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Fair compensation and the affective costs for indigenous doulas in Canada: A qualitative study

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ABSTRACT

Background: In Canada, Indigenous doulas, or birth workers, who provide continuous, culturally appropriate perinatal support to Indigenous families, build on a long history of Indigenous birth work to provide accessible care to their underserviced communities, but there is little research on how these doulas organize and administer their services.

Methods: Semi-structured interviews were conducted in 2020 with five participants who each represented an Indigenous doula collective in Canada. One interview was conducted in person while the remaining four were conducted over Zoom due to COVID-19. Participants were selected through Internet searches and purposive sampling. Interview transcripts were approved by participants and subsequently coded by the entire research team to identify key themes.

Results: One of the five emergent themes in these responses is the issue of fair compensation, which includes two sub-themes: the need for fair payment models and the high cost of affective labour in the context of cultural responsibility and racial discrimination.

Discussion: Specifically, participants discuss the challenges and limitations of providing high quality care to families with complex needs and who cannot afford to pay for their services while ensuring that they are fairly compensated for their labour. An additional tension arises from these doulas' sense of cultural responsibility to support their kinship networks during one of the most sacred and vulnerable times in their lives within a colonial context of racism and a Western capitalist economy that financializes and medicalizes birth.

Conclusion: These Indigenous birth workers regularly expend more affective labour than mainstream non-racialized counterparts yet are often paid less than a living wage. Though there are community-based doula models across the United States, the United Kingdom, and Sweden that serve underrepresented communities, further research needs to be conducted in the Canadian context to determine an equitable, sustainable pay model for community-based Indigenous doulas that is accessible for all Indigenous families.

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Introduction

The arrival of a new baby into an Indigenous family and community is an important signifier of the resiliency of Indigenous women as the backbone of community life. Doulas, or birth workers, have historically played a central role as assistance for pregnancy and birthing Indigenous women by providing cultural knowledge, often working alongside midwives to support delivery. Ongoing colonization and subsequent assimilative policies, patriarchal structures, and capitalist economies have impacted these vital roles as women were forced to consider birthing as primarily a medical experience largely out of their control. In recent years, the proliferation of Indigenous midwives across North America has been followed by the more widespread training and development

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of Indigenous doulas who reclaim and support cultural practices (Ireland et al., 2019). The word *doula* is a Greek term that has its roots in the tradition of women supporting other women during pregnancy, labour, birth, and postpartum and has come to be used in mainstream health care as "a trained professional who provides continuous physical, emotional and informational support to a mother before, during and shortly after childbirth to help her achieve the healthiest, most satisfying experience possible" (DONA International 2021).

As there is little existing research on the administrative structures, logistics, and challenges of Indigenous doula service in Canada, we conducted semi-structured interviews with representatives of five Indigenous doula collectives located in different provinces across the country. Five major themes emerged from our results: building connections with mothers and responding to the needs of the community (Cidro et al., 2021), navigating challenges within Western systems (Doenmez et al., 2022), sustainable funding models (Wodtke et al., 2022), culturally safe professional development, and fair compensation. This paper discusses the last theme of fair compensation in relation to tensions between the need to provide culturally safe support and the insufficient wages for this integral, and affectively taxing, work. First, we will provide a brief background on the economics of community-based doulas with respect to the Indigenous context in Canada before a discussion of the research results.

The economics of community-based doulas

An increased focus on Indigenous midwifery and birth worker services in recent years is a reflection and response to the long-standing colonial suppression of Indigenous rights to self-determination. Both Indigenous midwives and doulas provide Indigenous women with services that are culturally and spiritually appropriate, uphold the sacredness of pregnancy and birth, and recognize Indigenous sovereignty over their bodies and lands, acts that can be considered "transgressive" within a capitalist framework (Hall, 2016). Indigenous doula care and labour are essentially part of a mixed economy in which tensions exist between capitalist, colonial modes of production and reproduction and Indigenous approaches to land-based kinship networks and care that correspond to their own systems of economy (Hall, 2016). Though these kinship networks nurture the work and spirits of Indigenous women with positive experiences, including labour related to birth support (Cidro et al., 2018), their responsibility for maintaining these spaces of labour might clash with their roles in wage-labour (Hall, 2016).

In Canada, midwifery became a legislated profession in the last decades of the twentieth century with various models of service delivery and regulation depending on the region, meaning that in most provinces and territories they are salaried employees of the health care system or independent contractors paid via public funding/universal health care (Neiterman et al., 2021). Conversely, doula service is an unregulated profession in Canada and is excluded from universal health care funding despite evidence of its benefits, including a decrease in birth complications for mothers and their babies (Bohren et al., 2017; Gruber et al., 2013), especially for populations that face socioeconomic and health inequities (Abramson et al., 2006; Thomas et al., 2017; Bey et al., 2019; Ellmann, 2020; HealthConnect One, 2014; Mallick, Thoma, and Shenassa, 2022; Vonderheid et al., 2011). As a result, in many Western countries doula services for marginalized populations are community-based.

