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The need for sustainable funding for Indigenous doula services in Canada

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Abstract

Objectives: To interview representatives from Indigenous doulas across Canada in order to document how they manage the logistics of providing community-based doula care and understand their challenges. These objectives inform the development of an Indigenous doula pilot programme as part of the project, 'She Walks With Me: Supporting Urban Indigenous Expectant Mothers Through Culturally Based Doulas'.

Methods: In 2020, semi-structured interviews were conducted with members of five Indigenous doula collectives across Canada. Interview transcripts were approved by participants and subsequently coded by the entire research team to identify key themes.

Results: Our article explores one of the main themes that emerged from these interviews: sustainable funding for Indigenous doula services. Within this theme we identified two sub-themes: (1) limitations on and regulations for available funding and (2) negative impacts of limited funding on doula service.

Conclusion: A major challenge to providing Indigenous community-based doula services is sustainable funding. Current models of funding for this work often do not provide livable wages and are bound by limited durations and regulations that are unsustainable and can be culturally inappropriate. Due to this lack of sustainable funding, Indigenous doula service in Canada faces challenges that include high staff turnover and burnout and lack of time and resources to provide culturally safe care, pursue professional development and additional training, and keep their services affordable for the families who need them. Future research is needed to ascertain potential programmes and funding streams for sustainable Indigenous doula support in Canada, including possible integration of doula care into the universal public health care system despite the jurisdictional challenges in providing health care for Indigenous peoples.

Keywords

community-based doulas, health economics, Indigenous doulas, maternal health equity, perinatal care, sustainable funding

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Introduction

To address birth and health inequities for Indigenous birthing people, research suggests that the practice of cultural safety[1–6] is necessary. Cultural safety, first theorized in nursing in New Zealand to respond to health disparities of Māori people,[7] is 'the process and outcome of feeling comfortable, respected, and safe in one's cultural identity',[8] and culturally safe practice is 'characterized by holistic, continuous care, and empowerment of families and communities to become key actors in health programming'.[6] The terms cultural competency, cultural awareness, and cultural sensitivity have also been used in the context of Indigenous health care, but as Churchill et al.[8] argue, 'these approaches have been criticised for building on narrow understandings of culture that promote stereotyping, reduce human interactions to check lists, normalise the "Othering" of racialised communities, and obscure the influence that structural forces have on health and wellbeing'.

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Doulas, or birth workers, are paraprofessionals who provide continuous physical, emotional, and advocacy support during labour and birth, but do not provide medical, midwifery, or nursing care.[9] Research shows that the continuous emotional, physical, and advocacy support of a doula, especially a community-based peer doula, leads to improved health and well-being for underrepresented populations.[9–19] The community-based doula model provides 'culturally appropriate support to women in underserved communities', and the 'services are often more expanded than those of a traditional private-pay doula and may include an increased number of home visits during the prenatal and postpartum period, referral services to relevant social programs, and care coordination between different health care providers'.[20] Specifically, Indigenous doulas play a critical role in countering medical racism in hospital and clinical settings and advancing the resurgence of Indigenous birthing sovereignty.[21,22] Indigenous doulas are rooted in cultural teachings and spiritual connections, and therefore, play an essential role in the re-establishment of self-determined Indigenous birthing practices.[23–25]

Though community-based doula support, including that of Indigenous doulas, is shown to improve health outcomes for clients and infants, this support is often underfunded or not funded at all. As many of the historically excluded populations served by community-based doulas cannot afford to pay for doula services due to experiences with poverty, these services are most often offered at little to no cost to clients, limiting the revenue stream that private, mainstream doulas would receive. This article will discuss the results of semi-structured interviews with representatives of five Canadian Indigenous doula collectives in relation to funding sustainability for their services and the lack thereof. These interviews were conducted as part of a larger project to develop and evaluate a pilot Indigenous doula programme in Winnipeg, Manitoba, Canada. We will provide a brief background on the economics of community-based doulas before a discussion of the research results.

