Tammy:

A radically changed landscape for reproductive care. We speak with Dr. Mai Fleming, a primary care physician, about what it's like to provide options counseling and abortion services in California and across state lines.

Welcome To Coming Together for Sexual Health, where we talk about enhancing sexual healthcare.

Dr. Ina Park:

For most of us, having sex is easier than talking about it.

Dr. Rosalyn Plotzker:

This is not related necessarily to the people who have the infection. It's related to the healthcare system in which they exist.

Duran Rutledge:

What can I do? What can I learn that impacts change for the people that are in my sphere of influence?

Dr. Rosalyn Plotzker:

This is so, so, so preventable.

Tammy:

These conversations are brought to you by the California Prevention Training Center at the University of California, San Francisco.

It's time. Let's come together for sexual health. All views expressed are those of the person speaking and not of the CAPTC or their employer. Welcome to Coming Together for Sexual Health. Dr. Mai Fleming, thank you so much for joining.

Dr. Mai Fleming:

Thank you so much for having me today.

Tammy:

Absolutely. Dr. Mai Fleming has a breadth of experience working with people in primary care addiction medicine, and reproductive health across the gender spectrum. Some of her many roles include serving as faculty at the UCSF Family and Community Medicine Residency Program, providing telehealth abortion services via Hey Jane, primary care to university students, traveling to low resource areas to provide reproductive care, and providing telehealth gender affirming care across the country. That is quite a list of lots of multidimensional work that you do. And I'd love to hear if you could share a bit about yourself and how you came to this work.

Dr. Mai Fleming:

Yeah, absolutely. So, as you mentioned, I'm a family medicine doctor by training. And so what that means is that I really take care of all folks at all points of their lives. And abortion care, gender affirming care, addiction care is all really part of that. As a physician, it's my duty to really meet people where they're at, to treat them with dignity and respect, to provide compassionate care, and to just really help

people get what they need to live and thrive within the context of their families and their own communities. And I think this especially becomes important when working in particularly stigmatized areas of care. And so I think that is really what drew me to the areas of focus and is why I do what I do.

Tammy:

So in what context have you provided reproductive care and what type of care has that included?

Dr. Mai Fleming:

Sure. So reproductive healthcare is really expansive. Oftentimes we think about it in the context of abortion, but really what it incorporates is everything from pregnancy care, contraceptive care. Yes, of course abortion care, but also fertility and whole family care and community care. So when we think about the tenants of reproductive justice, it includes the freedom to have children, to not have children, and to raise one's children in safe and sustainable communities. And so reproductive healthcare is a part of that and really puts that into practice.

So as a family doctor, I have helped people discuss the reproductive health and family planning within the context of their lives, have helped to use my skills as a provider to help them meet their goals. And that includes providing prenatal care, delivering babies, contraceptive counseling, and contraceptive provision. So prescribing as well as procedures, a lot of options counseling and abortion care, and also including fertility counseling, so for folks who are either starting gender affirming hormones, for folks who have been trying to conceive without success, for family building for LGBTQ individuals, or for folks who decide to delay childbearing, and they want to preserve their fertility for the future. So really it's all encompassing in whatever form it really takes for the individual who comes to my office.

Tammy:

It's so refreshing to hear you speak in this broad way, speaking to the interconnections between different aspects of identities and people's needs around reproduction. What has changed in your work since Roe V Wade was overturned?

Dr. Mai Fleming:

So I think there's been things that have changed and things that will always remain the same. I think it's important to also focus on that as well. That there is and will continue to be dedicated and compassionate healthcare providers who are committed to helping people in a time of need as much as possible within the balance of the new sort of legislative and regulatory environment. So prior to SB8 I had actually myself been flying to Texas to provide care. Now post Roe, Texas has completely outlawed abortion. And so returning is no longer a possibility for me. In addition, I also provide telehealth medication abortion across seven different states where I'm licensed to practice and where telehealth medication abortion is legal and where there has been an influx of patients in this post Roe landscape and a combination of folks traveling from out state and those from within state whose capacity has become more limited, and wait times have become longer within the influx of travelers coming in for in clinic care.

