alexander, AR	2016-10-28	Although I am a medical professional, I support women trusting in God's initial design first. There is also a need for medicine and for women to trust in it at times. This petition supports my proven views.
Ruth Vacin	Fayetteville, AR	2016-10-28	Again, a woman's right to choose is in jeopardy. ADH should back off. Midwifery has rules and regulations. They do not need interference or hinderence from ADH. A woman should have to choose when, where, and with whom to give birth.
Julia Bennett	Conway, AR	2016-10-28	I am for mother choices!
Cassandra Dunn	Greenbrier, AR	2016-10-28	To have a midwife is our right, our choice, our birth.
Christy Peterson	San Antonio, TX	2016-10-28	Women should have the right to safe care and informed decision making. Midwives should safely be allowed to care for women without having the right to informed consent being taken from their clients.
Brooke Kochel	Cave Springs, AR	2016-10-28	As a midwife from Texas who had a baby with a midwife in Arkansas, I can tell you the extra restrictions here are burdensome. Many communities have OB practices that ban them from seeing midwife clients for the required by law visits so they are left with no care or the midwife at risk for loosing her license for noncompliance. Midwives and OBs need to work together for the safety of our moms and babies. Look to Texas's Dept of Health for a model that works!
Jayme Waggoner	Buda, TX	2016-10-28	My very good friend is a Midwife in Arkansas and I see the wonderful good she does #
Emily Snow	Fort Hood, TX	2016-10-28	It's a woman's body & she should have the right to choose where she gives birth & with who!
Bibi Chavez	Conway, AR	2016-10-28	Im sighing because I believe we should have a right to have our child at home!
Herman Chavez	Conway, AR	2016-10-28	Because I believe my wife should decided where she should have her baby. And she wants it at home.
Charles Hughes	Arkadelphia, AR	2016-10-28	I'm for women's rights to make their own reproductive choices. Freedom.
shea childs	Hot Springs, AR	2016-10-28	As a home birth mother of two and a licensed midwife in the State of Arkansas, I am very concerned that the women and families desiring midwifery care and the right to birth their babies where and with whom they choose is not hampered by over restrictive regulations.
Pam Sanford	Hot springs, AR	2016-10-28	when will our politicos butt out & let a woman make decisions for themselves?

Christina McConkey	Kannapolis, NC	2016-10-28	Birth options matter. There is not one birth method better than the other. The goal is to have the best possible birth for that specific family and pregnancy. Proper care at all times is a necessity. Taking away an option at a critical moment can be detrimental to everyone involved. Please don't take away or limit options for these mothers.
Tabitha Last Name	Fayetteville, AR	2016-10-28	I'm signing because I birthed six children at home in the state of Arkansas. Three of whom are young women who I hope will have freedom to choose how and where they birth in the coming years. Childbirth is an issue of reproductive freedom and human rights.
Lindsay Burks	Vilonia, AR	2016-10-28	I had a successful home birth with EXCELLENT care. My baby scored a 10 on th APGAR at birth and is healthy and thriving. I want to keep all my rights to participate in a home birth in th future.
Sarah Sowards	Conway, AR	2016-10-28	I'm signing this petition because as a first time mom pregnant with twins, I was unable to have a home birth under the care of a midwife. Because no obstetrician was willing to deliver my second baby breech, I had to have a cesarean section after giving birth naturally to my first baby. Now that I am pregnant again, I am being forced to have another hospital birth because of my previous cesarean section even though I desire to have a home birth under the care of a midwife. Until the law is changed, I will be forced to have a hospital birth under the care of an OB for all future pregnancies because of my previous cesarean section.
Crystal Carter	Fayetteville, AR	2016-10-28	I'm signing because it is not my body and not my choice! Every woman should be able to choose where she wants to have her baby.
Kerrie Rhinehart	Bentonville, AR	2016-10-28	Women should be able to give birth at home if they perfer with midwive even if they have had a C-section in the past.
Sandra Clarke	Conway, AR	2016-10-28	I'm signing because I had a rarity in home birth. Despite being mostly low-risk my baby was born not breathing. She ended up fine but spent 3 month in the ACH-NICU. MULTIPLE neonatologists told me that the skill and quick actions of my midwives SAVED my baby's life! Midwives need the freedom to practice quality care and women need the freedom to chose their full birth plans - including their type of provider.
Malinda Gills	Conway, AR	2016-10-28	I'm signing bc a well educated woman should be able to make the choice of how she wants to birth her own child. It's a choice to be made by the mother just as well as breast feeding. Nobody should be forced by a doctor to do what is convenient for the doctor. Our bodies were created for birthing and the American ways that have been chosen for the masses are not always the best for everyone.
Katherine Short	Perryville, AR	2016-10-28	I believe in freedom of choice
Tina Hofmeister	Dayton, TX	2016-10-28	Women should be able to choose their own birth plan.
Judith Zitko	Hot Springs Village, AR, AR	2016-10-28	And once again, we have men telling women what they can or cannot do. It's up to the woman to choose to have home birth or in a hospital. Doctors are limited and expensive.