Background

Health care in Canada lacks integration, including an absence of systemwide strategy,[26,27] 'no logic to the existing payment and accountability silos' despite its being a publicly funded system without multiple payers,[28] and dearth of progress in addressing the 'hardest silo of all: the small business model of medical practice with its fee-for-service compensation system' when compared with the United States.[28] Moreover, Indigenous peoples in Canada experience additional fragmentation due to jurisdictional conflicts between federal, provincial, territorial, and band governments on health care provision.[28–31] Despite the 2002 Multidisciplinary Collaborative Primary Maternity Care Project in Canada, which was 'designed to reduce key barriers and facilitate the implementation of multidisciplinary collaborative primary maternity care',[32] challenges such as structural factors and interdisciplinary rivalry between groups of providers remain.[32] Fragmentation of perinatal care exacerbates the barriers and discrimination already faced by Black, Indigenous, and People of Colour (BIPOC) populations,[33,34] and these silos extend to funding and resources[35] with ongoing funding shortages for community-based doulas despite their potential to save costs and address the health disparities experienced as a result of the social determinants of health.[13,36,37]

According to a recent literature review of the role and practice of Indigenous doulas within a Western care system, the three main funding models for Indigenous birth work are grant for private-fee-for service, private fee or Indigenous cultural exchange protocol-for-service, and community development partnership/social enterprise/university partnership.[38] All of these funding models were attributed to Indigenous doulas operating in the Canadian context. Unlike midwives, doulas remain unregulated in Canada and are not paid through the universal health care system. As community-based doula support for historically excluded populations, such as Indigenous peoples, needs to remain free or low cost for families, the mainstream private-fee-for-service model is problematic.

One of the longest running community-based doula models is by HealthConnect One,[39] a Chicago-based organization dedicated to 'advancing equitable, community-based, peer-to-peer support for pregnancy, birth, breastfeeding, and early parenting'. In the HealthConnect One community-based doula model, the average cost per family is US$4000 (approximately $5111 CAD), which includes staff salaries, materials, and administrative costs and aims to serve 50 families per year, making the total cost of this model US$200,000 (approximately, $255,555 CAD) annually.[40] This model includes an annual salary for doulas that ranges from US$20,000 to US$45,000 (approximately, $25,555 CAD to $57,500 CAD); notably, these data are from 2015, and when adjusted for inflation, would likely be closer to $29,213 CAD to $65,731 CAD. Their 2017 report, *Sustainable Funding for Doula Programs*, conducted policy analysis and a doula service survey within the American context, finding that the majority of community-based doula programmes in the United States are non-profit organizations largely funded by private foundations with a smaller proportion of them receiving government funding.[37] Most of these programmes serve clients insured by Medicaid, while more than half of them serve clients who have no insurance. Nearly 90% of the doulas in this survey are paid salaries rather than stipends, but they report that they are still not earning a livable wage. In fact, all doula organizations surveyed cited adequate funding as their greatest challenge. Therefore, their top priorities for policy change were Medicaid reimbursement for

full-spectrum (prenatal, birth, postpartum) doula services and mandated coverage for doula services. No comparable report or research has yet been conducted in the Canadian context, which primarily differs from the American context in provision of universal health care for physician and hospital costs.

Another American report published by Global Health Visions, Global Force for Healing, and the National Birth Equity Collaborative in 2021 makes several recommendations for more coordinated and sustainable funding for maternal and newborn health to advance health equity and reproductive justice.[35] Several of their recommendations are relevant to the Canadian context, including decolonizing philanthropy and international development; shifting significantly more funding to locally led, grassroots, and BIPOC-led organizations; investing in community power building for maternal and newborn health and rights advocates and leaders; and dismantling silos around intersecting health issues and artificial geographic boundaries.[35] Overall, these recommendations point to holistic, integrated solutions that remove barriers to perinatal care funding and empower communities and their grassroots organizations that have the expertise in serving their own birthing people.

