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Destigmatizing and Democratizing Postpartum Care: A “Black Woman-Person First” Approach

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Abstract: Optimizing postpartum care highlights the need for care coordination, enhancement, and expansion of health care services after childbirth. Yet the prioritization of disease surveillance, management, and mitigation during birth and beyond within the American College of

Obstetrics and Gynecology facilitates the medicalization and pathologization of Black bodies, voices, and power. Thus, we offer the Building and Bridging Black Futures Beyond Birth Model: A 12-Step Black Woman-Person First Approach, as a more humane and holistic model of culturally affirming and clinically responsive care. Destigmatizing and democratizing care bridges the gap between intent and impact in postpartum care optimization, particularly for Black women, girls, and gender expansive people and their communities.

Key words: postpartum care, Black women, Black Feminist theory, person-focused care

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In this commentary to reproductive and perinatal clinicians, we offer an unsolicited critique and analysis of the May 2018 American College of Obstetricians & Gynecologists (ACOG) Committee Opinion

titled *Optimizing Postpartum Care*, which was reaffirmed in 2021. Our primary motivation is to raise the consciousness of the members of one of the most powerful professional organizations in women's health and in sexual, reproductive, and perinatal health service design, provision, evaluation, and training. By transforming the individual and collective clinician consciousness through this example, we hope to facilitate the awareness and uptake of a more holistic and humanistic approach to postpartum care that operationalizes Black Feminist theory within person-focused care. Specifically, 2 Black feminists with public health degrees, an obstetrician-gynecologist who is also an applied epidemiologist, and an anthropologist who is also a doula, aim to build the capacity for clinicians to activate the power and potential of the public to be postpartum bystanders and first responders.

Postpartum equality means that all women and birthing people deserve more than 1 obligatory visit with a health care provider after giving birth. Yet all women and people do not share the same burden of systems challenges, complications including death, and collective grief and loss around postpartum experiences and outcomes. This first year after birth is especially critical because more than half of pregnancy-related deaths occur in the postpartum period. Of these deaths, 18.6% occurred on days 1 to 6 postpartum and 21.4% on days 7 to 42. Specifically, 1 in 8 people who die are lost after the standard 6-week appointment.¹ When stratified by race, as a proxy for racism, Black mothers and birthing people suffer a disproportionate number of deaths after 6 weeks postpartum and up to 1 year after birth when compared with white women (14.9% vs. 10.2%).² Approximately 60% of pregnancy-related deaths are preventable. Thus, the ethics of postpartum care raises several questions around the lack of widespread acknowledgment and uptake of evidence into the development, implementation, and evaluation of policies and

practices to close the postpartum death gap. Black mothers and birthing people deserve care and to be cared for in the most optimal manner that fulfills their care needs and facilitates agency and self-efficacy during service utilization.³

As an outcome, postpartum equity is achieved when individual life expectancy (length and quality of life) after pregnancy or childbirth is no longer determined solely by biology nor individual behavior. Postpartum equity is also a process.⁴ As a process, systems and structures operationalize postpartum equity when the community carrying the greatest burden of deaths and near deaths acquire the necessary power, funds, and talent to develop and implement institutional policies and practices with both cultural and scientific rigor.⁵ Ultimately, postpartum justice is necessary to address and eliminate the historical, structural, institutional, and interpersonal barriers to surviving and thriving together as a parent-child dyad within the context of larger family and community relationships. Postpartum justice, as defined by Mothers-For-Mothers (M2M) Postpartum Justice Project, is a set of values forming the foundation for fair and equitable postpartum care, free from sexism, racism, and capitalism. Postpartum justice recognizes society's collective responsibility for all parents of new babies and incorporates the sharing of postpartum rituals and wisdom across and within generations to honor the past and serve the future. Postpartum justice is operationalized through the implementation and sustainability of institutional and structural policies and practices that embody an authentic trust and belief in the power, promise, and potential, (and not pathology) of Black women and gender expansive people as autonomous agents of their lives, their families, their communities, and their futures.