Nadia Davis	Forrest City, AR	2016-10-28	Cut the red tape and let MOTHERS choose how they want to bring their children into the world!
Rachel Huff	Fayetteville, AR	2016-10-28	I believe in home birth.
Doris James	North Little Rock, AR	2016-10-28	I don't believe in government interference with women's reproductive rights!
Suzanne Smith	Heber Springs, AR	2016-10-28	I believe a woman should have the right to decide what type of care and birth is best for herself and her child!
Rebekah Scallet	Little Rock, AR	2016-10-28	I had 2 successful home births that were both beautiful experiences and safe. Other moms should have the right to do so too.
Robert Morrison	Beebe, AR	2016-10-28	In medically undeserved areas midwives are critical. Most are very well trained. Do not further restrict them. Not every town has a physician to assist pregnant women.
Christie Klepper	Bryant, AR	2016-10-28	As a person that chose to move to Arkansas specifically to be able to have my babies at home, this is very serious to me.
Jo'Meeya Waller	North Little Rock, AR	2016-10-28	I believe in women's natural rights to have a birth fitting to their lifestyle.
David Rice	Fort Smith, AR	2016-10-29	Because there is too much Bullshit Government in American lives and that includes Doctors who work for the Government who are working in our Public Hospitals! If they are supposed to be OUR Doctors then why are they so relentless about how they DOCTOR US and then on the other side of the coin except Payoffs from our Government and Pharmaceutical Company's at the same time?
Amber Fowler Boice	Springdale, AR	2016-10-29	I have the right to make decisions of how to birth my child!
tiffany tassin	Little Rock, AR	2016-10-29	My home birth experience was the most amazing and empowering thing I've ever done.
James Morphew	Lincoln, AR	2016-10-29	As always, the solution to every problem is LESS GOVERNMENT.
Casey Myers	Perryville, AR	2016-10-29	Women should have the right to choose where they give birth and how they are provided care.
Janna Ughenbaugh	Siloam springs, AR	2016-10-29	Women deserve informed consent and refusal. Prenatal healthcare should be up to the mothers and their midwives, not the government. Women should not be forced to see an OB simply because they choose to birth their baby in the safest, healthiest manner. Stop punishing homebirth!
Caitlyn Reed	Greenbrier, AR	2016-10-29	I had a homebirth experience 4 months ago. It was the best experience I ever had. No epidural, no ssggestions of a C-section, they push for those nowdays, and want to induce you if you're at your due date. It's ridiculous. Its a much healthier option. And I think women should have a harrassment free option to have a homebirth. I also think if they became more common Insurance would pay and cover alot of it too !

Jitka Sitter	Fayetteville, AR	2016-10-29	I believe that a woman and her family have the right to chose the care they wish to receive. In a hospital or out of it, it should be their decision .
Rebecca Minton	claremore, OK	2016-10-29	Women deserve basic human rights in childbirth
Rj Minton	Benton, AR	2016-10-29	This proposal is BS and it's way more harmful to mothers and babies than midwives ever were.
Bethany Fenlason	WICHITA, KS	2016-10-29	Women should have the right to choose.
Arianna Gaesswitz	Winslow, AR	2016-10-29	Body autonomy.
Tanya Smith	Benton, AR	2016-10-29	The midwifery rules and regulations prevent me from hiring the care provider of my choice. I strongly believe that this is a violation of the enabling statute of the Board of Health which states that the Board shall not interfere with a person's right to choose their health care provider. ACA §20-7-109
Marie Shipp	Fayetteville, AR	2016-10-29	I have five home birthed children. Everyone should be able to make their own birth choices without government interference.
Linda Payne	Piggott, AR	2016-10-29	I believe a woman should have the right to birth how, where and with whom they choose. Limiting services of midwifes will only put mothers more at risk whether they choose home birth and especially if they choose hospital births. Birth is a natural part of life women are made for and most hospitals intervene with the process when it isn't necessary.
Beverly Simpson	Winslow, AR	2016-10-30	I had my children at home with a midwife...people should have a choice where their baby is born.
Melony Pristas	Pittsburgh, PA	2016-10-30	I'm signing this because, although I dont live there I feel.all.women's rights should be respected! Whatever happens to living in a free country!? Furthermore, I dont want this comming to pa, stop it before it spreads!!!
Alyssa West	Independence, MO	2016-10-30	Birth matters, informed consent is VITAL, options in the delivery room (or at home, as the case may be) are for the parents to make NOT for the government to mandate.
Tommi Ryan	Fayetteville, AR	2016-10-30	A woman should be able to choose where she will give birth and who she will have assist. Can it be true that a woman can choose to have her baby in the womb killed, but not allowed to be in control of the birth of her child?
Laura Stout	Beaverton, MI	2016-10-30	I want to preserve women's rights to birth the way they choose and be allowed informed consent on medical treatment for home birth.
Emily Clark	Conway, AR	2016-10-30	Midwifery is an ancient practice and far safer than medical interventions and hospital deliveries. Where and how a woman gives birth is 100% her choice!
Alyssa S	Little Rock, AR	2016-10-31	A woman should have the right to care for her pregnancy, labor, and delivery in a way that she seems right, not as regulated by the

			state. Arkansas has some of the strictest midwifery regulations in the country. Something has to change. Women should not be physically or emotionally violated due to unnecessary testing, surgery, or be devalued because of government regulations. Please, give mothers back their God given rights. Let them go back to simpler times, if they so desire.
Rachel Powell	Jackson Center, PA	2016-10-31	Wow, get with the times. How uneducated are the people making these laws?
TASHA DAVIS	Maumelle, AR	2016-10-31	I was almost forced into a cesarean, everyone should have the right to birth however they wish. Thank God my daughter broke my water a week before the procedure. I was terrified thinking about surgery.
Jesus Lardin	Fayetteville, AR	2016-10-31	I birthed with a midwife and I don't want to have to make a different choice in the future!
KAYLA BRADBURY	Donaldson, AR	2016-10-31	Women and their families deserve to choose how and where they birth their children. Midwives are highly trained, capable and professional healthcare providers whose role should be supported, not further restricted by our state.
eilish palmer	conway, AR	2016-10-31	I'm signing because I believe in a woman's right to make her own choice when it comes to her body and the way she gives birth.
Rachal Cassity	Kansas City, MO	2016-10-31	Every woman should have the right to birth where ever she wants.
Michaela Green	Conway, AR	2016-10-31	As a previously pregnant woman, having someone else determine where and who you can give birth is outrageous.
Nelida Galvez	Laboulaye, AR	2016-10-31	no era un país que asumía ser el abanderado de la libertad?
Martie Glover	Maumelle, AR	2016-10-31	I had a wonderful home birth experience with experienced and professional midwives!!
Lacy Franks	El Dorado, AR	2016-10-31	I'm signing because I am a woman, and I have the right to choose!
Jolie King	El Dorado, AR	2016-10-31	I was not allowed to try natural for my 3rd birth, even though my 2nd birth was natural. Women shouldn't be forced into expensive, dangerous, unnecessary c-sections!
Dawn Jolly	Yorktown Heights, NY	2016-11-01	I believe in a woman's right to choose the best way to birth her baby and I'm a firm believer in home birth for healthy pregnancies.
Zoe Rusch	Shreveport, LA	2016-11-01	Choices in childbirth are essential for healthy mothers and babies.
Kerry Couch	Summers, AR	2016-11-01	It is my body and I should have the right to choose where I am most comfortable and with whom I am most comfortable. Surgical intervention is not always necessary and sometimes pushed upon another for the convenience of the doctor. As are some other unnecessary interventions that hospitals push. Midwives have been used for hundreds of years and is a medical fact that they are safer then doctors in hospitals.http://www.parenting.com/blogs/natural-parenting/ta