Furthermore, there have been studies in the United States[41–45] and one in Canada[36] that have analysed the cost-benefit of doula care and generally concluded that doula care is cost-effective, especially in reducing the costs associated with preterm births, caesarean deliveries, and epidural analgesia use; however, these studies are often limited by gaps in data collection and/or access. For example, researchers for the Canadian study could not access data on anesthesiologist fees and patients with atypical courses of care, such as transfer between acute care facilities and long-stay cases, and their 'cost estimates are limited to inpatient hospital costs and do not include payments to physicians from provincial health insurance plans, readmission costs, outpatients, or home care expenses'.[36] The Canadian researchers were also limited by the absence of national data on risk reductions associated with professional doula support and provincial data on which births were attended by doulas.[36] We note that researchers conducting these kinds of analyses also need to be mindful of the biases and omissions within these positivist, evidence-based methodologies, which often ignore or discount gender-based, intersectional concerns associated with social determinants of health and would benefit from a gender and diversity lens.[46]

In Canada, the costs of birth vary across provinces and territories with physicians providing the most obstetrical services.[47] In the last report on birthing costs in Canada, published by the Canadian Institute for Health Information[47] in 2006, there were still several gaps remaining in what was known about the costs of perinatal care, including how much physicians are paid for prenatal services, how costs for midwives and doulas compare across the country, and how much Canadians are paying out-of-pocket for non-insured maternal and infant health services. These data absences, like those cited in the one Canadian cost analysis of doula support, pose challenges to providing an evidence-based case for mainstream doula support in Canada, let alone community-based doula support. These challenges, in turn, make it difficult for Indigenous doulas and their collectives to obtain sustainable funding to support their work.

Methodology

This article is a qualitative study that draws on semi-structured interviews conducted in preparation for a larger project, 'She Walks with Me: Supporting Urban Indigenous Expectant Mothers Through Culturally Based Doulas', which is dedicated to the creation of an urban Indigenous doula programme to be piloted at the Aboriginal Health and Wellness Centre in Winnipeg, Manitoba, Canada. Our research team conducted interviews using the 'conversational method'[48] with one representative from five different Indigenous doula collectives across Canada (in British Columbia, Manitoba, Ontario, Quebec, and Nova Scotia) to explore how they worked through the logistics of providing doula care. Four of the six authors of this study are Indigenous (J.C., A.H., A.N., S.S.) and two are non-Indigenous settler allies (C.D., L.W.). Their fields of study include Medical Anthropology, Indigenous Health, Development Practice, and Peace and Conflict Studies.

This research received approval from the Human Ethics Review Boards at The University of Winnipeg and the University of Minnesota. We identified participants through Internet searches and purposive sampling. Our inclusion criteria were defined as Indigenous doulas/birth workers who currently provide their services to Indigenous birthing people in Canada. All participants are Indigenous and identify as cis-gender females. Participants were contacted via email, through which we explained the objectives of our research, and provided oral consent prior to the interviews, which was audio-recorded. Oral, rather than written consent, was obtained because it aligns with Indigenous community ethical protocols based in relationality.[49] All participants were provided with an honorarium and gift to compensate them for their time and knowledge.

The first interview was conducted in person in the participant's home city in February 2020; however, due to the COVID-19 pandemic, the subsequent four interviews were conducted virtually via Zoom. The duration of these interviews varied from 1 to 4 h, and they were audio-recorded and transcribed, as well as documented via field notes. Two to five members of the research team (J.C., A.H., C.D., A.N., S.S.), who identify as cis-gender females, conducted each of the semi-structured interviews, and there

was no one present except for the researchers and the participants. As we used the conversational method, an Indigenous research methodology that is consistent with the oral and relational knowledge sharing of Indigenous epistemologies,[48] we provided some initial open-ended prompts and then co-created knowledge via flexible, informal dialogue.

Through an inductive process, we achieved saturation once we reached 'conceptual depth' as defined by Nelson.[50] Following the interviews, the recordings were transcribed verbatim and returned to participants for review and edits. Once the transcripts had been approved by participants, all authors co-developed a coding framework. Transcripts were coded individually and then as a group through the constant comparative method and drawing from grounded theory.[51,52] Through an inductive coding process of the data, we derived 17 themes, including 5 dominant themes, across all interviews. Each of the five major themes is being developed into an article, and before submission for publication, we engage in member checking to ensure that our participants can confirm or correct our interpretations.[52,53]

Results

We identified five dominant themes: responding to community needs, troubleshooting Western systems, professional development, fair compensation for labour, and sustainable funding. The following article focuses on the theme of sustainable funding for Indigenous doulas in Canada. Within this theme, we found two sub-themes: (1) limitations on and regulations for available funding and (2) negative impacts of limited funding on doula service.

