Coming Together for Sexual Health Podcast

"Beyond Birth: Midwives' Role in Sexual Health"

Tammy Kremer (00:08):

Welcome to Coming Together for Sexual Health. I'm Tammy Kramer, and I'm thrilled to talk with you about the world we are creating by coming together for sexual health. Yes, the pun is intended. My background in thinking holistically about health as a facilitator and a doula helps me talk with our guests about celebrating pleasure, combating stigma, and making sexual healthcare both more accessible and more inclusive of the communities we serve.

(00:33):

We're powered by nationally recognized experts in sexual health at the University of California, San Francisco, and the California Prevention Training Center. All these expressed are those of the person speaking and not of the CAPTC or their employer. Subscribe to get our latest episodes, share with your friends, and leave us a five-star review to help more people find us. Thank you for coming together for sexual health.

(01:03):

Welcome to Coming Together for Sexual Health. I'm so excited to have you here, Dr. Bethany Golden, nurse-midwife. I am, as I've shared with you, a big fangirl of midwives, so it brings me a lot of pleasure to get to talk with you about sexual health and the care that midwives can provide in a sexual health context.

Bethany Golden (01:22):

It is an absolute pleasure to meet you, Tammy, today, and look forward to our robust conversations about sexual and reproductive health and all the services that midwives can provide.

Tammy Kremer (01:33):

So many. That you mentioned to me that you did sexual healthcare primarily for a long time as a midwife, is that right?

Bethany Golden (01:39):

Yeah, absolutely. My story starts in 2000 when I decided to become a nurse-midwife, and during the course of that, actually, got to learn many different types of skills, including primary care. Again, these are things that are required for us to get credentialed. Gynecology and later, our true scope of practice also includes making sure we're managing substance abuse, making sure that we're managing gender-affirming care, and many, many other things outside of the scope of birth.

Tammy Kremer (02:08):

Awesome. Well, so can you get into describing what is a midwife and what makes receiving care from a midwife different than any other provider?

Bethany Golden (02:16):

Yeah. First of all, we are lucky to have many different types of midwives in the country. I'm a certified nurse-midwife and there's over 14,000 of us in the country. I have the ability to prescribe medication. Again, I have to get licensed in every state, but all 50 states allow certified nurse-midwives to prescribe medication. We also have what's considered independent practice in many, many states. There's also professional midwives. Some people used to refer to them as lay midwives. Their scope is usually a little different and their setting is a little different. CNMs, certified nurse-midwives, you'll find them mostly practicing in hospitals and clinic settings and medical practices or midwifery practices. With professional midwives, often their focus is managing birth either at home or in a birth center setting, so outside of hospitals. There are some states that allow professional midwives to carry some medications, but they do not have the same scope in terms of being able to administer, prescribe, and dispense like nurse-midwives do.

Tammy Kremer (03:18):

Got it. What are some distinguishing factors or ways that you might think about how a midwife thinks or approaches a patient or client versus other providers?

Bethany Golden (03:28):

I think that we hear a lot of buzzwords now in general in healthcare that maybe we could have said was in midwifery. Patient-centered care is a concept that has been discussed very differently in midwifery but is something that has always been the focus, which is rather than being interested in a disease process, seeing people as healthy, active in their own health management, and therefore, making sure you're providing information that is requested and that is actually specific to the person you're speaking to.

(04:00):

In order to do that, we often have to build relationships. Midwives have a form of care that's called relational care, and that has to do with having two people in a room versus having a provider and a patient. Understanding what are the important indicators of health for the person you're talking to, what does it mean to them to be healthy. That's a very different conversation than when you're diagnosing people for disease states.

Tammy Kremer (04:26):

My experience with doing some research around midwifery is that it really comes from a space where the expectation is that every one that is in the normal category is one way that I've heard a lot of midwives describe it as opposed to being like what is needing to be fixed in a patient, it's how can we support this person's natural progression.