So I think the legal boundaries of cross state care is sort of new and unprecedented. I think pre Roe, there was really no medication abortion at all. Medication abortion was FDA approved in 2000 so while after 1973. And no telehealth existed at that time as well. So we're really just navigating new and untested waters here. And I think that has been the biggest thing that has changed is working in a pretty

ambiguous environment when it comes to what care is possible, what care is legal, and how to best meet the needs of people as they are also navigating these new waters for themselves.

Tammy:

Those are a lot of different aspects to be considering while trying to provide care to a patient, things that impact you as a provider, things that impact the patient that you're working with. Just want to acknowledge how big those questions are when you're just trying to provide someone with the care that they need in order to live their most fulfilling lives.

Dr. Mai Fleming:

Right. And it's a lot for a provider to consider, but really it's important to also realize how much that is for a person to navigate, right? Folks may have never actually needed to access healthcare prior to a pregnancy. Folks are navigating simultaneously a pregnancy that may be undesired, may even be desired, but they actually just don't have the capacity to care for a child at this time, having to navigate potentially leaving the community where they live in order to access healthcare, are potentially facing criminalization for seeking basic healthcare. And they're not sure what is legal or not. We talk a lot with lawyers as healthcare providers, as people who are working in these healthcare spaces. Most average folks don't actually have access to legal advice, right? To lawyers. A lot of folks on surveys even before Roe V Wade so after the leaked doc decision actually thought that abortion was illegal already. And so a lot of people don't actually have access to these really nuanced legal conversations that are happening. And so it has been tremendously difficult for people to navigate.

Tammy:

And I would imagine too, when people need that information and understanding is a short window with a lot of pressure to try to unpack this and break it down. Can you share a patient story with us that's emblematic of some of what you're describing?

Dr. Mai Fleming:

I can think of a million patient stories, right? As we are navigating these new waters, I think it's important to remember that the majority of people seeking abortion care are already parents, right. Already have families. And so a common narrative that I'm seeing is people trying to figure out and trying to navigate whether or not they have the capacity to incorporate another child into the household that they already have, how they're able to continue to provide a quality life for the children that they already have, how they may be navigating missed days of work, lost income, potentially being fired from their job, trying to figure out childcare, trying to figure out the finances of potentially traveling across state lines, just to access basic medical care. This is the majority of folks that we are seeing, being tremendously impacted by this new regulatory state.

Tammy:

And you started to describe a bit about providing counseling to folks who are making decisions. I'd love to hear what is options counseling in relation to reproductive care? And how is that different from services provided by so-called crisis pregnancy centers.

Dr. Mai Fleming:

So CPCs or crisis pregnancy centers are often not true medical facilities. They are funded by anti-abortion organizations and really decided to dissuade folks from obtaining an abortion often through a combination of misguiding, misinformation, and coercion tactics using biased counseling techniques. I've had patients who have come to me with ultrasounds where an embryo, or even a gestational sac with a pregnancy too early to even see an embryo having speech bubble saying, hi mom, I'm here, right?

These are the types of tactics that folks use. Folks are being told that abortions impacts your fertility, may lead to breast cancer, really things that have all been disproven in science. So options counseling as it should be, should be unbiased, open ended, really patient-centered in approach with a goal to uplift and center a person's circumstances and lived experience, to support their own context and goals, to help them come to a decision that feels right for them. Although we may use language like choice or decision when we talk about options counseling, I think it's also important to remember that a person's pregnancy outcome may not be experienced as a choice at all, but only the mechanism of upholding their own dignity, bodily autonomy, or safety at any given moment in time.

Tammy:

Yeah. I'm just taking that in. This framing, around someone coming in and weighing their options and making a choice, but just the reality that so often it's a forced choice or is not an experienced as an empowered decision for them to be making.

