HHS Public Access

Author manuscript

Clin Obstet Gynecol. Author manuscript; available in PMC 2023 September 01.

Published in final edited form as:

Clin Obstet Gynecol. 2022 September 01; 65(3): 538–549. doi:10.1097/GRF.0000000000000734.

FOREWORD Toward reproductive justice in postpartum care

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Introduction

The postpartum period is a precious part of life: the health and well-being of at least two generations are at stake. Although the World Health Organization calls for a standard of care that promotes "positive" postpartum experiences with a "resourced and flexible health system"[1], these goals are largely aspirational. In her book, *Baby Doctor*, pediatrician Perri Klass writes about the moments immediately following birth.[2] She describes how all eyes in the delivery room turn to the baby – except for the midwife or the obstetrician, who are the "only ones still paying attention to mom." Anthropologist Shelia Kitzinger similarly wrote that "the spotlights are dimmed" for women after childbirth.[3] In American medicine, we do not pay much attention to birthing people once the cord is clamped. The underlying notion of women as being worthy of focus only while they are vessels for new life is deeply harmful. It is as though the baby is the candy and the mother is the wrapper. After the candy is out, the wrapper is cast aside. This transactional thinking and treatment around childbirth is a tragedy, with short- and long-term consequences.

We are a medical anthropologist and maternal-fetal medicine physician who work on a range of postpartum research projects together and with colleagues. Through this work, participants have described postpartum health services as "after care," with the system being "jarringly obvious" that support for women and all birthing people after childbirth is not a priority. There is a mismatch of needs and resources. This conflict is particularly striking because we provide ample clinical care and attention to infants after delivery. In the United States, babies are seen for multiple health checks in the first days and weeks after birth, but many people who give birth are offered only a single visit around 6 weeks postpartum. In 2019 and 2020, health care between 7 and 84 days after delivery was not delivered to one in four US birthing parents.[4] This gap reflects, in part, lived experiences during perinatal care. For example, postpartum visit attendance is lower among those who experienced discrimination based on their language, health insurance status, or any form

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Disclosure Statement: The authors are inventors on a patented medical device, which is not addressed in this manuscript. The University of North Carolina at Chapel Hill intellectual property is licensed.

of discrimination during the childbirth hospitalization.[5] People remember how they were treated.

In multiple projects, birthing people have shared with us that they had not been provided with enough information or support for their postpartum journeys. They describe feeling alone, judged, and distressed about not receiving the care they deserve. Similarly, health care team members are understaffed and ill-equipped to care for patients are they would like. These experiences are the opposite of the sense of belonging that we all strive for as social beings. Postpartum care has long been neglected; indeed, the word “postpartum” itself is often considered shorthand for postpartum depression. Additionally, in the current culture of health, emphasis is on clinical screening, rather than leading with resources. For example, screening for postpartum depression is a US Department of Health and Human Services Healthy People 2030 objective (MICH-D01),[6] but increasing preventative care and referrals are only implied.

The US postpartum health care system is far from being optimized. Barriers to care begin with financing: postpartum visits are part of the global package for maternity care, and healthcare providers receive a flat fee for prenatal, intrapartum and postpartum care, even if the birthing person does not attend a postpartum visit. Further, there are marked differences in reimbursement for maternity care for patients with commercial insurance compared with patients with Medicaid. The financial structure also does not incentivize provision of resources for social determinants of health. In addition to these opportunities, we can also implement strategies including adherence to recommended nurse-patient staffing ratios, payer coverage of postpartum doulas; timing postpartum rounding to better protect patient sleep, and investing in workforce development and working conditions so that health care team members are more concordant with their patients on language, race, and culture.

Collectively, the postpartum care setting is not conducive to health. A birthing parent research participant shared this account of her postnatal unit stay:

> Like, I felt like I wasn’t receiving the proper care afterwards, whereas during and directly after [childbirth], like the first two hours after, I was receiving constant care. So to go from having a doctor constantly to being moved to like another floor after delivery, and just having a major surgery, and not having anybody to come check on you, it’s a really horrible feeling. I think that this type of stuff can attribute to why we have the highest maternal death rate of any developed country. Like, as a developed country, our maternal death rate should be really low, which I’m sure it is pretty low, but for it to be a lot higher than all the other developed countries, that says a lot about our health care, you know what I mean?