Bethany Golden (04:43):

Yeah, and their strength. That, again, back to relational model it requires time. Ideally, and of course, a lot of healthcare settings aren't like this, especially ones where certified nurse-midwives where they only get 20-minute slots. But if you look at midwifery in a more full fashion or how a lot of midwives might want to practice it, that relationship takes place in a setting of the patient's choice and a place

where they're comfortable in a place where they can talk freely. For many people, medical establishments are not that. So there's an investment of time, but also thinking about how and where and when is best for patients versus fitting them into a very regimented clinical space.

Tammy Kremer (05:25):

It makes me think about birth centers, home births, and just clinics that are a bit further removed from the hospital environment where there's beeping and bright lights. Like I said, I've seen places where there's a regular type of bed, like a double or a queen-sized bed instead of a hospital bed and things like that.

Bethany Golden (05:43):

Yes. For folks who've not been in a midwifery center or a birth center what that looks like is very different if anything the medical aspect of it is being downplayed. Again, certified nurse-midwives have to manage meeting the requirements of medical establishments too, so it's not always possible. But in midwifery practices where they focus on patient's comfort, you will see things like candles and you'll see music and you'll see comfortable spaces, and things that are not sterile. I mean, the equipment is sterile, but the actual environment is warm and not sterile.

(06:19):

There's several lineages of midwifery, and it's really important to remember that midwives go back hundreds and hundreds and hundreds of years. If we look worldwide, each type of midwife in different cultures is very different and responding to that needs of that community. That is something that's still very present in the United States too, where respecting health traditions, whether they're birth traditions or sexual and reproductive health traditions, that is unique to cultures. Of course, even the research shows that people's health outcomes are often better if they're in sync or concordant with providers who understand or represent or come from their community.

Tammy Kremer (07:03):

Can you speak to a bit of the research about outcomes for working with midwives?

Bethany Golden (07:07):

Yeah. I think often we talk about birth outcomes. Midwives worldwide get recognized by the World Health Organization as one of the most pivotal workforces, not only for maternal and child health outcomes but also for sustainable goals of 2030. If anybody wants to nerd out, go and read the UN report, it is pretty incredible if we look where we have countries that utilize midwives to their full potential, how effective they can be in helping specifically things like preterm birth, reduction of C sections, things that preterm labor. There's different forms and models of midwifery that we know that even support those things, and we see incredible outcomes.

(07:51):

There's a concept called centering, which comes out of midwifery, which is now used in many forms of both obstetrics as well as other specialties. But basically, what that is, it's a group prenatal where instantaneously you get a group of other people who are going through a transition from being a nonparent to a parent, or maybe not if they lose their pregnancy for whatever reason, but they've created a circle of support and that we know reduces preterm labor and birth.

(08:25):

Again, it seems pretty old-fashioned, but what centering does is often people will care for each other. That means doing checking heart tones on your friend to your right or your friend to your left or measuring the fundal height or checking each other's urine for protein or glucose or other signs that some complication could be developing, taking each other's blood pressure, but basically creating a communal space where healthcare can take place. That is something that, again, a woman named Sharon Rising developed over 25 years ago, building on practices that have probably been happening for a very long time, but systematically putting it together and offering it and it being adopted throughout the country.

Tammy Kremer (09:06):

It really strikes me as a model that focuses on empowering people to be the drivers of their own experiences.

Bethany Golden (09:15):

Yeah. I think if you look at the philosophies behind midwifery, that is a common theme and increasingly even patient-led, right? So empowerment still has the idea that there's something that midwives are offering people that's unique and special. I think it's more the idea that every person increasingly has something that's unique and special in their strength of understanding how to support them in moving through life. I think this takes us to the conversation of where we can find midwives. Is it in birth or other places?

Tammy Kremer (09:45):

Yeah. Well, let's get into it.

Bethany Golden (09:46):

Let's go.