Dr. Mai Fleming:

And it may be, and regardless, a person can still be empowered in the decision that they're making or the pregnancy outcome that they intend, even if they feel that their choices are limited, right. Or there's really only one route that makes sense for them. It can still feel empowering to have control over that one aspect when there are so many other unknowns, so many other aspects that are out of their control. So I think in any case, positioning options counseling in a way that feels empowering for the person that they are ultimately the final decider on the outcome that makes the most sense for themselves, their bodies, their families is of utmost priority.

Tammy:

And what are some of the most common conversations that you have with patients in options counseling, and has any of that changed over the course of this last summer?

Dr. Mai Fleming:

So each conversation is really, really different and individualized based on a person's life and context. Some common themes that do come up are often around money and resource scarcity, thinking about existing children and families, how folks are going to provide for the children that they have, the families that they have, oftentimes dynamics with partners and support systems that either exist or don't exist, that influence people's decision. Do they have somebody that is able to support them through childbearing or able to support them through an abortion? Do they have folks in their lives who they're able to disclose that they are intending to have an abortion and what are their support systems in place?

There are definitely those who had to make pretty quick decisions. When, for example, in Texas, when SB8 was soon to be enforced or after the leaked Supreme court document made it clear that the state of abortion access was going to change quickly. Some people had more limited time than usual to be able to obtain an abortion within their own communities and states, and may not have had as much time as they might have wanted to make a decision for those who meet or want time, which is not

everybody. There are some people who this decision is very easy, actually very straightforward and with no sort of question or consideration about it. And I think making space for whatever anybody is coming to the table with and whatever they are experiencing is really important.

Tammy:

I'll share that I actually had an abortion and making the decision for me, it was a very clear decision, but the hard part was waiting through all of the messaging that I had received about how to interpret and understand what abortion is. And just how having such a public conversation that weighs the ethics of the decisions that we make and lays all this judgment on us just does nothing to help us make choices that support our wellbeing. So yeah, I really appreciate all your work also from a very personal come from.

Dr. Mai Fleming:

There's no question that the stigmatization of abortion care is one of the largest barriers that people who have an unintended or undesired pregnancy face. Having an abortion medically is very straightforward. It's actually a very typical medical procedure, either medications or an in-office procedure. It's the same care that we carry out for a person who's undergoing a miscarriage. There's zero difference between the two. And it's really the stigma the misinformation, and oftentimes intentional misinformation that is put out there by anti-abortion folks that is the biggest barrier to care for folks. And oftentimes, may prevent them from even asking for help when they need it with their regular primary care provider.

Tammy:

And a lot of your work focuses on people who are facing additional barriers to care across all kinds of aspects in the experience that I saw you have had of working with university students, working with people who are in low resourced areas. So which patients are you most concerned about right now in terms of the impact of abortion restrictions and bans?

Dr. Mai Fleming:

Yeah. So a lot of these restrictions and bans disproportionately affect low income communities, communities of color, gender diverse people. Really, we can see these abortion restrictions as maybe even purposely actively oppressing these communities, right? And barring people from exercising their own bodily autonomy. We have talked a lot about those who are able to travel across state lines, what sorts of things they may need to consider, but that ability to travel to access abortion care comes with a privilege of time, of expense, of financial and logistical resources that many people don't have. These restrictions will and probably already have led to forced births, which we know comes with higher morbidity and mortality than abortion does and particularly so amongst black indigenous communities and forced child rearing for those who are already struggling to make ends meet for themselves and the children they already have, which will have generational impacts, will further widen the disparity gap for these marginalized and oppressed communities. And make no mistake that this disproportionate impact is likely not lost on the legislators that are enacting these restrictions and bans.

Tammy:

Also just taking in the intergenerational aspects that already show up in terms of barriers that people are facing from forced sterilization. We can go very far back of course, but just this much broader

picture of how this lands as another assault on people's autonomy, freedom, and ability to determine the course of their own lives.