The components of postpartum care systems that are deemed essential and the aspects that are expendable communicate a lot. Metlz and colleagues state that the COVID-19 crisis has made inequities more apparent.[7] They offer, “The opportunity exists to reimagine and redesign the health care delivery and education systems through a lens of health equity and racial justice.” The authors call for structurally competent healthcare systems, because “No one is safe until everyone is safe.”

Survival is a crude measure of health care quality, and it is unfortunately highly variable following childbirth globally and across populations within countries.[8, 9] Maternal mortality and severe morbidity are largely preventable,[10] yet in the US, pregnancy-related deaths have been increasing.[9] In 2020, the overall maternal mortality rate was 23.8 deaths per 100,000 live births, with 861 lives lost. Most of these pregnancy-related deaths in the US occur in the postpartum period.[10] Further, the US maternal mortality rate for non-Hispanic Black individuals was 55.3 per 100,000 in 2020, which was 2.9 times higher than the rate for non-Hispanic white individuals during this period, at 19.1.[9] While statistics on conditions including hemorrhage, amniotic fluid embolism, infection, hypertensive disorders of pregnancy, cardiovascular problems, and other leading causes of maternal mortality[10] are a critical piece of understanding the landscape of postpartum health, including disaggregation of these outcomes by patient ethnicity-race and other factors that reflect discriminatory care,[11] these contributors to health outcomes are the tip of the iceberg.

Looking deeper, we can uncover the underlying factors that influence trajectories of postpartum health and complications, including maternal feelings of autonomy and dignity from their care. Hardeman and Karbeth suggest that health disparities cannot be disengaged from racism, because disparities are avoidable injustices.[12] Inequities in clinical practices and subsequently health outcomes are the consequence of structural and interpersonal racism, classism, and other forms of oppression. As Harris and Wolfe write regarding maternity care,[13]

> Throughout the US history, the fertility and childbearing of poor women and women of color were not valued equally to those of affluent white women. This is evident in a range of practices and policies, including Black women's treatment during slavery, removal of Native children to off-reservation boarding schools and coercive sterilizations of poor white women and women of color. Thus, reproductive experiences throughout the US history were stratified. This ideology of stratified reproduction persists today in social welfare programs, drug policy, and programs promoting long-acting reversible contraception.

Unfortunately, the dominant culture of health in the United States reflects current societal values of individual independence and, as Joia Crear-Perry states, a hierarchy of human value based on skin color.[14] We expect people to navigate their reproductive lives through affordances of privilege, instead of structuring care for accessibility and meaningful support. Our values show.

Racism is so entrenched in the "groundwater"[15] that we may overlook how white supremacy drives the conditions in which we live, grow families, develop and age. The antidote for this ideology is reproductive justice, a concept formed by a collective of Black women in 1994.[16] Reproductive justice asserts each person's fundamental human right to bodily autonomy, to not have a child, to have a child, and to raise their children in a safe and healthy environment. Quality postpartum care is a social justice issue. Power dynamics matter when considering when and how birthing people access health care services, and the ways in which they are supported – and unsupported – through transitions of care.[17] We

can build our systems of postpartum care to be just, but that decision must be prioritized and accompanied with consistent follow through and accountability.

Purpose

For this symposium, we invited thought leaders in reproductive health, anti-racism, and clinical practice to address how we might move toward reproductive justice in postpartum care. Together, we envision systems of health care services that are non-harmful, accommodating, and uplifting. Disparities in health outcomes are a result of choices, expressed through policies, practices, and interpersonal dynamics. These barriers must be undone and rebuilt as part of "renovating" postpartum care. The physicians, midwives, nurses, doulas, lactation professionals, anthropologists, and advocates in this collection of manuscripts extend our perspective to identify what it means to effectively serve birthing parents. We are actively seeking to recognize and celebrate each birthing person as the protagonists in their story. Mothers are the ones who birth, breastfeed with their infants, and lead; how might their caregivers and community walk alongside them to support their journeys?