The Presidential Task Force on Redefining the Postpartum Visit Committee on Obstetric Practice published a Committee

Opinion on Optimizing Postpartum Care in 2018, which was reaffirmed in 2021.⁶ This document exposes 5 fundamental assumptions about the way ACOG contextualizes postpartum care in the United States: (1) Every postpartum patient identifies as a woman; (2) Every postpartum patient's humanity is valued equally by their obstetrician-gynecologist and medical home; (3) Every family that enters the hospital for a birth leaves the hospital after a birth with a live postpartum parent—newborn dyad; (4) Every postpartum patient who survives a birth leaves the hospital to participate in a medical home with the existing infrastructure and operations to responsibly address the complex multifactorial sociocultural, political, clinical, and psychological needs and priorities of every woman; and (5) Every obstetrician-gynecologist possesses the interest, agency, and self-efficacy to identify and advocate for policy changes to equalize postpartum life and livelihood for all postpartum patients.

Our overall impression of the Committee Opinion, whether intentional or not, is the blatant omission of an explicit discussion of the underlying causes of postpartum inequalities and inequities in care access, utilization, experiences, or outcomes. The ahistorical and atheoretical approach to the analysis of postpartum care facilitated a type of erasure or exclusion of communities with particular needs, priorities, and lived experiences, beyond controlling the reproducing body. Given ACOG's organizational power, one must continuously interrogate the motivation behind the omission and the groups who benefit the most from the hypervisibility of medicalized and pathologized postpartum bodies and the hypervisible invisibility of structures and systems of reproductive surveillance, control, and dominance that undermine postpartum justice. A single-issue analysis of postpartum care that is grounded in the biological construction of, and

medical/clinical only response to, a physiological human phenomenon consequently prioritizes the infrastructure, operations, and needs of the medical industrial matrix over the lived experiences and needs of patients and communities. In February 1982, Black feminist lesbian poet, writer, and activist Audre Lorde declared, "There is no single-issue struggle because we do not live single-issue lives."^{7,8} The absence of an acknowledgment and analysis of the overlapping and reciprocating, or intersecting, factors that structure how institutions and systems differentially treat people before, during, and after birth invalidates and erases the existence, experiences, and expressions of Black and Brown communities who carry the greatest burden of pregnancy-related mortality and morbidity.

A post 2020 re-reading of the Committee Opinion raises several concerns and questions about the reasons for the exclusion of a race and gender based, or intersectional, consciousness in the overall contextualization of contemporary US postpartum care from the perspective of the postpartum patient and their community. The egregious silence about the elephants in the postpartum space must stop, particularly in obstetric literature, discussions, and care. Racism,⁹ racial capitalism,^{10–12} misogynoir,¹³ structural racism,¹⁴ and obstetric racism^{15,16} in service provision must be named, measured, monitored, and modified in order to achieve and sustain postpartum equity and justice. The perpetuation of this egregious silence, within the context of a longstanding professional and privileged choice of willful ignorance and arrogance, feels woefully irresponsible and cruel, especially given incalculable cost of the lives lost such as Dr Shalon Irving, PhD, MPH, MS, CHES,¹⁷ Kira Johnson,¹⁸ Denise Williams,¹⁹ and Amber Rose Isaac,²⁰ or lives nearly lost such as Serena Williams and Beyoncé Carter.²¹

Optimizing an existing postpartum model of care assumes the current model produces favorable experiences and outcomes. However, optimization without an intersectional approach usually benefits the structurally dominant group and disadvantages the structurally marginalized and minoritized group.