Tammy Kremer (09:47):

What's it like and to provide sexual health care as a midwife?

Bethany Golden (09:50):

To go back to one of your original questions, I knew from a really early age that in my midwifery progression that I would not be doing many births. I realized that after spending several 24-hour shifts in hospitals after deciding that I really did like nine hours of sleep and that what the midwifery profession requires. Again, I applaud the people who can stay up all night, our folks who are so dedicated and committed and can go 24 hours at a time.

(10:22):

That realization myself, pretty late in my training, I did birth for about three years after I became a midwife. In 2006, I decided that I would exclusively focus on sexual and reproductive health, and that would include care for people from the age of 12 to the age of 92. That is what I did for the next 18 years in various different settings, and I did still do prenatal care, and I was lucky enough to do care in many settings in the world, also in many major cities, and also in many different types of clinics.

(10:59):

To understand how they operate differently and how different places utilize midwives as employees is a really interesting thing. I'm specifically interested in expanding this concept of midwifery. I think that

both the public and midwives themselves emphasize our role in birth. The truth is that our role in birth is just one part of caring for people throughout their entire lives, and there's many important parts of people's lives, and many people choose not to give birth.

(11:29):

Many people can't give birth. Those people need to be treated with the same type of dignity, respect, and compassion that midwifery brings to that particular moment. Those are probably three hallmarks of [inaudible 00:11:42] what differs midwifery is an emphasis on those three things. Dignity, respect, and compassion. With that in mind, one can do a lot with your midwifery degree.

(11:52):

There's newborn care, there's gender-affirming care. There is primary care where you're dealing with hypertension, diabetes, everything that you would expect a primary care provider to do. In terms of sexual reproductive health, there's all of contraception, which has been a huge focus of my life. Abortion services is another really important part, and we can talk specifically about abortion and midwifery, but the other elements of gynecological care and sexual and reproductive health for all people is really, really critical. Of course, increasingly the awareness of trans care in that is really important to you.

Tammy Kremer (12:31):

As you're speaking something that's coming to mind for me is how things like vulvodynia or vaginal dryness or these issues of pain that people might have can be often overlooked or misunderstood unless you go to a specialist MD, which are pretty hard to find from the folks in my life that I know personally who have suffered with various issues with their vagina and/or vulva and/or other parts. So it's just making me think about how a midwife might be trained or thinking in a different way to be a bit more attuned to some of those things.

Bethany Golden (13:06):

I think that writing prescriptions is just one part of a certified nurse-midwife's existence. But really back to this relational part, there are gynecological issues that come up for people that really need multiple, multiple, multiple visits to work out. It is not something that's going to be worked out in 20 minutes. I always like to use menopause because menopause is for some people, takes place over a nine-year period and the symptoms change and vary and differ from your peers. There's so many different elements of that.

(13:38):

The truth is that being in constant conversation, again, back to this relationship aspect of midwifery, it's really critical. You mentioned a couple ongoing bacterial vaginitis, vulvodynia, various conditions where it's not something that's solved overnight. Unfortunately, the model that we have inherited from medicine is come in for a 20-minute visit, let's fix it.

(14:03):

There are a lot of midwives who want to work on it over a duration of time. That's a really big difference. It's a different type of therapeutic model. We see it a lot in mental health, but there are lots of conditions. Again, even getting your period for the first time, getting cramps in adolescence, there's a few times when you're going to really need to be with a patient regularly to assess and help them understand what's normal for them and hopefully be able to give them some relief from the symptoms that are bothering them.

(14:39):

When we think about how often are certified nurse-midwives doing sexual and reproductive health, there was a study done of 7,184 certified nurse-midwives and certified midwives that were recertified, so that's by the board that we have to get recertified by. That's called the American Midwifery Certification Board between 2016 and 2020.

