

MAMAFESTO: Toward A Community-Driven Service Design Approach
For Black Maternal Health Equity

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Abstract

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Human Centered Design and Engineering

Black mothers and birthing people in the United States continue to experience profound maternal health inequities shaped by enduring histories of racism, medical violence, and systemic neglect. While dominant maternal health interventions often center hospitals, providers, and technological innovation as primary sites of change, Black communities have long cultivated their own infrastructures of care rooted in cultural knowledge, collective responsibility, and ancestral wisdom. This dissertation examines Black maternal health through the lens of community care, service design, and Black feminist thought, arguing that Black communities are not passively navigating maternal health systems, but actively designing alternative systems of care.

Guided by Ruha Benjamin's framework of Viral Justice, this dissertation takes a community-driven and justice-oriented approach to understanding how everyday practices of care generate broader possibilities for systemic transformation. Across three interconnected investigations, this work explores community care in Black maternal health through interviews with Black mothers in the Seattle-Tacoma area, a directed content analysis of Black-led maternal

health organizations, and a multimodal critical reflection on Cradles & Culture, a community baby shower I designed as a form of research reciprocity and community contribution. Through these investigations, the dissertation introduces the TRIBE framework to articulate five dimensions of community care in Black maternal health: Tangible, Relational, Informational, Birthworker, and Emotional support. It further develops the concept of community-driven service design (CDS), an approach to service design in which community-defined values and practices function as the primary organizing logic for how care systems are imagined, structured, and delivered.

This dissertation also advances marginal sensibilities and w/reckoning as critical approaches to design epistemology and research practice, arguing that the lived experiences of marginalized researchers generate important forms of design knowledge often excluded from dominant research paradigms. Together, these contributions challenge institution-centered models of maternal health innovation and reposition Black community care as a legitimate and generative site of design knowledge, technological imagination, and justice-oriented research practice. Ultimately, this work calls for maternal health systems, research approaches, and technologies that honor and extend the care infrastructures that Black communities have long enabled and sustained.

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Dedication

Cicely Whetstone-McKenzie

March 2, 1974 - September 3, 2009

Black mothers are deeply special to me. Whether it's my church mothers who carry songs in their hearts when the hymnals have disappeared, my friend's mothers who would let me come over to play even when they were exhausted, my peers who deem me a distant, yet dear, "facebook auntie" to their child, the Nana's who watched us when my parents had to make ends meet, the Ma's who looked after me like their own cause they saw something special in me, my Godmothers who pray for me when I can't do it for myself, my grannies who don't play about making food for the soul, my big sister who calls me *her* child or my mommy who I'm starting to see more of myself in everyday. They were my first display of what it means to care. Many of them may never read this particular body of work word for word, but it absolutely wouldn't have been possible without them. I am because they are. This dissertation is because we are.

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Chapter 1- Introduction

"For the master's tools will never dismantle the master's house... And this fact is only threatening to those [Women] who still define the master's house as their only source of support."

— Audre Lorde, 1979

These words from self-described Black, lesbian, mother, warrior, poet Audre Lorde invoke the very spirit of this dissertation. *Mamafesto* provokes questions around how care is redefined outside of “the master’s house” for Black birthing people and communities. As maternal health inequities have been worsening for Black birthing people (Centers for Disease Control and Prevention, 2024; Kyei et al., 2026), even as technology is “advancing”, we must, as technologists and designers, begin to wrestle with the roles of technology and design as a tool to maintain “the master’s house” (Costanza-Chock, 2020; Lorde, 1984). My research seeks to shift the narrative of where design research in Black maternal health care should be situated. Inspired by my own lived, shared, and observed experiences as a Black woman, I turned to the Black community as a robust, justice-oriented site of care. Within this site, I speculate everyday care practices as necessary design knowledge for the elevation of community-driven care systems and transformation within broader health systems in the US.

Research Motivation and Context

Much of the work to address Black maternal health inequities has centered on innovation within existing, dominant healthcare settings (i.e., hospitals and clinics) (Alio et al., 2022). While necessary, these approaches often remain confined within the same institutional systems that have historically produced harm. They focus on fixing outcomes without fundamentally rethinking the structures that shape them. What remains underexplored is how care itself is conceptualized, constructed, and delivered, and more importantly, who gets to design it. Design, particularly within fields such as human-computer interaction (HCI) and service design, has increasingly been positioned as a tool for addressing complex social challenges (Bødker & Kyng, 2018; Manzini, 2015; Sangiorgi, 2010). However, much of this work remains institutionally anchored, often centering hospitals, technologies, or governmental organizations as primary sites of intervention. In doing so, it risks overlooking the rich, existing systems of care that operate outside of these institutions.

Long before the medicalization of birth, Black communities cultivated their own systems of reproductive care. These systems were rooted in cultural knowledge, ancestral wisdom, relational networks, and collective responsibility. Grand midwives, elders, family members, and community healers played central roles in supporting birthing people across the perinatal journey (Gibson, 2024; Goode & Katz Rothman, 2017; Suarez, 2020). This support was ongoing, communal, and deeply rooted in everyday life. These traditions did not disappear. They were intentionally and systematically sabotaged. When birth was medicalized in the late nineteenth and early twentieth centuries, it shifted childbirth from a dynamic community system into sterile hospital systems predicated on Western, white, male-dominated medical authority (Wertz & Wertz, 1989). Black midwives were labeled as untrained or unsafe, despite generations of

successful practice, and policies were enacted to restrict or eliminate their work (Goode & Katz Rothman, 2017).

This transition not only displaced culturally-rooted care practices but also redefined what counted as legitimate knowledge. Yet, despite these disruptions, Black communities have continued to build and sustain their own care infrastructures. From mutual aid networks to community birthworkers, from informal support systems to culturally-grounded CBOs, Black maternal care persists as a site of resilience, resistance, and innovation.

This work argues that Black community-based maternal care systems are not merely supportive or supplemental; they are intentional, structured, and designed. They reflect decisions about how care should be delivered, who is responsible for providing it, and what values it should uphold. In this sense, community members, birthworkers, and CBOs are not just participants in care; they are designers of it. However, existing research across health services, participatory design, and human-computer interaction rarely recognizes community members as design knowledge producers (Costanza-Chock, 2020; Hekler et al., 2019). Even within participatory frameworks, communities are often positioned as contributors and not authors of systems and solutions themselves. This gap limits how we understand both care and design. To address this, this dissertation draws on Black feminist thought, design justice, and reproductive justice frameworks to reconceptualize community care as a site of knowledge production and design practice. It centers the lived experiences, cultural traditions, and everyday practices of Black birthing people and communities as critical to achieving Black maternal health equity.

How This Dissertation Is Situated

This dissertation sits at the intersection of Black maternal health scholarship, service design and human-computer interaction (HCI), and research on community-based organizations and community-led change. Within Black maternal health, scholars have documented persistent racial inequities in maternal morbidity and mortality, traced these outcomes to structural racism and obstetric racism, and demonstrated the importance of culturally responsive, racially concordant, and community-based models of care (Davis, 2019b; Falade et al., 2023; Gilliam et al., 2024; Karbeah et al., 2019; Navarro, 2026). Research has further highlighted the critical roles of doulas, midwives, peer support networks, and community-based perinatal support programs in reducing isolation, facilitating systems navigation, providing advocacy, and supporting emotional wellbeing during pregnancy and postpartum periods (Chaudhary et al., 2025; Collins et al., 2021; McLeish & Redshaw, 2017; Oparah et al., 2021; Rossman et al., 2015). At the same time, Black feminist, reproductive justice, and critical race feminist scholars have argued that Black women's experiences should be understood not only through narratives of disparity and harm, but also through the knowledge, care practices, resistance strategies, and community infrastructures that Black communities have long created in response to exclusion and neglect (Beck et al., 2024; Benjamin, 2022; Collins, 1986; Collins, 2000; Roberts, 2015). Yet much of the maternal health literature remains oriented toward documenting deficits, improving healthcare encounters, or addressing failures within existing systems. Comparatively less attention has been paid to the community assets, cultural practices, and care infrastructures that Black communities have already built to support maternal wellbeing.

Within service design and HCI, scholars have increasingly recognized that technologies alone are insufficient for addressing complex social problems and have called for greater

attention to services, relationships, infrastructures, and value creation within broader sociotechnical systems (Forlizzi & Zimmerman, 2013; Goldstein et al., 2002; Patrício et al., 2018; Yoo et al., 2019). Critical and emancipatory traditions in HCI have further challenged assumptions about who designs, whose knowledge counts, and how innovation is defined, arguing for greater engagement with questions of race, power, justice, and alternative futures (Barabas & Smith, 2026; Ogbonnaya-Ogburu et al., 2020; Smith et al., 2020). Nevertheless, innovation continues to be frequently imagined through institutional, technological, and expert-led interventions. As a result, community care systems and opportunities for contributing to them meaningfully through design and technology are obscured.

This dissertation bridges these conversations through a focus on Black-led maternal health organizations. Research on community-based organizations has demonstrated their capacity to cultivate trust, mobilize local knowledge, respond to community needs, and create culturally grounded forms of support that formal institutions often struggle or refuse to provide (Banks & Wilson, 2025; Collins et al., 2021; Potorti, 2017). However, relatively little design scholarship has examined how such organizations function as service designers, how they intentionally construct care infrastructures, or how service design might support and strengthen their work. Addressing this gap, this dissertation shifts attention from deficits to community assets, from institutional systems to community-driven care models, and from designing interventions for communities to learning from the systems of care communities have already designed. In doing so, it advances Black maternal community care as a site of design knowledge, sociotechnical innovation, and service design practice.

How Black Maternal Health Equity Is Used in This Dissertation

In this dissertation, I am intentional with language. The term "maternal mortality" centers death while obscuring the systems that produce it, reinforcing narratives that locate failure in individual people rather than in the structures that fail them. From a human rights standpoint, health, not death, should be the baseline expectation. Maternal mortality is a consequence of maternal health inequity, shaped by racism, discrimination, unequal access to quality care, and the criminalization of Black reproductive lives. The contributions of this dissertation are grounded in that understanding and seek to reaffirm Black birthing people's right to health.

Black Maternal Health Equity, as used here, means the assurance that Black birthing people have access to culturally affirming, community-based, and structurally supportive care that enables safe, joyful, and dignified pregnancy, birth, and postpartum experiences. Achieving health equity requires more than closing gaps in outcomes. It demands that we reimagine perinatal care as a system built with and for those most impacted and grounded in cultural identity, communal wisdom, and justice.

Personal Narratives

The Personal is Political

I remember the day clearly. It was my first day of EGPP 101: Introduction to Engineering. It was a medium-sized, lecture-style room filled with over 100 Black budding engineers at *Thee Illustrious* Howard University. I did not know much about engineering at the time, but I did know that computer science (CS) majors made the “mula”. When we finally settled down for the start of class, our professor asked us a simple, yet thought provoking question: Why do you want to be an engineer? I remember jokingly thinking, “are we not all here

for the mula?”. I sat and listened as other students, primarily Black students from Africa and the Caribbean, popped up to share their reasoning. “I want to improve this infrastructure in my home country!” “I want to rebuild communities in my country after climatic devastation!” The laughing in my head quickly stopped. Instead, it was replaced with a bout of shame. They spoke so boldly about their purpose in pursuing engineering, and it served more than just themselves. I remember leaving class during a break and just crying. I have always been a community and service-oriented person. How had I lost sight of that in my career path? Well, computer science was primarily framed for many other Black kids and me through a “promise of prosperity”. That if I could just trudge through this degree and get a job at one of the major tech companies, I would be set for life. Sounds like quite the deal for someone who was from a low-income background. I had witnessed the impact of money, or lack thereof, on my family and the surrounding community, and deeply wanted to break out of those cycles. However, in that moment, it became evidently clear to me that we were not just students being put into a machine and coming out on the other side as engineers. We could be intentional and critical as we journeyed through our engineering programs and eventually our careers. From that day forward, I wanted my CS education to mean something more than just a six-figure salary.

The Political is Personal

One day, as a peer and I were washing our hands in the bathroom of our engineering building, we noticed that the hand dryer was not working well for my peer, a dark skin Black girl. We had a conversation about her frustration in recognizing this “glitch”, as Ruha Benjamin frames it (Benjamin, 2019), as a pattern. A Black woman professor overheard this conversation, and she stopped to engage us further. She told us that this “glitch” was actually also a

documented problem with other technologies due to the lack of diversity in testing. It was through this sharing that she introduced me to Human Computer Interaction (HCI). I remember immediately being like, “Why would you not test the technology or products you are building with the people who would use them?” But my professor reminded me of something: Black people’s experiences and perspectives are seldom included in these processes, not just in testing, but across the entire technology development lifecycle. After that encounter, I went down a rabbit hole of trying to understand better the fields of HCI and user experience research (UXR). I was intrigued by this idea of meaningfully incorporating human perspectives in the design, development, and deployment of technologies. This was not something that was explicitly taught in our CS classes, but it seemed like the missing link to a more holistic engagement with CS. I quickly realized that I would want to do a Master’s Degree, or potentially a PhD, to further my understanding of and engagement with HCI.

“Why Black mothers?” Why not!

Fast forward to my junior year, I was participating in a winter study abroad program to learn machine learning (ML) and data science skills. Over the course of three weeks, I, along with other students from across the U.S., took classes to develop our ML and data science knowledge. In the final week, we participated in a hackathon where we had to apply our new knowledge to address a prevalent social issue. When researching various social issues with my group, I came across the maternal mortality crisis in America via Serena Williams' birth story. It was heartbreaking to hear what she experienced, but even more jarring to consider what everyday Black women were facing if even someone of Serena’s status could almost die during childbirth. I made a compelling argument to my group as to why we should choose this crisis as

our focus. They agreed, and we began brainstorming how ML could intersect with Black maternal health.

We created the Motherboard, an app designed to allow Black and brown mothers the unique opportunity to document any pregnancy symptoms they may be experiencing, similar to menstrual cycle tracking applications. Based on these symptoms, mothers would receive predictions of possible complications they could be experiencing or are susceptible to, accompanied by an information guide for each complication. These guides would explain the given complication in detail and possible treatment options that can be discussed with their OBGYN. The MotherBoard also included features such as Baby Stats, Things to Ask Your Doctor, and Community Resources.

When presenting our prototype and presentation to a program helper, a white man, he responded with an unsettling question: Why are you only focused on Black mothers, why not white mothers too? I erupted in anger internally, but could not fully articulate why that was such an arduous question to ask. I ended up leaving the group conversation to call my mama. After she calmed me down, I knew that this was what I would be doing for my PhD. I wanted to find the language to really articulate “why Black mothers” and take action to affirm it. Though I did not know much about the field of Black maternal health then, I knew how deeply my life and being were shaped by the Black m/others (Gumbs, 2016) in my life. I wanted my research to be a vehicle to support not only the mothers I knew, but Black mothers across the country, and eventually around the world.

Dissertation Overview

This dissertation, *Mamafesto*, is a call to remember and reclaim the care that has always lived in our communities. It explores how Black birthing people and communities define, experience, and enact care on their own terms through storytelling, community relationships, and culturally rooted practices. I conduct this work through three interconnected investigations:

- ★ Chapter 3: *What's the CommuniTEA?* documents how Black birthing people in the Pacific Northwest experience community care during pregnancy, birth, and postpartum. Through interviews with Black mothers, this study introduces the TRIBE framework, Tangible, Relational, Informational, Birthworker, and Emotional support, as a way to understand and articulate the collective, interpersonal infrastructures of care that sustain Black maternal health beyond clinical settings.
- ★ Chapter 4: *Community (En)counter* examines how Black-led community-based organizations (CBOs), or maternal health organizations, design and deliver maternal health services. Through a directed content analysis of their impact reports and websites, this project investigates how these organizations operationalize care in ways that reflect TRIBE and other values. This work positions Black birthworkers and CBOs as designers of care systems, arguing that their practices constitute critical forms of service design knowledge with broader implications for health systems, design justice, and community-driven service design.
- ★ Chapter 5: *Making a Way Outta No Way* is a multimodal reflection on the experience of designing and hosting Cradles & Culture: A community baby shower, offered to my research participants and broader Black community in the Seattle-Tacoma area.

The reflection contributes knowledge around the development of my critical design practice and how our position as researchers and designers should be used to innovate more creative-critical outcomes of research inquiry.

Together, these studies offer a framework for designing maternal health interventions that are culturally resonant, impactful, and accountable to Black birthing people and communities. They connect community and culture to systems change, affirming that everyday acts of care are acts of resistance. Mamafesto is a call to action to remember that care has always lived in our communities; in our auntie's extra plate, our mama's stories, our sister-friends' clothes, and our grandmothers' prayers. I am not here to innovate care. I am here to remember it, redesign it with community, and re-root it in culture.

Dissertation Thesis Statement

This dissertation argues that Black maternal care systems, rooted in lived experience, cultural knowledge, and community practice, constitute forms of design that challenge dominant, institution-centered models of healthcare. Through qualitative inquiry, content analysis, and reflexivity, this work demonstrates how Black communities not only experience care but actively design and sustain it, offering critical insights for reimagining maternal health systems through community-driven and justice-oriented approaches.

Dissertation Research Questions

RQ1: How do Black birthing people in the Seattle-Tacoma area navigate and leverage community-based care during pregnancy, birth, and postpartum?

RQ1.1: What roles do these networks play in shaping their perinatal experiences?

RQ2: What role does identity play in how participants define community, seek support, and experience joy in motherhood?

RQ3: How do Black/BIPOC-led CBOs, providing direct services and programming for Black birthing people and families, operationalize the TRIBE Care dimensions?

RQ3.1: How might this knowledge be relevant to service design?

RQ4: How can multimodal practices of reflection support marginalized researchers in engaging their lived experiences as sites of design knowledge?

Summary of Contributions

This dissertation contributes to Black maternal health scholarship, service design, and human-computer interaction by centering Black community care as a site of design knowledge and innovation. Through empirical, conceptual, and practice-based inquiry, it advances four primary contributions.

The TRIBE Framework

The first contribution is the TRIBE framework, a conceptual framework that identifies five dimensions of community care: Tangible, Relational, Informational, Birthworker, and Emotional support. Developed through semi-structured interviews with Black mothers in the Seattle-Tacoma area, TRIBE makes visible the care infrastructures Black communities have long cultivated in response to systemic exclusion and inequity. The framework provides both an analytical lens for understanding community care and a design orientation for creating services that support Black maternal health. As demonstrated in Chapter 4, TRIBE functions not only as a

descriptive framework but also as an organizing logic through which Black-led maternal health organizations structure and deliver care.

Community-Driven Service Design and the Mamafesto Service Concept

The second contribution advances a model of community-driven service design that positions Black-led community-based organizations as sources of design expertise rather than supplemental actors within dominant healthcare systems. Through a directed content analysis of fourteen Black-led maternal health organizations, this dissertation demonstrates how community values such as cultural relevance, collective responsibility, access, reproductive justice, respect and dignity, and education and empowerment (CARE) are translated into robust service infrastructures. These findings challenge institution-centered approaches to innovation by showing how communities design and sustain care ecosystems that respond directly to their own needs and priorities.

Building on the TRIBE framework and findings from the analysis of Black-led maternal health organizations, this dissertation also introduces Mamafesto, a community-inspired service concept that mediates between organizational intentions and the holistic needs of Black birthing people. Mamafesto serves as both a generative and evaluative service design tool grounded in Black community care values, experiences, and practices. It is rooted in community knowledge and offers a foundation for future development through direct collaboration with Black CBOs and the Black birthing people and communities they serve.

Community Contribution as a Research Outcome

The third contribution is methodological and practical. Through the design and implementation of Cradles & Culture, a community baby shower created for research participants and the broader Black community in the Seattle-Tacoma area, this dissertation argues that community contributions are a legitimate outcome of research. This approach positions reciprocal community engagement as a core outcome of research as opposed to a secondary activity that follows knowledge production. Cradles & Culture demonstrates how researchers can mobilize institutional resources, lived experience, and research findings in service of community needs. It offers a model for conducting accountable research that extends beyond participant compensation and toward meaningful forms of giving back.

Marginal Sensibilities and W/reckoning as Design Epistemology

The fourth contribution is theoretical and emerges through critical reflection on the research process itself. This dissertation introduces marginal sensibilities as a form of design knowledge produced through experiences in the margins of dominant systems. Marginal sensibilities encompass ways of seeing, interpreting, and responding to the world that are shaped by lived experiences of exclusion, resistance, and survival. This work positions marginalized perspectives and experiences as a source of critical insight into the social, cultural, and structural conditions that shape design and research.

Relatedly, this dissertation advances w/reckoning as a framework for understanding how marginalized researchers engage their own histories, identities, and experiences in the production of knowledge. W/reckoning describes a process of moving through anger, grief, inquiry, critique, resistance, memory, and imagination in ways that support more reflexive, expansive, and

accountable forms of research practice and outcomes. Together, marginal sensibilities and w/reckoning contribute new conceptual tools for community-accountable inquiry within design and HCI.

Taken together, these contributions position Black community care as a legitimate and generative source of design knowledge. They challenge institution-centered approaches to maternal health intervention, expand understandings of who produces design expertise, and advance a community-driven and justice-oriented approach to both health system design and research practice.

Chapter 2 - Literature Review

History and Evolution of Reproductive Violence in the U.S. Towards Black Women

The reproductive experiences of Black women and birthing people in the United States have been shaped by a long-standing legacy of harm that begins with slavery and persists through modern-day medical systems. Enslaved Black women endured brutal forms of reproductive violence such as forced breeding, sexual assault, and intentional separation from their children (Roberts, 1997; Washington, 2006). Scholars such as Dorothy Roberts and Deirdre Cooper Owens have also documented how Black women's bodies became sites of both production and medical experimentation (Owens, 2017; Roberts, 1997), laying the foundation for contemporary obstetric and gynecological practices. As medicine became increasingly institutionalized in the late 19th and early 20th centuries (Davis-Floyd, 1992), the medical model of childbirth gained dominance, displacing traditional, community-centered practices. Birth, once managed within Black families and communities by grand midwives and elder women, was increasingly moved into white, male-dominated hospital settings. This shift reinforced hierarchies of knowledge, devaluing cultural traditions and centering whiteness as the standard of care (Suarez, 2020; Wertz & Wertz, 1989).

Contemporary forms of reproductive harm have evolved, but remain deeply entangled with state surveillance (Roberts, 1997), institutional neglect (Briggs, 2017), and systemic racism (Davis, 2019). Roberts and Bridges have highlighted how racialized scrutiny of Black motherhood results in heightened policing, state-sanctioned trauma, and forced interventions (Bridges, 2011; Roberts, 1997). Various iterations of welfare reform have also functioned as modern-day tools of reproductive regulation, including Temporary Assistance for Needy

Families (TANF) family cap provisions that deny additional benefits to mothers who have children while receiving assistance, and behavioral requirements that subject poor Black women's reproductive decisions to state surveillance and control (Mink, 2001; Roberts, 1997). Reproductive control and coercion also persist through disproportionate use of long-acting reversible contraceptives (LARCs) and sterilization practices targeted at Black, immigrant, and low-income communities (Gomez et al, 2014; Stern, 2005).

These legacies manifest in today's statistics. Black women in the U.S. are three to four times more likely to die from pregnancy-related causes than white women, regardless of income or education (Hardeman et al., 2022; Petersen et al., 2019). Recent reports from the CDC emphasize that over 80% of these deaths are preventable (Centers for Disease Control and Prevention, 2024). Alarming, Black infants also die at twice the rate of white infants, underscoring the ways racism continues to shape both birthing outcomes and intergenerational health (Ely et al., 2023). Despite growing national awareness, these patterns persist, underscoring not only a crisis of care but a failure of accountability, cultural responsiveness, and historical reckoning.

Community Care as Resistance

Despite experiencing systemic neglect and state violence, Black communities have long developed their own reproductive strategies rooted in care and resistance (Roberts, 1997; Ross & Solinger, 2017). While dominant narratives often frame Black maternal health outcomes as a problem to be solved by institutions, a closer look reveals a lineage of individual and collective resistance that affirms Black reproductive autonomy and cultural knowledge. At the level of individual resistance, Black women historically enacted control over their reproductive lives

through subversive practices like the use of herbal abortifacients, contraception methods passed through oral tradition, and even mercy killings under the most violent conditions of slavery (Ross, 1992; White, 1999). These acts, while painful, represented efforts to reclaim agency in the face of dehumanizing systems. Black women's knowledge of healing and reproductive care was not only medicinal; it was political, a form of rebellion against both enslavement and imposed maternity (Roberts, 1997). Collectively, Black communities have cultivated interdependent systems of reproductive care rooted in ancestral knowledge and mutual aid. This care was embodied through grand midwives, elders, and other family and community members. Before midwives and doulas were "formally" defined in the U.S., these community members served as a model for what care should look like. Midwives not only delivered babies but also served as healers, counselors, and cultural stewards, supporting families across generations (Smith & Holmes, 1996; Stewart, 2021). Their practices reflected deep understandings of body, spirit, land, and community; forms of expertise systematically erased by the rise of medicalization and persistence of white supremacy.