The absence of a structural analysis of power and access to a culturally and clinically responsive postpartum medical home as well as the omission, whether intended or not, of words such as racism, sexism, or classism in the ACOG Committee Opinion, reinforces the lie that the individual or behavioral risk for missing the limited postpartum care offerings contributes exclusively to increasing pregnancy-related morbidity and mortality. Likewise, the avoidance of mentioning at least racism, not race, as the primary driver in influencing the unequal and inequitable distribution of structural and social determinants of postpartum health fuels a positivist and anti-Black racist mindset/consciousness that postpartum women and people are to be blamed for the current state of postpartum care experiences and outcomes. The use of language in the Committee Opinion informs the audience of how to situate postpartum women and individuals within the medical industrial complex as objects of pathologic vulnerability requiring increased surveillance and risk stratification as a standardized approach to care. Such thinking dissociates the patient's humanity from health service provision and obfuscates patients' authentic expression of their priorities and needs. Repetition of the word women does not make for a woman-focused approach. Instead, frequent use of the word women, to possibly to evoke emotions of sympathy among a growingly feminized specialty, repeatedly perpetuates harm because of binary thinking and gender exclusion. Likewise, the authors' use of passive voice facilitates the ongoing displacement of the

disproportionate burden of staying alive and thriving after birth solely on individual choices and behaviors. The consistent use and placement of language throughout the Committee Opinion raises questions about a shared mother blame ideology²² among the obstetric workforce, which is a byproduct from the operationalization of structural racism, misogynoir, and obstetric racism in the professionalization, medicalization, and pathologization of birth and motherhood/parenthood. For example, the Committee Opinion states in the abstract, "It is recommended that all women have contact with their obstetrician-gynecologist or other obstetric providers within the first 3 weeks postpartum." The statement is repeated on e144, "To address these common postpartum concerns, all women should ideally have contact with a maternal care provider within the first 3 weeks postpartum." The use of the word should implies an obligatory course of corrective action to mitigate postpartum inequities, which in these examples, assumes that low attendance rates at the single postpartum visit are the primary drivers of disproportionate outcomes and the direct and exclusive fault of postpartum mothers and patients. Likewise, word choice and placement of "all women have contact" and "all women should ideally have contact" can facilitate shame,^{23,24} an internalization of inferiority and inadequacy, and stigma and stigmatization,²⁵ a violation of dignity and power by health care institutions coupled with discrimination (eg, obstetric violence, misogyny, obstetric racism) and unjust actions in postpartum care. The hypervisible invisibility of repeated calls to actions for all health care institutions to provide approachable, acceptable, available and accommodating, affordable, and appropriate care without clear examples of structural and institutional change displaces the sole responsibility for improving postpartum care access and utilization on the individual.

Consequently, the use of passive voice with word choices such as “all women should,” instead of “all women deserve” contact with a maternal care provider, combined with mother blame, convey to the primary readers of the Committee Opinion, OBGYNs, and other clinicians, that postpartum women and people are exclusively responsible for following all the necessary steps to schedule and then show up for a 3-week postpartum visit despite contradictory evidence cited in the 2018 publication.

The authors made the followings points about the state of US postpartum service provision by focusing their problem analysis and solutions building on patient (“individual”) level behaviors:

- ~40% of women do not attend a postpartum visit.
- ~25% of women did not have a phone number for a health care provider to contact for any concerns about themselves or their infants.
- Lower postpartum visit attendance rates among populations with limited resources.
- Underutilization of postpartum care impedes management of chronic health condition and access to effective contraception.
- Strategies for increasing attendance:
 - Facilitate discussion about the importance of a postpartum visit to the patient.
 - Utilize peer counselor and additional support staff to encourage patient follow-up.
 - Schedule postpartum care visits during prenatal care or before hospital discharge.
 - Using technology for reminders to schedule postpartum follow-up.

The only structural level problem analysis and modification included increasing access to paid sick days and paid family leave, with 2 statistics included: (1) 23% of employed women return to work within 10 days postpartum; and (2) 22% of

employed women return to work between 10 and 40 days. On the basis of evidence cited by the Committee Opinion, women noted postpartum care services were infrequent and delayed. A description of a systems level analysis reported that <50% of women in a national survey who attended a postpartum visit reported that the provider/health system shared enough information at the visit about postpartum depression, birth spacing, healthy eating, the importance of exercise, or changes in their sexual response and emotions. Thus, optimizing the current US dominant postpartum model infrastructures and operations through the focus on the postpartum pathologization, disease surveillance, and individual level risk identification, stratification, and management recreates and/or worsens systems level incompetencies and inadequacies given the current evidence.