Community-based doulas can be defined as those who serve underserved communities to which they also belong in culturally appropriate ways that go beyond services offered by private doulas (Abramson et al., 2006; Bey et al., 2019). Furthermore, community-based doula programs "typically provide more home visits and a wider array of services and referrals for individuals who need more comprehensive support" (Bey et al., 2019) and are offered for free or at a reduced cost (Wint et al., 2019). This service model differs from the fee-for-service model practiced by those who run private doula businesses and often serve populations who can afford their fees and expect low-risk pregnancies. There is a range of existing economic models within the community-based doula framework, including volunteer services (Bondas and Wikberg, 2018; Cattelona et al., 2015; Darwin et al., 2017; Kane Low et al., 2006; Lagendyk and Thurston, 2005; O'Rourke et al., 2020; Richards and Lanning, 2019), services with hourly wages or contractual arrangements in hospitals and other health programs (HealthConnect One, 2014; Beets, 2014; Mottl-Santiago et al., 2020), services with insurance reimbursement (particularly in the US states of Minnesota and Oregon) (Kozhimannil and Hardeman, 2016; Kozhimannil et al., 2016; Strauss et al., 2016; Tillman et al., 2012), and salary-based services within community organizations and/or community-university partnerships (Abramson et al., 2006; Gentry et al., 2010; Wen et al., 2016). There are challenges for all of these models, including high turnover and scheduling inflexibility for doulas in the volunteer model and the lack of livable wage in the insurance reimbursement model (Bey et al., 2019; Thomas et al., 2017).

Many doulas, including Indigenous doulas, operate as private self-employed businesses in a fee-for-service model; however, there is a dearth of research on how Indigenous doula work models are resourced and sustained (Ireland et al., 2019). This model can lead to below minimum wages as doulas compete in a market that favours quantity over quality of care. Doula work then becomes a hobby or supplementary employment rather than a primary occupation.

The exclusion of doula services within the universal medical system in Canada has created a dilemma between a dependency on short-term or limited government grants to provide barrier-free doula care or providing care only to those individuals who can afford to hire a doula. This challenge is exacerbated by the knowledge that the Indigenous families who most need the support are often unable to pay doula fees. The aim of our study is to better understand the current administrative structures and challenges of Indigenous doula service in Canada, including their models for financial compensation.

Methods

Setting and population

This paper is part of a larger project focused on developing an urban Indigenous doula program in Winnipeg, Manitoba, Canada, to support Indigenous birthing people through their perinatal period with culturally based Indigenous birth workers. In preparation for this multi-year project, we conducted interviews in 2020 with one representative from each of five different Indigenous doula groups or collectives across Canada (one from the West Coast, one from the Prairies, two from Central Canada, and one from the East Coast). These collectives were identified using Internet and social media searches, and participants were recruited via direct email, through which we explained the objectives of our research. The researchers had no prior or existing relationship with the participants. All participants identified as Indigenous from what is now known as Canada through the introduction process. Four of the six authors of this study are Indigenous and two are non-Indigenous settler allies. Their fields of study include Medical Anthropology, Health, Development Practice, and interdisciplinary studies. This research received approval from the Human Ethics Review Boards at The University of Winnipeg and the University of Minnesota.

Data collection

Participants provided oral consent, and we provided each of them with an honorarium and meaningful gift. In the context of Indigenous research, it is imperative to provide a sufficient honorarium/gift for the time, lived experience, and knowledge of Indigenous peoples. The amount given and the kinds of gifts given demonstrate reciprocity in research and a way to demonstrate gratitude for sharing knowledge, a core component of Indigenous research methodologies (Fundación Sabiduría Indígena and Kothari, 1997; Hayward et al., 2021). These honoraria and gifts are not a method of coercion and were approved by the university research ethics boards. Our questions focused on understanding the administrative systems for service delivery, including fee structures, training, and referral practices for these doula collectives. Utilizing the "conversational method" (Kovach, 2015), which incorporates relational storytelling to better co-create knowledge with Indigenous peoples, we asked a variety of questions related to their experiences of providing doula support, including how the collective manages clients and referrals, what their fee structures and payment models look like, whether they had physical infrastructure for their services, what their logistical challenges might be, and what kind of training their doulas undergo. These questions functioned as open-ended prompts for co-creating knowledge via flexible, informal dialogue. Two to five members of the research team, conducted each of the semi-structured interviews, and there was no one present except for the researchers and the participants. All data collectors were either the director of the larger research project or graduate students who work with the project director. We interviewed the first representative in person in her home, and the remaining interviews were undertaken using Zoom due to COVID-19 restrictions on travel. Each interview varied in length, running from one to four hours. We audio-recorded the interviews using two devices in case one recording was damaged, and one author documented the interviews in which she was involved via field notes for the purpose of her own doctoral work. Using an inductive process, we attained saturation once we reached "conceptual depth" as defined by Nelson (2016).