As time progressed, the roles of midwife and doula, as Black women practiced, were vilified and eventually professionalized (Suarez, 2020). White medical institutions labeled Black grand midwives as "dirty," "untrained," and "dangerous" (Muigai, 2019), despite their proven effectiveness in safely supporting births for generations. Beyond verbal degradation, policies were also put in place to systematically sever Black grand midwives from their practices and communities from their care. Public health initiatives like the Sheppard-Towner Act, passed in 1921, provided funding for maternal and infant care, but also imposed regulations that effectively outlawed traditional midwifery practices unless practitioners held licenses that many Black midwives could not afford or access (Muigai, 2019; Wertz & Wertz, 1989). This delegitimization

was a tactic of control, displacing culturally grounded community care and imposing impersonal, medicalized systems. Still, these practices prevail, adapted and reimagined by new generations of Black birthworkers and community members who continue to operate from a place of collective responsibility, cultural sovereignty, and higher purpose (Oparah et al., 2021).

Despite evidence that doula and midwifery care improve outcomes, especially for Black birthing people, these models remain underutilized and underfunded in mainstream health systems (Kang et al., 2024). Research consistently shows that such care leads to lower rates of C-sections, shorter labors, increased satisfaction, and improved postpartum outcomes (Bohren et al., 2017; Sobczak et al., 2023). Yet, structural barriers like cost, geographic access (Comstock et al., 2025), low awareness (Kang et al., 2024), and institutional resistance towards doulas of color (Kathawa et al., 2022) limit widespread adoption. Additionally, policies shaped by insurance models systematically marginalize non-clinical forms of support, such as doulas, thereby limiting access to holistic, culturally relevant care (Mallick et al., 2022).

Doula and midwifery programs that are community-based and culturally specific often garner support through grassroots organizing, mutual aid, and passion-driven labor. However, this reliance on birthworkers of color to mitigate structural racism carries significant consequences. In a qualitative study of 24 birthworkers of color, Nelson et al. (2026) introduce the concept of *racialized burnout* to describe the compounded emotional labor, racial trauma exposure, and uncompensated justice-oriented work these providers endure. More than half of the participants reported burnout, particularly those serving Black communities and working in states without reimbursement mechanisms. Importantly, racialized burnout is not only a by-product of inequitable working conditions but also a producer of inequity, as it increases turnover among the very providers relied upon to address maternal health disparities. Thus,

efforts to expand doula access without addressing the structural conditions shaping birthworkers' labor risk reproduce the very inequities they aim to dismantle.

From neighborhood aunties offering postpartum meals to Black-led birth collectives training the next generation of doulas, Black communities continue to reclaim and reimagine care on their own terms. These practices challenge dominant paradigms of expertise, offering not just better health outcomes, but a more expansive vision of what maternal care can be. While community care has always been central to Black maternal health, traditional research and intervention models often fail to capture its depth, fluidity, and cultural specificity. This gap calls for new frameworks, ones that not only document injustice but also support communities in imagining and building the care systems they deserve. Here, design and participatory research emerge as powerful tools for rethinking how maternal health interventions are created, who gets to shape them, and what values they center.

Theories Informing a Critical Design Practice

Black Feminist Thought

Black feminist thought offers the central epistemological grounding for this dissertation. It positions the lived experiences, knowledge systems, and survival strategies of Black women as not only valid but vital to understanding and transforming systems of care. Patricia Hill Collins, Audre Lorde, and Kimberlé Crenshaw, whose work I will further expand on and engage with throughout my dissertation, have emphasized that theory is not confined to formal academic spaces but is produced through everyday life, particularly in conditions shaped by intersecting forms of oppression (Collins, 2022; Crenshaw, 1991; Lorde, 1984). This framework allows for a critical engagement with Black maternal health that moves beyond hospitals to communities to

interrogate how power, culture, and resistance are embedded in care practices. Rather than treating Black maternal health disparities as isolated clinical failures, Black feminist thought situates them within broader historical and structural logics such as racial capitalism, reproductive control, and the devaluation of Black life, while simultaneously illuminating the generative practices Black communities have cultivated in response.

Crenshaw's theory of intersectionality illuminates how systems of racism, sexism, and classism interlock to produce unique forms of vulnerability for Black birthing people (Crenshaw, 1991). Intersectionality is not only an analytic of identity, but it is also a structural lens that reveals how institutional policies, medical risk frameworks, insurance systems, and even design decisions disproportionately burden Black mothers and birthing people. In the context of maternal health, intersectionality exposes how Black women and birthing people are rendered hyper-visible as "high risk" within biomedical systems, yet invisible when articulating pain, intuition, or refusal. This analytic guides my inquiry into how community-based care practices operate not as supplementary services, but as structural countermeasures to intersecting harm.

Alexis Pauline Gumbs highlights such countermeasures by framing m/othering, memory, and survival as interconnected practices of liberation (Gumbs, 2016). Gumbs conceptualizes m/othering not solely as biological motherhood, but as a radical ethic of intergenerational responsibility and collective care. Through this lens, Black maternal health work becomes part of a longer continuum of survival practices. This framing deeply informs my understanding of community doulas, birthworkers, and organizers not simply as service providers, but as m/others engaged in world-building. Their work is both practical and prophetic, tending to immediate community needs while innovating alternative futures.

Collins' notion of the outsider-within resonates with my own position as a Black woman studying Black maternal health inside academia (Collins, 1986). The outsider-within occupies institutional spaces while maintaining critical distance from them, able to perceive contradictions that insiders may normalize. This dual position shapes how I approach community partnerships, interpret data, and remain accountable to the people and practices I study. It also requires continual reflexivity; recognizing the privileges and constraints of academic legitimacy while remaining accountable to Black birthing people and communities whose knowledge precedes and exceeds institutional validation.

Lorde's work underscores the significance of emotion, intuition, and embodiment in knowledge production, while also warning against the co-optation of tools that were never meant to serve us (Lorde, 1984). She cautions that "the master's tools will never dismantle the master's house," challenging scholars to question whether existing institutional frameworks can meaningfully address Black maternal health inequities. For Lorde, the erotic, understood as deep feeling and embodied knowing, is a source of power, not a distraction from rigor. In a field that privileges quantitative metrics and clinical objectivity, her insistence that anger, grief, and joy are sites of insight becomes methodologically significant. This framing helps connect embodied experiences to understanding and animates my commitment to community-informed, culturally grounded design practices that do not only retrofit inequitable systems, but create new ones.

Collectively, Black feminist thought helps me understand the particularly complex context that Black women and birthing people exist in and imagine otherwise, and my role in supporting them through design.

Justice Oriented Frameworks

This dissertation is further informed by a set of overlapping justice frameworks that extend the commitments of Black feminist thought into specific domains of practice: reproductive justice, design justice, and viral justice. Each of these frameworks offers a lens for analyzing and reshaping the systems and structures that impact Black maternal health. Together, they articulate an approach that is not only critical of existing harm but also invested in building new infrastructures of care. I deepen engagement with these frameworks in the discussion chapter.

Reproductive Justice

Reproductive justice positions maternal health as a human rights concern, emphasizing how structural conditions shape reproductive experiences, opportunities, and outcomes. Developed by Black women activists and scholars, this framework affirms the right to have children, the right not to have children, and the right to parent in safe and supportive environments (Ross & Solinger, 2017). Importantly, these rights are inseparable from the material conditions that make them possible, including housing, healthcare, environmental safety, freedom from state violence, and economic stability.

For Black communities, reproductive injustice has been historically produced through enslavement, forced sterilization, welfare surveillance, criminalization of pregnancy, and contemporary maternal neglect. Reproductive justice, therefore, refuses to isolate pregnancy outcomes from histories of reproductive control. Dána-Ain Davis (2019a) extends this analysis through the concept of *obstetric racism*, identifying the ways racial bias, diagnostic neglect, and institutionalized disregard function not as interpersonal anomalies, but as structural features of

maternal healthcare systems. This perspective challenges the idea that health disparities can be solved through clinical interventions alone and instead calls for changes to the political, social, and economic systems that limit reproductive autonomy.

This framework shifts the analytic terrain of this dissertation. It directs attention to the political, economic, and social structures that constrain Black maternal autonomy and asks what it would mean to design care systems that expand, rather than regulate, reproductive freedom. In this way, reproductive justice anchors this work in a rights-based and systematically grounded understanding of Black maternal health.

Viral Justice

Viral justice, introduced by Ruha Benjamin, offers a theory of change grounded in everyday acts of resistance and care. It draws attention to the cumulative power of grassroots practices and micro-level interventions in reshaping institutions, relationships, and possibilities for collective wellbeing (Benjamin, 2022). Viral justice is the idea that seemingly small, individual and interpersonal (micro) acts can have contagious, cascading effects that shape communities (meso) and broader societies (macro).

In the context of Black maternal health, this framework draws attention to practices such as community birth support, peer education, and culturally affirming rituals as legitimate and impactful forms of health intervention. Benjamin writes that we can “[draw] on the example of community-based health workers as a template for birthing a fundamentally different approach to healing. And we don’t have to start from scratch. Each of us can follow the example of doulas, caring for and accompanying people in our families, schools, workplaces, and neighborhoods as we confront a hostile climate together” (Benjamin, 2022, p. 203).

As micro-acts toward reproductive justice accumulate, meso-level organizing begins to form. Benjamin describes viral justice as a “practical and principled approach to spreading solidarity and justice,” drawing on historical and ongoing examples of mutual aid, community organizing, and collective healing (Benjamin, 2022, p. 18). One example that inspires my work is the Black Panther Party’s (BPP) People’s Free Medical Clinics, which partnered with community and trusted expert volunteers to provide preventative care, diagnostic testing, and referrals. Alongside broader civil rights health organizing, the clinics contributed to expanding community-based care infrastructure while also bringing attention to the structures and systems that necessitate such care. Bassett (2016) acknowledges that “in just a few years, the Party rapidly extended its initial commitment to armed self-defense against police violence to mobilization against a more ambitiously framed concept of violence. In this broader view, lack of adequate housing, education, and jobs were also forms of violence...Protection came in the form of programs, not guns.”

Through their example, viral justice frames care not only as a moral imperative but also as a political strategy. It helps position the interventions in this dissertation, whether tools like the TRIBE Framework or gatherings like Cradles & Culture, as more than isolated efforts. They are part of a broader cultural shift that begins with care, grows through community, and influences systemic transformation.

Design justice

Design justice builds on these insights by confronting the assumption that design is neutral, objective, or universally applicable. Sasha Costanza-Chock (2020) argues that design processes and outcomes are always shaped by power, and that those most impacted by structural

harm must be centered in the design of systems that affect their lives. Design justice, therefore, calls for redistribution, not just participation.

Within healthcare and human-computer interaction, design interventions often replicate inequity by privileging institutional efficiency over community knowledge. Equity-centered scholars such as Christina Harrington and colleagues (2019) emphasize culturally grounded methodologies that recognize lived experience as expertise and position communities as co-creators rather than end users. Similarly, organizations like Creative Reaction Lab (n.d.) advance community-led design processes that shift decision-making authority and resource control.

In this dissertation, design justice informs both my inquiry and outcome. My inquiry centered on Black community members as knowledge holders and designers of maternal health systems themselves. Substantively, it pushes beyond designing “better tools” for inequitable systems and toward designing new infrastructures altogether. Design justice demands that interventions address not only usability, but historical harm, cultural resonance, and power asymmetry.

The justice frameworks above establish the ethical and political commitments grounding this dissertation. What follows are five design and methodological frameworks that operationalize those commitments at the level of practice. Most, like value sensitive design, culturally relevant design, asset-based design, and service design, speak primarily to how design processes and outcomes can be structured to center community knowledge and values. On the other hand, community-based participatory research speaks to how knowledge itself is produced and with whom. Together, these frameworks interrogate how care systems are built, whose

values they encode, and how community knowledge can serve as a foundation for design, forming a scaffolding for the methodological and design contributions of this dissertation.

Relevant Frameworks for Design

Value Sensitive Design

Value Sensitive Design (VSD) provides a structured framework for identifying and integrating human values into sociotechnical systems. VSD argues that design decisions actively encode and reproduce values within technologies, services, and sociotechnical systems (Friedman, 1996). Through conceptual, empirical, and technical investigations, VSD encourages systematic inquiry into which values are prioritized, how they are operationalized, and whose interests they serve (Friedman et al., 2006). Importantly, later critiques of VSD caution against universalizing value claims and instead advocate for pluralistic, context-sensitive approaches that recognize cultural specificity (Borning & Muller, 2012). This shift toward pluralism is particularly salient in maternal health contexts, where dominant systems often encode values such as efficiency, standardization, liability management, and risk mitigation; values that may not align with the lived priorities of Black mothers, birthing people, and communities.

Culturally Relevant Design

Culturally relevant design has emerged as a critical approach for addressing health inequities, particularly within communities historically marginalized by mainstream health systems. Within this approach, culture and identity are understood as active, dynamic forces that influence how care is experienced, interpreted, and enacted (Keller et al., 2014). In design

contexts, this requires intentional engagement with community histories, values, relational practices, and everyday forms of meaning-making. Design justice scholars caution that without this grounding, even well-intentioned interventions risk reinforcing dominant norms and reproducing the harms they aim to disrupt (Costanza-Chock, 2020). Thus, culturally relevant design is not solely about representation or aesthetic inclusion; it is a structural and epistemological commitment to designing with communities whose knowledge systems have long been devalued or erased.

Within Black maternal health, culturally relevant design has functioned as both corrective and generative. Interventions rooted in cultural resonance, such as culturally centered birthing spaces (Hardeman et al., 2020), community-based doula models (Falade et al., 2023), and maternal storytelling practices (Johnson et al., 2020), demonstrate that when identity, history, and relational care are centered, outcomes extend beyond clinical metrics to include trust, dignity, and joy. Contemporary digital and service-based initiatives further illustrate this orientation. Platforms such as Health in Her HUE (n.d.) connect Black women to culturally aligned providers and resources. The Irth app (n.d.) enables Black and brown birthing people to review maternity care providers through a culturally specific lens. Community-rooted organizations such as BLKBRY (n.d.) and Mamatoto Village (n.d.) embed culturally grounded support within relational care networks. Across these examples, culture is instrumental to the design of technology and services alike.

Culturally relevant design, therefore, challenges dominant maternal health technologies and services to reconsider what counts as legitimate knowledge and whose definitions of care matter. It expands the focus from risk reduction alone to relational wellbeing, emotional affirmation, collective responsibility, and intergenerational continuity. In this dissertation,

culturally relevant design serves as a theoretical bridge between value inquiry and community practice. It frames community care not as an informal supplement to clinical systems, but as a foundation for rethinking maternal health infrastructures altogether.

Community-Based Participatory Research

Community-Based Participatory Research (CBPR) offers a compelling counter-model to extractive forms of academic inquiry. Rooted in Global South epistemologies and traditions of popular education and resistance, CBPR emerged in response to development challenges that disproportionately impacted marginalized communities under globalization (Racadio et al., 2014). It centers the expertise of community members, engaging them as co-researchers throughout the entire research process. This approach has been especially critical in health equity work (Cacari-Stone et al., 2014; Duran et al., 2019), where communities have long been studied without benefit, acknowledgment, or autonomy. In Black maternal health, CBPR enables research that is accountable to lived experience, culturally rooted, and oriented toward action. It affirms that those most impacted by health inequities are also best positioned to envision solutions. In design contexts, CBPR enables the creation of technologies and services that are more contextually relevant, emotionally resonant, and culturally responsive (Wallerstein et al., 2019). It prioritizes relationships, trust-building, and long-term collaboration, often with the explicit goal of community ownership over the final product or intervention. Scholars have also emphasized that CBPR is not just a methodology; it is a political stance against erasure and toward liberation (Cacari-Stone et al., 2014; Minkler et al., 2003).

Yet like all methodologies, CBPR carries limitations and tensions. Participatory ideals do not always translate into practice, especially in marginalized communities where historic trauma,

resource disparities, or institutional mistrust complicate engagement. Harrington et al. (2019) note that while participatory design aspires to democratize processes, structural and social realities often curtail genuine co-creation. In the context of Black maternal health, where storytelling may involve recalling trauma, such as obstetric violence, pregnancy loss, or systemic neglect, CBPR must be approached with sensitivity and care. These tensions do not discredit CBPR, but rather point to the need for participatory approaches that are reflexive, trauma-aware, and culturally grounded.

While CBPR represents the aspirational methodological orientation of this dissertation, the realities of doctoral research introduced constraints that shaped what was ultimately possible. Building the trust, relationships, and sustained engagement that genuine co-design requires takes time that often exceeds academic timelines. Alongside considerations of access, institutional approval, and the epistemic burden of asking community members to engage in research projects, these constraints led to a methodological pivot for this dissertation's second project. This project, instead, draws on a content analysis of publicly available impact reports and websites from Black-led CBOs providing direct services for Black mothers, birthing people, and families. This choice is intentional. It surfaces and honors the service design work these organizations have already been doing, work that often goes unnamed and undertheorized in academic literature. The field of design has a troubling tendency to leap toward creating something new without recognizing what communities have already built. As such, this dissertation prioritizes understanding existing community care infrastructures before imagining how design might contribute to them. Future research should build from these findings to pursue the direct, sustained community partnerships that CBPR calls for, co-designing with and

alongside Black CBOs serving Black mothers and birthing people and their communities more broadly.

Asset-Based Design

Parallel to participatory inquiry, asset-based design shifts the analytic lens from deficit to strength (Wong-Villacres et al., 2020). Derived from asset-based community development (ABCD), this approach centers the skills, relationships, institutions, and local knowledge already present within communities. Many scholars argue that a needs-finding approach to design “promotes dependency and robs agency from change-makers, thereby hindering sustained change” (Wong-Villacres et al., 2020, p. 529). Rather than framing communities through need or lack, asset-based approaches mobilize stories of success, map existing assets, and build cooperative relationships among them (Cho et al., 2019; Mathie & Cunningham, 2003; Xu & Maitland, 2017). In doing so, they resist dependency narratives and affirm community agency.

Within Black maternal health, this shift is particularly important. Much scholarship and policy discourse emphasize disparity and vulnerability, often obscuring the robust infrastructures of care that Black communities have built in response to institutional harm (Mollard & Cottrell, 2023; Nnodim Opara & Elmi, 2025). Asset-based approaches invite researchers and designers to ask not only what is missing, but what is already working. At the same time, asset-based methods must remain attentive to internal power differentials and broader structural conditions. Local strengths exist within political and economic systems that may constrain or exploit them. Thus, asset-based design must be paired with critical analysis of power.

Service Design

Service design provides tools for orchestrating experiences across stakeholders, touchpoints, and time (Lee et al., 2022). As it has expanded from business contexts into healthcare and public systems (Forlizzi & Zimmerman, 2013; Tan et al., 2023), it has increasingly been recognized as shaping not only functional outcomes, but relational and emotional ones (Forlizzi, 2018). In maternal health, where trust, dignity, and safety are paramount, service design offers a means of humanizing care and connecting fragmented systems.

However, much of the service design literature remains institutionally anchored. Frameworks often presume hospitals, insurance systems, or governmental agencies as primary sites of intervention; entities that have historically overlooked or harmed Black birthing people and communities. In community contexts, service design must do more than improve efficiency. It must confront harm, affirm cultural power, and enable care through sustained infrastructure.

Building from value-sensitive design, culturally-relevant design, asset-based design, and service design, this dissertation advances community-driven service design (CDSD) as an approach that situates CBOs as generative design partners and epistemological anchors. CDSD recognizes CBOs not as service gaps fillers, but as robust sites of innovation where care circulates and is sustained. In this framing, design becomes a mechanism for visualizing, strengthening, and extending existing infrastructures of community care.

Conclusion

In this dissertation, I build on these design foundations by shifting my focus from examining bias embedded in digital health systems to a generative exploration of the values that constitute community care and how those values translate to design considerations for broader health systems design. This work begins with the recognition that Black communities and organizations have already developed care systems that enact justice and sustain wellbeing. Correspondingly, my intended contribution moves from proposing a technical solution in a clinical context to advancing a community-driven service design approach, one that learns from and builds on existing community infrastructures.

Taken together, the frameworks and histories assembled in this literature review point toward a clear imperative: understanding Black maternal health requires moving beyond clinical and institutional framings to center the epistemological and methodological contributions of Black communities themselves. From the legacies of reproductive violence to the enduring practices of community care, from Black feminist thought to community-driven service design, this body of work insists that care is never merely technical. It is political, relational, and cultural. Together, these frameworks invite a deeper inquiry: if design is always value-laden, and if values are culturally situated, then how might maternal health systems be reimaged when community-held care values are centered rather than marginalized? This question moves beyond critiquing institutional harm and toward examining the infrastructures of care that already exist outside formal clinical systems, and what it might look like to design in ways that sustain and extend them.

Chapter 3- What's the CommuniTEA?: The Role of Community Care in Black Maternal Health

Chapter 2 left us with a provocative question: How might maternal health systems be reimagined when community care values are centered rather than marginalized? This question looks to move beyond critiquing institutional harm and toward examining the infrastructures of care that already exist outside formal clinical systems. This chapter takes up that question directly. Where Chapter 2 assembled the macro-level frameworks and histories that make Black maternal health inequities legible as political, relational, and cultural problems, this chapter descends into the micro: the interpersonal, everyday, and interdependent acts of care that support Black birthing people at the level of individual relationships, informal networks, and personal practice.

Through semi-structured interviews with 12 Black mothers in the Seattle-Tacoma area, I surfaced how community care manifests across pregnancy, birth, and postpartum. From this analysis, the TRIBE framework emerged. The framework is a conceptual model capturing five dimensions of community care: Tangible, Relational, Informational, Birthworker, and Emotional support. I also use the term "CommuniTEA" as a play on the cultural idiom "spilling the tea", which, among other interpretations, refers to sharing information within trusted circles. The term invokes the idea of Black communities transmitting care knowledge informally, but powerfully. Together, TRIBE and CommuniTEA offer not just a framework for understanding community support, but a design ethic rooted in the everyday. It is a call to recognize that the most foundational acts of maternal care have always lived at the level of people showing up for one another.

Historical and Contemporary Context

Black birthing people have long depended on community care, with midwives and family playing essential roles throughout the perinatal period (Suarez, 2020). Grounded in cultural, spiritual, and ancestral wisdom, these practices sustained Black families for generations. The conditions of chattel slavery in the United States necessitated the implicit and explicit adaptation and development of community care systems within Black communities, systems that ensured survival in the face of everyday and systematic oppression (Jones, 1985; Ross & Solinger, 2017). Organized around a set of often unspoken but deeply held values, including reciprocity, flexibility, and collective responsibility, these care practices were not incidental to Black life but shape how the Black community relates to and cares for each other.

As healthcare became increasingly medicalized, these community-based practices were displaced, discredited, or absorbed into professional frameworks that excluded the communities they had long served (Goode & Katz Rothman, 2017; Suárez-Baquero et al., 2024). Much of the subsequent scholarship and policy discourse on Black maternal health compounded this erasure by centering disparity and vulnerability, while remaining largely inattentive to the (counter)systems Black communities, and especially Black women, have continued to sustain in its absence. A growing body of evidence demonstrates that culturally congruent and racially concordant birthworkers improve care experiences and maternal health outcomes for Black birthing people across the perinatal period (Alspaugh et al., 2023; Falade et al., 2022; Kathawa et al., 2022). What remains undertheorized is the value system that makes such care possible and the mechanisms through which they are enacted in community-based organizational practice.

Engaging these community care practices as a serious site of inquiry requires a particular set of theoretical commitments. Value Sensitive Design holds that values are not abstract ethical

concerns, but are embedded in and shaped through design decisions (Friedman, 1996), such that every system encodes a set of priorities about whose needs matter and how care should be delivered. Asset-based design shifts the analytic lens from deficit to strength, insisting that communities are not best understood through what they lack, but through what they have already built, the skills, relationships, institutions, and local knowledge that constitute robust and often underrecognized infrastructures of care (Wong-Villacres et al., 2020). Culturally relevant design extends this orientation further, understanding culture as the cradle that holds care. Cultural understanding and resonance is the foundation from which care should be designed, a dynamic source of knowledge and healing that dominant systems have constantly deemed illegible (Costanza-Chock, 2020; Keller et al., 2014). Together, these frameworks orient this chapter toward interpersonal care practices for Black birthing people not as informal supplements to clinical systems, but as value-laden design knowledge.

Geographic Context

Seattle-Tacoma offers a meaningful setting for exploring these dynamics. Despite its progressive reputation, stark racial disparities in maternal health persist. Black residents make up 7.4% of King County and 8.2% of Pierce County (United States Census Bureau, 2021), yet continue to face disproportionate maternal health challenges, compounded by gentrification and the erosion of historically Black neighborhoods, community institutions, and support systems (Dekker, 2019; Riley et al., 2024). This study examines how Black birthing people navigate and leverage community care within this complex socio-geographic landscape.

Gaps in the Literature

Although the importance of community-based, culturally relevant care is well documented (Gjerdingen et al., 1991), less is known about the specific roles and mechanisms by which it supports Black birthing people specifically across the full perinatal spectrum. Much of the literature centers on hospital-based interventions (Montalmant & Ettinger, 2021), overlooking how expansive community networks function as ecosystems of care.