			href="http://mana.org/blog/home-birth-safety-outcomes" rel="nofollow">http://mana.org/blog/home-birth-safety-outcomes
Wendy Staten	Bentonville, AR	2016-11-01	I agree without reservation the statements made in this petition.
Carrie Palmer	Valparaiso, IN	2016-11-01	Most of my children were born in AR with a midwife. Women should be able to birth how they choose!
Faith Osburn	Enid, OK	2016-11-01	I am signing because I lived in Arkansas most my life and I have wanted a midwife with previous births but because of interventions from law I could not have a midwife deliver.
Sherree Alumbaugh	Conway, AR	2016-11-02	Home birth is a woman's right.
Becca Fairchild	Tacoma, WA	2016-11-02	I had my baby with a midwife and loved the safe, personal, and beautiful birth.
Hannah Pfaff	Cabot, AR	2016-11-02	I am a woman who values women's freedom to choose what they feel us in their and their families best interests. I believe a bridge between midwifery and physician administered care needs to be built not hindered.
Whitney Rolland	Leachville, AR	2016-11-02	I'm signing because I have two healthy, perfect grandbabies who were born at home!
Taylor Boness	Lake City, AR	2016-11-02	The hospital I'm attending has a de facto ban on VBAC. When my second child is born, it will be through c-section. I don't have a choice. There will be 4 years between these births. I just want a chance to have my baby the way I know I can.
Rebecca McKim	Centerton, AR	2016-11-02	Women should have a right to choose their birth plan. It is none of the governments business and quite frankly, "they" are already overstepping in other personal matters, birthing should not be one of them. Midwifery has been around for centuries and women have been giving birth with AND without their help for just as long. Women were created and built to birth their babies without Western Medicine intervening UNLESS it was NECESSARY to the survival of both mother and child(ren). This new act is completely invasive our ones right to choose and highly unnecessary. Please do not pass this.
Abram Harder	Little Rock, AR	2016-11-02	I was born at home, and my two children were born at home. Home birth is the safest and lowest cost option for low risk pregnancies.
Marla Talley	Leachville, AR	2016-11-02	My granddaughter had two successful home births. It was the right choice for her. It was an amazing journey for her and our family.
Tamara Matheny	Weaver, AL	2016-11-02	Even though I chose hospital births for my 3 boys I believe a woman should have a right a to where and with whom she wants to have her baby.
Joy Falcon	Bentonville, AR	2016-11-02	I want the right to choose
Leah Day	Rogers, AR	2016-11-02	The birth of my 9th child was with an Arkansas Midwife & was my BEST delivery of all!

Robin Moore	Camp, AR	2016-11-02	Women have the ability and bravery to educate themselves about their body ; they should have the choice to decide what type of birth experience they want for themselves and their baby.
Christopher McNamara	Bella Vista, AR	2016-11-02	This is the way life should be. Don't pigeon hole people into paying for things they don't want and to be treated like cattle rather than choosing a better way to birth.
Jaime Starling-Hodge	Little Rock, AR	2016-11-02	Because I deserve the right to choose how my body is treated. I signed for those who have experienced trauma and pain due to the inability to choose how/where they have their children. I signed for all of the woman in the world who don't get a choice!
Savanna Scott	Maumelle, AR	2016-11-02	My body, my choice!!!
Ruby Kendrick	Ivy, NV	2016-11-02	All women should be able to choose.
Nyier Arnold	Little Rock, AR	2016-11-02	I'm signing because I don't want to be restricted on the way I choose to have my children.
Kristin Crowder	Little Rock, AR	2016-11-03	Homebirth should be an option for all.
Mariah Reescano	N. Little Rock, AR	2016-11-03	I'm signing because I believe that a woman has the right to choose where and with whom she delivers her baby. I believe that when given accurate information and choices, a woman will make the best choice for herself, her unborn child and her family. I believe that who you are and where you live should not dictate how a woman gives birth. I believe that having a cesarean is not a life sentence to be forced into repeat, dangerous, and unnecessary surgery.
Stacey Fletcher	Pea Ridge, AR	2016-11-03	Because all women should have the right to choose what tests they consent to and how to birth. The vast majority of women who choose natural birth are very knowledgeable on these matters.
Chelsey neese	Fayetteville, AR	2016-11-03	Everyone deserves a choice
Kayla Rhoads	Springdale, AR	2016-11-03	I believe woman have the right to choose their care during pregnancy and birth.
Katy Nelson	St. Paul, MN	2016-11-03	I had two homebirths in Arkansas and do not believe women should be coerced into medical decisions that they do not believe are in their or their baby's interests.
Tonya Stover	Hartford, AR	2016-11-03	I believe it is every woman's right to birth her baby the way God intended,and the way she and her husband feel is best for them. The government shouldn't get to take that right and privilege away from the parent.
Anne Oliver	Rogers, AR	2016-11-03	I want parents to have the freedom to have the birth experience they see fitting based on their convictions and beliefs.
Lucy Claypool	Springdale, AR	2016-11-03	Birth is a beautiful thing. Therefore, the family (mother and father) should be able to decide, who and where they give birth.