Dr. Mai Fleming:

Absolutely. And there is an intersection here as well with regards to immigration, incarceration, ways in which the police state is used to enforce some of these restrictions. When we talk about travel, we had a lot of folks who live in the Rio Grande Valley in Southern Texas, who may be undocumented and subjected to ICE stops on the road who physically actually cannot travel outside of those spaces for risk of being captured and deported, of overlapping degrees of criminalization, of particularly communities of color of black individuals and the ways in which folks are more likely to be criminalized for their pregnancy outcomes based on their race, their socioeconomics, based on their geography. And I think that these have a lot of overlapping themes with the general power dynamics in this country.

Tammy:

And thinking about folks who, like you said, can't travel because they're undocumented or don't have the resources, can you tell me about your work with, Hey Jane and what self-managed abortion looks like?

Dr. Mai Fleming:

So I live in an area where abortion is really readily accessible. So while I do provide medication abortion integrated into my family medicine clinic at our readily qualified health center, I also provide telehealth medication abortion through company called Hey Jane and am primarily doing so to help broaden access to care beyond my geographic bubble. So getting medication through a telehealth clinic like Hey Jane is a bit different than self managed abortion where a person may be taking the same exact medications, but without the guidance and medical oversight and follow up that telehealth or in person clinic would offer. That being said, whether a person is prescribed medications from an in person clinic, a telehealth clinic like Hey Jane, or order their own medications online and self manage their medication abortion, the medications in the abortion process are actually exactly the same across the board, are proven to be very, very safe and very, very effective.

So regardless of whether the pills are handed to a person in clinic or mailed to their home, the medications are taken at home. The abortion occurs at home. So in clinic and telehealth care are able to offer additional clinical support in case of a rare emergency. However, for those who are self-managing their medication abortion, there are other resources like the miscarriage and abortion hotline, which is staffed by clinicians across the US who are able to counsel people on their symptoms or experiences as their self-managing their abortions at home. There were actually studies done on abortion pills that people are able to order online to self-manage. The majority of those pills come from pharmacies overseas, typically from India. And they have done testing on those pills, and they are the exact same pills that we would dispense here with the same quality and the same efficacy as the pills that we dispense from our own home pharmacies in the states where it's legal.

Tammy:

And when someone is taking those pills, what are some things that as a provider you have found are helpful that you can provide when offering those kind of telehealth services?

Dr. Mai Fleming:

Because an abortion happens at home, the majority of what folks want to know is, is what I'm experiencing normal or expected? Are the symptoms that I'm having consistent with what I should be having,? Is anything going wrong? People often just need reassurance and a supportive non-judgmental person on the other line that sort of walks them through, okay, what are your symptoms? Here's how we can treat it. Here's how we can make you a little bit more comfortable through this process. Everything that you're describing sounds very normal and expected to me. Here's how we will get through the next few hours together. And the rare instances of while it does sound like you're maybe having a little more bleeding than I would expect. Here's some additional medications that you can take to try and slow the bleeding to prevent you from having to go in. And so those are often the things that we walk through people with.

Tammy:

And what do you expect trying to access abortion might be like for those in the most restricted states going forward? There's a lot of emphasis in the movement on not eliciting images of coat hanger abortions, but what do you think people might resort to if they can't access other means or just don't have the information in order to access other means?

Dr. Mai Fleming:

Yeah, well self-managed abortion with medications remains a safe option for people living in restricted states. There are overseas healthcare organizations, such as aid access who are able to prescribe safe abortion medications to people and oversee their care. The website planc.org is a great website to search for information based on where a person lives. This is a different era right than pre Roe where access to information, access to safe medication, abortion pills is absolutely available and an option for folks regardless of where they live and the restrictions that exist in their state. Disseminating that information and making sure that folks are able to access that information is of utmost importance and something that we are always trying to work on, how to find the best ways to reach folks, to make sure that they have the information that they need in order to obtain this care as much as they can.