I find these community care practices to be a particularly undervalued yet powerful site of design knowledge. These community networks operate through a particular type of *algorhythm*, one that has been passed down through the experiencing and witnessing of community care across generations. This rhythm is value-laden and culturally situated. Yet it remains largely illegible to the institutions and designers tasked with building maternal health systems, precisely because it does not travel through the channels those systems recognize as authoritative. Understanding this rhythm and the values that undergird these practices could provide new knowledge around the design of maternal health systems, not by importing community care into clinical logic, but by centering community care logic as the design foundation itself.

Research Questions

This study seeks to understand the multifaceted roles of community care during pregnancy, birth, and postpartum for Black birthing people in the Seattle-Tacoma area, exploring

how various forms of support contribute to positive perinatal experiences. Specifically, this chapter asks:

RQ1: How do Black birthing people in the Seattle-Tacoma area navigate and leverage community care during pregnancy, birth, and postpartum?

RQ1.1: What roles does this care play in shaping their perinatal experiences?

RQ2: What role does identity play in how participants define community, seek support, and experience joy in motherhood?

Methods

Study Design & Participants

In collaboration with Jazmin, the founder of BLKBRY and community partner, I conducted semi-structured interviews via Zoom with 12 Black women (N=12) between May and June 2024. Jazmin was included in the interviews to guide the development of the interview guide with respect to her perceived community values and to provide local community presence. Eligibility criteria for participants included: (1) identifying as Black or African American, (2) having experienced pregnancy within the past five years, including those that did not end in a live birth, and (3) being located in Washington State for at least some portion of their pregnancy. While I use the term "mothers" throughout to reflect self-identification of participants in the study, I acknowledge that not all birthing people identify as women or mothers.

Participants were recruited through purposive and snowball sampling via local CBOs serving Black families in the Seattle-Tacoma area and social media. This strategy allowed me to engage individuals connected to both formal and informal support networks.

Table 1: Demographic Information of Participants Who Completed an Optional Survey (n = 7)

Characteristic	n	%
Race/Ethnicity		
African-American/Black	4	57%
Multiracial (Black & Asian)	1	14%
Multiracial (Black & Hispanic)	1	14%
Haitian	1	14%
Age Range		
25–29	4	57%
30–39	3	43%
Gender Identity		
Woman	7	100%
Education		
Trade School	1	14%
Bachelor's Degree	1	14%
Master's Degree	5	71%
Annual Household Income		
\$25,000–\$49,999	1	14%

\$50,000–\$74,999	2	29%
\$75,000–\$99,999	1	14%
\$100,000–\$149,999	2	29%
\$150,000–\$199,999	1	14%

Data Collection

The interview guide was co-developed with a community partner to ensure cultural relevance and appropriateness. Interviews lasted 40–60 minutes and were conducted by Jazmin and me, both Black women, to support cultural resonance and rapport. With consent, interviews were recorded and transcribed via Zoom and verified for accuracy. Participants received a \$30 gift card and were invited to attend Cradles & Culture™, a community baby shower hosted by me and Jazmin, fostering continued community engagement beyond the research process. Community resources shared by participants were curated and made publicly available (see appendix A).

Data Analysis

I employed a team-based thematic analysis guided by Black Feminist Thought (BFT), which emphasizes the validity of Black women’s lived experiences, knowledge production, and resistance to intersecting systems of oppression (Collins, 2022; Combahee River Collective, 1983). BFT informed both my conceptual framing and analytic process by centering participants’ voices as critical sources of knowledge and interpretation. I led the analysis using an iterative three-phase approach: (1) inductive open coding to identify emergent themes, (2) collaborative

theme development and codebook creation, and (3) deductive re-coding with the established codebook. The research team was composed of Jazmin, me, and five Master's students from the University of Washington's Human Centered Design and Engineering department. Weekly meetings ensured coding consistency and consensus. Reflective memos were maintained to document insights and positionality throughout data collection and analysis. Findings were also member-checked (McKim, 2023) with participants to validate resonance with their lived experiences.

Findings: The TRIBE Framework

Through our analysis, we determined that community care reflects what we call TRIBE (Tangible, Relational/Peer, Informational, Birthworker, Emotional) support during pregnancy, birth, and postpartum. To honor participants' identities and experiences, I refer to each as a Mother and the collective as Mothers (capitalized).

Tangible Support

I define tangible support as providing material assistance for a mother. For Mothers in the study, material assistance included community members preparing the home and caring for older children during the birth and postpartum periods. Mother 3 described how her community provided extensive preparation and support for postpartum, including stocking her freezer and providing childcare assistance. Online communities and mutual aid networks provided tangible support through meal trains and buy-nothing groups, where community members are able to post and seek items that are free of charge via Facebook and other online applications. Even distant family members contributed materially, as shared by Mother 1, highlighting how tangible

support is not confined to a specific location. Collectively, these forms of tangible support contributed to Mothers feeling physically relieved and materially prepared throughout their pregnancy and parenthood.

However, financial constraints and material barriers significantly impacted Mothers' ability to access certain forms of community care, particularly doula support. Mother 4 described having to choose between hiring a doula and purchasing baby necessities while saving for unpaid maternity leave. This financial barrier limited access to birthworker support that she recognized as valuable. The introduction of the Washington State Paid Family and Medical Leave Act (Washington Paid Family & Medical Leave Program, 2019), which provides paid family leave to eligible employees, improved her perinatal experience, allowing her to afford both a doula and recovery time without financial stress in her second pregnancy journey.

Relational/Peer Support

Relational or peer support encompasses connections with other expecting or new mothers during the perinatal period. While peers may provide tangible, emotional, and informational support, Mothers specifically valued their shared lived experience as a form of support and deep understanding. Mother 12 shared how peers supported her through specific perinatal experiences, such as breastfeeding and postpartum depression.

Mothers also turned to peer-support groups via online and community-based peer groups such as Being The Village, a culturally specific support group that caters to Black mothers, and the Program for Early Support (PEPs), a nonprofit helping parents connect. These groups enabled the sharing of pregnancy and parental experiences and led to Mother 2 feeling seen and in community. More broadly, engaging with peers through social media, like Instagram, provided

a sense of relief when Mothers realized other parents were dealing with similar challenges, particularly while connecting with other parents during middle-of-the-night feedings.

Informational Support

Informational support refers to access to relevant knowledge and advice that empowers birthing people to navigate pregnancy, birth, and postpartum. This includes formal sources such as midwives, doulas, and classes, as well as informal sources such as peer advice, storytelling, and digital communities. As shared by Mother 11, conventional sources like the internet were often overwhelming, with the "bottomless" nature of online resources sometimes leading to disconnection rather than support. Though online resources may have been difficult to navigate, Mothers still leveraged applications like Facebook and Reddit to develop online communities for knowledge-sharing, especially during the COVID-19 pandemic. Reddit was particularly useful as shared by Mother 2 who found remedies for colic from other parents in the online community. She reminds us that this support is mutual as she plans to help the next parent with the new information she's acquired.

Word of mouth serves as a tool for information sharing during the perinatal period. However, the stigmatization of the full spectrum of pregnancy and postpartum experiences created additional barriers, as Mother 7 didn't know what to expect in the postpartum period until having a conversation with another mother during pregnancy. On the other hand, birthworkers emerged as trusted information sources, guiding pregnancy, labor, and postpartum care. A doula also supported Mother 7 in getting the information she needed to prepare for the postpartum period.

Despite this community-driven information and resources, Mothers reported significant gaps in informational support by medical professionals, as Mother 6 was not properly informed that she was miscarrying in the emergency room. Additionally, Mothers showcase the need for a hands-on approach to information sharing. Mother 4 illustrated how information should point to resources that are actually useful and engaging. These experiences underscore the need for more accessible, culturally-relevant sources of perinatal information.

Table 2: Quotes Representing Tangible, Relational/Peer, and Informational Support

Tangible Support	
Mother 3	“...My freezer was stocked, so I didn't go into the kitchen for six weeks. We didn't get into a car for six weeks...I asked for food, I asked for help with, you know, ...for people to come and take my kid to the park.”
Mother 1	“my side of the family, even though they're far, would call and check in quite frequently, send packages and things that I might need ...they would be like, oh, you know, let me send you some of this or that.”
Mother 4	“I knew I wanted to have a doula. And so, you know, I had found someone, we connected, and then last minute, like, you know, my husband, I looked at each other, we were like, we can't afford this, to have this option...do we get the doula, or do we continue to be able to buy the things that we need for the baby, and also save for maternity leave, because at that time, we didn't have the Washington State family leave, so there was no financial support for recovery. And so we decided to forego the doula...”
Mother 4	“We were able to...sign up for The Washington State Family Leave Act...so we could actually enjoy the recovery period and not feel anxiety and rush to try to return back to work.”
Relational/Peer Support	
Mother 12	“I had one friend that was pregnant a year before me and had successfully breastfed for a year, and she was really integral in making, like, getting me through the journey, because I had no idea what I was doing, and I didn't know

	many people that breastfed for the entire time nonetheless, at all.” She goes on to say, “another friend of mine had really experienced, like, pretty severe postpartum [depression], and she reached out a lot and just making sure...was more proactive about checking in on me to make sure I was okay.”
Mother 2	“I mean, we're talking about like, 10 parents who are sleep deprived, whose baby is like screaming, and like moms who are trying to breastfeed, and we don't know what the hell we're doing, and we're all getting together, and we like we all made it out, and we're some of us on our second kid now, and so we would be able to, but it was a, it was a community of people I would never have met otherwise.”
Informational Support	
Mother 11	“the internet is like bottomless and so sometimes there's like, so many resources that could, like, lead to disconnection.”
Mother 2	“having no idea what the hell colic was. And then having a child who had colic it was really nice to be able to, you know, connect with other parents from all over the world and see, like, kind of what their remedies were. And so being able to use that knowledge for the next child, like, Okay, I'm kind of gathering this information. And so if anybody else asks, or anybody else has these issues, I can kind of give it to them as well.”
Mother 7	“I think my biggest thing though, was postpartum. I didn't hear a lot about it, but once I got pregnant, talk to other people about it, other friends. That's when they had shared their experience. And so for me, postpartum was, like, my number one, oh, I need to make sure, like, I have a plan. I'm ready for it. I know what to expect.”
Mother 7	“During my pregnancy, actually, with my doula, I was given information about like parenting classes and things like that to join after pregnancy. So I did know some things about what to do after pregnancy the postpartum period”
Mother 6	"I was miscarrying... that emergency room doctor, didn't even tell me I was miscarrying"
Mother 4	“The least helpful resources was whatever were on those pamphlets that the hospital gives you about, like, Come here for a birthing class or come here for parent support groups, because I did. I tried the first time around first pregnancy, and I mean it's like quick, wham bam. Thank you. Five Minute, 10 minute classes. You're not connected or engaged with anyone. No one's following up

	with you afterwards.”
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Birthworker Support

Birthworkers are a diverse group of trained practitioners, including doulas, midwives, lactation consultants, childbirth educators, and more. They provide physical, informational, emotional, and cultural support throughout the perinatal period. While their training may vary from formal medical certification to community-based knowledge traditions, birthworkers share a commitment to affirming birthing people’s agency, dignity, and well-being. In the Black community, birthworkers play a vital role in addressing systemic barriers, offering culturally resonant care, and countering negative experiences in clinical settings (Gruber et al, 2013; Guerra-Reyes & Hamilton, 2017; Kathawa et al., 2022).

Mothers often spoke of deeply personal and resourceful support received by birthworkers. Mother 4 exclaimed, “I’m gonna keep shouting it from the rooftops...truly having a doula the second time around made a world of a difference”, demonstrating support that constitutes true care. Additionally, Mother 5 shared how lactation support increased confidence in breastfeeding, while Mother 11 shared how doulas provided affirmation and relief in exhausting periods during postpartum. Though we asked questions around community support, Mothers inevitably shared some experiences with medical providers and in hospital settings. Mothers 8 and 1 both described feelings of being dismissed in medical settings with rushed, impersonal experiences.

While birthworkers typically provide more personalized, continuous, and culturally resonant support during the perinatal period compared to traditional healthcare providers, some Mothers shared frustrations when their expectations were not fully met. Mother 9 reveals

disappointment when hearing that a midwife was “supposed to be more personal”, but that was not her experience, while Mother 7 highlighted inadequate lactation support from an in-hospital lactation consultant that left her using equipment incorrectly for months.

Table 3: Supplemental Quotes Representing Birthworker Support

Birthworker Support	
Mother 4	“I’m gonna keep shouting it from the rooftops, and I tell everyone all the time, but like truly having a doula the second time around made a world of a difference...that right there was the true experience and definition of how, in my mind, community showed up for me and was present during my pregnancy. Was like literally having someone outside of the doctor checking in on me, 24/7 and being like, Hey, are you okay? Do you need anything?”
Mother 5	“[having a lactation nurse] helped me feel more confident in breastfeeding and being able to do it for longer this time compared to with my first.”
Mother 11	“then the doulas were incredible. I feel like they taught me I already had the knowledge that I needed to be this little girl’s mom, even though I felt like I had had no fucking clue what I was doing. They showed me how to care for her. They were there when I was, you know, like, exhausted and needed, like, reassurance. They literally came over to hold her in the middle of the night so that I could, like, get an extra sleep in.”
Mother 8	“They come in and do their spill and they’re like, Alright, anything else? And I’m like, Yeah, everything else”
Mother 1	“because hospitals are so, you know, regimented and sterile, not necessarily like a...they’re like in and out. You know, it doesn’t really feel like the special moment that it probably should be... then, you know, doctors are, you know, I don’t know, catching babies all day long, pretty tired and exhausted, and they’re just like, you know, it’s not as personal.”
Mother 9	“I chose a midwife because I heard it’s like more personal, um, and and I was in high risk, so I just chose the midwife route, but I don’t know the difference between that and OBGYN”
Mother 7	“the word that just comes in my... the most frustrating thing that I felt like I

	wish I would have known, as far as, like, my breastfeeding journey goes, because, like I said, I didn't find out how to use things properly until Nurturing Expressions and it was months so that was kind of sad. I'm frustrated. It made me sad. Like, okay, wow, the whole time. And like, my friend also, she had told me to like, oh, girl, you know you have to get different flanges. I'm like, No, I don't know."
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Emotional Support

I define emotional support as affirmation, encouragement, and presence that nurture mental and emotional well-being. Emotional support is not limited to professionals, but can come from partners, family, peers, or spiritual practices. While birthworkers often provide emotional care, I distinguish "Birthworker Support" as a category because it reflects a defined role that integrates multiple forms of support. "Emotional Support," in contrast, captures the broader affective care offered across relationships.

Several Mothers experienced meaningful emotional support during their perinatal journey. Mother 6 described an invaluable partnership with her spouse, stating, "my husband's, like, the sweetest thing... he's my person... he was so supportive". Similarly, Mother 12 highlighted a supportive partner who "read all the what to expect books, and was kind of with me on the journey". Birthworker support also proved crucial: Mother 5 described a midwife who provided "good words of affirmation" during a challenging three-hour delivery when her spouse couldn't be present. Community-based lactation support offered immediate assistance and reassurance, as Mother 7 notes: "they came out almost immediately as a home visit and did like a weighted feed... that gave me hope and a sense of peace". Mental health support through perinatal groups was transformative for Mother 4, who found her therapist through these

resources and continued care beyond the program. Creative support also emerged through non-traditional means: Mother 1 described how gardening with her aunt provided joy during pregnancy and NICU visits, creating "something beautiful" during difficult times. Additionally, Mother 12 also found emotional support through journaling while pregnant with her daughter.

However, significant gaps in emotional support persisted. Mothers with multiple pregnancies experienced declining community interest (Mother 3), faced lengthy wait times for postpartum support groups (Mother 6), encountered inadequate medical follow-up for postpartum depression (Mother 2), and struggled with family dismissal of fertility loss and miscarriage (Mother 4), creating compounded challenges of community and healthcare neglect.

Table 4: Supplemental Quotes Representing Emotional Support

Emotional Support	
Mother 6	“my husband's the sweetest thing, like fearless, like he's my person. And he was so he's so supportive, like, I don't have to deal with any of the weaponized incompetence a lot of people have to deal with, with spouses or partners. And he just like, is my best person.”
Mother 12	“my husband also was pretty supportive in like, he read all the what to expect books, and was kind of with me on the journey. So that was helpful too.”
Mother 5	“she was very empathetic and helped me push through and gave good like words of affirmations when I was super tired after pushing for three hours to push this little girl out. Midwife was very great, because my husband couldn't make it there because he had to watch our older daughter.”
Mother 7	“It gave me a sense of peace. I would say, because when I told them my situation and just not knowing what I was doing with breastfeeding, and they came out almost immediately as a home visit and did like a weighted feed. So for me, that was it gave me hope and a sense of peace to know, like your baby's getting enough. You're doing the right thing. Keep it up. He's laughing now. This is right, you know, so I would say definitely gave me hope as a new mom”

Mother 4	“I mentioned the Perinatal Washington Support Group for sure, in terms of being able to utilize them for mental health and counseling. My therapist was initially through there, and so I continue to see her outside of them, but that was really helpful, and helped me with just the the anxiety and the stress of just the initial pregnancy part, and then postpartum too, with the recovery”
Mother 1	“I was really into gardening at the time, and it brought a lot of joy for me during my pregnancy. And my aunt would come, and she would add new plants for me, water my garden, harvest things for me, really, really special. That's beautiful, really beautiful, really I mean, that was pretty memorable during my pregnancy, being able to come home from the NICU sad and I would get to see, you know, my garden is flourishing.”
Mother 12	“I journaled throughout my pregnancy with her, so I would like write down what was happening, how I was feeling, just so I could go back and that also helped”
Mother 3	“the second and now the third pregnancy, people just kind of stop. It's not that big of a deal.”
Mother 6	“So I called immediately and nobody answered. I kept calling for a whole week, and then after a week, somebody finally answered. When somebody finally answered, they didn't have an appointment for four months, or, like, something crazy it was, like, four to six months, they didn't have an appointment, and they're like, ‘oh, we have a wait list, but like, just a heads up, we're still recovering from COVID...we'll put you on a wait list, but you should definitely look at other places’...So like, that was a resource. I was like, oh, okay, well pass this is, like, a community resource that's supposed to be amazing, that's supposed to help.”
Mother 2	“it cast a dark light on the birthing experience. For me, I think you know, it wasn't like this beautiful floral experience after I really, you know, you don't really talk about, when you don't talk about, like, postpartum depression, like, that's not something that people bring up. And so to experience that, and just to feel helpless and to realize there's like nothing available was really disenchanting for me. And it, you know, the things that got me through it had nothing to do with the traditional things that you would think would get, like your doctor's office, like, yeah, they're going to check up on you. That's bullshit. They're going to have your six week appointment to make sure that everything is healing properly, and then they send you on your merry way with like, a kiss on your forehead. And so that was really disenchanting and really

	disheartening.”
Mother 4	“not having the emotional support in terms of like therapy and counseling, and then also, you know, still have to go to work because, you know you need to be able to have healthcare insurance...to be able to go to all these doctors appointments...it was hard to continually go back to that environment and not being able to take the time needed to recover in between miscarriages and recovery emotionally...A lot of us in the community don't talk about fertility and loss, even amongst my own family...I'd start talking about it with my mom, and she would casually just be like, Oh, that's because you guys are stressing out too much. You just need to relax. So that was a little hard to not feel like my emotions around it were being validated or supported.”

Identity

While TRIBE (Tangible, Relational/Peer, Informational, Birthworker, Emotional) captures the primary forms of community care described by Mothers, our analysis also revealed identity as a cross-cutting dimension that shapes how Mothers define community, seek support, and experience joy in motherhood. Identity was not included as a formal element of TRIBE because it does not function as a discrete form of support. Rather, it operates as the lens through which Mothers understand and engage with each type of support. For this reason, I present Identity as a separate but integral theme alongside TRIBE.

When defining community, Mothers described it as "circles of support" (Mother 10) centered on those who "look just like you" (Mother 7), particularly other Black mothers. This extended to workplace connections, with Mother 2 describing how Black coworkers kept her "in the loop" during maternity leave.

Identity influenced the many ways Mothers sought support. Mother 11 sought information that wasn't a "super white-centered approach to parenting" during postpartum. Additionally, Mothers specifically sought Black parent support groups, as seen in Mother 1's desire for someone who had experienced "going through the birthing process in Seattle as a Black woman". Mother 2 described how a Black parent support group was particularly helpful when deciding what school to send her child to. She emphasized that being surrounded by other Black parents was not only about sharing racial identity, but also about sharing the same fears and concerns, such as how their children would be perceived in school or stereotyped as they grew older. For her, this overlap created a space of affirmation, where she felt understood without having to explain or minimize her experiences as a Black parent.

Despite concerns inherent to Black parenthood in America, Mothers found profound joy through their identities. Mother 11 radiated joy, surrounded by her Black women best friends at a surprise baby shower. Mothers also derived joy from witnessing their children's unfiltered happiness. Mother 1 marveled that her child "haven't seen so much darkness yet in the world." Breaking generational patterns also emerged as the deepest source of joy. Mother 6 vividly described how her children know love in ways "[Her husband and her] didn't have as kids": "They see us smiling... see a full unit... see us happy... see us laughing, they see us hugging and like to me, that's joy... I broke every single curse in my family, and that's just the most joy I could ever have."

Additionally, Mother 4 described postpartum joy as "having the ability to be present and happy... with both of my babies and my husband and my village and not have to stress and worry about what I gotta do next", highlighting the relief of carefree moments within supportive community networks.

Table 5: Supplemental Quotes Representing the Role of Identity in Defining Community, Seeking Support, and Experiencing Joy in Motherhood

Defining Community	
Mother 7	“I feel like the community of people who look just like you, who know your struggles and who can relate to your experiences.”
Mother 10	“Community is just all of my circles of support. So it's a lot of things, other women, especially Black women, who have gone through the birthing process... Parent support groups. Especially those focused on my Black mom journey.”
Mother 2	“Some of the community people that showed up for me.. other Black coworkers. So we have this like, we have this text thread called [redacted]...But being able to have that group of people that I could, when I'm on maternity leave, can reach out to...I still felt like I was in the loop.”
Seeking Support	
Mother 11	“I feel like in postpartum, you're already overwhelmed, and there's, like, So much information on the internet, conflicting information, and it was, it would like, send me into a spiral sometimes, because I'm like, I just wanted, I'm trying to make the best decision. I don't feel like I know what to do, and I'm trying to find, like, reliable information. And it felt so hard to find that that wasn't like placing a judgment, that wasn't like, super white, centered approach to parenting.”
Mother 1	“I specifically sought out the Black moms group because I wanted to talk to other moms who had experienced going through the birthing process in Seattle as a Black woman. And that was really, really helpful. I did learn a lot from them, and I just also really appreciated all of their like honesty and authenticity. I suppose that I feel like I wouldn't have gotten from other people in my life who don't identify with the marginalized identity. I just felt like I could truly be myself, which was really helpful.”
Mother 2	“being able to talk about like, okay, what schools are we going to send our kids to? So you don't have to have that fear of my kid is the only one who looks a particular way, and so he's going to be judged a particular way. And you know, you can have these expectations on him of being like this stereotypical Black man or the stereotypical Black boy, when he's so much more than just skin color, and so being able to be with other Black parents

	who share, ironically, who are also Black, you guys shared, like, the same skin color. But who also realized, like, No, we have the same fears, the same concerns we also are raising Black kids”
Experiencing Joy in Motherhood	
Mother 11	“my best friends came and surprised me, and like, had been planning a baby shower with a close friend of mine. And all of them are Black women, and just being surrounded by them and like, the amount of joy that I felt like having, like my sisters here, like that was beautiful.”
Mother 1	“I think my kids bring it out in me...I'm like, it just amazes me that they just have so much joy because they haven't seen so much darkness yet in the world.”
Mother 6	“My joy, and I like, I take pride in this, is getting rid of.. I broke every single generational curse in my family...[her daughter] talks about love a lot. She'll be like love you. She'll check emotions, too, even though she's 17 months... [Her husband and her] didn't have that when we were kids like our kids. Our child knows love. They see us smiling. They see us together...They see a full unit, and they see us happy. They see us smiling. They see us laughing, they see us hugging and like to me, that's joy is I broke every single curse in my family, and that's just the most joy I could ever have.”
Mother 4	“Black joy is just, you know, having the ability to be carefree. Having the ability to just smile and not have to worry about anything, and to just be able to be present in the moment and not have to stress about what's next and what you have to do. That definitely showed up for me in postpartum the second time around, just being able to be present and be happy to be there with both of my babies and my husband and my village, and not have to stress and worry about what I gotta do next.”

Discussion

These findings reveal how community care provides multifaceted support for Black birthing people through what I’ve identified as the TRIBE framework: Tangible, Relational/Peer, Informational, Birthworker, and Emotional support. This framework reflects both the forms of

care enacted (Tangible, Informational, Emotional) and the relationships through which care is provided (Relational/Peer, Birthworker). Importantly, the enactment of care is not bound to a single relationship type: for example, tangible support may come from a biological aunt, a neighbor, or an online mutual aid group. Similarly, emotional support may be provided by a partner, sibling, or peer. In contrast, relational/peer support and birthworker support highlight the importance of specific relationship-based contexts: the shared lived experience of peers and the expertise and cultural resonance of birthworkers. This framing aligns with the socio-ecological model (Kyei et al., 2024), which recognizes multiple, overlapping layers of influence on health without rigidly distinguishing between family, peers, and community networks. What matters most is that care is enacted across different roles in ways that affirm, sustain, and protect Black birthing people.