Sofia Yarbrough	Rogers, AR	2016-11-03	All women shall be able to choose where and with whom they give birth as protected by Arkansas law, including those who have a history of previous cesarean delivery.
Bethany McCorkle	Fort Smith, AR	2016-11-03	I believe the family should be allowed to choose the location of their child's birth, whether they want it to happen in the comfort of their own home or in the hospital!
Jessica Uranga	Lowell, AR	2016-11-03	I have had a successful VBAC at home and plan to do it again.
Kerry Harrison	Farmington, AR	2016-11-03	I believe in womens' rights to choose
David Spruell	Hamburg, AR	2016-11-03	I know the struggle my wife went through with both of our children when dealing with lying doctors trying to convince us that the way my wife wanted to do things was wrong and that the best thing was for her to get cut open again. Women should be able to birth how THEY feel is right and doctors should help them along the way. Mid wives in arkansas should be able to do more as medical professionals and assist mom's with carrying out their birth plan.
Shira Martinez	Windsor, CO	2016-11-03	I have had a hospital birth and 2 home births! I prefer to have a home birth they have been the most meaningful and beautiful moment of life all 3 births! This big government getting into things that are not for them the have a say of is getting to be to much! Let women have the freedom to choose where they want to birth and with whom they do want to birth!!
Allison Woods	Fayetteville, AR	2016-11-03	I don't believe the government should have a say in how I get to bring my child into the world. If i don't have a right to refuse, I WILL birth unassisted in my own home. How is that safer?
Christina Grace	Greenbrier, AR	2016-11-03	America is billed as the "land of the free". Women should be free to choose how they birth their own children.
Morgan Lightsey-santos	Kennesaw, GA	2016-11-03	Informed consent. Right to liberty and person freedoms.
Peggy Vest	Conway, AR	2016-11-04	I believe in the freedom of choice.
Diana Irwin	Fayetteville, AR	2016-11-04	Women should not have their babies' births dictated by those in an office in a city far, far away. Moms want and know what is best for their children and themselves and should be allowed to make their own individual decisions about birthing the same way they have for thousands of years before recent decades.
Elene Murray	Alexander, AR	2016-11-04	Women should not be limited to the type of care they choose. My ob-gyn bullied me into having a CSection for his convenience. I was too young and uneducated to know. My subsequent children could have had the benefit of a natural delivery if I'd had a good midwife. Please don't limit mothers any more than they already are. Pregnancy is not a disease. Look at the statistics. Midwife assisted deliveries are safe.
Virginia Broadus	Gravette, AR	2016-11-04	I had two homebirths in Arkansas and every woman deserves the right to make the decisions surrounding how she gives birth. My

			body, my choice furthers the agenda of the pro choice movement, it is unacceptable that the same isn't applicable to those preserving life.
Craig Overton	Centerton, AR	2016-11-04	I'm signing because I believe that a woman should processes the right to choose how she gives birth to her child!
Kayla Barker	Conway, AR	2016-11-04	I had a csection for failure to progress because my doctor used scare tactics to convince me to induce unnecessarily when my body and my baby were not ready. Just because I am a young woman does not make me incapable of making good decisions for myself and my baby.
Sara Ritchie	Searcy, AR	2016-11-04	Women should have he right to educate themselves and choose home birth themselves.
Kathryn Marie Mainard O'Connell	Little Rock, AR	2016-11-04	It's the right thing to do.
Ariane Burgard	Kansas City, MO	2016-11-04	The restrictions for midwifery being proposed in Arkansas infringe on women's rights as humans and American citizens. I support this petition because the women in Arkansas deserve to have the same access and choice for their prenatal and postpartum care that I am afforded in the state of Missouri.
Emily Engelke	Alma, AR	2016-11-04	No one should be able to say that a woman cannot give birth in a specific manner just because they feel like they have to power to say so.
Tina Taitano	Benton, AR	2016-11-04	I have experienced both home and hospital birth and there is so much "bullying" through hospital assisted pregnancies and births that actually cause more harm than good. Each birth is treated as a "statistic" in a hospital not on an individual basis...Midwives face such a greater level of scrutiny than any doctor and yet doctors seem to have more control of our births than we as mothers do!! It should be our choice as parents how we handle the births of OUR children!
Kristin Sailors	Christiansburg, VA	2016-11-04	I'm signing because I support a woman's right to birth where and how she wants to.
Becki Campbell	Texarkana, AR	2016-11-04	I believe it's important for women to have the freedom to birth wherever and with the assistance of whomever she chooses.
Rebecca Boris Boris	Waterford Township, MI	2016-11-04	ALL women deserve the right to choose whom they wish to attend the birth of their children free from coercion. Midwives are a valuable resource for many women and the right of a laboring mother should not be infringed by the government.
Susan Gloor	Harrison, AR	2016-11-04	Midwives are more in tune with the mothers and babies than most doctors .
Kevin Williams	Mena, AR	2016-11-04	I believe that my wife and I should have the last say (outside of emergencies) in how our children are birthed.

Brad Dilday	Springdale, AR	2016-11-04	I believe home birth is the safest healthiest option for many couples.
Jennifer Baugh	Ardmore, OK	2016-11-04	I have birthed 3, about to be 4, children at home. I know the care I receive from my midwife is superior to that of a M.D. I would be furious if my right to choose were compromised.
Mildred Bisbee	Little Rock, AR	2016-11-04	To help protect the mothers and babies
Karen Shackelford	Waldenburg, AR	2016-11-04	I believe women should be able to choose who delivers their baby and where they deliver their baby without government intrusion.
Tracy Hester	Bentonville, AR	2016-11-04	Parents have God given rights.
Serina Allen	Fayetteville, AR	2016-11-04	I believe everyone has the right to choose their own health care. My body my right.
Brittaney Stockton	Conway, AR	2016-11-04	As normal advocate for Reproductive Justice, I believe that women should have control over their bodies and their pregnancies.
Jace Stephens	Greenbrier, AR	2016-11-04	Help keep the state from taking more of our rights! They'll make you pay thousands upon thousands to just give birth!
Bethany Alexander	Conway, AR	2016-11-04	Government shouldn't have more rights to my baby and my care than I do.
Shawn Jahoda	Jacksonville, AR	2016-11-04	As a woman who wants to have children, I feel that all mothers and families should have the right to choose how their journey throughout their pregnancy goes. No mother should fear she will lose acess to important tests and procedures while pregnant because of her personal choices and preferences for care. I'm signing because I'm a woman who wants to be a mother someday, but I'm also afraid, because, it seems all of the choices I thought I had a right to, when I become pregnant, seem to be dwindling, and that's not okay. Mothers deserve the right to choose!
Lynita Langley-Ware	Greenbrier, AR	2016-11-05	I had my first child at home and I believe that the medical model of care is invasive and insensitive to pregnant women. My home birth was low stress and beautiful. I had a hospital birth that was exactly the opposite. Women should be ableto choose how they give birth.
Sarah Meyer	Loveland, CO	2016-11-05	Giving birth is a very momentous and unique experience that should not be regulated by the government.
Kara Kenner	Hardy, AR	2016-11-05	It isn't our right to birth with whoever we please!!!
Elizabeth (Betsy) Orme	Little Rock, AR	2016-11-05	Every woman deserves the right to choose her prenatal care, labor and delivery experience, and postnatal care.
Cherish Cutler	Conway, AR	2016-11-05	I am a woman who has a right to choose my medical care, without persuasion from the state. My body, my baby, my way. Every woman deserves this right!
Amanda Cabaniss	North Little Rock, AR	2016-11-05	As both an obstetric RN and a homebirth mother, I support a woman's right to choose where she will birth and which