I worry that there may start to be folks who see an opportunity to take advantage of folks who are looking for help. There recently was circulating some advertising for sort of an offshore on the boat abortion option, where the abortion providing world is very small, right, very close knit, and often work together across the country to help get people what they need and help to facilitate somebody's care. So between abortion providers, clinics, abortion funds, we are all interconnected in some way, shape, or form. And it raises a red flag when a new service pops up that is not connected to any of the abortion funds, is not connected to any of the abortion providers that we sort of know it within our circles of who are the players here and are they offering safe and effective services for people in a way that is ethical?

We don't always know. And so we do rely on each other and our community to make sure that we are keeping people safe, that we're disseminating information as much as possible and making sure that folks know the best ways to access the care that they need. The other thing is that through abortion funds who have been doing this work on the ground for a really long time, there is logistical support available, to help folks with travel and to help folks with lodging, to help folks with getting childcare and to help with funding for all of those things, if they do need to cross state lines. And so there is help available. If people do need to travel for in clinic care, there are options available for safe self-manage medication abortion.

Tammy:

When I was in Trinidad in 2018, I was working on a project on birth, and I got a call one morning from a new friend asking me to attend an abortion with her. Abortion is illegal in Trinidad. And this is a provider who had clearly set up shop in an area where he was catering towards young women in need of abortion and who are willing to do whatever it takes in order to get it. And it was quite a contrast to the experience of accessing safe, legal abortion in the US.

And as something that is really sitting with me, seeing the kinds of environments that people might end up in, like you said, of folks who are taking advantage of the opportunity and people's needs to extort people for money and possibly unsafe conditions. Fortunately, my friend was fine. Traumatized, but physically fine. That's just something I've been thinking about and this emphasis of people in the movement are really wanting to emphasize all of the safe choices, that feels really true. And I also feel really aware of what can happen if folks don't know how to access or where to access those so the importance of getting that information out there before someone is faced with this question.

Dr. Mai Fleming:

Absolutely. And the other thing about pregnancy is that it continues to progress. And so the ability to access timely care is of utmost importance here. I had a colleague who took care of a patient at an in person clinic who just sort of Googled black market abortion pills and received fake pills. The pills didn't work. And then their pregnancy progressed until a later gestational age where they needed to have an in clinic abortion. And so these things are happening. With how expansive the internet is, it's really hard to try and make sure that the right information is getting into the hands of the right people and the way that's most accessible to them and the right language for them and information that is reliable and not intentionally put out there to misguide folks as well.

It is not an uncommon practice for anti-abortion organizations to put out ads online, covering as an abortion clinic and pretending to be an abortion clinic, putting their clinic's names under the abortion category in the phone book, so to say, the internet version, and really misleading people into their hands, and intentionally delaying people's care until they are to a point where it's no longer accessible for them.

Tammy:

There's a lot of fear among providers right now about criminalization and legal repercussions for providing abortions. What's been your experience with the legal system or with this fear? And do you have any advice or thoughts for healthcare professionals who have this fear around what might happen if they practice abortion care in ways that they don't realize even are not legal anymore?

Dr. Mai Fleming:

I have the tremendous privilege to be working in a state with expanded protections for abortion, where legislation is being actively written to specifically protect abortion providers, providing care for those who may be traveling across state lines. But it is really hard to sit with the fact that providing this ethical and compassionate medical care that is well supported in science and backed by every major medical organization is seen as criminal activity in some states rather than part of the healing arts, where it really belongs. I think healthcare providers are really well trained to compliance. This is like part of what we do, following laws and regulations and guidelines are a part of the practice of medicine. And so is some degree of risk and liability, right? There is no such thing as zero risk medical practice regardless of the field of medicine. So it's really important to familiarize yourself with the local laws and regulations as it pertains to your practice of medicine.

It's never a bad idea to consult with legal experts when you're not sure to sort of help guide and navigate through the complexity of the current legal and regulatory landscape. And especially as it pertains to cross state care. I think that we are, again, just navigating some really uncertain waters here. I don't think that anybody has all of the answers. And I think unfortunately, some of these new laws and regulations are going to have to play themselves out in the courts before we're able to really get a handle on where those boundaries are, because the areas are still very, very gray.