The tangible support described by Mothers, including meal preparation, childcare assistance, and material resources, aligns with previous research highlighting the importance of practical support during the perinatal period (Alio et al., 2022; Negron et al, 2013). However, our findings also reveal how financial barriers limit access to certain forms of community care, particularly doula services. The impact of Washington State's Family Leave Act on Mothers' ability to access birthworker support demonstrates how policy changes can enhance community care accessibility.

Relational and peer support emerged as particularly significant for Black birthing people seeking culturally affirming care experiences. Mothers specifically sought out community spaces with other Black mothers, where they could "truly be themselves" without the additional burden of navigating racial dynamics. This finding builds on literature documenting the importance of

race-concordant care in reducing stress and improving health outcomes for Black birthing people (Altman et al., 2020; Garcia, 2024; Jeffers et al., 2023).

Informational support also emerged as a critical form of community care. Mothers described both the overwhelming and sometimes harmful nature of generic online resources and the deep value of information shared within trusted community networks. Word-of-mouth knowledge, storytelling, and advice from birthworkers offered culturally grounded guidance that was often absent in formal medical encounters. These findings align with literature that positions information as a key determinant of maternal health, while also showing that the source of information, whether peers, elders, or culturally responsive professionals, can determine whether it fosters empowerment or reinforces isolation. Thus, community-driven informational support fills crucial gaps left by healthcare systems that frequently fail to communicate clearly, adequately, or with cultural humility.

While institutional healthcare settings were often described as impersonal and dismissive, birthworkers provided personalized support that affirmed Mothers' agency and knowledge. This contrast highlights the potential for community-based birthworkers to serve as a bridge between clinical and community care, particularly for Black birthing people who face documented disparities in healthcare quality and outcomes (Montalmant & Ettinger, 2024).

The experiences of emotional isolation and dismissal described by Mothers, particularly around fertility challenges and postpartum mental health, underscore existing research on the lack of culturally responsive mental health support for Black mothers (Estriplet et al., 2022; Matthews et al., 2021; Parker, 2021). Community care offered vital emotional validation that was often absent in clinical settings, though gaps remain, including limited access to culturally

responsive mental health care (Matthews et al., 2021) and the persistence of stigma around seeking help and the influence of harmful tropes such as the “Strong Black Woman”, which can discourage acknowledgement of emotional needs (Nelson et al., 2020). These gaps are further compounded by structural racism in healthcare systems, which often fail to provide Black birthing people with adequate screening, follow-up, or referrals for perinatal mental health concerns.

Our findings extend existing literature by demonstrating how Black birthing people actively construct networks of care that center their cultural identities and specific needs. Rather than relying solely on formal healthcare systems that have historically marginalized them, Mothers engaged multifaceted community care ecosystems that spanned digital and in-person spaces, professional and peer resources, and practical and emotional support.

Limitations and Gaps

This study has some limitations. Our sample included mostly college-educated mothers with healthcare access, which may not capture the full range of experiences among Black birthing people from different socioeconomic backgrounds. While the Seattle-Tacoma context shaped our findings, the insights generated, especially the TRIBE framework, can serve as transferable design principles for exploring, adapting, and co-creating community care models elsewhere. Future research should build on this work by examining how community care operates across different regions and exploring the long-term impact of such care on maternal and infant health outcomes.

Additionally, the community care ecosystems described in this study do not exist in a vacuum; they emerge, in part, as adaptive responses to systemic failures that persistently

underserve Black birthing people. Upstream structural factors, including inadequate Medicaid coverage for doula services, the absence of culturally responsive mental health infrastructure, and the entrenchment of structural racism within healthcare institutions, constrain access to both clinical and community-based care. Social and cultural forces, including internalized stigma around help-seeking and the pervasive "Strong Black Woman" trope, further suppress acknowledgment of need and limit the reach of available support.

Reimagining perinatal care in light of these barriers requires upstream intervention: expanding insurance coverage for birthworker services, mandating cultural humility training within health systems, investing in Black-led community health organizations, and integrating community-driven care models, like TRIBE, into institutional protocols. Policy levers such as state family leave expansions demonstrate that structural change is achievable and can meaningfully enhance access to community care. Ultimately, addressing these upstream factors is not supplementary to improving maternal health outcomes for Black birthing people, it is imperative.

Conclusion

The TRIBE framework reveals how Black birthing people construct holistic ecosystems of care that meet essential needs often neglected by traditional healthcare. These findings advance perinatal health equity by showing that culturally rooted community care can reduce harm, foster resilience, and restore joy across the reproductive journey. They also challenge dominant paradigms by recognizing community members, not just clinicians, as vital to maternal health outcomes.

This study also contributes to service design by offering a community-centered blueprint for reimagining maternal health systems. TRIBE serves not only as a framework for support but as a design ethic, inviting a shift from user-centered to community-embedded approaches. It calls on designers, community members, organizations, health systems, and policymakers to co-create care infrastructures that are not just efficient, but comprehensive and culturally responsive. Integrating these insights into community-based maternal health initiatives, digital platforms, institutional practices, and health policy transforms perinatal care from a transactional model into one that is relational, restorative, and equity-driven.

Future efforts to promote perinatal equity should prioritize funding, formal partnerships, and service integration that uplift community care models. By centering Black birthing people's voices and experiences, we can reimagine perinatal care as a collective practice of care, dignity, and liberation, where health equity is not just a goal, but a standard.

Chapter 4- Community (En)counter: How Black-Led Community Based Organizations extend the TRIBE Framework Through Service Design and Delivery

Chapter 3 descended into the micro level of Benjamin's viral justice framework, surfacing the TRIBE framework from the voices of 12 Black mothers in the Seattle-Tacoma area. Through their accounts of pregnancy, birth, and postpartum, I named the Tangible, Relational, Informational, Birthworker, and Emotional dimensions of community care that supported them in their perinatal journeys. What emerged was not only a framework for understanding community support, but a design ethic rooted in the everyday, recognizing that the most foundational acts of maternal care have always lived at the level of people showing up for one another.

At the meso level of Benjamin's framework, we find the organizations, networks, and institutions that sit between individual experience and macro systems serving as the intermediary structures through which community values are organized, sustained, and delivered at scale. Black-led community-based organizations (CBOs) occupy exactly this level. They are not individual actors, and they are not part of the government. They are the connective tissue between the care that Black mothers described in Chapter 3 and the dominant systems that have failed to provide it. This chapter asks how those organizations are already designing and delivering that care, and what the structure of their service design reveals about the values that undergird it.

Community (En)counter takes its name from the dual nature of Black communities' relationship to dominant care systems. To encounter is to meet, to come together, to show up for one another, and Black communities have always done this, creating organized and intuitive ecosystems of care in the face of systemic exclusion. To counter is to resist, to push back, to refuse the terms of a system that was never designed with Black life in mind. The parenthetical in (en)counter holds both simultaneously: Black communities are in-counter to violent, dominant health systems through encounter with one another. This chapter also takes its name from the service design concept of the service encounter, the moment at which a person meets a service. For Black birthing people, that encounter has too often been a site of harm. Community (En)counter asks what it looks like when communities design the encounter themselves, and what happens when we honor that design knowledge.

The core argument of this chapter is that Black-led CBOs are not supplementing clinical systems. They are authoring their own care ecosystems, and in doing so, they are extending the TRIBE framework through service design and delivery in ways that have not yet been adequately recognized as design knowledge. To examine this argument, I conducted a directed content analysis of the impact reports and websites of 14 Black-led CBOs providing direct services and advocacy for Black birthing people, using the TRIBE framework as an a priori codebook. Through this analysis, I uncover how these organizations operationalize TRIBE and express the values that embed their care practices.

The Marginalization of Community Values in Healthcare Design

The medicalization of birth did not only relocate care from community to clinicians. It relocated the values that defined what good care looked and felt like. Where community care had

been organized around kinship, cultural knowledge, relational continuity, and collective responsibility, the medical model introduced a different logic, one oriented toward efficiency, standardization, risk management, and institutional authority. Care became something delivered by credentialed professionals in controlled settings, measured by clinical outcomes. In this shift, the values that had sustained Black maternal care for generations were not simply deprioritized. They were rendered invisible and marginalized, coded as informal, unscientific, or supplemental to what counted as real care.

Service design provides tools for understanding how care is structured, delivered, and experienced across actors, artifacts, relationships, and time (Lee et al., 2022). At its most expansive, the field has moved beyond dyadic provider-patient encounters to theorize care as a networked, ecosystem-level practice in which value is co-created across multiple actors and resources simultaneously (Patrício et al., 2018). Transformative Service Research has pushed this further still, calling for service research centered on well-being outcomes at the individual, collective, and ecosystem levels, including access, decreasing disparity, and health, rather than satisfaction and loyalty alone (Anderson et al., 2013). Yet even the most progressive iterations of service design research remain institutionally centered, presuming hospitals, medical clinics, and governmental agencies as the primary sites of intervention. This situatedness of service design to begin with perpetuates the loss of community agency and autonomy. As Wright and Turoa (2026) demonstrate in their analysis of publicly funded health systems, coloniality continues to shape the knowledge systems, relationships, and care logics embedded in health service design, actively suppressing the epistemologies of marginalized communities. However, Community-based organizations and collectives working in precisely those margins have demonstrated that when the service encounter is designed by and for Black communities, on

community terms and with community values embedded in every touchpoint, outcomes improve (Hull, 2023).

The TRIBE framework, introduced in Chapter 3, offers a language for what that epistemology looks like in practice, naming the Tangible, Relational, Informational, Birthworker, and Emotional dimensions of care that Black communities have always provided for one another. Where medicalization centers efficiency and standardization, TRIBE centers presence, relationship, and cultural knowledge. Service design offers a complementary lens for understanding how these values are not just held but enacted, how care is structured, delivered, and sustained across touchpoints, artifacts, relationships, and time.

Community in Action Today

The lineage of community-designed care is not solely historical. It is alive and organizing today. Across the country, Black-led CBOs are continuing the tradition of designing care ecosystems that are culturally grounded, relationally centered, and accountable to the communities they serve. In Seattle, BLKBRY, a Black-owned and operated reproductive justice organization founded by Jazmin Williams in 2019, offers free doula services, a community pantry, and a milk-sharing program designed explicitly in response to gaps in existing care systems (Doyal, 2025). Williams describes BLKBRY's approach as one of continuous community listening and gap identification, not offering services for their own sake, but designing and redesigning in response to what is actually missing. In Washington, D.C., Mamatoto Village operates a culturally congruent perinatal home-visiting program that not only provides relational, community-based support to Black birthing people, but has demonstrated measurable improvements in gestational age at delivery, evidence that community-designed care

produces outcomes that clinical systems have struggled to achieve on their own (Snowden et al., 2024).

At the advocacy and systems level, the Black Mamas Matter Alliance (BMMA) has advanced a political and epistemic intervention into dominant narratives around Black maternal health. Peters (2025) frames BMMA's #BlackMamasMatter movement as a critical race counterstory, a deliberate act of resistance against the obfuscation of obstetric racism in policy, research, and public discourse. BMMA does not simply advocate for better clinical care; it challenges the epistemological foundations of how Black maternal health is understood, measured, and addressed, centering Black women's knowledge and leadership as the basis for policy change. Finally, the Tubman Center for Health and Freedom represents perhaps the most expansive example of community-driven design in action. Through a five-year community design process, Tubman conducted the DREAM Study (Knights-Shi, 2025), engaging medically marginalized communities in Seattle to articulate what a community-designed healthcare model would look like from the ground up. The result is the Relational Medicine Model, a community-authored care framework built on trust, whole person health, shared accountability, and relational medicine. Tubman's own framing captures the stakes of this work: improving access alone is insufficient if communities are excluded from shaping the systems they access. By asking "access to what?", they insist that communities must be at the center of designing the systems themselves.

Together, these organizations, across direct services, advocacy, and systems reimagination, demonstrate that Black communities are not waiting for institutions to catch up. They are designing, building, and refining care systems that institutions have yet to imagine.

Gaps in Literature

Yet much of the existing health services design research and practice fails to recognize communities as designers in their own right (Black Mamas Matter Alliance, 2019; Hekler et al., 2019; Scott et al., 2020). This framing cannot accommodate the possibility that communities have already built sophisticated care systems, systems with their own values, structures, and design logics, that exist entirely outside of clinical settings and that have been operating, innovating, and sustaining Black life for generations.

Community (En)counter refuses the framing that positions community as a resource to be tapped in service of institutional design. It asks not how communities can improve clinical systems, but what clinical systems can learn from the care ecosystems communities have already built. While community members, birthworkers, and CBOs have been included in health research, seldom has research treated these stakeholders as design knowledge producers. In the context of Black maternal health, the historical, organized, and innate ecosystems of care that Black communities create are rich sites of design knowledge with implications for CBPR, design justice, service design, and asset-based design.

Research Questions

This study seeks to understand how Black-led CBOs operationalize the TRIBE framework through their service design and delivery, exploring how care and the values that entail it are organized and enacted within Black communities. Specifically, this chapter asks:

RQ1: How do Black-led CBOs, providing direct services and programming for Black birthing people and families, operationalize the TRIBE Care dimensions?

RQ1.1: What are the implications for the broader design of maternal health systems and services?

Methods

Study Design and Rationale

This chapter originally set out to engage Black-led CBOs through co-design, a participatory research approach that would have invited organizational leaders and community health workers into the design process as co-investigators. That plan was shaped, and ultimately constrained, by the documented challenges of CBPR: the time, trust-building, and relational investment that genuine co-design requires does not always map cleanly onto the timelines that dissertation work demands. Recognizing that this process deserved more space and care, I turned to a different site of inquiry, one that allowed organizations to still speak for themselves.

Community impact reports and organizational websites emerged as a meaningful alternative. Unlike data collected through researcher-designed instruments, impact reports and websites represent organizations' own accounts of their work, their values, and their impact. They are documents through which CBOs choose what to make visible, how to narrate their services, and what counts as evidence of care. As such, they are not a substitute for direct engagement, but they are a legitimate and underutilized site of inquiry for understanding how organizations understand and represent their own values and design logics.

Data Sources and Inclusion Criteria

I collectively sourced community impact reports and websites with my research team of 3 University of Washington Master's students from a mix of sources including word of mouth,

internet searches, and the websites of other CBOs. Inclusion criteria required that organizations be Black or BIPOC-led with a focus on maternal health specifically (as opposed to say primary or family health), provide direct services and/or advocacy for Black birthing people, and have an impact report published after 2021 or a publicly available organizational website. When I set out to find impact reports, I either could not find one publicly available via an organization's website, or the organization or their report did not meet inclusion criteria. As such, I also included websites in the content analysis. The final sample includes 14 CBOs, comprising 3 impact reports and 14 websites.

Table 6: Black-Led Community Based Organizations (CBOs) Included in the Analysis (n = 14)

Organization	Location/Service Area	Source Analyzed
Ancient Song Doula Services	Brooklyn, NY and Montclair, NJ	Website
Aya Birth & Community Wellness	Durham, NC	Website
Ayan Maternity Health Care Support	Renton, WA	Website
Black Doula Project	Washington, DC and Baltimore, MD	Website
BLKBRY	Burien, WA	Website
District Motherhued	Washington, DC	Website
Global Perinatal Services	King, Pierce, and Snohomish Counties (WA State)	Impact Report and Website
Jamaa Birth Village Cultural Heritage Center	Ferguson, MO	Website
Mamatoto Village	Washington, DC	Website
Open Arms Perinatal Services	King, Pierce, and Snohomish Counties (WA State)	Impact Report and Website
Restoring Our Own Through Transformation - ROOTT	Columbus, OH	Website
Sankofa Reproductive Health and Healing	Syracuse, NY	Impact Report

Center		and Website
Shades of Motherhood Network	Spokane, WA	Website
Uzazi Village	Kansas City, MO	Website

Directed Content Analysis

I employed directed content analysis (Hsieh & Shannon, 2005), an approach that uses existing theory or prior research findings as the basis for an initial coding framework, allowing the researcher to validate and extend that framework through engagement with new data. This method was well suited to the aims of Community (En)counter. I brought TRIBE as an a priori codebook, asking how the five dimensions of community care were operationalized in how these organizations describe and deliver their services.

The codebook was originally deductively created with the values of TRIBE, with broad definitions for how each dimension might be operationalized through service design. For example, the code “TRIBE-Tangible” was defined as covering “material, financial, and logistical support that addresses needs during the perinatal period”. As the coding process ensued, I added new codes and subcodes that contributed more in-depth or expansive instances of the original TRIBE codes, as well as a broader understanding of organizational values and service delivery patterns that the original codebook had not captured.

When the initial codebook was developed, I began to transfer my data into Atlas.ti for analysis. For the impact reports, I uploaded them as PDFs to maintain the styling and imagery for context. The entirety of the websites were not coded. Instead, I pre-selected tabs to focus on for the analysis based on my research questions. I sourced the text from the Home, About, Services,

and Resources tabs, or the equivalent name that the organization used, along with other relevant tabs.

Findings

My content analysis identifies the ways in which Black-led CBOs have operationalized TRIBE support through service design and delivery. For example, organizations provided tangible support through diaper banks and freeze-dried breast milk and informational support through childbirth education classes and a documentary on doula support. Additionally, organizations were explicit about the values, like cultural relevance, collective responsibility, access, reproductive justice, respect and dignity, and education and empowerment (CARE), embedded in their practice. For data referencing a website, the tab where the information can be found will be listed as is or in “tab/subtab” format, if necessary. Findings should not be interpreted as a comprehensive account of each organization's full range of services, internal practices, or capacities, but rather as an analysis of how organizations publicly represent their work, values, and approaches to care.

Organizational Values

Cultural Relevance

Cultural relevance was among the most consistently named and most richly articulated values across the analysis. Organizations understood culture not as a characteristic to accommodate, but as the foundation from which care should be designed. Culture is positioned as a source of healing, knowledge, and identity, one that dominant healthcare systems have systematically devalued and erased.

Global Perinatal Services (GPS) named cultural responsiveness as central to their mission (Impact Report; pg. 2). Shades of Motherhood Network (SOMN) committed to ensuring every Black mother and mother of color has a high-quality, culturally relevant childbirth experience (Website; “Home”). Ancient Song Doula Services (Ancient Song) cited community voices and experiences as the basis of all their work, stating “We recognize and give voice to the joys and pains people of color experience when accessing healthcare services in their communities” (Website; “Home”). BLKBRY expressed their goal as building an intergenerational holistic wellness and healing space centering Blackness, offering support from doulas of the same background, culture, and shared identity (Website; “Home”). Aya Birth & Community Wellness (Aya Birth) recognizes the importance of the organization being “Black-led and Black-owned, grounded in lived experience and accountability to BIPOC families.” They go on to say “Our leadership model ensures that decision-making power, resources, and vision remain within the community most impacted by maternal health inequities” (Website; “About”).

Several organizations grounded cultural relevance explicitly in ancestral and Indigenous knowledge traditions. The Historic Jamaa Birth Village Cultural Heritage Center (Jamaa Birth) named their work as reclaiming and uplifting the sacred traditions of Black Diasporic and African Indigenous midwifery. The center “envision[s] and takes part in creating a world where birth is sacred, community-led, and anchored in cultural care” (Website; Home). Sankofa Reproductive Health and Healing Center (Sankofa) is committed to honoring the standard of care passed down from Black and Indigenous grand midwives and birthworkers with the belief that “Black women have the power to heal and transform their families through liberated birth practices” (Impact Report; pg. 2). Aya Birth named connection to ancestry as a core organizational value, grounding their work in African American knowledge systems and cultural

memory, asserting that “healing is not only clinical, but also cultural, relational, and rooted in the land and traditions that sustain us” (Website; “Services/Herbal Wellness”). Ayan Maternity Healthcare Support (Ayan Maternity) honored diverse cultural traditions around birth and motherhood and named multilingual support as a specific expression of cultural care, with one testimonial sharing “My doula from Ayan helped me through pregnancy, delivery, and after birth — in my own language. I felt heard, respected, and never alone” (Website; “About”).

Collaboration & Collective Responsibility

Collaboration and collective care were a key mechanism through which care became possible, meaningful, and accountable to the people it served. Across the analysis, this value extended beyond individual client relationships to encompass partnerships between organizations, cross-sector collaboration, and a shared understanding that Black maternal health is a collective responsibility.

Open Arms named relationships as the heart of what they do (Impact Report; pg. 2). Similarly, District Motherhued, a 501(c)3 organization founded by Black mothers to address the lack of representation amidst local mom groups, leverages being in relationship with other Black moms as critical support. Additionally, Black Doula Project, alludes to the power of the Black family unit simply asserting “Black families matter” (Website; “Who We Are”). Aya Birth shared that “strong outcomes are built through trust, continuity, and community-centered care” (Website; “Home”). Mamatoto Village defined collaboration as building partnerships across sectors to create opportunities, curate resources, and close gaps in care (Website; “About Us”). SOMN grounded collective care in the Kwanzaa principle Ujima, or collective work and responsibility, naming the shared responsibility of addressing maternal health disparities as a

foundational organizational commitment and calling on community organizations, families, and policymakers to engage together in improving maternal health outcomes (Website; “About/About Us”).

Several organizations named specific relationships as foundational to the collective care model. Restoring Our Own Through Transformation (ROOTT) named Black men and fathers as foundational to the values of the organization and the success of the Black family (Website; “About/Our Services”). BLKBRY extended the collective care value into their sourcing practices, committing to supporting the Black ecosystem by buying items from Black-owned businesses, particularly small and local ones that make products centering their community, for their community pantry program (Website; “Who We Are”). This reflects a deep understanding of collective care as extending beyond the service encounter into the broader economic and communal ecosystem.

Access

Access emerged as a core organizational value across CBOs, but organizations defined it expansively. They shared wanting to ensure that Black birthing people and families could receive care regardless of income, language, immigration status, geographic location, or insurance coverage, and that the care available to them was high-quality and culturally relevant.

Open Arms Perinatal Services (Open Arms) framed access to care as unconditional, stating that no matter what happens at the federal or state level, they would continue to provide free, culturally attuned doula care to their communities (Impact Report; pg. 4). GPS articulated access as a belief: all pregnant individuals should have access to exceptional prenatal care and to continuous, non-judgmental emotional, physical, and informational support (Website; “About

Us/Overview”). Mamatoto Village named service as a core value defined as working to reduce the barriers that prevent access to quality care and economic security (Website; “About Us”).

Ayan Maternity, founded by and for Black immigrant women, extended access to include language and immigration status, envisioning “a world where every mother, regardless of her language, income, or immigration status, has access to high-quality, culturally appropriate maternal healthcare” (Website; “About”). Ancient Song named perhaps the broadest access commitment in the analysis, listing the populations they serve including “low- and middle-income families, especially people of color, including those with fluid gender identities, teens, people pregnant while incarcerated, people in maternity shelters, survivors of sexual assault or trauma, and people with a history of substance use or mental health issues” (Website; “About”). Uzazi Village extended access beyond the perinatal period altogether, offering resources and services to keep families healthy whether they were expecting or not citing “For every baby, a healthy village; The health of the village is so important” (Website; “Home”). SOMN draws on Kwanzaa principle Nia, or purpose, to frame access as a collective purpose sharing that the application of this principle includes “Develop[ing] programs and initiatives that focus on reducing maternal mortality and promoting mental, emotional, and physical health during and after pregnancy”(Website; “About/About Us”).

Reproductive Justice

Reproductive justice, the right to have children, not have children, and parent in safe and supportive environments, functioned as the foundational value anchoring the majority of organizations across the analysis. Across organizations, Black maternal health inequities were

understood as a consequence of structural racism and systemic harm, positioning advocacy and social change as central components of maternal care.

Ancient Song named the reproductive justice and birth justice frameworks explicitly as the foundation of their work, stating “The birth justice political framework is integral to our efforts to center those clients who are most likely to face discrimination, medical neglect, and have their voices silenced or ignored when seeking care.”(Website, “Advocacy”). ROOTT similarly grounded its services in the principles of reproductive justice, naming autonomy, human rights, and the trust of Black women and families to make their own reproductive decisions as central commitments (Website; “About ROOTT”). Mamatoto Village framed their work as acting toward justice and liberation in the highest capacity possible, describing that they believe “Black women can be strengthened by one another giving rise to a more radical, collective, and supportive environment for wellness and thriving.” (Website; “About Us”). Open Arms named justice as a core organizational value defined as boldly disrupting oppression (Website; “About Us”).

Several organizations extended the reproductive justice framework to name the specific structural conditions they were working against. Ancient Song committed to addressing implicit bias and racism within healthcare systems by shifting the narrative and advocating for policy change (Website; “About Us”). Sankofa named medical racism explicitly, stating “Racial disparities are a consequence of long-standing structural and social barriers, including medical racism, which keep families from thriving” (Impact Report; pg. 5). BLKBRY asserted their commitment to Black maternal and infant health in direct relationship to health inequities, stating their goal as improving Black infant and maternal health and decreasing health inequities in mortality rates (Website; “Filling The Gap/The Healing Kin”) The question underlying their

work is not how to help Black birthing people navigate existing care systems more successfully, but how to create conditions in which they can exercise genuine reproductive autonomy.