			interventions she will receive during her obstetrical care, regardless of provider.
Cindy Sigmon	Rogers, AR	2016-11-05	I had all 3 of my children delivered by a midwife with 2 at a birthing house and 1 at my home. I wouldn't trade that experience for anything. My midwife was very diligent in my prenatal care, labor, and delivery. No woman should be denied the choice of where she births or with whom she delivers.
Sandy Moore	Little Rock, AR	2016-11-05	Families have the right to the birth experience of their choice.
Emma Ryder	Melbourne, Australia	2016-11-05	I know the positive effect of midwifery care for women and babies and society as a whole ##
Trey Golmon	Little Rock, AR	2016-11-06	The advisory board is trying to strip us of our God given rights and I am totally opposed to their schemes to line their pockets with more money by restricting birthing options. Shame on these doctors!
Karen Delavan	Little Rock, AR	2016-11-06	I believe strongly in home birth, the use of a midwife during pregnancy and childbirth, and the absolute right of the mother to choose where and with whom she gives birth. We do not need to return to the dark ages of childbirth in this state or country.
Donna Hope	Ash Flat, AR	2016-11-06	I had 3 safe home births in a remote area of Alaska. I would like my now adult children here in Arkansas to be able to choose home birth if that's their desire, without a bunch of restrictions/ government over reach prohibiting them from doing so.
Isa Muir	Hot Springs National Park, AR	2016-11-07	Every woman has a right to choose how she wants to give birth. Midwives have been aiding women for millennia to have safe and joyful births. Let them do their job!
Jason Skerbitz	Fort Smith,, AR	2016-11-07	Because I'm SICK TO DEATH of government bureaucrats (on EVERY level) dictating to people how they must live their lives.... BEYOND pissed off at this point.
Karina nagin	brooklyn, NY	2016-11-07	I believe it's a woman's right to be able to choose where and with whom to give birth.
Amanda Kennedy	Bigelow, AR	2016-11-08	I had a home birth in Arkansas and it was very safe. We don't need more restrictions.
Michael Hill	Fayetteville, AR	2016-11-08	Women need to have a choice!
Debbie Disch	Fort Smith, AR	2016-11-10	I'm a midwife! I believe women should have rights to birth the way they feel safe!!
Amanda Evans	Conway, AR	2016-11-11	I'm signing because I support the rights of women to choose their place of birth. I believe it is a basic human right to choose where and with whom you give birth.
Dr. Kelly Jennings	Hot Springs National Park, AR	2016-11-15	As a former US Army Company Commander, I fought for the right to choose which drugs go into my body, which tests that I and my child receive and how I bring life into this world. The State of Arkansas read the evidence on the safety of birth with midwifes verses hospital and OBGYN births. My rights say that I have the

			right to life. I should be able to choose how I bring new life into America.
Danielle Cheung	Midlothian, TX	2016-11-17	Every woman should have the right to choose.
Shavawn Collier	Booneville, AR	2016-11-20	If it's a womans right to do with her body as she chooses, then she should be allowed to choose where and how she gives birth.
Kristyn Sheets	Hot Springs National Park, AR	2016-11-24	The government has no right to make restrictions that could influence how or where a woman gives birth!
Anne Quinn	Hot Springs, AR	2016-11-24	Do what is best for women, children, and families! Leave the power to control reproductive decisions to the individuals, families, and care providers who know what is best for them!
linda childs	Hot Springs National Park, AR	2016-11-24	linda l. childs
Heather Ayers	Bentonville, AR	2016-11-24	Right to choose what's right for your self.
Gabriel Fisher	Hot Springs National Park, AR	2016-11-24	I support a women's right to choose how she wants to give birth. In many developed countries such as England and the Netherlands, midwives are widely used as normal part of the birth process, and c-section rates are over 300% lower than in Arkansas.
Katie Long	Hollister, MO	2016-11-24	My wonderful midwife is located in AR. I believe the right to birth where and how I feel comfortable is a very important human right. The AR Board of Health has no right to force me to make the choice between a procedure or test with which I am not comfortable, and cessation of my prenatal care, period.
Amelia houser	Hot Springs National Park, AR	2016-11-24	Midwives do a great service. Families have a right to choose a stress free birth with their help.
Nora Hinton	Wesley, AR	2016-11-24	Women's bodies. Women's rights.
Jacquelyn Fras	Winslow, AR	2016-11-25	I'm signing because women deserve the right to have a say in their birth!
Kathy Lee-Rhodas	Erie, CO	2016-11-25	All women shall be able to choose where and with whom they give birth
Jordan Travis	Fort Smith, AR	2016-11-25	I believe in the right of the parents to chose a home birth
Erin Albertson	Fort Smith, AR	2016-11-25	I should have the right to choose!
Ashley Bell	Batesville, AR	2016-11-27	I am a first time mother and received a cesarean. In my area they refuse women the option to have VBACs because our hospital "is not equipped to handle the possibilities" of a vaginal birth after cesarean. I do not wish to have another cesarean and if I have no other option other than cesarean I will not have any other children.
Amber White	Lebanon, MO	2016-11-28	Everyone deserves the ability to make their own informed decision without the State stepping into the medical decisions. Pregnant