Data analysis

Interviews were transcribed verbatim and sent to the participants for approval, and in some cases, amendment. Once the transcripts were approved by the participants, all authors used grounded theory to develop a coding framework collectively using the constant comparative method (Lincoln and Guba, 1985) to identify recurring themes. This analysis occurred approximately two months after the transcripts were approved. Field notes were not analyzed for the purpose of this study. The team prepared individual coding frameworks, and then the lead author compiled the frameworks into a common coding framework that we used for the coding going forward. Each author coded the transcripts individually, and then the group coded a master copy of each transcript by comparing individually coded transcripts. This selective approach allowed the research team to ascertain codes that were frequent and most pertinent to the original research question (Bryman et al., 2012). The team discussed all inconsistencies, which required a "sensitivity to differences between emerging concepts/categories" (Charmaz, 2000). After completion of the coding, our analysis determined which codes were most dominant. A draft of this paper was also sent to the participants to ensure that our interpretation of their experiences, and most importantly, the context in which we used their direct quotes were accurate and valid through the member checking process (Bryman et al., 2012).

Findings

As mentioned in the introduction, we have already published findings on three of the five central themes that emerged out of our larger analysis, including building connections with mothers and responding to the needs of the community, navigating challenges within Western systems, and sustainable funding models. This paper will focus on fair compensation. Within this theme, we identified two sub-themes: the need for fair payment models and the high cost of affective labour in the context of cultural responsibility and racial discrimination.

(1) The Need for Fair Payment Models

Most participants describe offering service packages with certain expectations in terms of number of visits and time spent with the mother and family. Often the cost of these packages is covered by limited grants received by the doula group or collective, so services are provided at no cost to the clients. One participant, working on the East Coast, adds their doula labour to their existing job within a Friendship Centre without additional compensation. Only one of the groups, located in the Prairies, has a salaried model for paying their doulas. The participants discuss the challenges and benefits of all approaches.

The package model is consistent with what is seen in many mainstream private doula service models, and participants describe looking at these approaches when they were developing their collectives and researching price points. One participant, who works in a collective housed in a Central Canadian community health centre with one-time grant funding, explains their cost breakdown in detail:

> *The model we have is $1,000 a birth. . . . Prenatal appointment one is $150, prenatal appointment two is $150, the birth itself is $450 with $100 for the backup doula, and then $150 for the postpartum appointment. . . . We have a postpartum package that is $400. That covers eight hours of postpartum support. We have a general support package that is $250, and this covers things like cloth diapering, baby wearing, food prep, time management, loss, fertility. . . . It's free for all of our clients.*

In this model, there is a limited amount of grant funding available, so doulas can only be compensated up to $1,000 per birth, and sometimes difficult decisions must be made regarding whether to use more funding to support a family with needs that require additional time or to put the same funding towards serving another family. In this collective, doulas do not receive financial reimbursement for out-of-pocket expenses such as mileage. This participant also notes that their centre employs a full-time Indigenous Perinatal Mental Health Worker, whereas doulas are contract workers.

Similarly, the participant from the Prairies outlines the differences between their model, which was based on mainstream doula models at $1,000 per family, and the time that they spend with their clients:

> *The difference between a mainstream doula and the doula service we offer is we're more extensive in the support that we provide. A mainstream doula might visit you once or twice prior to your birth, and then once or twice after, and then support you during your birth. Whereas ours is two to four visits prior to birth, two to four visits after. Then the actual birth.*

This collective eventually shifted from a fee-per-family model to a salary model, and it is the only collective among our participants to do so. This doula collective is funded through a social impact bond, or an investment contract "in which socially motivated investors—like high net worth individuals and institutional investors—provide working capital to social sector service

providers, allowing them to scale up high-impact social programs" (Scognamiglio et al., 2018), so their clients do not pay for this service. This particular social impact bond is connected to reducing the number of children in foster care. As the participant states,

> *My doulas are on staff. They're paid equivalent to provincial standards. They are paid $44,805 [per year]. They get benefits and pension, and they're slated to receive raises every year during the three years of the project.*

This participant notes how the salary model is their preference:

> *Definitely the salary model works a lot better. You have a lot more flexibility. I feel like you have a lot more control because the reports are a lot more extensive as well. The types of activities that they have to do with the moms are more extensive. Because we have a clinical supervisor on staff, [clients] all go through a wellbeing assessment. We have an idea of where [clients] are at whereas with the other [per family] model, you could never speak to a mom.*

With this kind of salary model, there are more efficient and stable methods of tracking and maintaining labour hours for doulas while ensuring that they have a stronger sense of the potential needs of the mothers before they even undertake care. The doulas can spend adequate time with each family because they are not limited to a particular number of visits within a $1,000 package. On the other hand, as a social impact bond depends on investors, who may or may not receive returns on their investments, this model can require more labour in terms of recording and evaluating impacts within a Western framework, and the funding is not guaranteed long-term.