Respect & Dignity

Respect and dignity appeared across the analysis as deeply operational commitments that shaped how organizations designed their service encounters. Organizations named autonomy, informed choice, and the right to be treated as a whole human being as foundational to their approach.

Open Arms named respect as a core value defined as holding complexity for people and cultures (Website; “About Us”). Ayan Maternity echoes this sentiment, sharing “We honor and respect diverse cultural traditions around birth and motherhood, creating safe spaces for all families” (Website; “About”). GPS stated that all pregnant individuals should be trusted to make choices they see are best for them (Website; “About Us/Overview”). SOMN deepens this trust by valuing “the humility to observe without assumptions” (Website; “About/About Us”). Mamatoto Village defined respectful care as approaching each individual with humility, compassion, and honor towards their choices while fostering autonomy over their lives, and named inclusivity as ensuring that each person is welcomed and served within an environment of dignity, respect, and acceptance (Website; “About Us”).

Aya Birth articulated this value most expansively, stating “We center people over policies, dignity over convenience, and relationships over volume” (Website; “About”). They named informed choice and bodily autonomy as fundamental to respectful, ethical care and committed to treating every client, family, and staff member as a whole human being with autonomy, voice, and the right to informed, respectful care. Sankofa affirmed dignity as a matter

of life and death, stating “safe, dignified and respectful maternal care saves lives. It is a human right, not a luxury. Our future demands that we ALL are reaching forward, while giving back” (Impact Report; pg. 21). The consistent appearance of autonomy and informed choice as components of respect and dignity across the analysis reflects a direct response to the documented experiences of Black birthing people in clinical settings, where those values have historically been withheld.

Education & Empowerment

In my analysis, education served as a tool of empowerment for Black birthing people and communities. Organizations understood knowledge as more than information to be dispensed by experts. It was framed as a tool for self-determination that communities had a right to access in forms that were relevant, accessible, and affirming.

GPS named education as a core organizational goal, stating they want to “educate low-income, refugee, and immigrant families and their communities about safe pregnancy, birth, and baby care practices through classes and workshops” (Website; “About Us/Overview”). SOMN framed education through the lens of Kwanzaa principle Kujichagulia, or self-determination, naming its role in empowering mothers to make informed decisions about their health and birthing journeys (Website; “About/About Us”). Uzazi Village stated that they believe education is one of the most important tools in supporting childbearing families in their community (Website; “Home”).

Aya Birth translated the value of education into a specific service design commitment, describing their visits as intentionally unhurried, allowing space to ask questions, name concerns, and make informed choices (Website; “Services/Pregnancy Care”). They make shared

decision-making, clear communication, and trust central to how they practice. Sankofa named the right to informed decision making as a demand, stating “We deserve informed decision making, not coercion or surveillance. We need providers and medical institutions to trust and listen to concerns and wishes for reproductive wellness” (Impact Report; pg. 21).

District Motherhood saw empowerment as creating a space to enhance the motherhood experience by sharing and tackling common struggles and triumphs (Website; “Home”). BLKBRY extended the empowerment orientation to include fathers, partners, and kinship caregivers alongside birthing people, centering their focus on the healing of Black/African American families across the full perinatal period (Website; “Filling The Gap/The Healing Kin”).

Additional Value

Beyond the six primary value dimensions documented above, the analysis surfaced an additional value that appeared across a smaller number of organizations, but nonetheless shaped how care was designed and delivered. This value, creativity, while not always explicitly named, is present across all organizations in the way they imagine services and the impact of those services on Black birthing people and families.

Creativity surfaced as an explicit value in the work of SOMN and Mamatoto Village. SOMN used creativity as a formal organizational principle drawn from the Kwanzaa value of Kuumba, calling for the use of art, storytelling, and traditional African practices in maternal health education and support and envisioning culturally rich programs that celebrate motherhood (Website; “About/About Us”). Mamatoto described their approach as fostering a space for resistance, restoration, and reclamation fueled by Black women's collective dreams of a more

just world to live, love, birth, raise children, and sustain families (Website; “About Us”). Both framings position creativity as critical to imagining new maternal health services and systems.

Values in Language

Across the organizations in this analysis, values were communicated not only through services and programs but through the language organizations chose to represent themselves publicly. Word choice, naming conventions, cultural references, and even spelling functioned as deliberate expressions of organizational values. Jamaa Birth, whose name means "family" in Swahili, grounded their organizational identity in kinship and ancestral tradition rather than a clinical framing. Extending that same logic into their family doula training program, they explicitly named “lovers, partners, spouses, parents, grandparents, aunties, siblings, cousins and more” as ideal people to apply for the training. (Website; “Midwife & Doula Training/Become A Doula”) Aya Birth drew on the Akan symbol Aya from West Africa, a fern representing their organizational commitments to resilience, endurance, protection, growth, and connection to ancestors (Website; “Home”). SOMN organized their maternal health principles around the Seven Principles of Kwanzaa, centering an explicitly African and African American tradition as the organizing logic for how they understand and address Black maternal health. Sankofa refused “mother blame” and softened institutional language altogether, naming medical racism plainly as a consequence of long-standing structural and social barriers. (Impact Report; pg. 5) Finally, I found BLKBRY’s assertion of a labor acknowledgement especially interesting. Land acknowledgements are typically expressed to respect and honor Indigenous stewards of land currently occupied by colonial powers and institutions. BLKBRY adapts this practice to honor a different but equally foundational history, centering the labor of enslaved Africans and their

descendants as the conditions that made this country possible. Across organizations, values were communicated not only through services and programs, but also through organizational language, cultural references, naming practices and counternarratives.

TRIBE in Action

The TRIBE framework was used as a priori codebook to document how the CBO's in this analysis operationalize each dimension of the TRIBE through their service design and delivery. As mentioned in Chapter 3, it is worth noting that TRIBE does not operate in isolation. A lactation home visit, peer support group, or childbirth education course can carry multiple dimensions simultaneously. Despite overlap, services and programs were placed in a primary dimension for the analysis based on the primary stated or perceived purpose of the service or program.

Services for Tangible Support

Tangible support covers material, financial, and logistical support that addresses needs across the perinatal journey. Across the organizations analyzed, tangible services took several distinct forms. Community pantries and material resource programs were among the most prevalent, offering community pantries (BLKBRY), diaper banks (SOMN), baby boutiques (Open Arms), care closets (Ancient Song), and clothing access (Uzazi Village). The Black Doula Project offered grant funding for doula services, extending material access to birthworker support for families who might otherwise be unable to afford it. We see organizations like BLKBRY and Open Arms offer their doula services for free. When services are compensated, we see organizations like Mamatoto Village offering flexible payment options.

Lactation support was a richly developed area of tangible service design. Organizations offered breastfeeding centers and milk bars, “a FREE, nurturing, and inclusive space for parents seeking support, guidance, and community on their lactation journey” (Mamatoto; Website; “Services/Classes”), breastfeeding clinics (Uzazi Village), in-person lactation lounges (Open Arms), and lactation hotlines, which a client described their experience saying “I was surprised to find out my infant was rejecting my frozen milk due to possible high lipase. I reached out to the lactation hotline to assist in a solution and was very happy with the help received” (GPS; Impact Report; pg 17).

SOMN connects community members to the broader landscape of available resources through family navigators, which is “a trained guide, often with lived experience, who supports families in accessing services, navigating complex systems, and finding the resources they need” (Website; “Home”). Additionally, Ayan Maternity provides referrals to International Board Certified Lactation Consultants (IBCLCs).

Convenience emerged as an implicit tangible design priority centering the birthing person’s comfort. Many organizations leveraged home visits (ROOTT, Mamatoto Village, GPS, Ayan Maternity) and lactation home visits (Open Arms) to bring services directly to families. BLKBRY partnered with an organization, Leche, to “provide Black families with more options for having access to breast/human milk” (Website; “Filling The Gap/Milk + Molasses”). Through innovative freeze drying techniques, Leche (About Leche, n.d.) has created the first of its kind, shelf-stable breast milk that provides birthing people with flexibility, convenience and optimal nutrition.

At the policy level, SOMN and BLKBRY extended tangible support through policy trackers to stay informed on policies relevant to Black Maternal Health and endorsements for the

Momnibus Act (Black Maternal Health Caucus, n.d.), a federal legislative package designed to address the full scope of maternal health inequities in the United States from ending preventable maternal death and health disparities to diversifying the perinatal workforce, expanding mental health care access, investing in community-based organizations, and improving data collection and research. Organizations also engaged in advocacy and policy development efforts across scale from local town halls to national movements (Ancient Song, ROOTT).

Services for Relational Support

Relational support covers services, programs, and practices that cultivate connection, trust, and community among birthing people, families, and care networks, and within and among community-based organizations. Peer support for mothers was the most prevalent relational service across the sample. Organizations offered peer support groups (Ayan Maternity), a peer support group list connecting community members to multiple groups (BLKBRY), lactation peer support group (Mamatoto), and events specifically designed to connect and engage Black mothers with each other, like District Motherhued's Boobs in the Park, a "casual gathering of black and brown expecting moms, breastfeeding moms and breastfeeding enthusiasts" (Website; "Our Work/Signature Events") or their 4th Trimester Initiative, which matches 10 moms each month to a Mommy Buddy, a member of the District Motherhued Society, and provides a new mom welcome box, regular Mommy Buddy check-ins and, one meal for their household in the first 12 weeks after birth.

Several organizations expanded the relational frame to include fathers and other family members. BLKBRY is hosting a "Fore the Fathers" event for Father's Day 2026, and ROOTT offered the Family Tree program, reflecting the importance of broader kinship networks in Black

maternal health. ROOTT's peer-to-peer education model and Ayan Maternity's peer navigators positioned community members' lived knowledge as a vital resource. Uzazi Village offered group perinatal care services, while Ancient Song's Doulas for Democracy program extended the relational model into civic engagement. Overall, community partnerships were documented across many organizations and extended relational infrastructure through connections to other CBOs, local businesses, collectives, and volunteers.

Services for Informational Support

Informational support covers access to knowledge, education, and guidance that empowers navigation of preconception, pregnancy, birth, postpartum, and loss, as well as the dissemination of knowledge meant to share impacts and address change on a systemic level. Organizations operationalized informational support across four modalities: structured classes for parents, asynchronous and self-directed resources, alternative and creative media, and reports, publications, and conferences.

Structured education for parents included childbirth and parenting classes (Mamatoto Village, Ancient Song), perinatal nutrition support (BLKBRY, ROOTT), and even workshops for dads (Ayan Maternity). GPS also reported on hosting a Community resource fair. These offerings reflect an understanding of perinatal education as an ongoing community-based process of learning and support.

Asynchronous and self-directed resources extended organizations' informational reach beyond what in-person programming could accommodate. BLKBRY offered self-paced childbirth education courses and maintained a Black Provider Directory to “specifically address the need for culturally congruent support across different cultures and many identities, as well as

the full spectrum of reproductive care for Black folks in the Pacific Northwest of the US” (Website; “Birthin’ While Black/Girl Get Yoself A Doula”) Additionally, Mamatoto’s Black Mama’s Guide was created to “remind you, beautiful Black Mama, that joy, love, pleasure, support, safety, and wellness are things you deserve” (Website; “Resources/Black Mama’s Guide”).

Alternative and creative media emerged as a distinctive modality. SOMN produced "Girl Get a Doula": A documentary which “chronicles the journey of The Shades of Motherhood Network and the community-led response to the Black maternal health crisis in Spokane, Washington. The film centers Black women’s lived experiences while highlighting culturally rooted solutions that save lives” (Website; “BMHW2026/Girl Get A Doula Documentary”), a podcast experience, which was hosted during Black Maternal Health Week 2026, “amplifying Black and Brown wellness movements and centering storytelling as a catalyst for systems change” (Website; “BMHW2026/BMHW2026”), and an art exhibit, which was a “multi-site cultural and educational experience honoring Black maternal traditions, adornment, and community wisdom” (Website; “BMHW2026/Childbirth Knowledge Art Exhibits”). The Black Doula Project created a docuseries campaign to “serve as a visual tool to aid in increasing awareness of the organization's efforts. The docuseries tells the story of how a doula can be a change agent and advocate in their client's health care during their pregnancy and postpartum experience” (Website; “Black Parents Deserve: Docuseries”). Jamaa Birth also founded the The African Indigenous Midwifery Museum, “A first-of-its-kind cultural space preserving and celebrating pre-colonial birthing practices, crafts, and midwife priestess histories” (Website; “About Us/Our Legacy”).

SOMN hosted a Black Maternal Health convention where their doulas “shared resources, community-centered action plans, and the real ways they are already creating impact for families” (Website; “BMHW2026/Black Maternal Health Convention”). Open Arms’ Lactation Clinical Lead presented at the inaugural Indigenous Milk Medicine Conference. Ancient Song hosted the Decolonize Birth Conference, a conference to address the issues of racial & gender injustices, communities being pitted against one another, and an attack on the sheer autonomy over our bodies. Along with informational gatherings, reports and publications served as informational infrastructure for both community members and broader public audiences. Annual and impact reports, functioning as public-facing knowledge dissemination, were authored by Open Arms, GPS, Ancient Song and Sankofa. Organizations like Mamatoto Village and Open Arms have also published work around their services in more formal academic spaces (Lee, 2020; Snowden et al., 2024).

Services for Birthworker Support

The organizations in this analysis share a collective commitment to building, sustaining, and compensating a culturally rooted birthworker workforce that reflects the communities it serves and spans the full reproductive spectrum. Across organizations, doula care is the most consistently offered service, covering prenatal, birth, postpartum, and antepartum support. Several organizations extend this further to include abortion, miscarriage, stillbirth, and grief support, reflecting a full-spectrum approach to reproductive care. Ancient Song Doula Services articulates this explicitly, noting that their doulas are trained to support individuals through the complete range of reproductive health experiences (Website; “Services”).

Several organizations center midwifery not solely as a medical service, but as an act of cultural restoration. Jamaa Birth Village operates Missouri's first Black-founded midwifery school, Okunsola's School of Traditional Midwifery, which trains practitioners through lineage-based, elder-mentored instruction rooted in African Indigenous knowledge (Website; “Midwife & Doula Training”). Aya Birth & Community Wellness, as North Carolina's only Black-owned midwife-led birth center, provides relationship-centered, trauma-informed care grounded in shared decision-making (Website; “Services/Pregnancy Care”). ROOTT operates a holistic health and wellness clinic modeled on midwifery-based care. Together, these organizations position midwifery as a reclamation of ancestral knowledge and community authority and autonomy.

Lactation support appears across nearly every organization and takes a wide variety of forms: one-on-one consultations, lactation lounges, home visits, and virtual sessions. Open Arms conducted 165 lactation home visits and hosted over 100 lactation lounges in 2024 alone (Impact Report; pg 6), and has actively developed BIPOC lactation consultants through its Community Lactation Specialist Pathway (Impact Report; pg 5). BLKBRY's Milk + Molasses program explicitly centers Black cultural infant feeding practices alongside clinical support citing the need to “re-indigenize our plates!” (Website; “Filling The Gap/Milk + Molasses”). Mamatoto Village offers free in-person and virtual lactation support weekly, moderated by Mamatoto Village Lactation Consultants. These programs reflect a shared understanding that lactation support must be culturally grounded, not just clinically available.

Many organizations see workforce development as inseparable from community health. Ancient Song has trained over 2,000 doulas since 2012 (Website; “About”). Jamaa Birth Village trained 463+ doulas through the STL 360 Doula Initiative, earning St. Louis a Safer Childbirth

City designation (Website; “About Us/Our Legacy”). Mamatoto Village offers distinct training tracks for Perinatal Community Health Workers, Lactation Specialists, and Community Birth Workers (Website; “Trainings”). Sankofa hosted their very first doula training in the fall of 2021, adding 7 new doulas to their collective (Impact Report; pg. 19). These efforts reflect a shared belief that increasing the number of Black and Brown birthworkers in communities is itself a health intervention.

Services for Emotional Support

Emotional support covers affirmation, presence, and mental and emotional support that nurtures psychological well-being. Organizations operationalized emotional support through mental health services, community-building events, grief and loss support, and the creation of physical and digital spaces designed to hold the emotional complexity of Black reproductive life. SOMN integrated emotional support through the doula relationship itself, reflecting an understanding that the doula encounter is inherently an emotional care encounter. They explicitly name emotional support as a form of support a doula can provide stating, “A doula provides a steady, calming presence, offering encouragement when things feel overwhelming and reassurance when you need to know you’re not alone” (Website; “Support/Girl Get A Doula”). Open Arms named helping parents feel prepared, supported, and confident (Impact Report; pg 2) as part of their service model, and Ancient Song named compassionate care as a part of their approach.

Community-building events designed around emotional experience created spaces for gathering that held grief, advocacy, and joy simultaneously. SOMN hosted a movie night to premiere their documentary, *Girl Get A Doula* and Policy and Poetry Night, which “uses poetry,

storytelling, and facilitated conversation to explore how social determinants like housing, education, economic stability, and healthcare access shape maternal outcomes” (Website; “BMHW2026/BMHW2026”). Each year, District Motherhued hosts an intimate gathering to “hold space for women with a lived experience of loss through childbirth, miscarriage, stillbirth, SIDS, or any other cause at any point in pregnancy or infancy” (Website; “Our Work/Signature Events”). Additionally, SOMN created a digital space of communal grieving to honor the lives of Black women who have passed away due to maternal health complications including: Kira Dixon Johnson, Dr. Shalon Irving, Yolanda “Shiphrah” Kadima, Tatia Oden French, Tori Bowie, and Krystal Lakeshia Anderson (Website; “Home”). Below the memorial, SOMN prompts birthing people to share their stories of mistreatment during pregnancy, birth and/or postpartum so as to not “suffer in silence”.

Sankofa and BLKBRY both hold Perinatal Safe Spot designations, which is “a nationally recognized model of care to reduce disparities in birth and parenting in areas where health inequities in the childbearing year are persistent and alarming” (Sankofa; Impact Report; pg 4). The goal of a Safe Spot location is to provide immediate and judgment-free access to community-led pregnancy and reproductive care. This intervention recognizes that emotional care depends on environments where participants feel safe, protected, and supported.

Discussion

The findings of this chapter suggest that Black-led community-based organizations are not simply delivering maternal health services. They are designing care systems. Across organizations, service offerings were shaped by a consistent set of values, including cultural relevance, collective responsibility, access, reproductive justice, respect and dignity, and

education and empowerment (CARE). These values appeared not only in organizational mission statements, but also in the services, partnerships, resources, and infrastructures organizations developed to support Black birthing people and their families. Taken together, these findings point toward what I term community-driven service design (CDS): an approach to service design in which community-defined values and practices function as the primary organizing logic through which care is imagined, structured, and delivered.

This conceptualization builds upon emerging discussions of community-driven design in HCI. Hekler and colleagues (2019) define community-driven design as work conducted by and for communities themselves, where leadership, direction, ownership, and movement emerge from within the community. Unlike professional-led design efforts that begin with institutionally defined problems, community-driven approaches begin with community assets, desires, and aspirations for collective flourishing (Hekler et al., 2019). The organizations examined in this chapter reflect these characteristics. Their work demonstrates how Black communities draw on existing knowledge, relationships, cultural traditions, and lived experience to design systems of care that address community-defined needs. This orientation echoes calls within reproductive justice scholarship to center the wisdom, assets, and leadership of communities most impacted by reproductive harm, challenging institutional monopolies on maternal health expertise (Scott et al., 2020). It also aligns with Black Mamas Matter Alliance's assertion that Black women must be recognized not only as beneficiaries of maternal health interventions, but also as creators of knowledge capable of shaping the conditions of their own care (Black Mamas Matter Alliance, 2019).

Community-driven service design differs from dominant approaches to maternal health innovation in another important way. Traditional healthcare improvement efforts frequently

focus on optimizing existing systems through greater efficiency, access, or quality while leaving the underlying assumptions of those systems intact. By contrast, the organizations in this study begin from fundamentally different understandings of what care is, who possesses expertise, and how wellbeing is produced. Reproductive justice, cultural relevance, dignity, collective responsibility, and empowerment are not supplemental values layered onto existing services. They function as the foundation from which services are built. As Scott and colleagues (2020) argue, Black feminism and reproductive justice provide a roadmap for the assumptions, goals, values, and interventions necessary for work conducted for, by, and with Black communities. The organizations examined here operationalize these commitments through tangible service infrastructures.

Importantly, these values are translated into services. Low-cost and free doula programs, childbirth education classes, lactation support, fatherhood initiatives, community pantries, provider directories, peer support groups, and policy advocacy efforts each represent mechanisms through which organizational values become enacted in practice. This finding resonates with service design scholarship, which conceptualizes services not as isolated encounters, but as value-creating systems composed of interconnected stakeholders, resources, and relationships (Forlizzi & Zimmerman, 2013; Yoo et al., 2019). From this perspective, the work of Black-led maternal health organizations can be understood as the design of service ecosystems that redistribute resources, cultivate relationships, and create conditions for care. The primary design object is not a discrete, singular intervention, but an interconnected network of support that spans multiple actors, artifacts, services, and stages of the maternal journey.

The significance of this shift becomes particularly evident in the context of Black maternal health. Existing maternal health interventions often center the patient-provider

relationship as the primary site through which inequities can be addressed. While important, this framing narrows maternal care to clinical encounters and overlooks the broader social infrastructures that shape maternal wellbeing, especially for marginalized groups. Research has consistently shown that Black women value care relationships characterized by trust, shared understanding, respect, and cultural connection (Altman et al., 2019). Communities of care have also been described as spaces of refuge from broader structural injustices, providing comfort, belonging, and support in ways that extend beyond formal healthcare systems (Alspaugh et al., 2023). Similarly, Golden and colleagues (2022) argue that emerging approaches to addressing reproductive health inequities are particularly effective when they are community-led and leverage the strengths of existing social support networks. Together, these studies suggest that maternal health is produced through broader networks of relationships, resources, and community infrastructures. The organizations examined in this chapter make these networks visible.

Viewing these organizations through a service design lens also challenges assumptions about who qualifies as a designer. Service design has historically emerged from professional practice and institutional settings (Yoo et al., 2019), yet the organizations in this study demonstrate how communities engage in design through the ongoing creation, adaptation, and refinement of care infrastructures. Many organizational leaders, birthworkers, and advocates entered this work after experiencing gaps, harms, or exclusions within dominant maternal healthcare systems themselves. This phenomena problematizes the user-designer paradigm by blurring the line between those who experience and those who imagine. Similar patterns have been documented among aspiring midwives of color, who describe their pursuit of birthwork as a response to inequitable treatment and a commitment to creating more just forms of care for their

communities (Alspaugh et al., 2023). Their work illustrates how lived experience captures instances of harm, but it also has driven Black women to resist that harm in generative and collective ways. Communities, in this sense, become actors of innovation and agents in shaping the futures they wish to inhabit.

Ultimately, the community-based maternal health ecosystem documented in this chapter demonstrates that maternal wellbeing is produced through far more than clinical encounters. It is cultivated through relationships, collective responsibility, cultural knowledge, advocacy, and community infrastructure. Recognizing these sites of care not only broadens our understanding of maternal health, but also opens new possibilities for technology design by centering community-defined values, relationships, and infrastructures of care. In doing so, Black-led maternal health organizations challenge (institutional) researchers and designers to reconsider where innovation happens, who drives it, and what futures become possible when communities are regarded as the designers of their own systems and those systems are engaged intentionally.

Gaps & Limitation

This chapter's findings must be read in light of several methodological constraints that shape what the analysis can and cannot claim. The most significant limitation is the nature of the data sources themselves. Community impact reports and organizational websites are self-authored documents. They are accounts that organizations choose to make public, and they reflect organizational priorities, communication strategies, and the practical realities of nonprofit communication, including the pressure to demonstrate impact to funders. They do not capture the full texture of organizational practice, the informal relational work that happens between documented service encounters, the tensions and constraints that organizations navigate, or the

full experiences of the people they serve. This analysis surfaces design knowledge as organizations represent it; it cannot claim to fully represent how that knowledge is enacted in practice. That understanding requires direct engagement with organizations and communities in future work.

Additionally, the organizations included in this study were selected based on the availability of public-facing materials sufficient to support systematic analysis. As a result, this chapter may not capture the practices of smaller, less-resourced, or more informal community initiatives whose work is documented through other means or remains largely undocumented. Future research should examine how community-driven service design manifests across a broader range of organizational forms and community contexts.

Directed content analysis using an a priori codebook also carries inherent interpretive constraints. The TRIBE framework, derived from the accounts of 12 Black mothers in the Seattle-Tacoma area, is powerful as an analytical lens because it is grounded in community experience. At the same time, it is neither exhaustive nor neutral. Bringing TRIBE to organizational data foregrounds particular dimensions of care while potentially obscuring others. The additional codes and subcodes that emerged through the coding process represent an effort to remain attentive to what the data offered beyond the initial framework. Nevertheless, the framework structures the inquiry in ways that both enable and bound what can be found

Conclusion

This chapter examined how Black-led community-based organizations support maternal health through services, programs, partnerships, and community infrastructures. Using the TRIBE framework as an analytic lens, the findings demonstrated that organizations operationalize multiple dimensions of care simultaneously, providing tangible resources,

relational support, information, emotional care, and access to birthworkers across the perinatal journey. In doing so, they address maternal wellbeing not as an isolated clinical encounter, but as a collective and community-based endeavor.