(15:01):

When they asked that question, 55.1% said that they were providing reproductive healthcare, and 38.5% offered primary care services as part of their employment. Now on top of that, when there was another study done of 1,231 members of the ACNM, which is our professional organization, 76% of people said they offered reproductive health services, and 49% said they provided primary care. This is a large portion of what we do. So the public perception, even what is promoted in our own circles, and I can speak to this, is that we are doing pregnancy-related care. That is part of what we do, but we spend a lot of time focused on other moments in people's lives.

Tammy Kremer (15:50):

Yeah. Those are really helpful stats. I was wondering, as you were describing contraceptive care and gender-affirming care, would it be true to say that you have a similar toolkit to what other providers have, but a different approach to using those tools? Is that a fair way to think about it, or are there other tools that you might be bringing in as a midwife that could be additional?

Bethany Golden (16:12):

Yeah. I mean, it's a process that goes back and forth. There's a symbiosis between lots of different things. For instance, OBGYNs have adopted some midwifery practice like sweeping membranes. What is sweeping membranes? What is that? If someone is overdue and they were really eager to have their baby, but they want to hold off having an induction, you can sweep membranes. That is a technique to get prostaglandins flowing. Basically, it requires getting into the cervix and swiping an area outside of the amniotic bag. So that process is something that midwives have done for years and is now something that is regularly done by OBGYNs. The flow of this goes both ways. Delayed cord clamping is another thing that happens in midwifery. The idea was that there was still a lot of oxygen in the blood that was flowing from the placenta to the baby after delivery.

(17:04):

So rather than clamping and cutting really fast, actually allowing that to continue to oxygenate the baby while the baby was getting its lungs up and running. It goes both ways, of course, what you said, yes, we use toolkits from all over the place. When I say all over the place, I mean, genetics, do a lot of genetic testing though. There's a lot of midwives who use herbs, so that's from a different tradition. We have a lot of midwives who have learned things from nursing and from medicine. Different midwives' approach is different. I think that's really important. Everything I'm saying is generalizations. If we got down into very specific settings, and I think this is where qualitative research can be really helpful to us because we can look at very specific settings. I'm particularly interested in telehealth and how it impacts midwifery.

(17:53):

One of the things, another core concept that has been promoted for many years is the importance of presence in midwifery. When that was originally conceived, it was conceived of two people in a room sharing intimate conversation. Increasingly, presence is very different. Maybe actually texting somebody when they're on the bus and between things is being present for them in their lives, maybe being able to have a quick call or have a video chat on an issue that arises after an abortion or during menopause that is present. As we integrate technology into midwifery, we really have to blow up some of the

concepts like not only that we do pregnancy-related things, but that we're in the same room with people.

(18:41):

That increasingly midwives, which is considered a high-touch profession, meaning that the importance of physical touch with consent with patients and the question of that not being able to be achieved yet through telehealth, maybe technology will take us there. But some people really reconceiving in midwifery of what touch means. Is it physical touch, or is it availability? If we think of the importance of availability, especially right now with record high isolation, people feeling very, very not supported at times during pregnancy, postpartum after their abortion, when they first try birth control pills, seeking out online support, how are we there and how do they find us?

Tammy Kremer (19:26):

That's really interesting to think about. I think I first learned about midwifery and then had this romantic notion of midwifery being practiced in backyards and all of that has a place in history, but we are also-

Bethany Golden (19:38):

Absolutely.

Tammy Kremer (19:40):

... evolving to integrate different technologies.

Bethany Golden (19:42):

It was very interesting in midwifery school. I've been lucky to be in several different university settings, but I remember this real tension that existed in my midwifery cohort. One, I always called the goddess contingent that they had that same conception of midwifery, like birth is just beautiful. I was like, "It can be or not." I came from a really politicized space of bodily autonomy that this is something much bigger than... Again, we call it the woo-woo, which I also, again, I'm a big believer of the woo-woo too. Midwives out there, you know I love you. But I also think we need laws and policy that support people to decide what is best for them and their bodies. How important is that reproductive justice is able to help us really understand why people need to decide when, where if, how, or not to have children?