			women are capable of making the decision that bests fits their situation.
Pamela Brott	Colbert, OK	2016-11-28	I am a midwife and I believe in a mother's freedom to birth where, with whom and how she wants with our restriction. I believe the birth belongs to the mother and child and they should be the sole authority in the birthing process.
cassie disch	Charleston, AR	2016-11-28	Women have a right to their bodies and WOMEN should be the ones choosing their healthcare provider and where they birth without having to jump through hoops! I am a woman and I have the right to choose whom I want to give me the care I deserve and where I give birth and how I give birth!
Terrie Gandy	Mena, AR	2016-11-28	I believe that the mother and/or both parents have the right to decide where, when, how and with whom the will receive prenatal care and delivery of their baby. This decision is personal and does not belong to anyone else.
Emily Jacks	Fort Smith, AR	2016-11-28	Women deserve to have the freedom to birth safely at home with the midwife of their choosing! Instead of regulating, how about training??!
Stephen Prado	Rudy, AR	2016-11-28	This is nothing more than a power grab by a few bureaucrats who want to make sure the few people who have said we do not need you pay homage to them.
Tanya Polk	Fort Smith, AR	2016-11-28	I believe that there are already too many restrictions on midwives in Arkansas today. In addition, I believe that many women would be restricted more if this were to pass. Not because of medical issues, but due to the biased views of many health care professionals.
Raven Fisher	Fort Smith, AR	2016-11-28	I believe that women should have this right.
Stephen Graves	Rudy, AR	2016-11-28	Too many regulations for home-birth already.
Cassidy Henson	Chester, AR	2016-11-28	This is crazy! Women shouldn't have anything forced upon them and then threatened that they would lose the care that they hired.
Kendra Lacy	Fort Smith, AR	2016-11-28	Women have the right to choose which reproductive healthcare is right for them!
Tiffany Brown	Mountainburg, AR	2016-11-28	I'm a concerned and educated proponent of home birth. I also have had both home and hospital births and by far my best birthing experience was with a midwife. My birth was easier, and healing time shorter, much better outcomes. Anecdotal and evidence based evidence supports this as well. it works best for most families and women, please do not restrict farther. Most women who choose a midwife do so simply to have more choice and say in their care, not less.
Amy Minden	Greenwood, AR	2016-11-28	I had a home birth in Arkansas and I believe if this was supported we could have access to useful information and good board certified midwives.

Rebecca Taylor	Lonoke, AR	2016-11-29	I'm signing because if our family grows we will be seeking our care from a midwife. We believe Arkansans deserve to choose.
Billye Matthews	Tucson, AZ	2016-11-29	I support a woman's right to birth in the location of her choice and to have the care provider of her choice. Women should have the right to control their own bodies. As a mother of 3 children, born at home in Arkansas, I ask the ADH to support the rights of women to choose their place of birth, choose what testing they want to refuse or accept, choose their care provider. The state does not have the right to govern a woman and her medical care. To do this is to put women into slavery. This proposed rule is unjustified and does not support the health and well being of the women and babies of Arkansas. It is dangerous!
Gidget Hawley	Waldron, AR	2016-11-29	Why is there so much support for a woman's right to choose the termination of an unwanted pregnancy, resulting in the gruesome murder and disposal of a viable human being, WHILE a woman who wants to keep her baby and make the process comfortable and pleasant for both her and her baby, is prevented, hindered, and regulated away from doing so?WHY?Crazy mixed up world!!!
Gail Harley	Fort Smith, AR	2016-11-29	I believe you should have the right to choose where your baby is born as long as it is in a safe environment. This is America.
Lorraine Barker	Alma, AR	2016-11-29	I'm signing because I'm sick and tired of hearing that pregnant mothers can't receive the prenatal and birthing care they need because the Midwifery Board decided they "needed" different help.
Meloni Cutberth	Seligman, MO	2016-11-29	I believe strongly in homebirth. It's much safer and easier on mom and baby. And there is always an intervention plan if needed.
Lindsey Clarke	Benton, AR	2016-11-29	Because I've been forced to have four c sections due to no other options
Amanda Johnson	Pocahontas, AR	2016-11-29	I'm signing because I never had the right to a vaginal birth. My first birth was an emergency c section and because of Arkansas law I never had the option to be able to birth the way I wanted to.
Alan Brott	Colbert, OK	2016-11-29	This is a violation of civil rights and the coercive acts by this entity are based on ignorance, animosity and greed. That anyone wants to take away the decision of a mother and father on where and how to care for their newborn is offensive. Those trying to coerce parents in this manner are the ones who should be facing jail time.
Amanda Blundell	Fayetteville, NC	2016-11-29	I had a previous cesarean in another state and went on to have a vaginal home birth in Arkansas unassisted due to the strict regulations. I would have loved to legally hire an experienced and trained midwife.
Meghan Sever	North Little Rock, AR	2016-11-29	I am a VBAC mom and believe women should be able to choose the circumstances surrounding the birth of their children.
Holly Ballew	Mayflower, AR	2016-11-29	I'm signing because this isn't just a birth issue, it's a human rights issue. Becoming pregnant does not negate my rights to choose medical care for myself. I am a citizen of a free country and as

			such should be able to make these choices for myself, without unnecessarily restrictive regulations.
Madeline Luff	Harrisburg, AR	2016-11-29	I had a vbac and I think all women should have that choice
Betty Jo Clark	Fort Smith, AR	2016-11-29	We should have the right to choose the birth path that's right for us! I had a midwife with both of my children. Great experience and healthy babies!
Lizzy Hanks	Fayetteville, AR	2016-11-29	Because, "Once a cesarean" doesn't have to mean, "Always a cesarean."
Adrienne Wiese	Alexander, AR	2016-11-29	It is a woman's right to choose how she has her baby. I've had both of my babies at home using a wonderful midwife and i do not intend to do anything differently the next time around!
Nayeli Collier	Little Rock, AR	2016-11-29	Although I chose to birth in a hospital due to weighing my personal risks and history, I went as natural as possible having researched everything. ALL of the mothers I know who have decided to have a baby at home researched, and made an educated decision on what they believed was the best choice for them and their baby (not true of many women who give birth in a hospital). We live in America and we should have the freedom to make our own medical decisions. Other countries with better maternal care do homebirths and midwives over hospital intervention births for lower risk mothers!
Cullen Cabral	Little Rock, AR	2016-11-29	Because I love to sign things
Ebony Johnson	Pecan Gap, TX	2016-11-30	Women have the right to choose when, where, who, and how their baby is delivered and that right sold be protected. Mothers should be protected! More regulations will make it harder for mothers too choose a safe comfortable route.
Laura Johnson	Little Rock, AR	2016-11-30	What about the babies?
Bob Beck	Vancouver, WA	2016-11-30	3/4 of my children were born in AR, and the high amount of "medical intervention" with those experiences was insulting and demeaning. My 4th child was born in WA, where we were respected and not treated as uneducated plebs.
Sharaya Lockhart	Fort Smith, AR	2016-11-30	Everyone should have the right to birth how they want. It's not right to force people to accept different procedures they would refuse.
Jamie Henderson	Perry, GA	2016-11-30	My daughter lives in Arkansas and I have witnessed the differences between her giving birth to a child in the hospital and in the comfort of her own home. There is no comparing the two. Home births are less stressful on the mother and therefore better for the baby. Home birth is a beautiful option for those that choose it and should remain so.
Julie Hurlburt	Cammack Village, AR	2016-11-30	My 1st son was born in a hospital and my 2nd born was born with a midwife. My midwife was so much more careful and attentive to my needs than my doctor was. I felt like I was so much safer in her care.Every woman deserves that right to choose.