Beyond documenting these organizational activities, this chapter argues that Black-led maternal health organizations are engaged in a form of community-driven service design. Across organizations, values such as cultural relevance, collective responsibility, access, reproductive justice, respect and dignity, and education and empowerment functioned not as aspirational commitments, but as organizing principles that shaped how services were designed and delivered. These values are translated into service ecosystems that coordinate resources, cultivate relationships, expand access, and support Black birthing people and their families in ways that extend beyond formal healthcare settings.

The findings further challenge assumptions about where design expertise resides. The organizations examined in this chapter reveal communities as designers of care systems, generating, adapting, and sustaining them over time. Through lived experience, cultural knowledge, and ongoing engagement with the realities of Black maternal health, these organizations have developed practices and infrastructures that respond directly to community-defined needs. Their work suggests that design knowledge does not originate solely within professional design disciplines or healthcare institutions. It is also produced through the everyday work of communities building alternatives in response to systemic exclusion and unmet need.

At the meso level of Benjamin's (2022) Viral Justice framework, these organizations reveal how collective action can reshape the conditions through which maternal health is produced. They make visible a network of community-driven care infrastructures that often

remain peripheral in dominant maternal health discourse despite their central role in supporting Black families. Recognizing these organizations as service designers expands how scholars, practitioners, and institutions understand innovation in maternal health. In this way, this chapter extends this dissertation's thesis from the level of individual care practices to organizational infrastructure. Black-led CBOs are not supplemental to institutional healthcare, they design and sustain alternative systems of care grounded in community knowledge, offering a structural counterpoint to dominant, institution-centered models. Taking this system seriously requires recognizing Black communities as capable of shaping more just futures for maternal health.

Chapter 5 - Making A Way Outta No Way: A Multimodal Reflection on Designing at the Intersection of Justice and Joy

Introduction

In chapter 1, I shared personal narratives of moments in my life that instinctually changed my engagement with and understanding of technology and society more broadly. The truth of the matter is, I've had, and continue to have, these moments for as long as I can remember, despite only now being able to articulate these moments and their impact. When I started my PhD program, it opened up a world of language that I didn't even know existed. Suddenly, many of my life experiences were being named and categorized in a way that contextualized my life in society more broadly. It's like being from a place where you don't have easy access to fresh food and produce options, only to learn that it's a "food desert" (Thibodeaux, 2016; Walker et al., 2010), a human-engineered site of harm as a product of racism and capitalism. With this deeper societal perspective, my experiences have been compiled together like a literature review embodied to critically shift, shape, and stretch my research/design practice over time.

The idiom “making a way out of no way” is the essence of the Black spirit and community. It speaks to the creative and resilient ability of Black people to take what little we have because of anti-black and systemic racism, and despite our best efforts, and make the most of it. It is where the limits of our environments and situations meet the infinite possibilities of our minds. It is where we turn what was meant for violence, division, disillusionment, and destruction in our communities into care, unity, vision, and power. Making a way out of no way happens from church mothers watching neighborhood children so their mothers’ can work to Black people organizing voter registration drives in Black communities under the threat of violence and intimidation. Making a way out of no way happens when Black people choose joy in a society engineered to produce anger and rage. Making a way out of no way happens when Black communities design entire counter-systems of care and survival. It doesn’t look like one

thing or follow any particular rules, but it shares the common thread of making something necessary to Black survival and flourishing happen in the face of seemingly impossible circumstances. Making a way out of no way exposes the narrow limits of what counts as valid or worthy of being visible through Black experimentation and deliberation. When a maker “makes a way out of no way,” their use of their agency, creativity, and resilience makes them keenly aware of their power. But it also illuminates the constraints they operate within and the limits of our society as it is currently imagined and maintained. My ability to make a way out of no way, coupled with my doctoral education, has sent me on a journey that pushes the boundaries of research as understood in the academy.

In the first quarter of my PhD, I read a paper outlining the seven contributions of HCI research (Wobbrock & Kientz, 2016). I read the paper and felt that a key contribution was missing. I decided to type up my argument and share it with my advisor in our next one-on-one, considering she was the last author on the paper. I remember being nervous about sharing my argument with her because I found it difficult to assert that the “feelings” I had while reading the paper were valid. In my very first publication, “Why You Being WEIRD To Me: Reflections of a Black Researcher in HCI”, I shared that it was difficult to assert my critique of the field because I had “imposter syndrome” (Coney, 2022). I overcame my anxieties and shared my Google doc, arguing for an eighth contribution, a community contribution. In the document I wrote:

“While the original seven contributions are great measures of a researcher’s impact on the field of HCI, they miss the opportunity for researchers to be more intentional about contributions that expand beyond academia into the communities researchers engage with. I agree that the seven current contributions may overlap with community contributions, but there is a certain

intentionality that comes with assessing contributions for a community versus academia/academics.” (Google doc, 11/18/21)

My advisor was appreciative of my engagement with the paper and thought the idea was great, but she pushed back, sharing that the seven contributions fell under the National Science Foundation’s (NSF) criteria for intellectual merit (National Science Foundation [NSF], 2024), which is defined on their website as “The potential for the proposed project to advance knowledge and understanding within its own field or across different fields.” She suggested that a community contribution might fall under the broader impact category (NSF, 2024), which is defined as “The potential for the proposed project to benefit society and contribute to the achievement of specific, desired societal outcomes.” With these definitions in mind, I added to the bottom of my document a line of questioning that I wanted to unravel about who gets to define merit and the modes or extent of its impact. This is especially important to consider now as the NSF has been used as a Trojan horse for the current US administration’s gutting of critical research funding (Deák, 2025; Mackenzie, 2025; U.S. National Science Foundation, 2025). After mulling this over for some time, I knew I wanted to find a way to give back to my research participants more tangibly and intentionally, centering them instead of traditional research outcomes.

This led me to design and implement Cradles & Culture, a community baby shower held for my research participants in the TRIBE study and the broader Seattle-Tacoma community. After almost two years, I’ve finally found the language for why and how Cradles & Culture makes the case for centering community *and* creating new knowledge for the field. Below, I share reflections from my experience designing and executing the baby shower. The two major contributions of the shower include an emerging theorization of what I call marginal sensibilities

as a design epistemology and aesthetic, and a method for engaging a critical design practice. My reflection on my experience developing the baby shower manifested in a nine- page scrapbook. To close the reflection, I put select pages in conversation with each other to share takeaways from my experience.

From Imposter Syndrome to Marginal Sensibilities

I come from a small, far-south suburb of Chicago, Illinois. My experiences sit at a peculiar intersection of advantage and disadvantage. While we were a “suburban town”, we did not actually embody the stereotypical suburban neighborhood. Our predominantly Black community was impacted by poverty, a lack of funding and access, gun violence, an under-resourced education system, and other ills plaguing Black communities. Despite this reality, my first experiences of community care were in these same environments. My church, a Black Baptist church in a predominantly Black neighborhood in Chicago’s south suburbs, was a critical network of care in my life. Many of the women in the church helped raise me, whether it was through watching me while my parents worked, developing my talents (like singing, sewing, and taking care of children in the church nursery), or through loving correction. It was in this space that I learned of a responsibility greater than myself. This context molded my preliminary perceptions of myself, my community, and the way the world worked.

Howard University completely changed my view of Blackness. There, I encountered a wide variety of Black people from across the African diaspora. I didn’t even really have a concept of the diaspora when I first got there. I remember the first international friend I made. She told me she was from Guyana, and I told her I couldn’t wait to visit the continent! After the perplexed look she gave me, I went to look for her home country, only to discover it was located

in South America. These gaps in knowledge were not only exposed through my interactions with Black international students, it was also illuminated through class differences between other Black Americans and me. I vividly remember wrestling with the reality that my home community needed programs like TRIO, a college opportunity program that motivates and supports students from disadvantaged backgrounds in their pursuit of a college degree, to support college readiness in high school, whereas I was meeting upper-middle-class Black students whose parents' engagement with exclusive organizations like Jack and Jill of America, a membership-based social organization for Black families that fosters leadership and lifelong networks among their children, and Greek-letter organizations supported their college preparedness over time. These experiences revealed to me that Blackness was not just one thing, and that it didn't manifest in any one particular way. It also revealed, however, gaps in what my home community and I were/are subjected to, as well as what's possible for our communities and lives. These experiences in the margins deeply shaped my perception of Blackness, myself, and my community.

In the first year of my PhD program, my battle with imposter syndrome had less to do with any objective feelings of not belonging and more to do with my identity not being reflected back to me. Imposter syndrome, first named by Clance and Imes (1978) as the imposter phenomenon, has since been reframed by scholars like Hewertson and Tissa (2022), who argue that for marginalized groups, imposter syndrome is not merely a personal feeling but a culturally conditioned response to navigating a "culture of power" not built for them, one shaped by the intersecting oppressions of race, gender, and class. Imposter syndrome assumes a questioning of the self, but I believe this line of questioning is part of a greater sensemaking process for marginalized people gaining consciousness about their own marginalization and the greater

function of it in society. It is not a response to perceived or objective lack. It is, in part, a response to constantly not seeing yourself reflected positively, or at all, in your environment. Coming to this realization shifted my paradigm. I no longer felt like an imposter, but a person living in an impossible system. Eventually, in my sensemaking journey, I stopped being skeptical of myself and individuals and started being skeptical of systems that split realities across race, class, gender, socioeconomic status, (dis)ability, education, and healthcare access. These split realities are hierarchically organized, prioritizing white, male, cisgender, heteronormative, and capitalistic ways of knowing and being. For lived realities outside of this context, their world is regarded as only marginal to *the* world, when in reality it is marginal to *that* world. While dominant actors and perpetrators of this reality may paint this out as negligible, dismissing those marginal realities and the knowledge they produce, I see it as a superpower producing marginal sensibilities.

Marginal sensibilities are ways of seeing the world that can only be produced by and in the margins. These sensibilities are developed by a marginalized person's embodied and emotional experiences as it relates to marginalization, whether implicitly or explicitly. They speak to the experience of existing on the edge or out of bounds of dominant narratives, practices, and systems. To exist in a world not designed with you in mind and to develop, over time, a finely tuned awareness of exactly how and where that design fails. Marginal sensibilities are not a liability to be managed or a bias to be corrected. They are a form of knowledge production that is affective, embodied, and generative. They are what the canary sings in the coal mine. For marginalized researchers, these sensibilities will inevitably be triggered as we operate in dominant academic spaces and practices (Collins, 1986). I've learned to let these senses create a critical lens for developing my own research/design practice, true to my values.

From Bias in Digital Health Systems to Community-Driven Service Design

After my experience at the hackathon shared in Chapter 1, I'd decided that I wanted to use my computer science skills to help address Black maternal health inequities. So, I wrote my PhD application on bias in digital health systems toward Black mothers and how I wanted to further develop the prototype from the hackathon, the Motherboard. As I started engaging with literature on the use of technology in hospital and clinical settings for Black women and literature on Black maternal health inequities, I found the experience quite depressing. This work was inevitably enmeshed with my being as a Black woman. I'd uncovered a violent obstetric history for Black women and birthing people. Not only that, it's been made very clear that the contemporary impacts of this violent history are preventable. Yet, a culture that experimented on Black people's bodies is absolutely one that would continue to disregard them. Additionally, technology, as it is designed and deployed widely, perpetuates and obscures this violence.

This experience took my focus from misogynoir bias in hospitals to care in communities. While I acknowledge that technology and its development are not neutral, they are malleable, and only one artifact in a broader system. Service design, then, became a lens for thinking about the design of counter-systems of care. From my lived and shared experiences of community care, I saw community care as an invisible counter-system, one with its own logic, values, and infrastructure that dominant health systems had rendered illegible. Making this system and the values it embeds visible would provide not a solution to a problem (Cunningham et al., 2023), but a world of opportunities for more meaningful, intentional technology development and use, or non-use, in a community-based context.

This transition from bias in digital health systems to community-driven service design leaned into a more joyous lens and approach for Black maternal health equity. It's taught me that justice is not only defined by making wrongs visible, but also by making them right. The pursuit of justice is a fraught journey, and joy is necessary not only for survival but for creating worlds beyond it (hooks, 2000; Love, 2019). This new lens has not taken away my pursuit of justice for Black mothers and birthing people; instead, it has altered how I pursue it. This intersection of justice and joy is especially ripe with opportunities to imagine other worlds (Barabas & Smith, 2026; Benjamin, 2024; King et al., 2020).

Leveraging My Academic Position for Community Benefit

Although I come from a low-income background, my socioeconomic status has shifted due to my education. From my current position, I have access to information, tools, and resources that aren't readily available for Black and other marginalized communities. This context situates me as what sociologist Patricia Hill Collins calls an “outsider within” (Collins, 1986). I find myself between two worlds: institutions that do what they want and communities that do what they must. Hosting Cradles & Culture was, in part, about deciding which world I was designing for. What followed was an intentional effort to leverage what the institution afforded me in service to what my community needed.

As a participant of this counter-system, I wanted to be very intentional about how I represented the Black community in my research and how I used my position in academia to create a more tangible way of giving back to my research participants and broader communities. Deeper than compensating participants for their time, giving back to my participants was more about, for example, moving from only reporting that Black mothers need to be in community

with other Black mothers to designing a space to bring them together. It's a call to researchers, particularly of marginalized communities, to turn insight into action, even in small, localized ways.

I learned about community baby showers and immediately saw it as an opportunity to create and host one. I thought about how baby showers are cultural sites in the Black community for gathering and celebrating parenthood. When I shared this vision with Whitney, a Black woman and one of my maternal health mentors, she thought it was a great idea. However, she'd cautioned me against recreating an atmosphere of a “disengaged resource fair”; that I should pay special attention to the details in baby showers that contribute to them as sites of joy and gathering, with like games, soul food, DIY projects, a “cookout” playlist, warm and sometimes familiar faces, and so forth. Expanding it to a community model and leveraging my research and lived experience for the design seemed like the perfect way to embody what a community contribution could be.

My community partner Jazmin and I had already been working together throughout the TRIBE study, where she served as a co-interviewer and community guide, bringing cultural resonance and local presence to the research process. When we wrapped up interviews in the spring of 2024, we began planning Cradles & Culture together. Jazmin's rootedness in the Seattle-Tacoma area was indispensable. Through our weekly planning meetings, she helped identify venues that would be accessible to honorees, flagged important dates in the local Black maternal health calendar to avoid overlap, and connected us to the broader network of people and organizations excited to be a part of this work. When registration data revealed that most honorees lived further south in Pierce County, it was Jazmin's knowledge of the area that helped us make the decision to relocate the event to Tacoma, a move that reflected our shared

commitment to meeting the community where they actually were. She also served as a sounding board for design ideas throughout the process. I didn't want to burden her with the intricacies of putting materials together for the shower. As such, we decided that I could handle those things informed by our research data, my lived experience, and her feedback.

Though my partnership was not only made possible through the institution (i.e. I believe I could have reached out to Jazmin without being a university student, as it relates to innovative Black maternal health ideas), it was solidified through funding received from the University of Washington's Black Opportunity Fund. While there was a valid critique of the fund as performative in the wake of the murders of George Floyd, Breanna Taylor, and countless other Black people at the hands of police (UAW Local 4121, n.d.), I've found this funding impactful for redistributing resources and funds back to the local Black community. The funding covered many expenses, including catering, decor materials, game prizes, two car seats, and our largest expense, a reimbursement to Jazmin for the resources she supplied for the honoree gift baskets. We filled 20 baskets directly from her community pantry, an existing program of hers that offers free resources such as pacifiers, infant CPR wraps, baby carriers, and Black-owned items such as Black Girl Sunscreen for kids and "Wipe me down" baby wipes. For Jazmin, it's not only important that these resources were made accessible; she intentionally sourced the items from Black-owned businesses and Black community members to pour back into the broader Black ecosystem. This "for us, by us" model in the pantry speaks to this notion of community systems.

As a researcher, I leveraged my access to data to make informed design decisions. My interviews revealed several patterns that shaped how the shower was designed. Many participants had expressed a desire for birthworker support during pregnancy and postpartum, which directly informed the type of community partner organizations we reached out to.

Recognizing that perinatal mental health is often less talked about in community spaces, we also included Kyla Care Therapy, a Black woman-owned perinatal therapy practice, as one of our tabling partners. Mothers in the study had spoken about how much it meant to have partners and family members included in their perinatal experiences, particularly in hospital settings where that access is often restricted. I made it explicitly clear on the event flyer that partners, fathers, family members, and children were all welcome. One mother had mentioned feeling like her older kids and toddlers weren't fully considered when a new baby came into the picture, which led me to set up a kids' table separate from the gift table where young children could pick a free toy or book. It was a nice-to-have to take home, but it turned out to be immediately useful as toddlers grew restless over the course of the event. The community partner organizations brought physical pamphlets and anatomy models with them for educational purposes, and the information they shared was already tailored to the demographics of the honorees, which mattered because mothers in the study had emphasized the importance of information coming from trusted, culturally relevant sources.

My skill set as a researcher also contributed to my ability to manage the many moving parts of this project. Relationship-building, coordination, budget management, and serving as a connector between people and organizations were all capacities I had developed through my research practice and drew on heavily here. When the date and location of the shower changed, I did my due diligence to ensure everyone received word about the update. Despite my efforts, one mother drove over an hour to the original location. I felt terrible about the miscommunication and reimbursed her for her gas and her time. That moment stayed with me as a reminder that designing for community means being accountable to real people. I also emailed each community partner individually and set up separate meetings to share the vision for the shower

and discuss what to expect if they participated. They were all excited to be part of the event and appreciated the opportunity to simply show up with their resources while I provided the space, atmosphere, and community members to engage with. After the concept of the baby shower was structurally oriented, it was time to put the “culture” in Cradles & Culture.

Marginal Sensibilities as a Design Aesthetic

When the "what" of the baby shower was figured out, it was time to start thinking about the "how" aesthetically. It was important to me that these mothers and their families saw themselves reflected in this baby shower. As such, I set out to infuse Blackness and joy into every aspect of the event. It is not an uncommon practice in the Black community to DIY a project, particularly on a tight budget or in response to excessively priced items or services. I also enjoy the creative process that comes from DIY projects. My mother is a craftswoman, so my artist's eye is generational. I have watched her turn materials bought at the dollar store into artful masterpieces. This sensibility, more than any single design choice, shaped how I approached every element of the shower below.

Nourishment: Food and music have been central to nourishing Black people's bodies and souls. The food was catered from a well-loved Black-owned Seattle staple, Simply Soulful. We had a spread of traditional African American cuisine, or soul food, along with snacks, fruit, and of course Capri Suns, with to-go containers so honorees could take food home with them. I also put together a playlist pulling from songs affectionately known as "cookout music" among many Black people, like "Before I Let Go" by Frankie Beverly, alongside songs showing deep reverence, gratitude, and celebration of Black mamas from various Black artists, like "Dear Mama" by 2Pac.

Decor and Culturally Informed Activities: I sought out Black women-owned businesses for services such as photography and balloon decor, the latter provided by a decorator who self-defined as a "mompreneur." I tapped into my own DIY skills to create affordable centerpieces for the tables and to spray paint the gift baskets and other decor gold to match the color palette of the shower. I chose purple and yellow/gold for the colors to signify royalty for the mothers rather than subscribe to traditional sex-based color themes like pink and blue.

In our weekly meetings, Jazmin and I also mulled over good game ideas that were both engaging and respectful of people's boundaries, given that this was a more public setting than traditional baby showers for friends and family. We decided to do paper-based games, namely Baby Bingo and Guess That Celebrity Baby. When I searched for templates via Google, the search results featured pictures of white icons and celebrity babies. I decided to use Canva to recreate the games using images that reflect and resonate with honorees. The event flyer and a resource list, which compiled local resources shared by Black moms in my TRIBE study, were also designed in Canva to be accessible and resonate with honorees (See appendix A).

A Mother's Hands, From Afar: For the gift baskets, I designed a Cradles & Culture logo on my iPad and created cradle-shaped bag tags that read "thank you for joining" along with the date of the shower. My mother brought the designs to life with her Cricut machine and shipped the materials to me from Chicago, extending her making practice across distance into the heart of the event.

These details, from the cuisine selected, to games that reflect honorees' identities, to my own labor of love creating DIY decor, didn't come from a research paper's findings section. They came from a place of knowing and being that is deeply tied to my identity as a Black woman. I struggled to articulate my experience designing the baby shower, or even how to frame it,

primarily because I struggled to situate these sensibilities within existing literature. This requirement within academia to only validate my methodological approaches based on literature obscured my marginal sensibilities. Rather than dismissing the experience as "just a nice thing to do for the community," I decided to take it seriously and lean further into the sensibilities that made the experience powerful as a type of tacit design epistemology.

Experience of the Baby Shower the Day Of

The day of the baby shower was beautiful. Seeing the physical layout of the room come together from a measly iPad design was surreal. Everyone pitched in on setup, including community partners and my own friends who volunteered to support. I remember being grateful for the amount of natural sunlight the room had. It made for great lighting for the photographer and an overall light and airy atmosphere that set the tone for the whole event. Connecting with all of the community partners in person, some again and some for the first time, was amazing. There was an energy in the room from the very beginning that felt like something we had all been building toward together.

The games were so much fun. Even honorees who didn't recognize a celebrity by name were engaged. I'd hear things like "Ain't that the woman from Orange is the New Black?!" I also loved that honorees brought other people with them, including their husbands, sisters, younger children, and even their own mothers. Everyone loved the food, and I was constantly being asked where we ordered it from. It was beautiful to see families speaking with each other and with community partners, and to see different members of the community holding different babies across the event, which is not unheard of in the Black community. I didn't get to personally document the day as much as I had hoped, but that is also why we hired a photographer, so we

could be present as planners while knowing the moment was still being captured. I ended up doing quite a bit of running around during the event, and I would have loved more time to sit with honorees more intimately to ask about their experience at the shower. But even from the periphery, what I witnessed was exactly what we had set out to create.

The honorees felt it too. I shared a brief, optional survey for honorees on each of their tables and in their gift baskets. One mom shared that the event accommodated everyone, saying she really felt like everyone was catered to: mothers, babies, and older kids. Another noted the thoughtfulness of the gift baskets and expressed hope that the event would continue for the community. One honoree captured what many seemed to feel: from the time she got out of the car in the parking lot, it felt like she was at a family reunion. Everyone was so nice and welcoming. She felt all of the love and warmth from her village. Another said she was so happy to participate in such an uplifting and engaging project, and one more urged us to keep going, writing that we needed more financial and organizational support to host bigger events and be able to give families more for “new additions to the community”. These testimonials speak to the rich experience that was created through intentionality and collaboration. It affirmed that there are meaningful ways to use my research and positionality as a way to support my community.

If It Ain't One Thing It's Another

Not only did I struggle to articulate my marginal sensibilities as a design aesthetic, I also didn't know how to hold the complexity of the process, not just as Leslie the researcher, but as Leslie the person. While I was spray painting the honoree gift baskets on my apartment rooftop, after getting permission from our maintenance man, I was approached by my white woman property manager. I didn't know who she was because she had just started working at the

apartment. She told me that I couldn't spray paint. I was almost done, so I told her it was for a community baby shower and that I had received permission from a staff member. She insisted that she didn't care and that I needed to stop. I started cleaning up the area and finished the last three baskets. It was spray paint, so that took all of five minutes. By the time my materials were put away, I was issued a ten-day notice to comply with my lease or vacate the apartment. In the days following, several “suspicious” events started happening, like my mail not being delivered and my key fob being deactivated on the same day as the baby shower, leaving me locked out of my apartment when I returned from the event. Months of harassment ensued in the form of thirty-day notices to pay my rent or vacate, even though my rent was paid. Ultimately, my lease was unlawfully terminated, and I was effectively displaced from my home. To no surprise, I was one of three Black women having simultaneous, unjust experiences with the same property manager. Their leases were terminated as well.

There was no ACM paper format that could carry this story wholly and connect it to why the baby shower was such an important endeavor. As I saw it, the same racist logics that displaced me from my home were the same reasons why the baby shower had to be moved from Seattle proper to accommodate honorees who primarily lived further south. My understanding of these logics, both embodied and intellectual, fueled the very need for action to promote community care, resources, and joy for Black mothers.

Scrapbooking as a Critical Reflective Tool

I originally thought I'd share the baby shower experience through an artifact analysis. I had many photos from the baby shower and thought it would be great to tie the story to the visual elements of the shower. In an effort to make the photos more uniform, I uploaded them to ChatGPT and asked the bot to make them all watercolor style. Later, in a meeting with one of my

committee members, I expressed that I didn't feel right using the AI-generated photos for two reasons. First, the content I wanted to speak to, a story about Black community care, joy, and resistance, felt incongruent with a tool whose widespread deployment actively and disproportionately harms Black communities (Djanegara et al., 2024; Iloanusi & Chun, 2024; Weidinger et al., 2021). Second, the generated images felt disconnected from the realness of what the day actually was. She simply encouraged me not to feel compelled to use the tool and reminded me that I could create the visuals by hand. Something about that suggestion immediately made me turn to scrapbooking. Not as an avid scrapbooker tapping into an established craft, but as a woman with her mama's artistic eye, ready to apply it to any endeavor, including research.