In fee-per-family models that are unsupported by grants or external funding, collectives note that one way to manage time and compensation is to set up parameters for a payment schedule to ensure doulas are fully paid for their services. The doula who works in a collective in Central Canada with this model explains that they ask for half of the payment upfront and then the remaining half following the birth. She also describes how the doulas will inform their clients in advance that they can only attend a maximum of eight hours for the actual birth, which helps the clients consider the point at which they want their doulas to come into the hospital or space in which they are birthing and provides boundaries for the doulas' time.

All participants note the limited financial and human resources available for Indigenous doula care. One participant recounts how their doula services emerged organically out of their Friendship Centre in an Atlantic province. She describes how they attempt to integrate this work into their regular health programs, despite financial barriers, to provide substantive doula care:

> *We typically work six days a week, plus three to four nights a week. This is work that was added onto the regular programming, basically something I've always done personally, and it became part of the centre. There is very little time or finances to do any administrative work around this. I have heard of people being gifted crafts and things. I've personally been gifted medicine pouches and different things. I have not heard of monetary transactions. We're drastically understaffed.*

In this case, doula labour is added to the workload of existing employees providing other services without an increase in financial compensation. This participant also noted that their funding from the federal government for operating the Friendship Centre had not had an increase in well over a decade. The existing funding for these organizations is limited and stagnant, which prevents increases in living wages and the hiring of new staff to focus on birth work.

Other financial costs for these doulas include ongoing training and professional development. The second participant from Central Canada explains that they end up taking training that is perhaps less useful because they face their own economic challenges:

> *Virtual [training sessions] tend to be cheaper, but they're not going be a lot because hands-on training is better. We're mostly all young moms, so it's harder to get to those in-person things on your own time and money, right? We go for the cheaper ones.*

This point demonstrates the impact that insufficient compensation can have on the quality of doula care provided to Indigenous women, creating a hierarchy of care that disadvantages those who already experience poorer health and social outcomes. Additionally, this comment demonstrates the limited financial position of the doulas themselves who experience many of the same socioeconomic barriers and challenges as their clients.

While mainstream private doula care is typically funded directly by the clients, our participants observe that very few of their Indigenous clients have the means to pay for these services themselves. Because of this financial insecurity, these doula collectives often face a discrepancy between their cultural responsibility, including providing protection against racial discrimination, and fair compensation.

(1) High Cost of Affective Labour in the Context of Cultural Responsibility and Racial Discrimination

The doula collectives mention the difficulty in obtaining payment from their clients who are often socioeconomically disadvantaged. They speak about the reality of many of the Indigenous families who are unable to provide any payment and the doulas who are left essentially not only volunteering but also using their own resources to cover expenses such as parking, gas, and supplies. One participant observed that their required payment for services resulted in some lost clients because of an unwillingness or inability to pay. Another doula, who works in a collective paid through a grant-per-family model on the West Coast, remarks,

> *On the one hand, our families cannot afford to pay for our work, and on the other hand, they deserve high-quality doula care. Our doulas cannot afford to work for free, and they also deserve to be paid to be able to sustain their work. And there's obviously a long history of Indigenous women's labour being exploited and care work being undervalued.*

This inability to pay is especially difficult for these Indigenous doulas because their motivation to undertake this work is providing accessibility to care for Indigenous families who often face complex issues, such as housing instability, domestic violence, poverty, and intergenerational trauma, that require time and care outside of the typical number of hours in a mainstream doula package. For example, the second participant located in Central Canada who does not have grant funding, discusses one of the cultural approaches that they incorporate into the postpartum care of their clients:

> *We usually include a soup with [the package]. That's about thirty bucks to make a soup, depending on the size of the family. . . . We usually wait a couple of days, and then Day Two or Three or the first day that they're home, they have a meal.*

These necessary components of cultural care, which are often not included in mainstream doula service, must be considered when setting prices for Indigenous doula packages, but also exacerbate the issues surrounding fair compensation for doulas and accessible care for families.

The Indigenous cultural context is pertinent to the sense of doulas' responsibilities to family and extended relations. This ex-

perience is elucidated by the second doula participant in Central Canada:

> *So, [clients are] usually family friends, friends of our friends. They're either unable or unwilling to pay for services. We do have price points that we like to meet. That was a big issue in our group. Nobody wanted to put a payment on it. Like, "Hey, we're worth it, we need to charge. Hospital [parking] costs money, and we're going to be at a twenty-hour birth. We need to pay for sitters. We're worth the money!"*

Dealing with clients who are unwilling and unable to pay is challenging for doulas who engage in this intensive labour as "heart work" while still maintaining a wage to support their own households and families.