Aysleth zeledon	Russellville, AR	2016-11-30	I am a mother and know what it feels like to fear for my baby's well-being when forced to have him at a certain location.
Jennifer Buchwalter	Fayetteville, AR	2016-11-30	I am a Firm Believer in choice and that All Women should have the choice who , where, and how they give Birth!
Justin Mudge	Bald Knob, AR	2016-12-01	The freedom of a living child birth should be a right not a governed by lawyers to the extent of making it next to impossible. After all the state agrees to the freedom to abort birth... yet dictates natural birth with a midwife. Arkansas DH should be ashamed of itself.
Ilyssa Foxx	Little Rock, AR	2016-12-01	I'm signing because midwives and doulas saved the life of my child and made my deliveries positive empowering experiences.
Destiny Bomar	Farmington, AR	2016-12-01	My mother is a midwife, and it is the biggest blessing she could have given to the children she helped birth. Every single one of those children were born healthy and perfect. America is supposed to be a free country, isn't it? No one should be able to tell women where to birth their children. It is up to us, the women who grow and birth all the children in the world, whether we want to have a midwife or not; wether we want to birth at home or in the hospital. It is our choice as mothers. Let us be.
Rose Horst	Huntsville, AR	2016-12-02	I want to see women get the care they deserve and are knowledgeably choosing to have with midwives who are trained and equipped to handle normal healthy births.
Heather Nelson	Bentonville, AR	2016-12-02	I'm signing because the government has no right to tell me how I am to raise my children, beginning in the womb. Licensed and certified midwives have received more classroom training and hands-on experience than most doctors and should be treated as such, highly skilled and trained health practitioners. It saddens me to see the ignorance that is driving this and current strict regulations on midwives that are unnecessary. Surrounding states have found ways to embrace that both the medical and natural communities have the same end goal: healthy babies and healthy mommas. Why is Arkansas so behind? This would force me to deliver in another state to have the rights I deserve as a mom, which is dangerous as it requires more travel while in labor. I never signed up to be a slave to the medical community the moment my pregnancy test turned positive. This is a natural, wonderful blessing in a woman's life (we've been doing it for centuries). Stop treating pregnancy like a disease.
Katherine Alldredge	Bella Vista, AR	2016-12-02	I belive a women should have choices in the Healthcare options during her pregnancy. It's not a disease
Sarah Foster	Ponca City, OK	2016-12-02	Midwifery care should be expanded and embraced by a system that is already struggling to take care of people. Choosing a midwife should never mean abandoning your rights to autonomy. Nothing should.
Cara Boyd-Connors	Little Rock, AR	2016-12-05	I care about my privacy rights and those of others like me.

Jamee O'Kelly	Siloam Springs, AR	2016-12-08	Had 2 boys at home. Economical and simple. We chose this option because of these 2 reasons.
Julia CRESS	Mountainburg, AR	2016-12-13	I believe midwife assisted births are a viable option and mothers should have that option.
Tamera Weis	Sioux Falls, SD	2016-12-17	When the medical profession makes the rules--they are increasingly self serving and not evidence based!All new laws should be required to have evidence which proves that the laws are good for women. (NOT just hearsay from physicians.)
Larry Karigan-Winter	Huntsville, AR	2016-12-18	You need to get out of people's lives and stop enacting regulations that interfere with an individual's belief system. We had all our babies at home in the '70's and '80's, as mothers have since the beginning of time. It's no one else's business. You are regulating a natural event that a greater force created.....the beginning of life itself. This is none of your business !!
Rachael Rochier	Bella Vista, AR	2016-12-20	I believe women should be able to choose the birth they want for their families and not the one the state chooses for them by a lack of options.
Daniel Hopwood	Little Rock, AR	2016-12-22	Why right does government have to tell a woman how to have a baby? None! Government would have no problem if the woman wanted to murder her baby!
Emily Faye Proffitt Cole	Winslow, AR	2016-12-27	I strongly believe in the Midwifery Model of care & have recently had my first child. We struggled to find this & had to seek care out of state at a great expense to us due to it not being covored by insurance. I did not receive maternity care for much of my pregnancy because of this, despite first visiting a doctor within the first month. All advertised midwives have already been run out of the state & those still here have to lie low so that finding one is impossible & all midwives we interviewed had terrible stories dealing with the state gov. We where fortunate to get to homebirth (at a birthcenter) & had to fight for even that! America's childbirth mortality rate has not improved since the 80's, while afganastan rankes better than us in recent years! Ditch the drugs & medical interventions and let birth be the natural process in the comfort of our own homes as it had always been until western society twisted it into a 911 emergency!
Linda Proffitt	Ozark, AR	2016-12-27	I'm signing because I believe women have the right to choose how and where they will give birth.
Veronicca Mayner	Mulberry, AR	2016-12-28	I had both my babies with midwives and i loved it. I learned a lot and basically gave birth on my own!
Marilyn Neely	Conway, AR	2016-12-28	I feel that the government intrudes too much into our lives. This is usually a well thought out decision already. If there were to be a problem, the midwife would be the first to change the venue. Let people think for themselves and make their own decisions.