Considering I already had physical photos of the baby shower, I went to Michaels to get a scrapbook and a few more craft materials. To figure out how I'd organize the scrapbook, I journaled about the experience of designing and hosting the baby shower, including what happened with my apartment. In rereading my entries, I saw that I had written I was still “wreckoning” with displacement. When I realized it was spelled wrong, I took it as a Freudian slip. Leaning into this idea of w/reckoning and what it may look like, I divided the concept into eight facets based on my own experiences of reckoning across this project, but also in my life more broadly: anger, grief, inquiry, critique, remember, resistance, imagine, and otherwise. W/reckoning becomes a frame for marginalized people to consciously unpack their own marginalization and the unjust treatment of others. I believe that for marginalized people born into a system of marginalization, w/reckoning starts with embodied understandings, even if the connection to larger powers at fault has not yet been made. Anger and grief represent a broader set of embodied emotions that may arise from experiences of marginalization and unjust

treatment. Inquiry and critique represent a critical pursuit of knowledge and a cognitive understanding of the conditions and systems that shape marginalization. Remember and Resist represent lived and historical forms of counteraction to those conditions and systems, including community care, protest, and joy. Finally, Imagine and Otherwise represent how these prior knowledges work to inform new conditions and systems altogether.

Scrapbooking became a medium of critical and creative refusal, and it enabled w/reckoning in four specific ways. First, counterstory: deconstructing and reconstructing materials allowed my counternarrative to surface visually, placing my own account of events in direct conversation with the documents, images, and artifacts that shaped the experience. Second, tactility: working with my hands offered a grounding alternative to AI-mediated creativity and challenged hierarchies of what counts as critical and creative work. There is knowledge that comes from making with the body that no prompt can generate. Third, reflexivity: engaging with the materials prompted sustained reflection on design, displacement, and the broader experience of Black people making a way amid systems designed to enforce no way. Fourth, creativity: academic spaces often suppress creativity in the name of scholarly rigor. This project affirmed that we can be both rigorous and creative, and that the suppression of one in service of the other is itself a form of institutional harm worth resisting.

Taken together, this framework of w/reckoning and the unique, to traditional research dissemination practices, properties of scrapbooking created a more robust visual of my experience. Additionally, this medium allows for deeper engagement and discussion with those who encounter the visuals. As such, the discussion section is oriented by putting two collages in conversation with each other to surface themes and broader takeaways for design and research communities.

Discussion



Figure 1: First Anger Scrapbook Page

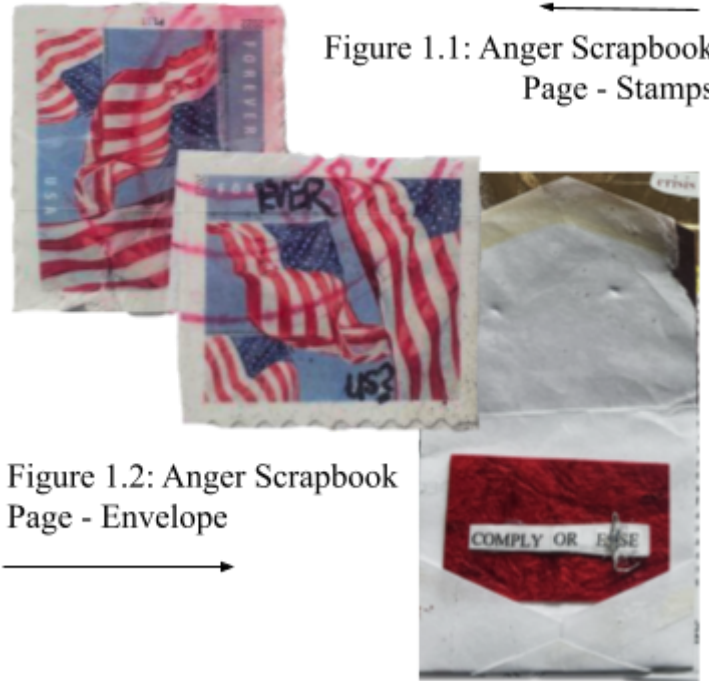


Figure 1.1: Anger Scrapbook Page - Stamps

Figure 1.2: Anger Scrapbook Page - Envelope



Figure 2: Second Anger Scrapbook Page



Figure 3: Resist Scrapbook Page

Anger + Resist

Anger has been a productive force in my research practice. I am not easily angered, but I do hold a deep, innate sense of (in)justice. These sensibilities have served as sensors, identifying gaps so that I can bridge them instead of falling into them. These bridges, in many cases, take the form of resisting dominant narratives that invalidate marginal lived and shared experiences.

Encountering paywalled research, even as a scholar with institutional access to an abundance of information, is extremely frustrating. It makes me wonder how we price out knowledge. How do you quantify the line between who can and can't have the privilege and power of knowing? To resist this in my own work, I took the community-based resources shared by moms in the TRIBE study, which I felt were the most important and immediately available knowledge, and curated a list to share with participants and the broader community of Black birthing people I encountered throughout my time in Seattle, whether through research or by happenstance. Additionally, honorees were able to receive culturally-relevant information about pregnancy, birth, and parenthood more broadly from CBOs at the baby shower.

My anger is also fueled by the ways clinical and deficit-oriented research has framed Black mothers and birthing people as problems to be solved instead of people to listen to, learn from, and be in community with. I was enraged reading literature that treated Black maternal death as just a statistic, erasing the deliberate systemic violence and structural neglect that produces it. Outside of death, Black mothers and birthing people were still more likely to have poorer experiences and outcomes. It made me anxious for the new and future mothers in my life,

including myself. It almost felt as if it were inevitable or would take a long time to actually transform. I refused to replicate that framing in my own work. Instead, I drew on community presence and practice, on what Black communities already knew and already did for Black mothers, as the foundation of my research rather than supplemental. This does not negate my need to also make visible the structural harms that have been produced and reproduced by our society. A deeper understanding of that history was enraging. Yet it did contribute to my own micro-practices of resistance. For example, I found myself about to ask ChatGPT a quick cooking question one day. In that same moment, I realized I could, and should, just call my grandmother and ask her. She hasn't been the sole chef of Thanksgiving since before I was born, for me to seek cooking knowledge from an AI bot. Plus, our cooking practices are deeply intergenerational and healing. Understanding the harm that disconnects Black people from these knowledges will have you thinking more intentionally about how to maintain them in your own life.

Additionally, when we turn to our communities as sites of gathering and support, we are often met with institutional opposition. This angered me at first because it communicated that not only were we not wanted in dominant spaces, but those in power wanted to control what happened in our marginal spaces so as to keep us in the margins. I am indebted to my ancestors, who were also angered by this opposition and kept going anyway. They understood that continuing in the face of that opposition was itself an act of resistance. I embodied that spirit when I filed a complaint with the Seattle Office for Civil Rights. Despite the mental and physical turmoil of that process, it was imperative for me to speak truth to power, not only for myself but to document the pattern. What happened to me and my Black women neighbors were not an isolated incident. They are the invisible logics that disrupt Black lives daily, and they have to be

named and made visible. The city issued a ruling in my favor. That ruling will not undo what happened, but it exists now as material evidence of what many Black people and I already feel in our bodies.

Finally, to minimize bitterness or stagnation from my anger, I've used it to fuel my creative practices. These practices are also, in and of themselves, a type of resistance. The anger pages were actually the first two pages of the scrapbook that I made because I was so excited to cut and rip up the notices I had received. In this process, I surfaced my own feelings of the experience and my own voice in response. These elements are most visible in the poem in the bottom right and the postage stamps. For the poem, I turned their sense of urgency to get me out of the apartment into my sense of urgency to leave for my safety. Additionally, the postage stamps, as designed, read “forever USA”. I annotated the stamps to draw out a pressing question, “Ever us?”



Figure 4: Inquiry Scrapbook Page



Figure 5: Imagine Scrapbook Page

Inquiry + Imagine

Inquiry shapes what we are able to imagine, and imagination shapes the questions we think to ask. These two forces are not sequential. They are cyclical, each one expanding the limits of the other. My own experience of this cycle is perhaps most visible in the distance between the Motherboard and Mamafesto. When I first entered this field, my inquiry was anchored in clinical settings and technological solutions. I had read about bias in digital health systems, about the ways algorithms and tools deployed in hospitals failed Black patients, and so I imagined a solution that lived in that same space. The Motherboard was a symptom-tracking app designed to help Black mothers document their pregnancy experiences and receive predictions about possible complications. It was a good idea shaped by a narrow inquiry. It focused on what technology could do inside a system that was already harming Black birthing people. This line of thinking could not have imagined Mamafesto because I had not yet asked the questions that would make Mamafesto possible. Over time, I became more interested in understanding the care practices Black communities had already developed and the role technology might play in supporting, extending, or simply learning from them.

Reading *Viral Justice* was one of the first inquiries that fundamentally changed how I imagined addressing Black maternal health. Ruha Benjamin gave me a scaffold of language for understanding how the invisible networks of community care I had witnessed my whole life were not just cultural practices, but sites of design knowledge and knowledge production. She

reoriented my focus from top-down approaches to bottom-up design ideals, starting with how communities care for themselves even through opposition, rather than focusing primarily on the harm that creates the need for such systems. When she signed my copy of the book she wrote, "Dear Leslie, Another world is possible." I lined that inscription with purple rhinestones in the inquiry collage to signify the baby shower as part of the other world I was beginning to imagine through my research.

Black feminist thought and the Combahee River Collective did something different but equally important. They did not just change what I was imagining. They changed how I trusted myself to imagine. Following my marginal sensibilities had always felt risky in academic spaces, like I was asserting something I couldn't prove. Black feminist scholarship gave me a lineage of Black women who had been questioning, inquiring, and building something else for generations. I was no longer feeling left out or left behind. I was just left in between as the outsider within. I was in the "ivory tower" but always *of* the town's folk spirit. My confidence in my work and my thought processes grew when I understood that I was conferring with that lineage, not inventing from scratch. For this reason, I drew out Pan-African colors in the collage, red, green, black, and yellow, as a way of honoring what these scholars, along with other marginalized scholars, and their work made possible in me.



Figure 6: Critique Scrapbook Page



Figure 7: Otherwise Scrapbook Page

Critique + Otherwise

In a recent talk on Faith and AI in Washington DC, Ruha Benjamin expressed that it is not enough to know what we want to tear down. We also have to know what we want to build up. In my practice, it wasn't enough to just report on community care practices. I wanted to design a space that embodied them, driven by my research and lived experience. While critique is necessary for challenging thoughts, practices, and assumptions, it must not only take written form. We critique to illuminate possibilities, and through design, we can create otherwise.

My early critiques of research dissemination stemmed from the reality of research extraction. People share their stories and insights only to have the synthesis of those stories locked behind paywalled journals or buried in verbose academic jargon. I'll even lose access to some of this knowledge when I lose my UW email after graduation. I have always seen the Black mothers and birthing people I work with as the primary beneficiaries of my research outcomes. One response to this critique has been intentionally submitting my work to open-access publishers like Health Equity. But the critique to action didn't end there. Cradles & Culture became a way to explore my research in material and embodied form, bringing knowledge from the TRIBE study to life through design and sharing it with research participants in ways that were meaningful and responsive.

My critique of the seven contributions framework had a lot to do with questioning who defines rigor and impact, how we center communities across our research practices, and a desire

to transcend rigid boundaries between knowledge production and lived experience. It has been difficult to assert these critiques because I can't cross-reference a marginal sensibility in the traditional sense. There is much Black feminist literature that speaks to the difficulty of asserting oneself as a Black woman and the grave need to find the means to do so (Collins, 2022; hooks, 1989; Lorde, 1984) . These sensibilities led me to both Cradles & Culture and the scrapbook as alternative methods for more expansive approaches to knowledge production and knowledge sharing.

Finally, my critiques of Seattle became fully realized when my lease was unlawfully terminated. For a long time, I tried to keep separate the personal ways Seattle was taking a toll on me from my on-campus student life, because I really loved my PhD program. I'd always known that HCDE was the best department for me to pursue my PhD. As I was navigating the process of deciding what program would be the best fit, I ran into discouraging and outright rude conversations like being told I should apply for a master's program because I wasn't ready for doctoral level work, after 10 mins of speaking to me might I add, or being told that Black maternal health was too political of a topic by a white man professor. These interactions signaled to me that I would not be safe, regardless of how "prestigious" the professor, program, or university was. HCDE is not a perfect department, as no department is, but compared to other engineering colleges and departments, especially ones of high notoriety, it has a more inclusive, flexible and critical environment that I've been able to learn within. This bubble created what has felt like a safe space to grow intellectually in my research, but it was still in the context of a draining environment.

When I received feedback during one of my annual reviews about concerns for my performance as a teaching assistant, I couldn't help but think about how my everyday

experiences as a Black woman in Seattle significantly impacted how I showed up, or didn't, on campus. When I shared instances that affected my presence, like being aggressively called a “dumb n-word” on public transportation, the teaching committee was deeply appreciative of me sharing my perspective, with one professor responding, “Your writing is eloquent and powerful. And, your writing also does a great job of illustrating the injustice of needing such writing to capture the inequity in the experiences (because the inequities shouldn't be there and thus need to be captured). Thank you for trusting us enough to share all of that.” They worked with me to find solutions to matters within my control, which ultimately helped in future positions. I had also intentionally moved to Seattle's historically Black neighborhood in search of some level of respite. When my lease was terminated, I told my advisor that if I couldn't be safe in the historically Black neighborhood of Seattle, I wouldn't feel safe anywhere in the city. I packed my things and relocated back to Washington DC.

DC provided something necessary for my research/design practice that people don't always consider. It put me back in proximity to Black scholars across intersectional fields, where I could engage in real conversations about how we build for our communities. It put me back in community with Black people who have affirmed my being, like my Howard network and DC-based church. My mental health improved drastically, and parts of my creative identity resurfaced that I believe the scrapbook is evidence of. DC is not without its own struggles, though. Shortly after I arrived, the streets were overtaken by the National Guard's deployment. Despite the lies that prompted their placement, the local community responded as they always have, with gathering, protest, and action. One event turned the parking lot of an abandoned AutoZone into a block party with line dancing, chalk art, skating, afros, chess games, and

information on DC's fight for statehood and self-representation. It was a reminder that our critiques of society have always also existed as something else. As other possibilities



Figure 8: Grief Scrapbook Page



Figure 9: Remember Scrapbook Page

Grief + Remember

In the early stages of my research, I held a lot of grief as a Black woman living in Seattle, transitioning to a predominantly white institution (PWI), and doing Black maternal health research through a deficit lens. I had only ever occupied Black spaces before, and through the good, bad, and better, it was still my community. The loss, or really the physical distancing, from this community took a toll on my mental and physical health. On my first day of class at UW, I sobbed on campus. I had not experienced the loneliness of being the "only one" before. At Howard, when my family dropped me off in my freshman year, we were saying our goodbyes tearfully when two Black girls yelled across the street, "Don't worry, we got her!" I think about that moment often. At UW, people barely make eye contact in passing.

For Black women, mothers, and birthing people, I grieved the realities of our experiences. While I am not a mother, I do have my fair share of disheartening reproductive health experiences. These realities were made plain through my inquiry: Black women's pain is a product of our constant, pervasive dehumanization. I often thought of my mother and grandmothers and the many things they have had to overcome or still quietly endure.

Memory is a powerful thing, though. When I remembered what has always mattered to me, community, I knew I would be okay. I was not the only Black person who had just moved to Seattle on a prayer to pursue their first post-grad endeavor. The Black community I created in Seattle saved me. It was not that I did not feel grief anymore. It was that I was not feeling it alone. Suddenly, I could laugh and cry my way through Seattle because I had others to do it with. On the many days Seattle's gray skies overtook my mind, my Seattle community showed up with the warmth of the sun. A few of them even helped with the baby shower, from giving rides for Office Max runs to volunteering on the day of the event. We created a network of support to not only survive but thrive as well. From the "Black Recent Grads" GroupMe chat to the Black Graduate Student Association (BGSA) to the Good Black Birth Initiative (GBBI), finding Black community at UW, in the Black maternal health sphere, and in Seattle more broadly was imperative to my success and healing.

Finally, Black maternal health research has caused me to reflect more deeply about my own matrilineal lineage. I think about my knowledge of and relationship with my foremothers, past and present, often. This has also brought me grief at times, but has illuminated the deep importance of knowing who I am and who I come from. Throughout my PhD, I found myself drawing from their care practices, cooking, art, and music, and extending them through photography and poetry, to not only sustain myself but to encounter myself more deeply.

I remember what you taught me, even if you don't

I remember how you taught me, feel it in my bones

I remember why you taught me, need it to get through

I remember when you taught me, the things I wish you knew

Poem by Leslie Coney

Conclusion

This chapter began with a simple but pressing question: What does it mean to make research accountable to the communities it engages? Through critical reflection on the design and hosting of Cradles & Culture, I explored this question not only through writing but through practice. The baby shower became more than a dissemination activity or community engagement event. It became a site for interrogating how research, design, care, and lived experience intersect in the lives of marginalized researchers/designers and communities. In doing so, this chapter argued that a community contribution should be understood as a legitimate and necessary research outcome, particularly in work involving communities that have historically been overstudied, extracted from, and underserved.

This chapter also introduced marginal sensibilities as a form of design knowledge produced through embodied experiences of marginalization. I argued that they function as a valuable epistemological resource, generating critical awareness about the limits, exclusions, and harms embedded within dominant systems. Across the reflections shared in this chapter, marginal sensibilities shaped what I noticed, questioned, resisted, and ultimately designed. They informed how I understood community care, how I approached Black maternal health research,

and how I imagined possibilities beyond dominant institutional logics. The scrapbook, likewise, became a multimodal expression of this epistemological stance, demonstrating how critical reflection, creativity, tactility, and storytelling can work together to produce and communicate knowledge.

At the center of this chapter is the argument that critique alone is insufficient. Critique helps us name harm, but design asks what becomes possible beyond it. Throughout this dissertation, I have wrestled with the violence embedded in Black maternal health systems, from histories of obstetric racism to contemporary experiences of neglect and bias. Yet this chapter reflects a shift in my own orientation toward justice work. I came to understand that justice is not only about exposing what is broken, but also about participating in the creation of conditions under which Black people can live, gather, care, and thrive differently. Cradles & Culture emerged from this orientation as an attempt to materialize community care through intentional design.

The reflections throughout this chapter also demonstrate that the boundaries between research and lived experience are far more porous than academic conventions often acknowledge. My experiences with displacement, grief, joy, resistance, and community were not external to the research process. They shaped how I interpreted systems, what questions I pursued, and what futures I could imagine. In this way, the chapter contributes to broader conversations in HCI and design about reflexivity, positionality, and the role of lived experience in knowledge production. It argues that marginalized researchers do not simply bring diversity to research spaces. We bring ways of seeing that can illuminate possibilities and failures otherwise left unseen.

Ultimately, “making a way out of no way” became both the subject of this chapter and the method through which it was produced. Black communities have long transformed conditions of exclusion into infrastructures of care, creativity, resistance, and survival. *Cradles & Culture* was one small continuation of that lineage. It reflects what becomes possible when research is approached not only as a site of critique, but also as an opportunity to build, gather, remember, and imagine otherwise.

Chapter 6 - Discussion & Conclusion

This dissertation began with a provocative question: How might maternal health systems be reimagined when Black community care is centered rather than marginalized? Across interviews with Black mothers, analyses of Black-led maternal health organizations, and a multimodal reflection on community contribution and research practice, this work has argued that Black communities are not just passively navigating maternal health systems, but actively designing alternative infrastructures of care. These infrastructures are shaped through

relationships, cultural knowledge, collective responsibility, advocacy, and everyday acts of survival and support that often remain invisible within dominant institutional understandings of health innovation.

Taken together, the findings across this dissertation challenge several prevailing assumptions within healthcare, design, and technology research. They challenge the assumption that innovation emerges primarily from institutions, drawing attention to the innovative capacities of communities. They challenge the assumption that care is produced primarily through clinical encounters, highlighting the relational and social infrastructures that sustain wellbeing. They challenge the assumption that marginalized communities are recipients of design, demonstrating how communities design their own systems, practices, and ways of knowing. Finally, they challenge the assumption that research and design can remain detached from the communities and conditions they seek to address.

In this final chapter, I take a reflective and future-oriented approach to synthesizing these findings and articulating their implications for service design, human-computer interaction, Black maternal health, and justice-oriented research practice. I propose Mamafesto, a community-inspired service concept, examine the role of designers in centering the everyday through viral justice, explore how community care expands the contexts through which we imagine technology, and advance marginal sensibilities, w/reckoning, and community contribution as critical approaches to design epistemology and research practice. Together, these sections argue for a broader reorientation of design toward community-driven, relational, and justice-oriented ways of imagining care systems and possible futures.

Mamafesto: A Community-Inspired Service Concept for Black Maternal Health

Manifestos have long functioned as declarations of refusal, vision, and possibility. They emerge in moments where dominant systems fail to recognize the humanity, needs, and futures of marginalized communities, offering instead a collective articulation of values, commitments, and alternative ways of being. Within Black political and feminist traditions, manifestos have historically served not only as critiques of oppressive systems, but also as invitations to imagine and build otherwise worlds. In the context of Black maternal health, where Black birthing people continue to experience disproportionate rates of maternal morbidity and mortality, medical racism, and systemic neglect, a manifesto becomes not only a declaration of critique, but also an articulation of care. Mamafesto emerges from this lineage as a community-inspired service concept grounded in the maternal care infrastructures Black communities have long cultivated and sustained. Mamafesto translates Black community care values and infrastructures into a framework for imagining, designing, and evaluating maternal health services. In decentering institutional values and frameworks for care, Mamafesto illuminates the robust care systems derived from lived experiences, cultural practices, relationships, and survival strategies Black communities have developed across generations in response to exclusion from dominant healthcare systems.

The Service Concept

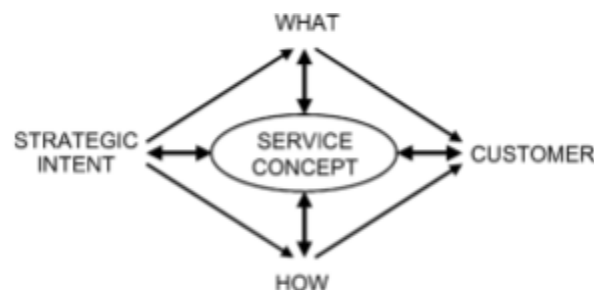


Figure 10: Goldstein et al (2002) Service Concept Model

Goldstein et al. (2002) argue that the service concept is the missing link in service design research, the connective tissue between an organization's strategic intent and the value a customer ultimately receives. They define it across four dimensions: the service operation (how the service is delivered), the service experience (what the customer directly encounters), the service outcome (the benefits and results for the customer), and the value of the service (what the customer perceives as worth receiving). The service concept, in their framing, mediates between what an organization intends to provide and what the people it serves actually need. Without a clearly defined and shared service concept, the how and the what of a service become misaligned, and the gap between intent and experience widens. Building from this understanding, Mamafesto functions as a community-inspired service concept for Black maternal health. It mediates between the values Black-led CBOs articulate as essential to maternal health equity and the systems, services, and relationships necessary to enact those values in practice. In this dissertation, the CARE values identified through the content analysis, cultural relevance, collective responsibility, access, reproductive justice, respect and dignity, and education and empowerment, establish the philosophical orientation of the concept, while the TRIBE dimensions, Tangible, Relational, Informational, Birthworker, and Emotional support, articulate the forms of care that maternal health systems must provide. Together, these dimensions offer a way of understanding maternal care as more than a sequence of isolated clinical encounters. This service concept reveals and hopes to contribute to a relational and community-centered service ecosystem designed to sustain Black birthing people across the perinatal journey.



Service Concept Components

Mamafesto is organized through four interconnected components that together articulate how Black community care infrastructures support maternal health wellbeing across the perinatal journey. These components emerged through the synthesis of findings across Chapters 3 and 4, combining Black mothers' accounts of community care with the organizational values and practices of Black-led maternal health organizations. Together, they demonstrate how values, forms of support, and community-based service infrastructures work in concert to shape maternal experiences and outcomes.