Limitations on and regulations for available funding

Of the five participating doula collectives, two are funded by one-time grants, one is funded by provincial grants-per-family, one is funded by a social impact bond – 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'[54] – and one is housed in a Friendship Centre, which receives operational funding from the Public Health Agency of Canada. There are limitations and regulations governing all of these funding sources, often making it difficult to sustain their birth work financially in the long term. Those who received one-time grants note the limited durations, which varies from 1 to 3 years. Though these grants provide funding to begin supporting Indigenous birthing people with doulas, these relatively short funding time spans force collectives and organizations to find additional revenue streams, including offering training for a fee. For example, the Ontario-based doula collective that works out of a community health centre obtained a 3-year grant from the province to fund seven part-time doulas supporting a maximum of 30 births a year at no cost to First Nation, Inuit, and Métis individuals and families. Notably, these doulas are part-time and are paid per client via the grant funding at a rate of up to US$1000. As they are nearing the end of this grant, they are trying to plan for a more sustainable solution:

> So, we're in the preparation of making this a sustainable venue, where if we can fundraise the funds, then we can continue providing it free and also welcome non-Indigenous members. We're in the process right now of developing an Indigenous perinatal compassionate care training online course, and we're marketing this to direct and indirect birth workers – doulas, midwives, physios, chiropractors – to pay for this course as a certification to count for their professional credits. The money from this online course will go to the collective.

The potential solution for sustainable funding for this collective is predicated on additional labour from the doula collective and staff to manage and provide this training.

The doula collective in Quebec received a 1-year community grant, but unlike the Ontario group, this funding did not allow them to provide all doula services for free. They compare their context within an Indigenous community to a mainstream urban context:

> Like some places are charging two thousand dollars. If you're in a big city, absolutely that makes sense, but we're not, and we're an Indigenous community with a lot of people that we want to support who would not be able to afford those prices. Ideally supporting a woman through her pregnancy, birth, and a postpartum visit would be a thousand dollars. We adjust from there based on a birthing person's preference for support. The base cost for supporting just a birth is four hundred dollars. Postpartum support is thirty dollars an hour.

This pricing, which ranges from $400 to $1000 per family, creates potential financial barriers to care for Indigenous families who may already face socioeconomic challenges rooted in colonial contexts and underpays the community-based doulas who provide culturally safe care.

The doula collective from British Columbia primarily generates funding for their work through the provincial grant of $1000 available per Indigenous family. This grant is limited both in terms of total funds and regulations governing its use:

> the grant is not full spectrum, so they fund prenatal care, birth, doula care, and postpartum doula care, but you have to register for the grant before three months postpartum. If you're past that point, you can't apply for the grant anymore, which is really weird, honestly, because nowhere else says that postpartum ends after three months. In BC I think it's a year

> or 18 months of time off you can get for work, and I mean, physiologically, it's at least two years, but there are a lot of physiological outcomes of postpartum that, until they are addressed, they will still be present in the body. So, postpartum could honestly be anytime after having a baby. And our families definitely still want support for the first year at least.

According to this participant, this grant structure imposes both limits on the care the family can receive and the compensation for the doulas providing the care:

> I feel like just because we're fighting for this little scrap of one thousand dollars, we're also obscuring the fact that a thousand dollars isn't even fair compensation for the work that we're doing. Birth doula packages in Vancouver are usually around $1,200 to $1,700. And most people do charge as a package. So, families that want doula care with a thousand-dollar grant have to choose whether they want prenatal or postpartum care. Or if they want a birth doula and one postpartum visit . . . like, that's not adequate care!

These challenges echo the difficulties faced by the other two collectives funding their doula services through grants.