Tammy:

And what do you see as provider's role in supporting patients during this time?

Dr. Mai Fleming:

Well, specifically to the consideration of criminalization and specifically criminalization of patients having providers know that having a miscarriage or self-manage abortion is not illegal. I think this emphasizes the importance of responsible reporting of providers. There are certain scenarios in which healthcare providers are mandated to report certain circumstances, whether that is abuse of an elder or a minor, and that having a miscarriage or an abortion is not a mandated reporting scenario in California. And so there is no need to report to authorities a person whose pregnancy ended by any means, right?

I think that healthcare providers have a big role in the criminalization of pregnant people and of pregnancy outcomes. That the cases that we have of people being criminalized for pregnancy outcomes were because a healthcare provider reported them to law officials. And so thinking through the ways in which we don't implicate our patients just for having a pregnancy outcome is going to be really, really important in supporting people during this time, regardless of where they live, right? Pre Roe, this was the case across the country. Now there are more states looking to actually criminalize abortion in many ways. As of yet, most are specifically targeting providers rather than patients. So I think sometimes providers are preemptively making these reports to sort of protect themselves, but we really need to think about who are we protecting and why. I know California specifically is also working on some legislation to help protect patients from being criminalized for a pregnancy outcome.

Tammy:

What are some lessons you've learned from practicing medicine and providing abortion in other parts of the country and in more rural areas that you wish more healthcare professionals in urban coastal cities were aware of?

Dr. Mai Fleming:

Yeah, I think it can be really easy to take for granted all the resources and ready availability of care that exist in urban coastal locals and to try and apply that same lens to solving accessibility barriers in other areas, which I think what is really important to keep in mind is that there are many local grassroots organizations often led by people of color built out of these communities who have been doing this work for a long time through mutual aid, through nonprofit work. Rather than supplanting them with what we think communities might need, we need to be working to utilize our resources and power to really uplift and fund these organizations that are on the ground, doing the work and helping get people the aid. I think that's really important for us to keep in mind.

Tammy:

Yeah, there's like this saviorism that can happen, especially right now as people are really fired up and lose sight of the fact that people have been caring for themselves and their communities all along and have systems in place that we can maybe provide support to, but don't need to replace or supplant, as you said. And can you tell me about the Hyde Amendment and why it matters in this conversation?

Dr. Mai Fleming:

Sure. So the Hyde Amendment is a budget provision, I'll say, that prohibits federal insurance coverage of abortion care. It has been inserted into every federal budget since 1976. Only 16 states in the country allow state Medicaid funding to go towards the coverage of abortion care. So for those who have Medicaid insurance coverage which are amongst the lowest income folks in the country in the other 34 states, paying for an abortion out of pocket is the only available option and may be cost prohibitive for many lower income folks.

Oftentimes abortion, depending on where you are, the type of abortion can cost hundreds and sometimes thousands of dollars. So for many people, especially in lower income brackets, is really unattainable. This often ends up being the costs end up being offset by abortion funds which help people to cover a portion of their abortion care. But because it's particularly important in this post Roe era, when we have folks crossing state lines potentially to receive abortion care because of the states who do allow their state Medicaid funding to go towards the coverage of abortion care, it is limited to people who actually reside, have residency in that state.

And oftentimes is county by county. It limits the ability to actually use this funding for people who are crossing state lines. It excludes their eligibility. And additionally, we already know that the Hyde Amendment disproportionately impacts people who are already facing systemic barriers to care, particularly Black and indigenous communities and other people of color who are more highly represented amongst those insured by Medicaid.

Tammy:

I'll admit that I didn't realize for a long time how little Medicaid coverage there was of abortion and how even with the legality of abortion in many states, how many barriers there were for people to access it.

Dr. Mai Fleming:

Absolutely.