The most compelling advice from the ACOG Committee Opinion requires a cultural consciousness raising for institutions and clinicians to reimagine the comprehensive postpartum visit as a medical appointment which does not guarantee an “all-clear signal”: Obstetrician gynecologists and other obstetric care providers should ensure that women, their families, and their employers understand that completion of the comprehensive postpartum visit does not obviate the need for continued recovery and support through 6 to 12 weeks postpartum and beyond. Decentering the office visit as the preferred method of service provision is the second most compelling advice given by the Committee Opinion, which moves away from blaming and stigmatizing postpartum women and patients for underutilizing a failed postpartum model of care. Through this Committee Opinion, ACOG asserts that a postpartum assessment need not always include an office visit and invites OBGYNs and other clinician providers to examine the utility of an in-person assessment by considering

the burden of traveling to and attending an office visit with a newborn. The authors go on to offer additional mechanisms for assessing women's health needs after birth such as home visits, phone support, text messages, remote blood pressure monitoring, and app-based support.

Although the Committee Opinion opens the possibility for reimagining postpartum care, the ethos of care continues to pathologize and medicalize a physiological process and experience for sustaining life after birth, without an explicit acknowledgment and explanation that 80% of the determinants of health originate outside of medical care services. In the consideration of optimizing postpartum care, we highly recommend asking postpartum women and people what they desire in a model of postpartum service provision that optimizes their care access and utilization based on their abilities to perceive, seek, reach, pay, and engage in postpartum care at the intersections of institutional approachability, acceptability, availability and accommodation, affordability, and appropriateness.²⁶ Second, we offer a person-focused, not patient-centered, ethos and praxis of care that acknowledges the value of understanding patients' health problems as defined and experienced in the fourth trimester as they see them, and not only

through the lens of physicians and the medical industrial complex.

According to the late pediatrician, public scholar, epidemiologist, and health care policy champion, Barbara Starfield, MD, MPH, "Care is better when it recognizes what patients' problems are rather than what the diagnosis is."²⁷ Starfield contrasts patient-centered care with person-focused care (Table 1). By optimizing postpartum care within a person-focused care model that explicitly recognizes birthing parents as interconnected with their infants and others, the opportunities for growth focus more on the 5 dimensions of institutional accessibility as defined by Levesque and colleagues 2013: approachability, acceptability, availability and accommodation, affordability, and appropriateness.

Grounding the optimization of postpartum care within a person-focused care model prioritizes continuous care over time, coordination of care within health care systems, and timing of when patients must receive care elsewhere (outside of a traditional office setting). The ethos of person-focused centers the essence of time, and not the visit attendance, and strengthens a movement towards redefining quality of care through patient experiences and outcomes of care in service provision and quality improvement in quality improvement. Patient-centered care is essentially a physician-system centered model of care

TABLE 1. Comparison Between Person-centered Care and Person-focused Care (Starfield)²⁷

Patient-centered Care	Person-focused Care
Refers to interactions within visits	Refers to interrelationships built over time
Organized by episodes of care in response to acute pathologic changes	Organized around episodes of care defined as part of life-course experiences with health
Prioritizes disease management in care	Prioritizes diseases as interrelated phenomena in care
Views comorbidity as number of chronic diseases	Views morbidity as combination of types of illness (multimorbidity)
Perceives body systems as distinct	Perceives body systems as interrelated
Uses coding systems that reflect professionally defined conditions	Uses coding systems that allow for specification of people's health concerns
Prioritizes the evolution of patients' diseases	Prioritizes the evolution of people's experienced health problems as well as with their disease

that prioritizes visits, disease management, coding, and reimbursement, while person-focused care is a relationship centered model of care that prioritizes patient and community knowledge, wisdom, and experience over time (ie, life-course approach) with consideration of the conditions in which people live, work, play, worship, partner, and pray (ie, social determinants of health) and incorporation of the social implications of health and disease. Person-focused care moves with the lived experiences of postpartum women and people over time through the fourth trimester, while patient-centered care manages the diseased bodies of postpartum women and people during timed visits.