Tammy Kremer (20:42):

I was really struck when you and I first met a couple of weeks ago to hear about the work that you're to start training more midwives in providing abortion. Can you talk a bit about that?

Bethany Golden (20:53):

Sure. One of the things that was startling to me was when I finished my rotation training at Yale as a midwife, I said, "Well, when will I learn how to do abortion?" They said, "Well, you won't." I said, "That's interesting. I've delivered a lot of babies. I've handled a lot of postpartum hemorrhages. I've done things much more complicated than a basic abortion procedure." As I went through my career over the last 20 years, there had been very few pathways created, even though we are having laws, slowly but surely, in this country, allowing certified nurse-midwives and nurse practitioners and physician assistants to conduct first-trimester abortions.

(21:28):

Again, this is before medication abortion, which is a different conversation, but a very important conversation too. There were no learning pathways. That was something that was very deeply personal to me, that this was a type of care that you would only maybe be trained in if you were very lucky by an OBGYN colleague, or if you worked in the right Planned Parenthood or you were part of a larger research study.

(21:48):

But for the vast majority, even though we had the legal right to do this in so many states, we couldn't actualize it. Moving on 2022 occurs the Dobbs decisions. Even before that, the governor and the Women's Caucus in California came together to say what would make the state the best reproductive access state in the country. There was an incredible collaboration by many, many, activists and clinicians and researchers and policymakers come together to try to figure out what that would look like.

(22:21):

Part of what came out of that was the Reproductive Health Service Corps. The conception of that was what if we actually trained not only midwives but EMTs, medical assistants, doulas like everybody who's part of the healthcare system to understand or engage with abortion care to the max of either their scope of practice or their regulatory ability in California.

(22:46):

This idea was something that was not only wholly passed and signed by the governor, but it's something that we're implementing now. So we're creating those pathways and they differ, of course, like what a curriculum. The information doesn't necessarily differ. But an EMT may be the first person who arrives after a serious complication of all sorts of reproductive health. They may not even have heard of it at all in their training. This is really, really important for us to fight misinformation, to give people evidence-based science in all professions.

(23:18):

We specifically have set up the Reproductive Health Service Corps accelerator program, which allows existing providers to get trained in medical abortion and procedural abortions. Specifically, we're interested in trying to help people in rural areas access this. We're looking for rural providers as well as diversifying the workforce. Looking for different folks who represent their communities for this particular program. It's one of many in the Reproductive Health Service Corps. Feel free to check out our website.

Tammy Kremer (23:48):

What's your role with the Reproductive Health Service Corps now?

Bethany Golden (23:50):

Well, I happen to be the co-director. I worked on conceiving of the idea of the passage of the bill. I now work at TEACH, which is Training in Early Abortion for Comprehensive Healthcare. TEACH has been around for 20 years. Their focus has expanded to advanced practice clinicians, so CNMs, PAs, and PEs. However, they started with their focus on making sure that family medicine doctors and residents received abortion care training because they were not systematically. That's where I'm currently at.

Tammy Kremer (24:21):

Nice. Shout out to TEACH. I know they also produce a abortion storytelling event every year, and they put those stories up as a podcast. Y'all can check out the show notes and we'll put a link there to TEACH's podcast as well.

Bethany Golden (24:35):

Yeah. You should come next year if you can. It's really a special, special event. It's usually held at the end of August or early September. The other thing is the TEACH curriculum, which you can download and read for free. Chapters one through nine is the gold standard on how to perform an abortion. Also, their CME there too, if you want it. For both patients and for providers, it's a really important resource that's used throughout the nation and internationally at a lot of nursing medical schools, and a lot of other institutes.