Again, because of these doulas' intersectional identities as Indigenous women who perform care work, they face additional responsibilities and labour in relation to representing their Indigeneity and educating others on their cultures and lived experiences. The participant from the West coast notes that

> *It's not just that families contact us for doula care, but also, there's been lots of media requests, lots of organizational requests for workshops and creating prenatal or postpartum workshops or cultural safety workshops, and then lots of other health care and birth work organizations asking us to come in and do cultural safety training.*

This labour, which is deeply tied to racial and gendered relations and expectations, increases the existing affective labour already being performed as a birth worker.

Furthermore, for some of the doulas, undertaking this work has not only left them without fair compensation, but has come at a financial cost to them, which devalues them both economically and culturally. The West Coast doula observes,

> *We have Indigenous teachings about when you ask for help, there are teachings around reciprocity, and you offer something for that help. If you do not offer something for that help, there's the understanding that that person who gives help can get sick. . . . The teachings emphasize always looking out for the person who is helping and for their health and spiritual wellbeing because if you do not, they'll get depleted. And we were all finding that, as much as we care about the work and believe Indigenous families should get access to our care, when we still have to pay for parking, and we still have to pay for childcare, and we still have to take time off work . . . we just end up burning out. It does not feel good, and it does not feel right. . . . The history of this work is that midwives and medicine people would have been really well-compensated and valued in terms of our own Indigenous economies.*

Though vestiges of an Indigenous gift economy exist, as detailed by the doula who has been given objects such as medicine pouches, these doulas still face the realities of a Western capitalist economy in a colonized state, just as their communities do.

In addition to the sense of cultural responsibility to relations, these doulas take on the affective labour of negotiating racial discrimination on behalf of their clients and themselves. The participant from the West Coast explains these challenges:

> *We're still working within a larger context that is creating barriers at every single level for Indigenous families to achieving wellness and good health, and we, as Indigenous doulas, cannot overcome that socioeconomic context, but we can soften or ease that a little bit for the families. We can make sure that they know that somebody cares about them and that there is somebody whom they can reach out to that works for them, and not the system, and who is not going rat them out to the Ministry of Children and Family Development or Child and Family Services. I really see it as harm reduction.*

Similarly, the participant in the Prairies refers to the doula role as providing advocacy that goes beyond that of doulas who serve non-Indigenous clients because of the systemic racism and discrimination within the health care system:

> *A lot of the times [the clients] are very shy and very passive, so when things are happening in hospital or even in medical appointments, they do not speak up for themselves and they do not advocate for themselves. There are a lot of assumptions that are made, that they're alcoholics or drug addicts, and you know, having a really shitty attitude towards the moms when they come in for their prenatal appointments or when they come in to deliver. And so, we're able to be that buffer and say, "Wait a minute, this is not acceptable to be speaking to her this way or treating her this way."*

This participant goes on to discuss the ways in which Indigenous and racialized birthing people require more support in relation to respect and safety than white birthing people,

> *A lot of times the birth plans of Indigenous women and people of colour are not supported, but the birth plans of white women would be supported and respected. So, it's really important for [Indigenous women] to be able to have some control at a really vulnerable time for them. . . . A lot of women that we work with are victims of sexual abuse, and so there're a lot of issues around their bodies and what they're comfortable with.*

The need for these additional affective supports extends beyond providing safety, protection, and care within a racist health and social system environment; often Indigenous doulas must also respond to complex care needs outside of the typical scope of doula care, which limits who can sustain this kind of labour and forces doulas to set boundaries on care plans and case management. In the Prairies, the participant recounts that

> *one of our birth helpers got called at three in the morning because the mom needed to be picked up because she was in a domestic violence situation. You know for somebody who is 65, waking up at three in the morning and going to pick somebody up, that's a bit much for them. . . . And that does not necessarily mean that's their only hours. . . . If [clients] are high-risk and need ten hours a week, we do not want to give [doulas] five people that need ten hours a week. So, we often have to review the client's support plan: how does driving you to your boyfriend's house support the implementation of your support plan? So now what we're trying to do is . . . when they visit with the moms one week, it's, like, okay, how do we want to utilize that time for the next week? So, having them make some decisions around what that looks like. It could be grocery shopping. Maybe they want to go see their boyfriend. Some of the moms we work with, their boyfriends are incarcerated, and they have no other way to go and visit, right? That is something that we would support and do for them. It would not be every week, but we will support that. Or maybe they want to go visit their family in [their First Nation community], so we would take them there because they have no other way.*

It becomes clear from these remarks that Indigenous doulas regularly face needs and requests that exceed the purview of a mainstream doula's services.