Optimizing postpartum care for Black women, girls, and gender expansive people by operationalizing Black Feminist theory requires a model of care that maintains fidelity to 4 core principles: (1) Black women activate their own power to define their own worth and value outside of mother blame, racism, and misogynoir; (2) Black women confront and dismantle systems and structures of intersectional oppression; (3) Black women intertwine intellectual thought and political activism; and (4) Black women honor their innate and inherited energy and skills to resist and transform daily discrimination.²⁸ As a result of the means and mechanisms by which postpartum Black women and people must navigate and negotiate harmful structures and systems throughout society and health care, we invite ACOG clinicians and their professional peers and allies to consider a Black Feminist person-focused care model that optimizes postpartum care in the form of mobile units.

In a post 2020 era, community and academic led postpartum mobile units emerged in Boston,²⁹ Detroit,³⁰ and Washington, DC³¹ to close equity gaps in care provision and utilization by improving alignment with and accountability to patient and community postpartum

needs and priorities. The postpartum mobile units address institutional level factors such as approachability (ie, outreach), acceptability (ie, dyadic care—Midwives support parent while Nurse Practitioners supports the newborn), availability and accommodation (ie, geographic location is the community which the Black parent and child reside); affordability (ie, no cost with funds from local legislation, Medicaid reimbursement); and appropriateness (ie, elimination of the physician centered model within the 4 walls, incorporation of broader services such as depression screening and resources, lactation consultation). Postpartum mobile units also maintain fidelity to person-focused care and community-informed models of perinatal and reproductive health services provision that facilitate a justice-centered consciousness toward equity among Black birthing and parenting communities as defined by Julian et al in 2020.³ More importantly, postpartum mobile units within person-focused care models provide opportunities for capacity building within the OBGYN physician workforce in the following areas: (1) racial and epistemological diversification; (2) a reckoning with the professional legacy of obstetric racism and misogynoir in service design, provision, evaluation, and training; and (3) innovation in interprofessional, transdisciplinary, and community collaboration.

Therefore, we call upon OBGYNs and other postpartum care clinicians to acknowledge and amplify the agency and self-efficacy of postpartum Black women, girls, and gender expansive people by applying The Building and Bridging Black Futures Beyond Birth (“Black Futures Beyond Birth”) Model of care (Fig. 1) in any postpartum care model or setting. The Black Futures Beyond Birth Model is a 12-Step Black Woman-Person First Approach in optimizing postpartum cares that holistically recognizes and responds to the full humanity of Black women and

**Building and Bridging Black Futures
Beyond Birth: A 12-Step Black
Woman-Person First Approach to
Optimizing Postpartum Care**



FIGURE 1. The building and bridging Black futures beyond birth model: a 12-step Black woman-person first approach to optimizing postpartum care. Design idea and illustration commissioned by Birthing Cultural Rigor, LLC and created by Cheyenne Varner of The Educated Birth.

people during health services provision. As an ethos, Black Futures Beyond Birth embodies the 4 principles of Black Feminist theory and the 7 components of person-focused care. As a praxis, Black Futures Beyond Birth destigmatizes and democratizes postpartum care design, experiences, and outcomes by challenging power differentials and dynamics in the interactions, communications, counseling, shared decision making, and documentation and dissemination of care information in warm patient handoffs and electronic health records. Black Futures Beyond Birth builds clinician capacity in any care setting to activate the power and potential of the US public, in biological or social

kinship with Black women and gender expansive people, to be postpartum bystanders and first responders. Black Futures Beyond Birth also destigmatizes the individual and collective Black life beyond birth by humanizing the voices, lived experiences, and acts of daily resilience and resistance to survive and thrive in community through a reclaiming of language, roles, and imagery. Black Futures Beyond Birth also democratizes postpartum care by activating the power of biological or social kinship to take up space and participate in postpartum rapid responses at home or community settings making the first call to primary maternal, reproductive, and perinatal care providers for acute changes and concerns, with the guidance of patient experts, community leaders, and local clinicians.