Only one of the doula collectives interviewed was incorporated with a board of directors. This collective also pays their doulas a salary because they are funded by a 2-year social impact bond. Despite the benefits of being able to provide a full-time salary to their doulas, this type of funding also has drawbacks and limitations, including bureaucratic systems with funding partners that act as intermediaries between the investors and the doula collective:

> So, the investors . . . invest their money in the [partner organization], and then we have a service agreement with the [partner organization]. So, one of the administrative issues was that in June of last year, the [partner organization] got a new board, and by September, had turned over all of their senior staff or the majority of their senior staff. Every person that had worked with us on the development of the social impact bond no longer worked for the [partner organization], including finance support, the CEO, and the Director of Programs, so it's really difficult to work with the new board and try to bring them up to speed as to where everything was.

This potential inconsistency and instability in leadership can make it frustrating for the doulas who continually need to make a new case for their care. In addition to this dependence on another partner organization to be the intermediary between the doulas and the investors, there are also legal regulations to obtain and maintain funding, including issues of liability. The participant explains the costs associated with liability insurance:

> One of the administrative issues that we've had a problem with, and still have a problem with, is that the amount of liability that they requested for omissions and errors is really high. It's like $5 million, and every insurance company that our insurance broker has approached has denied us because they say, 'You don't belong to a college, you don't have a professional designation'. Why are they asking for this? Well, they ask that of the [partner organization] because they are professionals, you know what I mean? And doulas are unregulated. And, so, because they're unregulated, they're saying, 'Well, why would we provide you with professional omissions and errors insurance when you're technically not professionals?'

Therefore, this regulatory aspect of professionalism or certification creates pressures to become certified doulas even though many of the most recognized doula training certification do not necessarily fit the cultural needs of Indigenous populations:

> Our curriculum is not DONA-certified, and DONA would be the most recognized doula training organization. So, people want to see that you're DONA-certified, but in order to be DONA-certified, your curriculum needs to be DONA-certified. It cannot include any religious content or traditional/cultural content in it.

This tension between Western forms of certification and bureaucratic/legalistic systems on the one hand and Indigenous ways of knowing and birth sovereignty on the other can make it difficult to maintain compliance that regulates funding.

The Indigenous doula collective based in Nova Scotia, which is housed within a Friendship Centre, is run by existing staff who are paid through operational funding from the Public Health Agency of Canada, a federal governmental body that 'offers a number of off-reserve health programmes specifically designed to meet the needs of marginalized populations, including Aboriginal peoples living off-reserve'.[30] Though this model may lend stability to the doula programme by utilizing existing staff, the stagnation of this funding pool prevents the programme from expanding and overburdens the doulas who add this birth work to their existing positions:

> One of our funding pots hasn't had an increase in 24 years, and one hasn't had an increase in 17 years. We're drastically underfunded, and we need more staff. It's just really hard to stay competitive with wages, let alone hiring new staff. So, there are several of us in the community to whom this has been heart work, but there's just not enough time to devote to it.

This stagnation in operational funding makes it difficult to expand or implement new programming such as doula services within the Friendship Centre, putting staff in a position of volunteering their time with little to no compensation. This issue of fair compensation is one of several that negatively impact Indigenous doula service and providers.

Negative impacts of limited funding on doula service

One of the most persistent negative impacts of limited and unsustainable funding for Indigenous doulas is the lack of fair wages and compensation. Many of our participants are paying for their own overhead costs without receiving enough grant funding to cover their labour. One participant notes,

> just being on call for the birth alone is a huge energetic commitment. It requires being on call two weeks before and two weeks after someone's due date, and that is very difficult for your own personal life and scheduling. So, to be on call for even two births a month is a lot. And two births a month at $2,000 is $24,000 a year. And it can mean never being able to take a vacation for yourself or leave town or be more than 50 kilometres out of town. That's crazy. Nobody can live off of $24,000 a year! And support a family?

Because of the lack of livable full-time wages and benefits, as well as uncompensated out-of-pocket expenses such as hospital parking fees and mileage, our participants reported high staff turnover due to financial need and burnout. As community-based doulas support underrepresented populations who often require services that exceed those offered by private doulas,[1,2,9] including trauma-informed and culturally safe care and advocacy within a systemically racist environment with higher commitments in time and emotional labour, they are at risk of burning out. As the participant located in Manitoba recounts,

> we have lost three, four staff. . . . one of them just left to go to a better paying job, but with our birth helpers, they left because the work was a lot more than what they thought it was going to be.