Because these doulas need to provide additional support to mitigate and protect their clients from racism and sexism within the health care system, they, who are Indigenous women themselves, can experience trauma. One of the participants from Central Canada notes that "you get triggered by events or in dealing with your own birth traumas and things that you've seen," which high-

lights the affective toll Indigenous doulas experience within their work. This trauma, then, requires that Indigenous doulas make space and time for self-care, as described by the participant in the Prairies:

> *We have regular self-care sessions, ceremony. All of our staff participate in the seven sacred ways of healing trauma because, essentially, they're support workers too, not just birth workers. So, there are a lot more issues that they're dealing with than just those related to providing doula care. The intensity. . . not so much how many moms they have to work with, but the types of social issues that they have to work with.*

Therefore, these community-based doulas essentially take on the double role of social worker and birth worker, which is not considered within most doula payment models.

Discussion

As stated in our introduction, the aim of our study is to better understand the current administrative structures, logistics, and challenges of Indigenous doula service in Canada, including their models for financial compensation. Regarding the overarching theme of *fair compensation*, our findings align with other research on community-based doulas that discuss the challenge of unlivable wages (Ellmann, 2020; Everson et al., 2018; Lee, 2020; Marshall et al., 2022; Yiya Vi Kagingdi Doula Project, 2020). Notably, our participants did not discuss or mention community-based doula models, which are prevalent in the United States, especially through the work of HealthConnect One, an organization that grew from the community-based Chicago Doula Project in the late 1990s, and its replication sites across the country (HealthConnect One, 2014). Our participants overwhelmingly looked towards private fee-for-family models as starting points rather than models that specifically target underrepresented groups, such as those who are Black, Indigenous, and People of Colour (BIPOC) and/or low-income. Reasons for this difference may be the dearth of discussion using this terminology in academic and non-academic spaces within the Canadian context. The literature that uses the term *community-based doula* does not come out of Canada, but instead the United States, the United Kingdom, and Sweden. Moreover, the orientation towards private fee-for-family models of these Canadian doula groups aligns with data collected by a *Maternity Support Survey* of doulas, childbirth educators and labor and delivery nurses in the United States and Canada, which found that over 70% of surveyed doulas considered their doula practice to be a business (Roth et al., 2014). Despite the numerous differences in health care provision and costs to clients between Canada and the United States, it would be fruitful to learn from the administration and pay structures for these community-based doula services, which specifically employ community members to provide birth support to underserved communities rather than through a private fee-for-service model.

The need for fair payment models

By using the private fee-for-family models, the Indigenous doulas who we interviewed are engaging in labour that includes entrepreneurship and business administration, which adds to the cost of the doulas' time, as well as detracts from the amount of time doulas can focus on caring for their clients. Moreover, this kind of private business model, even when used by collectives, is rooted in a Western capitalist system of privatized health care in which aspects of maternal care become a commodity (Taylor et al., 2004). In other community-based models, this administrative part, including training, is handled by other units of an overarching organization (community/health care service), and there are often supervisors for the doulas to ensure that they are consistently supported as full-time employees.

Our findings corroborate other studies and models on the need for more hours with clients than is typically provided in mainstream, private doula care. Other sources indicate that community-based doulas, who are members of the underserved community with which they work, spend between 38 and 45 h with each client (Bey et al., 2019; Yiya Vi Kagingdi Doula Project, 2020), which is significantly higher than mainstream fee-for-service doulas that usually offer roughly 20 h and hospitals/clinics that offer 5.75 h (Bey et al., 2019). Indigenous groups, such as the Yiya Vi Kagingdi Doula Project in New Mexico, have specifically advocated for a living wage, arguing that to do otherwise is "keeping skilled professionals in poverty, in the name of public service" (Yiya Vi Kagingdi Doula Project, 2020). In the HealthConnect One model, a community-based doula typically "attends up to 25 births a year, and most program sites employ two full-time doulas" (HealthConnect One, 2014). Furthermore, "[b]ecause the program supports an extended and intensified role, caseloads should not exceed more than 12 women at one time" (HealthConnect One, 2014). These kinds of parameters would be of benefit to the doulas we interviewed, who would currently need to take on over thirty-five births per year to earn a living salary.

The lack of regulation and professionalization for Indigenous doulas, in comparison with midwives, can be seen as problematic, yet in some ways, preferable. While midwives are more fairly compensated for their labour, as well as funded more significantly by Canadian government health care, midwives also have a regulatory body that ensures professional standards and training are maintained. Though quality assurance in service delivery is important, the lack of regulation and professionalization for Indigenous doulas has allowed for a wider scope of practice, which may include engagement with traditional ceremonies, and this flexibility has allowed for the proliferation of the Indigenous doula movement to grow in a way that is responsive to the cultural needs of the families and communities being served. In this sense, these doulas echo the concerns in the United States, where the few states that have implemented Medicaid reimbursement procedures for doula care have required specific training certifications and registration fees, generating barriers for community-based doulas to operate (Bakst et al., 2020). As community-based doula services must be responsive to the needs of each unique community, this standardization of training, competencies, and certification can be seen as problematic (Bakst et al., 2020), and by making the cost of becoming a doula so prohibitive, the peers of underrepresented communities who have the lived experiences to support mothers with cultural safety cannot afford to choose this work (Bakst et al., 2020; Bey et al., 2019).