Destigmatizing and democratizing postpartum care through the uptake of the Building and Bridging Black Futures Beyond Birth Model liberates postpartum Black women and people from the limitation and lack of the traditional 1-time physician-pathology centered model of care. In Table 2, we rename the components of postpartum care from Box 1 in the May 2018 Committee Opinion as theorized domain names, that all begin with the letter B, to better reflect the experienced health challenges and diseases of a postpartum Black woman or person using culturally and clinically aligned words, feelings, and emotions, from the crown (head) to the feet of a postpartum Black woman or person. For example, the Building and Bridging Black Futures Beyond Birth Model prompts the postpartum workforce to initiate the visit, by phone, video, or curbside mobile unit, by first asking about postpartum expectations around the desires (preferences and priorities), dreams (vision), and destiny (goals). As 1 moves along both in time and within the body from head to toe (Fig. 1), the Building and Bridging Black Futures Beyond Birth Model prompts the

TABLE 2. The Building and Bridging Black Futures Beyond Birth Model Names, Meanings, and Alignment With ACOG Optimizing Postpartum Care Components

Name of 12-Steps	Domain Names as Defined by Black Women and People's Experienced Health		Alignment 2018 ACOG Care Component
	Challenges and Diseases	Domain Meanings and Measures	
Step 1	Brand	Postpartum desire, dream, destiny	None
Step 2	Beauty	Crown/Hair/Head—Appearance, Skin Care, Hair Care, Old or New Headaches, Vision Changes	Chronic disease management
Step 3	Blues+	Mental and emotional support, coping skills, and resources inside and outside the home; sleep, fatigue	Mood and emotional well-being, sleep, and fatigue
Step 4	Blood pressure	Remote monitoring and upload data online through e-mail, text, e-chart, app	Chronic disease management
Step 5	Breathing	Shortness of breath, labored or painful breathing	Chronic disease management
Step 6	Breast/chest	Lactation initiation, continuation, successes, challenges, support, or binding, weaning, donor milk, blocked duct, mastitis, mammogram	Infant care and feeding; health maintenance
Step 7	Bonding	Role and relationships with self as new/different woman/person, with infant as parent, with old or new romantic partner, with peers, and with chosen and given kinship	Sex. Contraception, and birth spacing
Step 8	Boundaries	Social, emotional, mental, cultural, and physical safety—intimate partner violence/domestic violence, community violence, police violence, workplace violence Bodily autonomy, coercion, control, choice, communication and prioritizing needs; Involved family and friends in care responsibilities; financial, food, and housing insecurity Pleasure, sex, STI/HIV COVID, contraception, vaccination for self, infant, partner, peers, and kinship	Sex, contraception, and birth spacing; health maintenance
Step 9	Belly	Abdominal pain, fundal height self-check and massage; wound care an incision check, nutrition; nourishment; food insecurity	Physical recovery from birth
Step 10	Bleeding	Unusual bleeding from external genitalia, perineum, uterus, or abdominal/wound incision	Physical recovery from birth
Step 11	Bones	Pain or discomfort in back/spine, pelvis, legs/lower extremities, unusual swelling, mobility, flexibility	Physical recovery from birth

TABLE 2. (Continued)

Name of 12-Steps	Domain Names as Defined by Black Women and People's Experienced Health Challenges and Diseases	Domain Meanings and Measures	Alignment 2018 ACOG Care Component
Step 12	Black bag	Medical bag with thermometer, blood pressure cuff, pulse oximetry, incentive spirometer, acetaminophen, ibuprofen, wound care supplies, menstrual pads, etc.	Chronic disease management; health maintenance

postpartum workforce to explore Beauty which includes questions about Black hair and skin care, headaches, and vision changes. For Beauty, the ACOG aligned postpartum care component is Chronic disease management. For Brand, there is no ACOG aligned postpartum care component which represents a gap in providing care with cultural rigor.^{31,32} The 12th B represents the Black bag filled with various postpartum supplies to support patient and community self-care, agency, and self-efficacy, further democratizing access to collecting, storing, sharing, and utilizing clinical data to drive more recognizable, responsive, and rigorous care. Implementation of the Building and Bridging Black Futures Beyond Birth Model is intended to activate bodily autonomy and humanize care seekers, care providers, care experiences, and care outcomes among postpartum Black women and people, the communities from which Black women and people reside, and the postpartum workforce.