The participant from British Columbia views this extensive labour without fair compensation as systemic exploitation:

> I feel like . . . the health care system right now is really interested in doula care, and yeah, of course they're interested because it's a super cheap intervention than can produce better healthcare outcomes. But I worry it's of interest because it's a cheap way around the systemic changes that are needed. This approach leads to doulas being structurally impoverished and burning out.

Her comment about the doulas themselves being 'structurally impoverished' is a significant challenge within community-based doula work, in which doulas are drawn from the same underserved populations for which they care. She also points to a need for long-term, well-funded systemic change rather than depending on individuals who cannot afford to labour in this way.

In addition to the precarious and emotionally demanding nature of Indigenous doula work, our participants report that due to their unsustainable, insufficient funding sources, they often lack the time and resources to manage the administrative aspects of providing doula service, including fielding external requests for services, training, and media interviews; processing payments; seeking and managing grant funding; and managing human resources and client records. The participant located in British Columbia describes how their collective considered becoming a non-profit organization to be able to apply for and raise their own funding to better support their collective. She stresses that

> the administrative piece is secondary to the funding piece, in terms of doulas actually being able to do the work. Because everybody that I've seen come into the collective and then have to take time away. . ., I feel like they wouldn't be stepping away from the work if they were able to get properly paid. There's a lot of excitement around doula care, and it feels like really important work that is a calling, but I think when doulas realize there's no money in it, despite the extreme demands on your energy, time, and resources, it becomes unsustainable.

Our participants reveal that sustainable funding is at the root of maintaining both the service delivery and the administration of Indigenous doula care.

Several of the collectives also face a lack of physical space and access to equipment. The collectives housed within a community health centre and Friendship Centre are able to book spaces within the centres, but others have been meeting in and working out of their own houses. In addition to a dearth of funding to support fair wages, administration, and infrastructure, there is little funding for maintaining professional development and training, which is key for both providing competent doula service and certification if collectives want it. The participant from Quebec explains,

> [There are] currently no plans to fully certify with DONA or any other doula organization. Again, we're willing to take more trainings and stuff that serves us, our group, but we're small, we're running off our own personal money, and we're kind of limited. When you're supporting a lot of women and have a family and are not making a ton of money, it's kind of just going with the flow here.

This same participant recounts how their collective shares training and knowledge through one doula taking a particular training and sharing what she learned with the rest of the group. In this way, they manage to stretch their existing resources to serve the collective. This sharing of knowledge is also often applied to equipment. In the case of the British Columbia group, the doulas asked for partner communities to purchase equipment and supplies to be shared:

> We compiled a list of things that we thought they could house in the community, a sort of lending library of doula supplies, so that not everybody would need to invest in the things that go in a birth bag. Things such as a TENS machine, as well as other essential supplies and books. We suggested that the local midwife could keep those things in her space, and people could borrow them. Or they could be kept in the health centre of a remote community.

This creativity and ingenuity are indicative of the dedication of these Indigenous doulas to serve their communities despite limited funding and resources.

Discussion

Our findings demonstrate that Indigenous doula collectives in Canada appear to fall into the funding models found in the recent literature review of the role of Indigenous doulas[38] with the exception of those who also access Public Health Agency of Canada and other grant funding through their umbrella organizations for those collectives housed within community centres. Several of these collectives also attempt to generate revenue through providing training for a fee, but this revenue stream requires additional labour and administration that could exacerbate labour exploitation and burnout. Their challenges in obtaining sustainable and adequate funding are consistent with the findings from the American context of community-based doulas but differ significantly in that they do not receive funding from private foundations and that only one of the groups pays their doulas through an annual salary. Excluding the collective funded by a social impact bond, our participants reported that their doulas are either part-time, adding doula work to their existing job, or being paid $1000 or less per family whom they serve. Even with adjustments for different costs of health care and living expenses between the United States and Canada, $1000 CAD per family is well below the $5111 CAD cost per family employed by HealthConnect One.[40] Some of our participants are also still needing to charge fees to families who often cannot afford the cost.