Tammy Kremer (25:14):

I would like to double down on this question around sexual health because our audience for the podcast are primarily sexual health providers, which, of course, includes abortion, includes birth control, includes a lot of care for the LGBTQ community, including gender-affirming care, but also including your basic STI, HIV counseling. Can you share a story, either real or imagined of what it might be like for you to provide care to someone coming in with a concern about an STI or some exposure? How might you approach that and how does that show anything about the role of a midwife or a midwife's perspective on providing that care?

Bethany Golden (25:56):

Often, if a person comes in for STD treatment, say for chlamydia, we know from the CDC what medicine to give and the four talking points of education that we need to give in terms of condom use and prevention, as well as making sure the partner was treated. However, if you work with folks who maybe have multiple STDs. One of the approaches that I've often taken with patients who seemingly may have something else going on, whether that is trying to tease out whether the infections is something that they have knowingly consented to, or whether there's any other form of coercion that's happening.

(26:45):

One of the things that's nice about midwifery training is that our approach of bringing folks back to start that relational aspect of care. It's something that where in STDs and especially in repetitive STDs is really, really important because it will take potentially multiple sessions to build the trust and confidence that someone needs in order to explain the more full situations or the fuller risks that they may be finding themselves in.

(27:16):

So back to this relationship form of care, it's not only during pregnancy, we also have a lot of evidence that trust is not developed all the time and that there's a lot of harm that's done in reproductive health settings. So I don't want to give the impression that trust can be obtained or there aren't a lot of other systematic problems and systematic forms of racism that influence whether trust is something that's able to be established. But in relationships where it is functioning and it is working, then the same sort of relational concept can be put into some of the other issues where it's not just see and treat. There's something larger going on for that person and their relationship to their self, their relationship to their partners, their relationship to their family, their relationship to their community. Teasing that out and trying to understand what is the fullest picture and trying to provide support knowing that.

Tammy Kremer (28:16):

That's really helpful, I think, to give me a sense of how those interactions might go or what is prioritized in those interactions.

Bethany Golden (28:24):

It allows for a two-way conversation to develop. I think that often when you first meet a provider, there's a checklist that they're getting through. They ask you, "What are your concerns today?" But there's also a checklist that they're trying to get through and it changes the direction of that.

(28:38):

I mean, I've had several patients who've come back to see me like 26 times in 3 months. What's really going on there is that their ongoing questions about their own sexual health that aren't being answered and their questions, whether they can pose them and who they can pose them for whatever reason, that it's within our relationship, that they feel the safest to start developing questions.

(29:02):

I've also had patients who have been sexually assaulted or raped, it takes time to want to share that or reveal that at times. That can also be relational. I think that the complications of people's lives, midwifery at times can provide a forum and an ongoing space where intimacy can be shared.

Tammy Kremer (29:24):

I have just a few more questions for you. My first one is about the sex and gender of your clients. Who can see a midwife?

Bethany Golden (29:33):

Oh, great question. Everybody can see a midwife. Literally, I've seen trans males, trans females. I've also seen men who identify at birth and continuously as men, I do see people who identify as women from birth. Everybody gets to see a midwife, and there's no age. I think that's, again, people think of midwives just dealing in the timeframe of fertility, but we go much further beyond on both ends. We also do newborn care. When I say I did a lot of adolescent care, but midwives also do newborn care. I don't know many midwives that do from 2 to 12, but I know a lot of midwives that do 12 through 100.

Tammy Kremer (30:19):

One of the things that I find so compelling about midwifery in the US is the stats that show the impact in terms of health equity like maternal mortality rates that can be different. Can you speak to how midwives are part perhaps of the solution to the inequities around healthcare?

Bethany Golden (30:36):

First of all, community midwives. Those can be both certified nurse-midwives as well as professional midwives. Community midwives are making the biggest impact there. Specifically, Black community midwives... Where we need to make the difference is in Black maternal mortality. The real way to get rid of the incredible discrepancy between races and birth in our nation is to really support community-based midwife and birth centers. The system is clearly harmful to a lot of patients. It's not only doesn't meet their needs, it goes far beyond that, both causing injury, causing death.