Organizational Values (CARE)

The first component, Organizational Values (CARE), represents the foundational commitments that orient the service concept: Cultural Relevance, Collective Responsibility, Access, Reproductive Justice, Respect and Dignity, and Education and Empowerment. Across

the content analysis, these values appeared consistently within mission statements, programming, public language, and service infrastructures. Existing maternal health literature has consistently demonstrated the importance of culturally relevant and culturally concordant care in improving trust, communication, patient satisfaction, and birth outcomes for Black birthing people (Falade et al., 2023; Karbeah et al., 2019; Navarro, 2026). Organizations communicated cultural relevance through explicit engagement with Black cultural traditions, African diasporic symbolism, and culturally concordant care models. Collective responsibility appeared in the ways organizations framed maternal health as a community concern requiring shared support rather than an individualized burden. Black feminist scholarship and Black community studies have long documented traditions of collective care, othermothering, and communal responsibility within Black communities as responses to structural exclusion and survival under racial oppression (Bryant 2022; Collins, 2000; McClain, 2019). Access was addressed through free or low-cost doula services, home visit programs, telehealth resources, community directories, and efforts to reduce barriers to culturally relevant care. Reproductive justice shaped how organizations connected maternal health to broader structural conditions, including housing, food access, policy advocacy, environmental conditions, state violence, and bodily autonomy (Beck et al., 2024; Roberts, 2015; Ross & Solinger, 2017). Respect and dignity were operationalized through organizations' insistence on affirming Black birthing people's autonomy, humanity, and right to informed decision-making within systems where Black people are often dismissed or disrespected (Davis, 2019a). Education and empowerment were reflected through childbirth education, advocacy training, maternal health workshops, and culturally grounded informational resources intended to support self-determination and healthcare navigation. Together, these

values established a shared orientation toward maternal health that prioritizes culturally-relevant care, autonomy for Black birthing people, accountability, and justice.

Community Care Types (TRIBE)

The second component, Community Care Types (TRIBE), identifies the forms of support necessary for sustaining Black maternal wellbeing across the perinatal journey: tangible support, relational support, informational support, birthworker support, and emotional support. These dimensions emerged directly from interviews with Black mothers who described maternal care as extending far beyond clinical interactions. Tangible support included assistance with food, diapers, housing, financial support, and childcare during pregnancy and postpartum periods. Participants described the importance of people showing up physically and materially during moments of need, particularly within broader contexts where Black families disproportionately experience structural inequities related to housing, food access, and economic precarity (Bowen et al., 2021; Hill et al., 2014; Letiecq et al., 2023). Relational support reflected the role of trusted relationships with other expectant or new mothers, family, elders, doulas, and community members who offered encouragement, support, affirmation, and shared understanding. Prior research has shown that care relationships grounded in trust, shared lived experience, and cultural understanding contribute to positive outcomes and overall feelings of security (McLeish & Redshaw, 2017; Rossman et al., 2015). Informational support included culturally relevant guidance around pregnancy, labor, breastfeeding, healthcare navigation, and advocacy within medical settings. Many participants emphasized learning through trusted community members and birthworkers as opposed to relying exclusively on institutional healthcare systems or overwhelming, untailored information online, reflecting broader patterns of mistrust shaped by

histories of medical racism and obstetric violence (Altman et al., 2019; Davis, 2019a) . Birthworker support highlighted the significance of doulas, midwives, lactation consultants, and other culturally concordant providers whose care practices often foster trust, communication, advocacy, and improved birth experiences for Black birthing people (Alspaugh et al., 2023; Guerra-Reyes & Hamilton, 2017; Oparah et al., 2021) . Emotional support encompassed reassurance, validation, mental health care, grief support, and spaces where Black birthing people could process fear, joy, frustration, and vulnerability without judgment. Existing literature has increasingly recognized the emotional burden Black birthing people carry while navigating racism within maternal healthcare systems and experiences and the importance of holistic and community-based emotional support infrastructures in mitigating those harms (Gilliam et al., 2024; Jeffers et al., 2025; Parker, 2021). Together, these dimensions revealed support during maternal health as relational, communal, and infrastructural in nature.

Community Care Modes

The third component, Community Care Modes, represents the mechanisms through which organizational values and community care types become operationalized in practice. Across the organizations analyzed, these modes took the form of programs, resources, events, advocacy efforts, and community infrastructures designed to sustain Black birthing people before, during, and after pregnancy. Diaper banks and mutual aid initiatives addressed tangible support by redistributing essential resources directly within communities, reflecting broader traditions of Black mutual aid and collective survival strategies (Banks & Wilson, 2025; Potorti, 2017). Advocacy initiatives worked across both institutional and policy levels to address structural inequities impacting Black maternal health, including insurance access, provider

accountability, reproductive rights, and birth equity legislation (Black Mamas Matter Alliance, 2019; Ross & Solinger, 2017). Peer support groups, mommy meetups, and healing circles created relational infrastructures where Black mothers could connect through shared lived experience and community affirmation. Informational support was operationalized through Black maternal health guides, childbirth education classes, podcasts, digital media campaigns, and culturally relevant educational resources designed to improve healthcare navigation and informed decision-making (Collins et al., 2021; McFarlane et al., 2025). Full-spectrum doula support expanded birthworker care beyond labor itself to include prenatal preparation, postpartum support, abortion support, and miscarriage care, reflecting reproductive justice frameworks that understand reproductive wellbeing across the full spectrum of reproductive experiences (Carathers, 2019; Chaudhary et al., 2025; Lindsey et al., 2023). Perinatal therapy services and pregnancy loss gatherings support the emotional dimensions of maternal health often neglected within dominant healthcare systems and normalized in community spaces. These care modes illustrate how organizations translated values into ongoing systems of support that extended across multiple stages of the maternal journey. In no way are the manifestations of these community care modes fixed. This particular component is meant to be inspirational and generative to other organizations and collectives who may want to design services to support Black birthing people and families.

Impact for Black Mamas

The final component, Impact for Black Mothers, captures the outcomes these interconnected care systems seek to produce. Across participant interviews and organizational materials, maternal wellbeing was understood expansively through material stability, emotional

affirmation, agency, safety, and health equity. Material needs being met reduced stress and increased families' ability to focus on healing and caregiving during vulnerable periods (Negron et al., 2013). Shared lived experience created opportunities for connection, trust, and validation among Black birthing people navigating systems where they are often isolated or marginalized (Johnson et al., 2020). Self-determination emerged through access to information, advocacy support, and culturally affirming care relationships that leads to strengthened confidence in making informed-decisions (Mollard et al., 2024). Culturally relevant, high-quality care with Black birthworkers fostered feelings of trust, understanding, and respect within service encounters, outcomes that have been associated with improved maternal experiences and engagement with care. Safety and wellbeing extended beyond clinical survival to include emotional security, reduced stress, community support, and the ability to experience pregnancy and parenting with dignity. Collectively, these impacts reflect broader understandings of maternal health that account for the social, relational, cultural, and emotional conditions necessary for Black families to thrive.

Why Mamafesto is Important

One could argue that dominant maternal health systems already provide many of the supports represented within TRIBE. Hospitals distribute diapers, provide educational materials, employ doulas, facilitate provider interactions, and offer referrals to mental health services. Yet the findings across this dissertation demonstrate that care is shaped not only by the presence of services, but by the values, relationships, and social conditions through which those services are delivered. Across participant accounts, what distinguished meaningful care from inadequate care was rarely the existence of a resource alone. It was whether care felt culturally grounded,

relationally affirming, emotionally safe, and accountable to Black birthing people's lived realities.

The identity finding from Chapter 3 illustrates this tension clearly. Mother 9 selected a midwife because she associated midwifery care with relationality, attentiveness, and personal connection, only to find that the experience felt indistinguishable from a standard OB visit. The credential itself did not produce the experience she sought. Similar distinctions appeared throughout the organizational analysis. A diaper bank sourced through community economic circulation carries different social meanings and relational commitments than resource distribution detached from collective responsibility. A culturally concordant birthworker often offers not only labor support, but also shared understanding of navigating pregnancy, birth, racism, vulnerability, and survival as a Black birthing person in the United States. Across Black-led maternal health organizations, care consistently operated through relationships, cultural grounding, collective responsibility, and advocacy in ways that extended beyond institutional models of clinical service delivery.

Mamafesto therefore contributes a way of understanding maternal health services through the logic of community care rather than institutional optimization and standardization. The CARE values identify the commitments that orient maternal health systems toward justice and accountability, while the TRIBE dimensions illuminate the forms of support communities understand as necessary for sustaining holistic maternal wellbeing. The Community Care Modes demonstrate how these values and supports become operationalized through infrastructures such as peer support groups, mutual aid networks, birthworker programs, educational initiatives, healing spaces, and advocacy efforts. Together, these components reveal maternal health as an

encompassing ecosystem shaped through social infrastructures, cultural practices, and collective care.

Importantly, the significance of Mamafesto lies not only in proposing a service concept for Black maternal health, but in reframing where service design knowledge comes from. The mothers in Chapter 3 did not describe TRIBE as a formal framework. They lived it through family networks, sisterhood, group chats, baby showers, church communities, doulas, and everyday acts of support. Black-led organizations then translated many of these same community understandings into scalable service infrastructures through workforce development, policy advocacy, resource redistribution, and culturally grounded care models. Mamafesto names the connective logic across these scales of care, linking lived community practice to organizational service design.

I framed the service concept as “community-inspired” due to the way in which it was developed. While the components of the service concept are derived from my interviews and content analysis, further research and direct engagement with Black-led CBOs is necessary to develop this concept into a robust, community-driven tool for service design and delivery of maternal health services within both current and future CBOs and broader health systems.

Concluding the Mamafesto Service Concept

This reframing has important implications for maternal health research, service design, and HCI. Goldstein and colleagues describe the service concept as the mechanism that aligns organizational intent with the needs of those being served (Goldstein et al., 2002) . The organizations examined throughout this dissertation suggest that meaningful alignment becomes possible when service design begins from community knowledge itself. Within Black maternal

health ecosystems, lived experience, cultural memory, relational care practices, and intergenerational survival strategies function simultaneously as forms of expertise, infrastructure, and design knowledge. Black communities therefore emerge within this dissertation not as stakeholders of maternal health interventions, but as designers of elaborate systems of care whose practices offer critical insight into how maternal health services, technologies, and research might be reimagined more broadly.

Ultimately, Mamafesto argues that maternal wellbeing is cultivated through conditions that enable Black birthing people and families to feel supported, affirmed, informed, connected, and safe across the perinatal journey. In centering these conditions, the service concept challenges dominant assumptions about what care entails, who qualifies as a designer, and what forms of care matter most in sustaining Black life.

Viral Justice: Designers' Role in Centering the Everyday in Design

The maternal health infrastructures documented throughout this dissertation reveal a form of innovation that dominant design paradigms often struggle to recognize. Across Black communities, support frequently emerges through small, relational, and everyday acts of care: a doula checking in after birth, a group chat sharing provider recommendations, a community pantry redistributing diapers, or a baby shower ensuring a mother feels supported entering parenthood. Together, these practices function as infrastructures through which Black communities sustain life under conditions of systemic neglect. Ruha Benjamin describes this phenomenon as viral justice, the cumulative power of everyday actions to generate broader social transformation (Benjamin, 2022). Viewed through this lens, Black maternal care infrastructures

illuminate how justice-oriented design can emerge through relational care, collective responsibility, and community survival.

This framing challenges dominant assumptions about innovation within healthcare and design. Across technology industries, HCI, and health systems research, innovation is frequently associated with novelty, scalability, efficiency, and the optimization of institutional systems through technologies, provider training, or clinical process improvements. Yet the findings across this dissertation suggest that Black maternal wellbeing cannot be understood exclusively through clinical encounters. In response to exclusion, neglect, and structural abandonment, Black communities have developed their own systems of support capable of sustaining life where dominant institutions have failed. Importantly, these infrastructures operationalize values often absent from dominant healthcare systems, including affirmation, cultural grounding, justice, and collective responsibility. A peer support group creates space for Black mothers to process racism and vulnerability with others who share similar lived realities. A community baby shower redistributes resources while cultivating belonging and celebration. A culturally concordant doula relationship offers advocacy alongside shared understanding of navigating birth while Black in the United States. Across these examples, care carries social, emotional, political, and cultural meanings that exceed traditional transactional service delivery.

Ultimately, viral justice offers a different orientation toward design and social change. Transformation does not emerge exclusively through large-scale reform or technological disruption. It also unfolds through the cumulative force of everyday care practices that reshape how people experience support, dignity, belonging, and possibility within their daily lives. For designers, this requires learning to recognize and support the infrastructures communities already

use to sustain life while remaining accountable to the values and histories that make those infrastructures meaningful.

Where We Situate Ourselves is What We Imagine

This dissertation invites a reconsideration of where maternal health technologies are imagined, designed, and deployed. Much of the existing maternal health technology landscape has been situated within formal healthcare systems, producing tools focused on clinical decision-making, monitoring, documentation, and patient-provider communication. I even wrote my PhD application on understanding and addressing bias in digital health systems towards Black birthing people. Implicit within many of these efforts is the assumption that hospitals and clinics are the primary sites through which maternal health is produced and improved. This dissertation highlights how maternal wellbeing emerges through relationships among families, birthworkers, peer networks, community organizations, advocates, and cultural institutions. Recognizing these infrastructures as central to maternal health expands the contexts in which technological interventions can be imagined (Barabas & Smith, 2026; Costanza-Chock, 2020).

This shift becomes particularly apparent when revisiting prior work examining how patients designed technologies to address experiences of implicit bias in healthcare encounters (Yang et al., 2024). Participants frequently proposed technologies that could document clinical interactions, collect evidence of symptoms, or create accountability within healthcare systems. These proposals reflected more than a desire for improved communication technologies. They emerged from concerns that patients' symptoms, experiences, or perspectives might be dismissed or distorted within unequal clinical relationships. Technology was therefore imagined as a mechanism for defending one's self, surveillance, and accountability within contexts

characterized by mistrust and anticipated harm. Importantly, participants also imagined interventions before and after healthcare encounters, including tools for identifying providers, documenting experiences, and sharing feedback about care. Some of these ideas already exist within Black maternal health ecosystems. Health in Her HUE, for example, helps users identify culturally relevant healthcare providers and resources, while Irth allows birthing people and birthworkers of color to review hospitals, providers, and maternal health services. These platforms demonstrate how Black communities are already designing technological infrastructures that respond to community-defined concerns around trust, safety, and accountability.

Viewed through this lens, the technologies imagined in prior work can be understood as responses to the conditions of institutional care itself. When healthcare systems are experienced as sites of dismissal, inequity, and mistrust, technologies become oriented toward oversight, documentation, and protection. The findings of this dissertation suggest that different care contexts generate different technological possibilities. Across Black-led maternal health organizations, care was organized through networks of trust, cultural connection, advocacy, education, and collective support. These environments invite different questions about what technology might do, whom it might serve, and what values it might embed and extend.

This perspective aligns with service design scholarship arguing that technological artifacts alone are insufficient for addressing the relational and institutional dimensions of care (Forlizzi & Zimmerman, 2013; Patrício et al., 2018; Yoo et al., 2019). It also resonates with maternal health scholars who argue that technological advancement alone cannot resolve inequities rooted in racism, discrimination, and structural inequality (Black Mamas Matter Alliance Research Working Group, 2019; Golden et al., 2022; Ross & Solinger, 2017). The

organizations examined throughout this dissertation make visible alternative possibilities for technology grounded in community infrastructures. Technology might support coordination across organizations, strengthen peer support networks, facilitate culturally relevant information sharing, or assist community-based organizations in sustaining their data infrastructures. These possibilities emerge not from technology development itself, but from attention to the relationships, values, and systems that shape the context of development more broadly.

Marginal Sensibilities and W/reckoning as Design Epistemology and Practice

This dissertation also raises broader questions about how marginalized experiences shape the ways people perceive, critique, and imagine systems. Throughout this work, my analysis was informed not only by formal methods, but by lived experiences of navigating institutions not designed with Black life, care, or wellbeing in mind. These experiences shaped what became visible to me within maternal health systems, technology design, and research practice itself. I refer to this orientation as marginal sensibilities: forms of attentiveness, perception, and critique cultivated through living within the margins of dominant systems.

Black feminist and HCI scholars long argued that marginalized positions generate particular forms of knowledge about power, survival, and social organization (Collins, 1986; Collins, 2022; hooks, 1989) . Concepts such as the “outsider within” (Collins, 1986), Black feminist standpoint theory (Collins, 2022), and counterstorytelling within critical race theory (Ogbonnaya-Ogburu et al., 2020; Smith et al., 2020) all suggest that navigating systems structured through exclusion produces distinct analytic capacities. Importantly, marginal sensibilities are not reducible to identity alone. They are cultivated through repeated encounters with structural contradiction, dismissal, vulnerability, and adaptation. Across the organizations

and participant accounts examined throughout this dissertation, Black mothers, birthworkers, and community leaders demonstrated acute awareness of how systems failed to account for their realities while simultaneously creating alternative pathways for support and survival. This attentiveness informed everything from provider selection and advocacy strategies to the creation of peer support networks, culturally grounded birthwork, and mutual aid infrastructures.

Developing this dissertation also required what I describe as w/reckoning, an ongoing process of critically engaging my own relationship to the systems, histories, and harms under examination. W/reckoning reflects the tension between emotionally, mentally, and intellectually reckoning with structural violence and tearing those systems down to imagine otherwise possibilities through design. Across the research process, this involved moving through anger, grief, inquiry, critique, remembrance, resistance, and imagination while interrogating my own assumptions about design, technology, rigor, and impact. For marginalized researchers in particular, w/recking positions the critical reflection on the relationship between self-systems as central to justice-oriented design research. This orientation became especially important as I grappled with dominant definitions of contribution and innovation within academia and HCI. Much of design research continues to privilege technological novelty, institutional legitimacy, and detached notions of rigor (Costanza-Chock, 2020; Cunningham et al., 2023). Yet the findings across this dissertation suggest that some of the most significant forms of innovation emerge through community care practices, relational labor, and infrastructures often excluded from traditional definitions of design knowledge. Marginal sensibilities therefore offer a way of recognizing forms of expertise, survival, and imagination that dominant systems routinely overlook.

For design and HCI, this has important implications. Marginalized communities are frequently positioned as users, stakeholders, or populations impacted by technology and design. This dissertation instead suggests that marginalized experiences can function as critical sites of epistemological insight and design knowledge production. Black maternal health infrastructures reveal how communities continually generate strategies for care, coordination, accountability, and survival under conditions of structural inequity. Attending to these sensibilities requires more than inclusion. It requires rethinking whose ways of knowing shape the foundations of design itself.

Community Contribution: Toward a Critical Research/Design Practice

Finally, I end my discussion reflecting on broader questions about what research owes to the communities whose knowledge, experiences, and trust make scholarly work possible. Across HCI, design, and health research, marginalized communities are frequently engaged as participants, stakeholders, or populations affected by inequity, while the benefits of research often remain concentrated within academic institutions through publications, grants, and professional advancement. Communities contribute stories, labor, emotional vulnerability, cultural knowledge, and lived experience, while the outputs of research circulate primarily within scholarly systems. This dynamic has led many scholars to critique research practices as extractive, particularly within work focused on marginalized communities (Costanza-Chock, 2020; Harrington et al., 2019; Racadio et al., 2014).

Throughout this dissertation, I increasingly grappled with questions about what counts as contribution, impact, and rigor within design research. Existing academic structures often distinguish between intellectual merit and broader societal impact, positioning community

engagement and reciprocity as secondary to theoretical or technical advancement. Yet this separation felt increasingly insufficient for research grounded in Black maternal health, where communities are not only sites of study, but sources of care, theory, innovation, and survival knowledge. The Black-led CBOs examined throughout this dissertation demonstrate that care itself operates through accountability, reciprocity, and sustained forms of support. Research conducted within these contexts cannot remain detached from those same responsibilities.

Cradles & Culture emerged from this tension as both a community intervention and a methodological proposition. Designed as a community baby shower for my research participants and Black families in the Seattle-Tacoma area more broadly, the event redistributed material resources while also creating space for celebration, connection, affirmation, and community care. The project challenged assumptions about what research outputs should look like by translating research insights into a tangible community event grounded in care and reciprocity. Design research scholars have argued that artifacts themselves can function as sites of knowledge production and theory construction (Zimmerman & Forlizzi, 2008). This dissertation extends these conversations by arguing that community contributions can also operate as legitimate forms of scholarly contribution.

Ultimately, this section proposes community contributions as part of a critical research/design practice grounded in accountability, relational engagement, and tangible support for marginalized research populations. Such a practice asks researchers to consider not only what knowledge is produced, but how the researcher themselves participates in the communities and conditions they study. The Black CBOs documented throughout this dissertation already model this orientation through their continual transformation of knowledge, advocacy, and care into infrastructures that sustain their communities. Research, similarly, should not only document

inequities or theorize justice. It should also participate in creating the conditions through which communities are able to survive, heal, and thrive.

Conclusion

This dissertation began with a question about Black maternal health, but it concludes with a broader argument about design, knowledge, and the possibilities for creating more just futures. Across three studies, I have shown that Black community care is not merely a response to gaps in existing systems, but a sophisticated form of design practice that generates knowledge, coordinates resources, sustains relationships, and supports reproductive well-being in ways that dominant institutions often fail to recognize. By centering Black mothers, Black-led maternal health organizations, and Black community care infrastructures, this work shifts attention away from deficit-based narratives and toward the ingenuity, expertise, and innovation embedded within communities themselves.

The contributions of this dissertation collectively demonstrate that many of the solutions needed to address Black maternal health inequities already exist within Black communities. The TRIBE framework makes visible the multidimensional care infrastructures that support Black birthing people and offers a conceptual foundation for understanding community care as an interconnected system of tangible, relational, informational, birthworker, and emotional support. The analysis of Black-led maternal health organizations further reveals how community values are translated into service ecosystems that are culturally relevant, responsive, and accountable to the populations they serve. Together, these findings challenge assumptions that innovation must

originate from formal institutions and instead position Black communities as producers of knowledge, care, and design expertise.

Building on these insights, Mamafesto illustrates how service design can be grounded in community wisdom as opposed to institutional priorities. Beyond designing *for* Black birthing people, Mamafesto represents an effort to design *from* the knowledge, practices, and aspirations that already exist within Black communities. In doing so, it demonstrates how service design can function as a bridge between community values and future possibilities, creating opportunities for more holistic, equitable, and culturally affirming forms of support. This work suggests that the future of maternal health innovation may depend less on creating entirely new interventions and more on recognizing, strengthening, and learning from the care infrastructures communities have already designed.

This dissertation also argues that the outcomes of research should extend beyond knowledge production alone. Through Cradles & Culture, I demonstrated how research can serve as a vehicle for reciprocal community engagement and material contribution. Rather than treating community benefit as an aspirational byproduct of research, this work positions it as a meaningful outcome in its own right. In doing so, it invites researchers to reconsider what accountability looks like and to imagine forms of scholarship that redistribute resources, create value alongside communities, and contribute to collective well-being while generating knowledge.

Finally, this dissertation contributes to ongoing conversations within design and HCI by advancing marginal sensibilities and w/reckoning as conceptual tools for understanding how knowledge emerges through lived experiences of marginalization, resistance, and survival. These

concepts challenge longstanding assumptions about who produces knowledge and what forms of knowing are considered legitimate within research and design practice. They suggest that perspectives forged in the margins offer not only critiques of existing systems, but also unique capacities for imagining alternatives. *W/reckoning*, in particular, highlights how personal and collective histories can become resources for imagination, allowing researchers to engage grief, anger, inquiry, resistance and hope as generative forces in the pursuit of more accountable forms of scholarship.

Taken together, this dissertation argues that designing for equity requires more than improving systems. It requires transforming how we understand expertise, participation, and innovation. It requires recognizing that communities most affected by inequity are not simply stakeholders in the design process, but are often already engaged in acts of design themselves. Black communities have long imagined, built, and sustained care infrastructures that support reproductive survival and flourishing despite systemic neglect. The challenge before researchers, designers, healthcare institutions, and policymakers is not to determine what Black communities need, but to learn from what they have already created. By treating community care as a site of design knowledge, this dissertation positions community organizations as design experts. It also frames lived experience as a legitimate and generative source of theory. Together, these commitments offer a vision for a more equitable and accountable design practice. This is a practice that begins not with intervention, but with recognition. It begins not with extraction, but with reciprocity. And it begins not with the assumption that solutions must be invented, but with the understanding that many already exist, embedded in the practices, infrastructures, and everyday care work of Black communities. Realizing more just and accountable design futures

necessitates that we see and value these forms of knowledge as already shaping how care is built and sustained.

Appendix

Appendix A: Resource List Created From TRIBE Study



Community Organizations



Program for Early Parent Support (PEPS) -
<https://www.peps.org/>

Atlantic Street Center -
<https://atlanticstreetcenter.org/>

Families of Color Seattle (FOCS) -
<https://www.focseattle.org/>

BLKBRY - <https://www.blkbry.com/>

Being the Village - <https://www.beingthevillage.com/>

Rainier Valley Birth and Health Center -
<https://www.myrvcc.org/>

Open Arms - <https://openarmsps.org/>

Surge Reproductive Justice -
<https://www.surgereprojustice.org/>

Perinatal Support Washington -
<https://perinatalsupport.org/>

Pierce County Early Childhood Network (PCECN) -
<https://www.pcecn.org/>

Nurturing Expressions -
<https://nurturingexpressions.com/>

Technologies



Youtube Learning Center

Facebook Groups
Seattle families of color group
Seattle Black moms group

Black Doula Directory-
<https://www.blackdouladirectory.com/>

Mocha moms Seattle group-
<https://www.mochamoms.org/>

Flo App

Baby Center App

Peanut App for moms

What to Expect App

Aya Educational Cooperative (Online group)

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