As a result of our commentary, we urge you to call your department chair, medical school dean, and your department chairs in the social sciences, medical humanities, and public health to build up applied knowledge and skills of medical students to be better history takers by learning feminist ethnography. Assign medical students to follow and support a postpartum woman or person from 0 to 3 weeks until 1 year postpartum. When

the physician author of this essay matriculated to medical school in August 1998 at Case Western Reserve University School of Medicine, the school assigned each first-year medical student to 1 of 2 patients in a novel and innovative approach to medical education that humanized health care, their learners and their learner's learning experiences: a geriatric patient and a teenage pregnant. The physician author chose to learn with and from a pregnant teen, her partner, and baby from the third trimester until the infant's first birthday at the community hospital across town. Imagine destigmatizing postpartum women and people, particularly postpartum Black women, girls, and gender expansive and parenting communities by matching a medical student to a Black postpartum person/family or community and meeting up with a multidisciplinary team consisting of a cohort other medical students and content and community experts for weekly experiential learning activities and discussions. Back in 1998, problem-based learning was an evidence-based pedagogy to supplement didactic teaching for medical students that improved knowledge acquisition, retention, and recall. More importantly, problem-based learning fostered team-based learning, communication, and collaboration to address biopsychosocial and clinical needs in a manner that focused on the patient's expressed and experienced health challenges

and disease management. We invite OBGYNs and other postpartum clinicians to meet with leaders in and funders of interprofessional education and training, and speak positively about investment and implementation of an adaptation of problem-based learning that maintains fidelity to Black feminist person-focused care and the Building and Bridging Black Futures Beyond Birth Model, with the participation of a social scientist, a medical humanities expert, a social workers, an OBGYN, a Nurse Midwife, Registered Nurses, a public health scholar, a pediatrician, a lactation educator, a doula, a policy maker, a funder, a legal studies scholar, a mental health professional, and a reproductive justice/birth justice activist (1 patient, community, or content expert can serve multiple roles)—with prior training in Black feminist praxis, obstetric racism, reproductive justice, Sojourner syndrome, and misogynoir.^{13,33,34} We strongly believe widespread implementation, scale-up, and spread of Black Feminist person-focused care and the Building and Bridging Black Futures Beyond Birth Model for Black girls, women, and gender expansive people can restore the medical humanities and social sciences to health services provision and interprofessional education and training.

In this commentary, we guide OBGYNs and other clinicians to reimagine an approach to postpartum care that rests on the radical notion that Black women, girls, and gender expansive people are not broken and do not require being fixed. The evidence describing the current failures and flaws of the existing postpartum care model requires that we lead with curiosity, courage, and compassion. The uptake of person-focused care models within a Black Feminist praxis activates the power and potential of family and friends as the first responders to the make first call to primary maternal, reproductive, and perinatal care providers for

acute changes and concerns. Integration of the Building and Bridging Black futures Beyond Birth Model within phone calls, text messages, video visits, digital platforms, or mobile units elevates the quality, reach, and impact of postpartum care, care defined, for, by, and with the community. The Building and Bridging Black Futures Beyond Birth Model honors the sanctity and sovereignty of Black bodies, voices, and power within community and medical spaces. The radical clinician actualizes and practices radical care by recognizing the importance of the reifying the family space as opposed to thinking of the family pathologically.

According to a 2019 Centers for Disease Control and Prevention (CD) report, more than 60% of pregnancy-related deaths are preventable. Consequently, the safest place for Black women, girls, and gender expansive people after birth is in the care of our community, and not in the hands of health care workers as they are currently trained and supported. Black women and people deserve and desire living and thriving beyond birth together with their newborn and given or chosen family. Black women and people are much more than the sum of our diseases and risk factors.

We deserve more than 1 day of care.

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