This compilation offers actionable strategies for providing more respectful, equitable, and supportive postpartum care that sets up parent-infant dyads and families up to survive and thrive.[18] The chapters in this symposium advance maternal health equity by identifying practical steps that health team members can take to improve care for postpartum individuals and families, as part of a continuum of reproductive health services. The topics addressed in this collection are not comprehensive. Instead, the contributions are intended to offer insights to better prepare clinicians to center birthing parents, particularly Black individuals, in the ongoing movement for reproductive justice. Postpartum is a special part of the life course, for families and communities.

Symposium

In Chapter 2, obstetrician Amina White and her multidisciplinary colleagues apply a trauma-informed lens to postpartum care. They critically assess the standard of interpersonal health care provider and patient interactions, outlining a future in which care is structured to be more humane and effective. By applying universal trauma precautions, postpartum practices can prevent harm and promote healing. Awareness and implementation are essential not only for individuals and families who experience poor outcomes, including intensive care or death, but, critically, for everyone. They offer that it is the patient's perspective that matters most. Because their traumatic experiences might not be apparent to the healthcare team or disclosed by the patient or family, the standard of care with every patient encounter should be trauma-informed.

In Chapter 3, Kanika Harris of the Black Women's Health Imperative and her colleagues present a composite patient, Maya Howard, and walk through the ebb and flow of her preparations for childbirth and the devastation that occurs from missed opportunities during inpatient postpartum care and the discharge transition. Their chapter opens with a powerful quote on moral apathy, challenging us to unlearn what has become acceptable within

the current, dysfunction system of perinatal care. Establishing a shared mental model of postpartum recovery begins with knowing what safety and dignity mean to the people we serve. This shared mental model is essential to re-envision care for positive trajectories, which many health care professionals, parents, and policymakers have never seen.

In Chapter 4, maternal-fetal medicine physician Jasmine Johnson and her colleagues position patient-reported pain as a fifth vital sign. They identify multiple contributors to postpartum pain experiences, including the normal physiological response after childbirth, a warning sign of impending complications, a physical symptom of underlying mood disorder, a component of chronic conditions, and a marker for experiences of racism and discrimination. They call for adequately assessing and managing pain from patient perspectives, including considering positive and negative coping strategies. Johnson et al. describe how our racist history continues to influence present day inequities health care, including substantial variation in postpartum pain management by patient ethnicity-race that reflects racist myths that Black people have a higher pain tolerance or thicker skin. They call for “an active unlearning of the explicit and covert manifestations of racism which pervade contemporary medical training.”

In Chapter 5, physicians Ivana Thompson, Amy Bryant, and Alison Stuebe describe the importance of centering patients in postpartum contraception counseling. They note that discussing contraception on the postnatal unit may not be ideal, or appropriate, because the emphasis on contraception can translate into patients’ feeling like the goal is to “keep people like me from having more children.” Instead, they call for promoting and protecting the birthing parent’s autonomy while identifying and serving their reproductive goals. Thompson et al. highlight the importance of asking about women’s values and preferences first, and then sharing information and recommendations.

In Chapter 6, midwife Déirdre Daly and her colleagues present what is known and unknown about trajectories postpartum recovery. In summarizing the literature and their work from Ireland on how women experience wellness in motherhood, they invite us to question what is to be expected and accepted in the postpartum period. Their research participants described inconsistent services, concerns that were dismissed by the health care team, and lack of needed health information. Daly et al. highlight that the presence or absence of postpartum symptoms are not adequate measures for health. Instead, if the goal is for birthing families to thrive, we might investigate “resilient or recovery” postpartum trajectories.