Janet jennings	Little Rock, AR	2016-12-31	I had a midwife through all my pregnancys. I even had Phoenix in a birthing pool in my kitchen. It isn't fair to take these options away from woman. Thanks again Arkanastan.
Kelly Avants	Bryant, AR	2016-12-31	Women should be able to give birth however they want.
PAMELA McARTHUR-ELLIOTT	BELLA VISTA, AR	2017-01-03	As a woman & a registered nurse of 37 years, I support a woman's right to choose how & where they wish to give birth.
amber lea	Santa Fe, NM	2017-01-06	I believe in the right to choose.
Anita Kanitz	Stuttgart, Germany	2017-01-07	You cannot hope to build a better world without improving the individuals. To that end, each of us must work for his own improvement and, at the same time, share a general responsibility for all humanity, our particular duty being to aid those to whom we think we can be most useful. Marie CurieThe purpose of life is to obey the hidden command which ensures harmony among all and creates an ever better world. We are not created only to enjoy the world, we are created in order to evolve the cosmos. Maria Montessori
Sarah landers	Fayetteville, AR	2017-02-14	It's insane to think people handling newborns will be for vaccinated then have to pray they don't pass on diseases via shedding. That's completely IRRESPONSIBLE.
Jaimie Teel	Lake City, AR	2017-02-14	I had a home birth but chose to have a regular doctor first. When discussing my options for delivery with the doctor, it was clear to me that non invasive was not an option. I believe that women's bodies are for the most part perfectly capable of delivering healthy babies without interference by medical doctors and we should have the right to choose which procedures and where we deliver.
Linda Flatt	Cabot, AR	2017-02-14	I'm signing because women have the right to birth when, how and with whom she sees fit. Her body, her baby, their birth.
Halee Burchfield	Conway, AR	2017-02-15	We neither neither need nor desire the ADH's protection from our choices. We are intelligent adults, able to weigh our individual risk and benefits without state interference. A scar on one's uterus does not affect one's ability to think. It is not your responsibility to save us from ourselves.
Kristell English	Heber Springs, AR	2017-02-15	Ive watched friends and family be pushed into doing things they didnt feel were right during their pregnancies and deliveries. The options were only to lay on my back with a painful back delivery!! It was so awful, so painful. I prayed many times I could just deliver alone in my tub...women deserve the right to do what they feel is best for them!!!!
Kathy Bryan	Heber Springs, AR	2017-02-15	Midwifery is a fabulous, and safe option for women, and should stand. The government need not get any more involved in conflating the issue with more laws and regulations. Statistically giving birth utilizing a qualified midwife is safer and produces less intervention than a "normal" hospital birth. See this quote form a study done by the government: "Planned home birth attended by a registered midwife was associated with very low and comparable rates of perinatal death and reduced rates of obstetric

			interventions and other adverse perinatal outcomes compared with planned hospital birth attended by a midwife or physician." (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC27421)
Lindy Johnson	Viola, AR	2017-02-15	I believe a woman has the right to choose where she gives birth. Our state will allow a woman to choose the person or doctor who will murder a baby, but they can't choose who can bring her into the world? 37/
Sherry Cagle	Leachville, AR	2017-02-16	A woman should have her right to have a home birth for her and her family
Sarah Moore	Batesville, AR	2017-02-16	I think everyone should have a choice of home birth.
Andrea Levitt	Cave City, AR	2017-02-16	I signed
Jacqueline W. Dutton	Fayetteville, AR	2017-02-16	Midwifery should be an option determined individually. It can be far less stressful for mother and baby.Freedom of choice! I personally know a midwife for23 years delivering homebirths. Medical practices connected with big Drug Companies for control of dollars in their pockets should not brainwash families not to make their own decisions on personal matters.There is a place for medical intervention AND Home Births.
Tanya Holt	Batesville, AR	2017-02-16	I believe in our right to have freedom of choice.
Sarah McGraw	Warren, AR	2017-02-16	Parents should have the freedom to birth their children when, where, and with whom they feel most comfortable.
APRYL BORGES	Blytheville, AR	2017-02-16	I'm signing because I was nearly killed in an unnecessary cesarean.. Since then I have suffered from PTSD not wanting any more children in fear of hospital births! Midwifery offers SO MUCH MORE than hospital births. I long for a homebirth, feeling safe in my own home with a licensed midwife and doula.. It's impossible for me in Arkansas. WHICH IS WHY I AM DRIVING TO MEMPHIS, TN TO GIVE BIRTH!!!!
Jasmine Holloway	Ithaca, NY	2017-02-16	I was coerced into TWO unnecessary csections and I refuse to have another unless life-threatening issues arise. My body! My baby! My birth!
Amber Cherry	Steele, MO	2017-02-16	As a mother who had given birth to my first child in a hospital setting, then to my second child from a midwife at home (with no adverse events), I support the right for women to choose how they want to birth .
Resa Garner	Fayetteville, AR	2017-02-17	I'm signing because a woman should be able to control decisions about her own body and I plan to become a midwife and offer my services to Arkansas. We deserve choices.
Sarah Munson	Smithville, AR	2017-02-17	I believe in women's rights.
charles kochel	Cave Springs, AR	2017-02-21	I believe

Erin Hamilton	Ozark, AR	2017-03-01	I believe that a fetus is a living, breathing thing.
PAMELA McARTHUR-ELLIOTT	BELLA VISTA, AR	2017-03-03	As a Maternal Child Nurse of 37 years, I have worked to save babies. I've seen too many babies born too soon naturally struggle to survive. I don't understand how anyone can think they are not living little people, who feel pain!
Teighlor Chaney	Beebe, AR	2017-03-07	I'm not a mother, and have no plans to become one, but if I were to become a new mom, I'd want a midwife.
Rebecca Tripp	Heber Springs, AR	2017-04-03	I want the right to chose when and where I have my baby.. I also want my Midwife to have more options and and ease of practice.
Stephanie Marr	Green Forest, AR	2017-06-02	I am signing this because every woman should have the right to choose what is right for her child. We are all individuals with individual thoughts and experiences. Its impossible to place every woman in the same mode of care. Hospitals do not always look out for the best interest of the mother and child. That has been proven. Please dont take are God given rights away.