The participants we interviewed have various levels of experience as Indigenous doulas individually and as collectives. Some of the larger and more experienced doula groups see value in establishing models with salaried employees who are fully compensated at market rates with accompanying benefits and pensions, a finding that verifies the results of research with other community-based doula groups such as SisterWeb in San Francisco, a doula network that moved from a contractor model that paid $1,600 USD per client to an hourly employment model ($25 USD/hour) with health insurance and sick leave (Gomez et al., 2021). At the same time, the conditions of these salaries may regulate the work of the doulas, requiring them to provide reporting to meet government or other external funding standards. These salaried doulas, who are working within a Western administrative system, may not be able to function within the same kinship structures that support the intergenerational transfer of knowledge in such an organic manner, complicating arguments for Indigenous sovereignty. They may also be more cognizant of maintaining professional boundaries and

tracking information that is required by the funding body while maintaining the trust of their clients.

High cost of affective labour in the context of cultural responsibility and racial discrimination

The economic position of Indigenous doulas is complicated by their cultural roles. Having a sense of personal and cultural responsibility to communities as advocates and intermediaries within Western systems, which includes systemic racism, is challenging for these birth workers. This work is heavy on the spirit, and the motivation for doing such work is often directly connected to the Indigenous doula's own pregnancy and birthing experience. These motivations often outweigh the reality of low-paid labour and financial instability. In the Indigenous context, this form of labour is often referred to as "heart work," or meaningful and relational affective labour in service of the self and others. Whitney (2016) argues that racialized women often experience an "*unmanageable* by-product" of their labour, which is usually already affective in nature, meaning that they must deal with systemic and everyday violence of racism in excess of their paid affective labour. In the case of Indigenous doula labour, this may involve careful navigation of conversations with hostile hospital staff on behalf of the labouring mother while also negotiating epistemic violence within colonial institutions (Krzywania, 2018). Whitney (2016) describes these experiences as distinctive from those of white women, and she refers to these experiences as the "affective costs" that add to the existing financial cost of this low-paid wage labour. In many ways, the experiences of the Indigenous doulas who we interviewed reflect the experiences of other racialized birth workers, including black doulas and midwives, who see their role as an intervention for racism and obstetric violence while also experiencing secondary trauma or feelings of alienation from mainstream and/or white birth work (Davis, 2019; Hardeman and Kozhimannil, 2016; Kathawa et al., 2022; Lee, 2020; Wint et al., 2019). Doula work is already recognized as affectively taxing and prone to burnout (Green, 2013; Moffat, 2014) before the introduction of potential re-traumatization due to racism and colonialism, which only compounds the affective cost for BIPOC birth workers.

These conflicts are evident from the responses of the Indigenous doulas we interviewed. This "heart work" is described as the motivation for the work of the Indigenous doulas, but it often contrasted with the lived reality of the need for wages to support their own Indigenous families as described by Hall (2016). As one participant recounts, the funding that their centre receives from the government has not increased in twenty-four years, and it is increasingly challenging to find staff to undertake and sustain this type of work. All of the doulas we interviewed are Indigenous women, therefore, these experiences are imbricated with their own intersectional experiences. As such, the gendered element of Indigenous birth work is a significant factor in fair wages. As the participant from the West Coast reports, she has needed to take on the additional role of advocate for pay equity in relation to funders: "Every time we've gone to a meeting, we've made some sort of plug about how we're underpaid and exploited labourers. We just keep planting this seed of how the health system is exploiting our labour. Now we almost never get invited to a meeting without an honorarium being offered."

Indigenous doulas are increasingly seen as an intervention for the health inequities that are so pervasive in Indigenous maternal health care (Kolahdooz et al., 2016; Kozhimannil et al., 2020). The need for the doulas comes from a push against such health inequities, but it is also based on cultural resurgence and reclaiming of Indigenous values that inform practices and approaches to health that re-centre Indigenous knowledge. In our current wage economy, we know that Indigenous doulas, who are primarily women, are unable to undertake and sustain this work without sufficient and dependable compensation. The potential for wage exploitation of this para-professional labour is troublesome. Equally as problematic, the expanded role of the doula in the community-based setting needs to be considered when developing models of compensation; as several of our participants commented, Indigenous doulas are often navigating a broader community/social health worker role rather than a role confined to birth and labour support, and they, thus, deserve fair compensation for this additional complex care. This kind of role expansion is echoed in other literature on community-based doula work (Gentry et al., 2010; Wint et al., 2019). Doulas are arguably less costly than midwives and are shown to have positive impacts on birth experiences; however, their true value is not reflected in the current compensation models across Canada.