In Chapter 7, midwife Jennifer Fahey describes how whole-person postpartum care can improve engagement with their health care team and patient outcomes through the 4th trimester and beyond. To better align health needs and systems of care, she defines whole-person postpartum care as “considering the unique set of factors that promote either health or disease in an individual.” Importantly, Fahey explains how referral-based, means-tested service structure in the United States produces gaps in eligibility and stigma. She offers multiple patient-centered care strategies to enact whole-person postpartum care.

In Chapter 8, medical student Cathleen Mestre, nurse colleagues, and maternal-fetal physician Adetola Louis-Jacques address breastfeeding as a public health priority for

maternal and infant health. Lactation is a fundamental part of postpartum care, and providing equitable support would be would be transformational. To achieve lactation equity, the authors describe considerations for various, intersecting needs, and they outline the importance of anti-racist and trauma informed practices. Further, the authors address the opportunities and challenges with telelactation in the context of the COVID-19 pandemic, the role of human-centered design in breast pump improvements, and the value of culturally competent support through community-based organizations like Reaching Our Sisters Everywhere (ROSE).

In Chapter 9, postpartum care as a pathway to future health is presented by Valene Garr Barry and multidisciplinary maternal-fetal medicine and cardiac care physician colleagues. They position adverse pregnancy outcomes within a life course approach to health, outlining how postpartum care can heal and improve long-term health outcomes. The authors focus on the risks of future cardiovascular disease, positioning pregnancy as both a “maternal stress test” and a doorway to optimizing birthing parent well-being. Garry Barry et al. cite multi-disciplinary postpartum transitional clinics as a promising strategy for care coordination, enabling lactation, and affecting health trajectories with continued support through the transition to primary care, and as potential pre-conception care for future pregnancies.

In Chapter 10, physician and applied epidemiologist Karen Scott and anthropologist and doula Dána-Ain Davis present a “Black Woman-Person First” approach to postpartum care. Through a critique of the American College of Obstetricians & Gynecologists Committee Opinion, Optimizing Postpartum Care, they underscore the importance of a structural analysis of power and access to culturally and clinically responsive postpartum services. They highlight that racism, sexism, or classism are not addressed in the Committee Opinion, noting that this omission directs attention and policy toward birthing parent choices and behaviors instead of strengthening systems of care around the lived experiences and needs of patients and communities. They define postpartum equality, equity, and justice and offer the “Black Futures Beyond Birth” model of care to build clinician capacity to destigmatize and democratize postpartum care.

Collectively, the symposium directs health care team members to support patients/ family members by centering them, engaging communities, better aligning clinical encounters, and revising institutional structures and health care system policies. The heart of this purposeful approach for postpartum justice is a narrative that names racism and uplifts patient agency. As a part of these multi-level strategies, Table 1 highlights selected symposium recommendations that clinicians can implement in their next patient encounters to demonstrate respect and more effectively care for birthing people.

Discussion

This symposium offers ways that we can strive toward reproductive justice in postpartum care. We have opportunities to strengthen clinical encounters while establishing more just, resilient, and enjoyable healthcare systems. As Kitzinger wrote, “There is a 4th trimester of pregnancy, and we neglect it at our peril.”[3] For too many and for too long, systems of maternity care have not been designed to support birthing parents or to effectively

address their health needs.[19, 20] It is time to change our perspectives and hold ourselves accountable for safer patient journeys through care. We can stop harms and advance healing by recognizing and reckoning with the root causes of inequitable outcomes, so that resources can be directed appropriately. The singer-songwriter Rihanna has a song called “Stay” featuring Mikky Ekko with lyrics that include, “Funny you’re the broken one, but I’m the only one who needed saving.”[21] Our postpartum health care system is the broken one. Alongside attention to “saving mothers,” we must focus on interrogating, renovating, and reinventing postpartum system of care. Requiring patients to navigate a dysfunctional system and blaming them when they run aground is harmful.

Reinvention requires both individual adaptation and broad restructuring. In the chapters of this volume, we invited authors to share actionable steps for clinicians to implement in their next postpartum encounters and to outline broad strategies to transform care through the 4th trimester and beyond. This work is about validating birthing people’s importance and elevating their strengths, to better enable their self-determination over life after childbirth. Here, we present key principles for health care team members to intentionally work to create safe and healthy postpartum care environments, for patient well-being.