(31:17):

The realization of that is how do you create a safe space and providers that are responsive to a public health emergency and the Black community midwifery leadership are the most responsive, the most activated, and providing solutions where we're seeing these incredible results.

Tammy Kremer (31:40):

Just to impress upon our listeners, I would love to imagine a world where there's an abundance of midwives and birth centers and they're opening all the time, but my understanding is that a lot of these spaces are struggling to stay open and we're struggling to have enough midwives. Can you speak to where we're at and where you wish we were or where we are trying to get to?

Bethany Golden (31:59):

In some directions, we're moving forward. I have to give a shout-out to the Biden-Harris administration for really taking on Black maternal mortality and morbidity and giving hundreds of millions of dollars to making sure that there's community doula support, making sure that universities have what they need in order to create another generation of midwives and many other initiatives that HRSA has put forth. But with that said, even though we're getting the policy recognition on some level, the actual infrastructure of our birth centers as well as our institutions is not growing at the speed it needs to do in order for us to have the transformative workforce that we need.

(32:46):

We have many birth centers closed in California, 20, I think. We also have a lot of community hospitals that are also gone. The concept of really having people who are pregnant, having to drive hours and hours, or because of Catholic hospitals not being able to get their services in rural areas and being transferred. Recently, there was a very serious situation out of Eureka, California where a patient who had twins with one demise, as well as I think her water had ruptured, was transferred from Eureka to another hospital because they did not know whether they could do the services there, even though we have EMTALA.

Tammy Kremer (33:24):

When you say demise, can you say what you mean by that?

Bethany Golden (33:26):

Sure. One of the twins was dead. Clearly, in order not to become septic, meaning an infection in your blood that kills you, in order to avoid that the fetus that was dead would need to be removed. This hospital did not feel prepared, ready, or willing to do that, putting the mother's life in serious jeopardy, even though there's a federal law. Again, shout out to our Attorney General Bonta, who is taking legal action against that hospital.

(33:55):

Some of the concerns that we know that exist in states where people can't get full comprehensive care for miscarriage, fetal demise, abortion. We have our own struggles in our state with those matters as well. To answer your other question, I think that what we can do right now because of the momentum and the interest in midwifery and doulas is to really start reimagining how we can make more learning pathways.

(34:25):

The Reproductive Health Service Corps is one example of that, but there's many examples actually of that going on right now in the country. So I think really creating a blueprint that starts merging abortion

justice with birth justice and reproductive justice to come up, again, this goes back to not siloing any of these things back to sexual and reproductive health. Really looking at how all of these institutions, both learning and healthcare institutions impact people's lives throughout their entire life. Creating a more coherent ability for people to access these services. Again, there's a lot that needs to happen in the insurance world for that to happen, but I think it's also a good time to try to reimagine that.

Tammy Kremer (35:07):

I mean, it's really cool to see how doula care is now growing. Just for our listeners, doula, and you can help me out here, I actually am a practicing doula, volunteer doula. Doulas support people as they're in the process of giving birth, oftentimes before and after as well. There's postpartum doulas, but doulas, unlike midwives, generally are not nurses. At least that's very much not required. My experience in that role is that I'm really focused on supporting the parent, supporting the person as they go through the experience, whereas the midwife present, or nurses or doctors are focused on making sure that the delivery goes smoothly for both the pregnant person and for the infant. I'm really focused on the emotional well-being of the person in the room.

Bethany Golden (35:57):

I think midwives are very grateful for doulas in a different world. I think midwives would like to be serving that function as well. Doulas are increasingly critical as a constant force of advocacy for patients, as you know. But there's also abortion doulas, again, for a ongoing presence, back to this concept of presence. But due to how clinics and hospitals flow is how they're set up to function, it doesn't necessarily allow for the same support that doulas give. So shout out to all the doulas. We love that doulas are getting paid for their services and that we have starting to have reimbursement from Medi-Cal and other sources.