Tammy:

For providers who are providing this type of care, there's so much anti-abortion rhetoric around the idea that abortion is morally wrong, is murder. And I'm curious for you, how it feels on a psychological level to have your career, your beliefs, your passions, your actions called into question by so many people publicly, especially hearing from you. What makes you so passionate about the work that you do?

Dr. Mai Fleming:

There is a really fantastic quote by a provider who is Lisa Harris, who does a lot of research around abortion providers, abortion seeking patients, and what compels people to do this care. And just note that this quote uses the term women, although people of all genders do need abortions and get abortions. She says that providers continue to offer abortion care because deeply held core ethical beliefs compel them to do so. They see women's reproductive autonomy as the linchpin of full

personhood and self determination, or they believe that women themselves best understand the life context in which childbearing decisions are made among other reasons.

So I really see it as a moral and ethical duty to provide this care, to meet people where they're at in a time of need and vulnerability, to help use my medical knowledge and skills to meet their need, trusting that they are the experts in their own lives and what is best for them to live and thrive within their own context. It is really the impact and the life saving qualities of abortion care that armor me against a rhetoric that I just don't find rings true at all in reality.

Tammy:

And how do you care for yourself amidst all of this?

Dr. Mai Fleming:

Well, to be honest, providing abortion care is one of the areas of medicine that really is fulfilling. It fills my cup. It makes me more motivated to be a better provider at all times. It fulfills me personally, as well as professionally. And so I find that even providing abortion care in a way is self care.

Tammy:

That's beautiful to have those things line up.

Dr. Mai Fleming:

Absolutely.

Tammy:

Where do we go from here? What's currently your number one on your list of priorities in terms of the fight for reproductive justice?

Dr. Mai Fleming:

Well, I think there are many things that we need in order to achieve true reproductive justice in this country. Dismantling systemic racism and systems of oppression, abolition of our current criminal and legal system for one. A federal protection for comprehensive reproductive healthcare, including abortion care so that these state by state bans can't hold. And the Senate did bypass an opportunity for this, with the Women's Protection Act, which did not pass. Repealing the Hyde Amendment, so folks can afford their care. And a robust social system where people, when they do decide to have children, they're able to raise them in safe and sustainable communities. We have many, many things that we can do to really help support people achieve true reproductive autonomy.

Tammy:

Yeah. I'm appreciating from the beginning of our conversation that integration again of these different aspects of who we into this conversation and not just looking at abortion in a silo from other aspects of our lives or other aspects of reproduction. Last question, this podcast is called Coming Together for Sexual Health. You started to get at this a bit in your last answer, but what do you hope we can create by coming together for sexual health?

Dr. Mai Fleming:

Yeah, I hope we can come together to really reframe sexual and reproductive health as just that, a matter of health and wellness, free from stigma and judgment so that people can experience true liberty and joy in their sexual and reproductive lives.

Tammy:

Beautiful. Well, I want to thank you, Mai, once again, both for coming on and speaking with me and also for the work that you do every day, I know it makes a huge difference in people's lives. I look forward to continuing to follow your journey.

Dr. Mai Fleming:

Thank you so much for having me.

Tammy:

Absolutely. Thanks for listening and check out the show notes for the resources mentioned in this episode. You'll also find the link to the transcript of the show. Please follow and rate us wherever you get your podcasts. This will help more people find us. Connect with us on Instagram at Coming Together Pod and learn more about us and get in touch at ComingTogetherPod.com. This podcast is brought to you by the California Prevention Training Center, where we build the capacity of healthcare professionals working in sexual health and emerging infectious diseases. Check us out at californiaptc.com and follow us on Twitter at California PTC. This podcast is produced by me, Tammy Kremer, with Laura Marie Lazar and Catalina Macdonald. It is edited by Layla Mohimani and Isaiah Ashburn with original music by Layla Mohimani. We're based at the University of California, San Francisco and would like to acknowledge the Ramaytush Ohlone people, the traditional custodians of the land that UCSF sits upon. Thank you for coming together for sexual health.