1. Critically assess policies and practices to replace embedded racism, classism, and other intersecting forms of oppression with the human rights-based framework of reproductive justice.

As Laurie Zephryin writes, disparities in maternal morbidity and mortality are the legacy of systemic racism and the “hierarchy of human value entrenched in policies and practices affecting health and health care” [22]. In a qualitative study, Treder and colleagues explored the reproductive health experiences of US-born Black women.[23] One participant said, “If I felt like someone’s already prejudiced before they even see me, before they even look at my chart, I’m not going to show up.” For too many birthing people, healthcare is a place of last resort rather than a source of ongoing support. How might we instead treat people with love and earn trust? We can look to scholars, such as bell hooks, for direction on what it might mean to bring more humanity into health care. She writes,[24]

> Imagine how much easier it would be for us to learn how to love if we began with a shared definition. The word “love” is most often defined as a noun, yet all the more astute theorists of love acknowledge that we would all love better if we used it as a verb… To truly love we must learn to mix various ingredients -- care, affection, recognition, respect, commitment, and trust, as well as honest and open communication.

We see the identification of person-, dyad-, and family-focused needs and addressing them in clinical practice as a path for advancing health equity and a just culture. If postpartum care were continually critically assessed and strengthened through a Cycle to Respectful Care,[25] then we would see more opportunities to practice love and act on these insights. The RJ framework positions the ultimate objective of health care as promoting human rights and optimizing individuals’ potential for health, as a part of support across their lifespan.

2. Respect birthing parents and families, especially those who have been marginalized, by co-designing solutions that center strengths and heal vulnerabilities.

Collectively, the contributions to this symposium call us in to have a dialogue and to critically assess and re-engineer the content, patterns, and relationships within postpartum care. Postpartum discussions are “crucial conversations,”[26] in which opinions vary, the stakes are high, and emotions can be intense. When clinical care falters, one party might see that as a discrete problem, and for others, the problem is part of a pattern that reflects deeper, relational issues, thereby leading to distrust and disengagement as a form of self-preservation.

Until we truly center those being served in postpartum care, policy decisions, healthcare system structure, institutional protocols, and daily practices will continue to be inequitable and unjust. Seeing birthing people as the problem or denying systemic variation in the way people are treated will perpetuate or widen disparities in health care processes and outcomes. This complicity is unacceptable. As Ibram Kendi writes, “There is no neutrality in the racism struggle. The opposite of “racist” isn’t “not racist.” It is “anti-racist.”[27]

An intentionally inclusive and positive approach, responsive to birthing parents’ lived experiences and values, is required for meaningful advancements in healthcare. People are more than clusters of health issues and there are steps we can take now to operationalize care for patients as whole people. For example, rather than assessing a postpartum symptom or a structural determinant of health in isolation, we can work in partnership with patients to identify their priorities and create care plans that are consistent, cohesive, and tailored for each birthing family.

As Scott and Davis outline in this symposium, existing healthcare system structures and practices are driven by surveillance and management of medical complexity, rather than being built for birthing people, with humane clinical care and publicly-engaged support. They challenge us to extend the scope of postpartum services beyond symptom management and health maintenance to include birthing parents’ postpartum goals and desires for their health, coping, beauty, and relationships. The ideal postpartum care scenario might be “medically boring” for clinicians and emotionally fulfilling for patients.

3. Create and sustain systems of postnatal support that care for birthing parents, rather than demanding that they seek care.

Maternal postpartum health has not been falling through the cracks; rather, the system is not designed to care for the birthing person after childbirth. Jabina Coleman, licensed social worker and international board-certified lactation consultant asks, “Everyone wants to hold the baby -- who will hold the mother?”[28] Healthcare systems and the team members within them should be accountable for offering timely, accessible, and supportive resources.