Implications for future research

One potential step forward for these Indigenous doula groups is to connect with community-based doula models outside of Canada, especially those in Indigenous communities, such as the Yiya Vi Kagingdi Doula Project in New Mexico and the HealthConnect One replication sites run by Great Lakes Inter-Tribal Council and Mille Lacs Band of Ojibwe, to learn from their experiences. Further research needs to be conducted to compare the Canadian context with that of the United States in terms of models that best serve underrepresented groups and best support a living wage for community-based doulas/birth workers. There have been calls for doula services to be included in Medicaid health coverage in the United States as a cost-effective service for socially disadvantaged populations (Kozhimannil and Hardeman, 2016; Kozhimannil et al., 2016; Strauss et al., 2016), but as noted earlier, the Medicaid reimbursement process for doulas has encountered bureaucratic and financial barriers (Bakst et al., 2020; Bey et al., 2019; Ellmann, 2020; Van Eijk et al., 2022).

Another existing model of doula compensation in the United States, which has been used by HealthConnect One and its replication sites, is targeted federal grant funding from the Health Resources and Services Administration's Maternal and Child Health Bureau; however, this particular stream of funding had a limited timeframe, ending in 2012 (HealthConnect One, 2014). As Canada's universal health care system is significantly different and further complicated for Indigenous Peoples because of federal/provincial jurisdictional issues, additional research needs to be done to determine potential funding sources within the Canadian context. One possible solution is better integration of community-based doula care with existing health care and community services including augmentation for their funding streams to employ full-time Indigenous doulas (Ellmann, 2020; HealthConnect One, 2014).

Limitations

The main limitation for this study is the small number of collectives interviewed. Nevertheless, because we are conducting this research to inform the development and piloting of an urban Indigenous doula program, this sample size was appropriate based on actively practicing Indigenous doula collectives in Canada. We recognize that additional Indigenous doula collectives exist across North America, and we are currently undertaking an environmental scan to identify them. At this stage in our research, we wanted to interview only those in the Canadian context to understand their administrative model, acknowledging that there are opportunities to learn from other Indigenous doula collectives in similarly colonized countries such as the United States, Australia, and New Zealand.

Conclusion

This study contributes to the growing body of work on community-based doulas, as well as Indigenous doulas specifically. Indigenous doula groups have emerged across Canada in recent years as a response to the health and social inequities facing Indigenous women and families in health and social services. This paper explored the experiences of five Indigenous doula collectives in Canada with a specific focus on fair compensation. Within this focus, we found two sub-themes: the need for fair payment models and the high cost of affective labour in the context of cultural responsibility and racial discrimination.

The doulas we interviewed shared how their motivations for undertaking this work and their cultural obligations are often in conflict with the colonial systems under which they were required to work. While the salaried doulas within this group certainly experienced less wage exploitation, they were still required to work under a Western-based regulated system, and their salary is not guaranteed long-term. The other doula groups expressed that many of their clients were unable to compensate them financially, and many of these doulas struggle with continuing to find ways to receive fair compensation while still honouring their kinship connections and roles as Indigenous birth workers. Whitney's (2016) arguments about the racial dimension of affective labour help us to understand that the work of Indigenous doulas is not just about supporting a women's birthing experience. This support takes place in environments that are hostile to Indigenous women, and the "affective cost" that she describes takes a tremendous toll on the Indigenous doulas.

Our findings will be used to develop a pilot Indigenous doula program in inner-city Winnipeg, which will include fair financial compensation in balance with emotional and professional supports for the doulas in recognition of their affectively heavy labour; however, these results will also be of interest to other researchers and practitioners who work within the field of community-based doula services for underrepresented, racialized populations. These populations often require culturally safe and congruent care in addition to specific advocacy to safeguard against racism and sexism in medical and social services. This study demonstrated the need to provide fair compensation and professional supports that address and value the intense affective labour of Indigenous doulas to maintain a sustainable, accessible service for Indigenous populations.

Ethical statement

The University of Winnipeg Human Research Ethics Board approved the research presented in this article that was conducted by JC, LW, AH, AN, and SS (Ethics permission number 14981).

The University of Minnesota Institutional Review Board approved the research presented in this article conducted by CD (Ethics permission number STUDY00007650).

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

CRediT authorship contribution statement

Jaime Cidro: Conceptualization, Formal analysis, Investigation, Methodology, Resources, Supervision, Writing – original draft, Writing – review & editing. **Larissa Wodtke:** Conceptualization, Formal analysis, Project administration, Writing – original draft, Writing – review & editing. **Ashley Hayward:** Conceptualization, Formal analysis, Investigation, Writing – review & editing. **Alexandra Nychuk:** Conceptualization, Formal analysis, Investigation. **Caroline Doenmez:** Conceptualization, Formal analysis, Investigation. **Stephanie Sinclair:** Conceptualization, Formal analysis, Investigation.

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