Tammy Kremer (36:42):

So huge. It's so exciting to see that change and just to experience talking to more people and them mentioning doulas and them having any idea what I'm talking about. It's incredible and very different than it was 10 years ago.

Bethany Golden (36:55):

Oh, Yeah. I think actually doulas are now more recognizable than midwives, whereas I wouldn't have said that 15 years ago. But I think that the prominence culturally and the importance of doulas and the acceptance of doulas and awareness of their role, critical role in reducing Black maternal mortality is really exciting. Also, though, there's still a huge piece of how doulas are accepted and integrated into existing healthcare systems and how they're received sometimes, again, seamlessly, and that the best of situations, and in other places, they're seen as not necessarily an accepted force in the healthcare team.

Tammy Kremer (37:33):

It can be a tricky balance to also be advocating on behalf of patients to providers when that role is not a familiar one. One group we haven't discussed much is cis men and their role in midwifery as well as their role in reproductive healthcare.

Bethany Golden (38:00):

When I was in midwifery school, I wrote my thesis on male contraception, and I think that midwifery has not always created space for people who identify as male from birth. When we think about the idea that

we want everybody to have the best reproductive health life they can have, making sure that we have inclusion and choices and bodily autonomy and all of those important things that I think we often reference to a lot of other people, but we don't necessarily include people who identify themselves as cis men, specifically.

(38:37):

I think that cis men have very few access points to reproductive healthcare, that even though there are many clinics that are open to them, just in terms of socially and culturally, the acceptance of caring for oneself sexual health has not been as prominent as it has been for others. So I hope that we can think of midwifery as even more inclusive. I've had cis male patients in reproductive health, however, the stigma and the barriers and the burden that they had, even just walking in the door to see me was a really heavy load. So I think if we start thinking about re-imagining reproductive health and midwifery, just making sure that we really are creating spaces that are inclusive of everyone.

Tammy Kremer (39:26):

I so appreciate that. Also, in terms of how we can create a wider investment in a variety of options when it comes to birth control and fertility.

Bethany Golden (39:36):

This is a topic that in other places plays out. In places like India and China, the research in this is far beyond what has happened in the United States due to population concerns. Also, if you look at old literature from World Health Organization, basically it was saying that cis men do want to decide when and where and how they become parents too and are willing to do contraception options that aren't just at the time of sex or a forever solution like a vasectomy and not having short-acting or long-acting forms of contraception for men really limits their ability to decide when and how they should be parents, which I think impacts a lot of public health issues.

Tammy Kremer (40:18):

I'm going to bring us to a close here. I like to end by asking our guests, what's one thing you hope we can create by coming together for sexual health?

Bethany Golden (40:26):

I hope that we can allow people to make decisions that are best for their lives. That's it.

Tammy Kremer (40:33):

Boom. Mic drop. Well, thank you so much, Bethany. I really just appreciate getting to talk with you and hear about the work that you're doing. I think it's so exciting to be training midwives on abortion as well as other providers and to really be thinking about how we can access midwifery care at different stages of development. I really appreciate everything you've shared with us today.

Bethany Golden (40:56):

Thank you for having me. What a pleasure.

Tammy Kremer (41:00):

Thanks for listening, and please follow and rate us wherever you get your podcasts to help more people find us. Hey, how about sharing this with a friend or a colleague you'd like to talk with about sexual

health? Check out the show notes for the resources mentioned in this episode and the transcript of the show. Connect with us on Instagram at comingtogetherpod, on X @CaliforniaPTC, and at comingtogetherpod.com. This podcast is produced by me, Tammy Kramer, with our co-producer and editor, Isaiah Ashburn, brought to you by the California Prevention Training Center. 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.