Critically, it is not appropriate to expect patients to advocate for themselves in order to navigate their care. Recently, a research participant shared her “terrible, dehumanizing” postpartum experience with one of us. She described feeling like she was being tortured and then she “finally broke down.” Her health care team member then replied, “some people

respond this way and they just don't have more kids." After the gaslighting account, the participant went on to explain why patient self-advocacy is inappropriate:

> You might think, "Oh, I need to try and repair this," but you don't have the interpersonal skills to do it. And I think the thing that a lot of people would say, who have not been in this situation is like, why didn't you advocate for yourself? I'm an attorney, by the way. I advocate for people all the time. But it's just like, whenever you're in the ocean, like if you've ever been caught in a rip current, and then you get a wave, and then you get a wave. That's how people drown.

The symposium chapters expose waves of postpartum harms, which include insensitive communication, inappropriate timing and manner of assessments, directive counseling and care plans, birthing parents feeling isolated and uninformed, encounters structured and billed around patient "problem lists." The issues might accumulate into series of negative experiences, more so for Black individuals and other birthing people of color. Yet their ethnicity-race and challenges may be hyper-visible to clinicians while biased treatment and unjust system structures are unseen and unaddressed. The authors in this collection call us to recognize and reshape postpartum stories. Considering the symposium messages together is important, as the issues are intersecting, disproportionately experienced, and modifiable. Broadening understanding is a key step toward change and accountability for continual improvement.

The flaws in current systems of care are multi-faceted, and we fully recognize that it is not enough to appeal to health care professionals' personal motivations "to do better" without addressing individual capacity, social context and support, and structural incentives and tools.[29] Similarly, encouraging or incentivizing patients to attend postpartum visits, if care they received during pregnancy or the childbirth hospitalization was marginalizing, or undermined well-being, is not an effective public health strategy. Policymakers, healthcare systems, and institutional leadership might look inward to assess their readiness to offer quality maternity care that is worthy of engagement. Scott and Davis describe that this development and sustainability can derive from trust and belief in "Black women and gender expansive people as autonomous agents of their lives, their families, their communities, and their futures."

4. Honor the 4th trimester and elevate birthing people in their transition to parenthood.

This postpartum care symposium poses big questions. How might we structure support for the postpartum period to celebrate birthing people as they transition to parenthood? How might we honor this rite of passage and re-envision the "social womb"[30] that, throughout human history, has nurtured growing families in the weeks, months, and years following birth? And how might we center birthing people as protagonists in their stories? As anthropologist Tsippy Monat writes,[31]

> Birth is a rite of passage–a clear-cut event, full of significance, which irrevocably changes the role of at least two of its central characters. The woman is transformed into a mother and the fetus into a baby. The community that surrounds the birth also undergoes changes, because a new member is added to it and an old member has changed her status.

Birth affects multiple generations. Stepping back and reflecting on the importance of the 4th trimester and the people living through it may help reestablish the postpartum period as valued and protected.

As we continue to consider layered and cumulative contributors to maternal mortality and morbidity and broaden understanding of what it means for postpartum people and families to be safe and well, we can apply SisterSong's wisdom to the 4th trimester: "Our society will not be free until the most vulnerable people are able to access the resources and full human rights to live self-determined lives without fear, discrimination, or retaliation."[32]

Conclusions

It is our hope that this collection will contribute to a shift in mainstream thinking about what is acceptable in postpartum care and what is not. Since our perspectives and our behaviors are culturally constructed, we can grow and change. As we co-design more humane postpartum care, the clinical community can look to birthing parents for the definitions of success. Medical training, continuing education, and public discourse can shift to embrace newborns and parents as whole people, interconnected with each other and with their community. Core to this process is positioning equity in care practices and health outcomes as "desired end in and of itself," which Elizabeth Howell and her colleagues write, must be "specifically acknowledged, discussed, measured, monitored, and the subject of continuous quality improvement efforts."[33]

The insights in this symposium offer new standards for realizing positive postpartum care, by dismantling oppressive structures and practices and by building on what is working well to better protect and care for birthing people. When health care systems are responsive and just, they can become the ongoing resource that people deserve. Women and all birthing people need more control of their stories and celebrations of them, through pregnancy, birth, the 4th trimester and beyond. The postpartum period is sacred. We can honor this rite of passage by operationalizing postpartum love. This means structuring multidisciplinary clinical teams to address patient and family strengths and needs, as they, the stakeholders, define them. The goal of postpartum belonging and health is achievable, together.