In many ways, the four strategies developed in the HealthConnect One[37] report on sustainable funding for doula programmes are potentially useful and responsive to the challenges we see in the Canadian context. These strategies include pursuing a blended approach of public, private, and third-party funding; developing and consolidating evidence for the community-based doula model; advocating for doula services to be integrated into existing payment models; and developing and implementing an advocacy plan to secure sustainable funding.[37] At the same time, the Indigenous context of this doula care affects many aspects of funding, including regulation, training, methods of data collection and analysis, and populations served. To remain culturally safe and appropriate, Indigenous doula care must be rooted in Indigenous ways of knowing and conceptions of holistic health and well-being, as well as the complexities of colonial, intergenerational trauma experienced by Indigenous peoples. Therefore, regulations governing Indigenous doulas, the training provided to Indigenous doulas, and the way in which data are collected and analysed need to be mindful of the specific cultural and social contexts of Indigenous peoples and their self-determination. For example, any data collection and analysis should be conducted with Indigenous data sovereignty and governance and decolonized epidemiology[55] in mind, including community-determined guidelines such as the CARE (Collective Benefit, Authority to Control, Responsibility, Ethics) Principles.[56] Furthermore, Indigenous populations are greatly diverse across individual First Nations, Métis Nations, and Inuit, which needs to be taken into account when developing and providing doula training and evaluating cost-benefit.

In Canada, a blended approach in funding would likely be favourable since the federal government transfers funds to provinces and territories, but health care provision is primarily the responsibility of the provinces and territories, which vary in their approaches, amount of decentralization, and financial oversight.[57] In addition to these differences among provinces and territories, health care for Indigenous peoples is funded differently depending on whether the care is provided on-reserve or off-reserve, to Inuit living within their traditional territories or those who are not, and to status or non-status First Nations people with 'Métis, off-reserve registered Indians, non-registered Indians, and Inuit living outside of their traditional territories fall[ing] under the purview of territorial and provincial governments'.[30] The result of these jurisdictional complexities is a 'patchwork of policies and programmes for First Nations, Inuit and Métis'.[30] With respect to these complexities, it may be more feasible to seek funding first at regional levels.

As there is a notable lack of data and research on the impact and costs of community-based doulas in Canada, including Indigenous doulas, there remains a need to continue developing and consolidating evidence for the impacts and cost-benefits of their work to support advocacy for sustainable funding. Regionalization, which decentralizes Canadian health care and focuses on rationalization of services,[58] can make the collection and analysis of perinatal health data across jurisdictions and the country challenging, with the added difficulty of reconciling Western-based ideologies of rationalization and cost–benefit analysis with Indigenous feminist perspectives on what should be measured and/or valued and how data should be interpreted in ways more aligned with the social determinants of health and intersectional identity factors.[46] In sum, applying an intersectional lens to cost–benefit analysis would recognize that 'the gendered work of parenting, educating, feeding, clothing, and caregiving done within households is a critical input into the production of

health and the prevention of illness and disease'[46] and consider how socially determined inequities across diverse populations may impact the efficacy of health policies and interventions, thus leading to higher costs in the long term.[46] Hankivsky and Friesen point to an example of cost cutting that is relevant to maternal health care:

> the decision by the British Columbia government to implement a reduction in the length of hospital stays for maternity patients in 1995 disproportionately affected women, especially Aboriginal women and those in rural areas, and their health through two avenues. First, maternal health was adversely affected by the reduction in professional care: maternal re-admissions increased substantially as a result of the policy change. . . . Second, the policy shifted the burden of caring for new mothers and their infants from paid professional caregivers to unpaid non-market caregivers.[46]

Furthermore, by '[t]racking the incidence of costs across diverse groups of women within economic costing studies', health economic policies could benefit from evaluation that takes both equity and efficiency into account.[46]