Funding Sources and Role of Funding Source:

Financial support for Tully and Stuebe provided by the Agency for Healthcare Research and Quality, R18HS027260. The funder had no input or influence on literature review, data analysis, interpretation, or synthesis, reporting, or decision to submit for publication. The content is solely the responsibility of the authors and does not necessarily represent the official views of the Agency for Healthcare Research and Quality.

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Table 1.

Opportunities for health care team members to better align clinical encounters with patient-family needs.

Health care team members need…	***Opportunities for quality health care encounters***
…to do no harm	*Affirm health and safety as positive concepts*. Recognize that the absence of negative symptoms or adverse medical events is not equivalent to well-being. Health care is about service to people as a part of optimizing their potential, not only treating pathology. *Share power*. Demonstrate trustworthiness by 'walking with' patients, who may not know the range of options available and may be fearful of a system which can harm. *Set expectations*. Share the prevalence of postpartum healthy symptoms, and communicate strategies for recovery *Recognize stressors*. Pregnancy is not the first "stress test" for many, especially Black birthing people. Allostatic load and weathering affect health across the life course, which can be another layer to perinatal physiology. *Strive for reproductive justice (RJ)*. Consider the RJ framework and definitions of postpartum equality, equity, and justice. Provide care that protects each person's human right to bodily autonomy, to have children, not to have children, and to parent their children in safe and healthy environments.
…to be accommodating	*Believe patients*. Affirm that you see them as a person, with value, and that you are here for them. Convey respect, hopefulness, and partnership for what's next. *Set patients up to thrive*. Lead with resources and ask what is working for patients, to further engage in collaborative care planning around emerging needs. Celebrate successes. *Include intentionally*. In written, visual and verbal communication with patients and families, through documentation, and when coordinating with other clinicians, use inclusive and respectful language to describe people, their history and needs, and opportunities. *Be responsive*. Proactively uplift patient agency and self-efficacy, by asking, "What's going well?" Address feelings of shame and blame by normalizing ambivalence about parenthood. Listen in order to hear and understand issues as patients experience them. Validate patients as worthy of care and support.
…to uplift	*Implement anti-racist practices*. Recognize that health experiences including patient pain, coping strategies, and communication may be rooted in structural oppression and lived experiences of discrimination. Engage with humility and de-stigmatize health issues. *Create safe spaces*. Design clinic lighting, imagery, structure, and positioning of the built environment for patient and family access and privacy. Listen to patients, without interrupting, to understand their needs. *Facilitate informed consent or decline*. Explain assessments and procedures, and the rationale for them, and obtain permission before physical contact. Respect the patient as the expert in their preferences and values. *Counsel to patient needs and values*. Facilitate this shared decision making by first ascertaining patient goals, such as "Do you think you want to have another baby? If so, when?" and then offering medical expertise in a conversation, like "Would you like to use birth control to help accomplish this goal?" *Define the purpose*. Separate medical assessments of healing from "all-clear" signals of postpartum recovery. Confirm there is a distinction between being able to do something and implying it should occur, such as resuming vaginal intercourse. *Affirm patients as the protagonists*. Communicate to patients about their leading role in their stories, such as "your strength pushing on hands and knees was the key…without your actions, we wouldn't have been able to assist the way we did." *Facilitate ongoing dialogue*. Invite patients to confidentially share their experiences and recommendations through advisory committees and other feedback mechanisms. *Promote continuity of care*. Maintain ongoing person-focused support through care transitions, including postpartum discharge, primary care, and with specialists. Engage community organizations for program access and thought leadership. *Assess for equity*. Identify, measure, evaluate, and strengthen healthcare practices, disaggregated by patient ethnicity-race. Consider the context of clinical care, including nurse-patient staffing ratios and language access.