Without being appropriately integrated into existing perinatal care systems and resourced as such, Indigenous community-based doula services in Canada will continue to face precarious and unsustainable funding, as well as the resulting negative impacts in terms of high turnover, burnout, and insufficient administration and infrastructure to provide adequate doula care. This integration requires interprofessional collaboration and coordination at regional levels between the variety of perinatal services, including obstetricians, midwives, social workers, and birth centres. By avoiding duplication of services and integrating Indigenous doulas into the various services that are already part of the social services and health care for Indigenous peoples, resources could be used more efficiently and recognize the value of doulas as being part of the holistic, continuous care for Indigenous birthing people. This integration would differ depending on the jurisdiction under which it operates, potentially funded differently between reserve/rural/urban and provincial/territorial settings. As part of the universal health care system and under the 'accessibility' condition of the *Canada Health Act*, Indigenous doulas would then be paid a fair salary and Indigenous birthing populations would have free access to their services. Furthermore, the doulas would have the guaranteed support of a team with different areas of expertise and an existing administrative infrastructure. This integration into the existing system would also potentially safeguard against insecurity in the face of changes in leadership and governance. Knowing that full-time Indigenous doula positions existed would also support strategies for Indigenous doula recruitment and training. However, if Indigenous doulas were to be integrated into the existing perinatal care system, it is also crucial to be mindful of the potential challenges, including the possibility of requirements for certification approved by mainstream bodies rather than culturally safe and distinct training, and the importance of focusing on peer support from those with lived experiences rather than birth workers employed as hospital staff, especially as research shows that birthing people underwent fewer caesarean sections when 'supported by a companion who . . . were not hospital staff'.[12]

Currently, advocacy for sustainable funding is coming from separate Indigenous doula groups in provinces and territories across the country but not at a collective, national level as there has been for Indigenous midwifery through the National Aboriginal Council of Midwives.[59] This collective approach to advocacy could work with partner organizations to promote the benefits of Indigenous doulas and request sustainable funding and policy change from various levels of government. In these efforts, the differences between community-based doulas and private fee-for-service doulas and the different populations they serve need to be made clear. A national effort may also find ways to exchange knowledge and build activist campaigns with counterparts in other countries.

Despite their funding challenges, the doula collective representatives whom we interviewed show remarkable ingenuity and tenacity in providing their services to the Indigenous communities who need them. As with other community-based doula groups who serve underrepresented populations, the interviewed doulas view their motivations as honouring the culturally specific needs of their communities, 'holding space' for their clients by countering racism in medical settings, and 'being good relatives', callings that are rooted in relationality and reciprocity.[21,23,60]

Limitations

The main limitation for this study is the location of the Indigenous doula collectives that we interviewed, which are primarily in or close to urban centres. None of the interviewed doulas work in remote communities; however, as we are using this research to develop and pilot an Indigenous doula programme in an urban centre, this scope was appropriate. Moreover, we expect that additional Indigenous doula collectives exist across North America, and we are currently undertaking an environmental scan to identify them. At this phase in our research, we wanted to interview only those in the Canadian context, recognizing that there could be significant opportunities to learn from other Indigenous doula collectives in countries such as the United States, Australia, and New Zealand.

Conclusion

In interviewing representatives from five Indigenous doula collectives across Canada, we have found that a major

challenge to providing Indigenous community-based doula services is sustainable funding. Current models of funding for this work often do not provide livable wages and are bound by limited durations. Due to this lack of sustainable funding, Indigenous doula services in Canada face challenges that include high staff turnover and burnout and lack of time and resources to provide culturally safe care, pursue professional development and additional training, and keep their services affordable for the families who need them. Future research is needed to ascertain potential programmes and funding streams for sustainable Indigenous doula support in Canada, including possible integration of doula care into the universal public health care system despite the jurisdictional challenges in providing health care for Indigenous peoples.

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Author contribution(s)

Larissa Wodtke: Conceptualization; Formal analysis; Project administration; Writing – original draft.
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.
Jaime Cidro: Conceptualization; Formal analysis; Investigation; Methodology; Resources; Supervision; Writing – review & editing.

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The University of Winnipeg Human Research Ethics Board approved the research presented in this article that was conducted by LW, AH, AN, JC, 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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