

Chapter I

Rights vs. Reality: Results of the Fact-finding

Thousands of Malian women every year—an estimated three thousand in 1995—do not survive the journey from pregnancy to childbirth and the post-partum period.¹⁹ For most of these women, marriage by the age of 16 and frequent childbirth starting soon thereafter are the rule.²⁰ The vast majority have undergone some form of FC/FGM.²¹ Many have to travel long distances to reach facilities providing minimal obstetric care. Most of these facilities lack basic materials and few are equipped to handle obstetric emergencies. Their staff often lack training and supervision. What is more, the decision to seek out their services is often not the pregnant woman's to make; husbands or in-laws determine how family resources are spent and whether health care will be sought outside of the community.

International legal and policy standards lay the foundation for recognizing the right to survive pregnancy and childbirth as a basic human right for women in every country of the world. The Malian government has ratified the relevant international conventions and has therefore bound itself to these standards on behalf of all of its citizens.²² The reality for hundreds of thousands of Malian women, however, is that pregnancy and childbirth continue to pose a substantial threat to their lives. The result is a violation of women's right to survive pregnancy and childbirth—indeed, **their right to life**. The many factors contributing to this violation may be examined in categories corresponding to three distinct rights: the **right to health care**, **non-discrimination** and **reproductive self-determination**.

The government of Mali, like all governments, has a duty not only to refrain from directly violating human rights norms, but also to intervene in pervasive human rights violations by third parties. Governments are also obligated to help prevent human rights violations by reforming their laws and policies and committing the funds to improve social services so that all citizens—especially women and girls—can enjoy the full range of human rights, including reproductive rights.

We have organized the results of our fact-finding according to the rights in question, pointing out both government actions that compromise these rights and the

social and cultural realities that contribute to maternal mortality and therefore require greater governmental attention and intervention.

A. RIGHT TO REPRODUCTIVE HEALTH CARE

International law guarantees everyone the right to enjoy “the highest attainable standard of physical and mental health.”²³ States are thereby obligated to ensure universal access to necessary health-care services. In the context of pregnancy and childbirth, these services would include the following: skilled care at the time of delivery; access to lifesaving care during pregnancy, delivery and the post-partum period; prenatal care; access to contraceptives, safe abortion services and post-abortion care.²⁴

The Committee on Economic, Social and Cultural Rights, the UN body charged with monitoring states parties’ implementation of the International Covenant on Economic, Social and Cultural Rights, provides a framework for identifying clear shortfalls in governments’ implementation of the right to health. In its General Comment on the Right to the Highest Attainable Standard of Health, the Committee has noted that the right to health contains four “interrelated and essential elements”: **availability**, **accessibility**, **acceptability**, and **quality**.²⁵ During the course of our fact-finding, the Center for Reproductive Rights and AJM identified inadequacies in health-care provisions for Malian women for each of these elements.

1. Availability of Care

The Economic, Social and Cultural Rights Committee has stated that functioning health care “facilities, goods and services, as well as programmes,” should be available “in sufficient quantity.”²⁶ These facilities, goods and services should include “hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs”²⁷

The government of Mali has not yet ensured the availability of basic maternal health care to vast portions of the population. Health care in Mali is characterized by a lack of health-care facilities, severe material shortages, and a lack of human resources. Forty-three percent of women do not receive prenatal care²⁸ and only 16% of women have access to postnatal care.²⁹ As already noted, a mere 26% of all births

are aided by skilled attendants.³⁰ While low utilization of services is attributable to a number of factors, the lack of equipped and staffed facilities is an undeniable barrier to health care. The societal pressure to bear children, combined with the lack of a supportive environment for doing so, create a climate in which women's health and well-being are severely compromised.

a. Lack of health-care facilities

Beginning in 1991, with strong incentives and financial assistance from the World Bank as well as the support of UNICEF, Mali has implemented a policy of health-care decentralization.³¹ This policy has put responsibility for primary health care in the hands of the village or "commune," making community health centers Malian's first contact with the health care system.³² Referral centers at the district (*cercle*), regional and national hospitals are financed and supervised by the state through the Ministry of Health.³³ The community health centers, in contrast, which are responsible for a minimum package of preventive, curative, and promotional health-care activities, are established with financial support from the government but are maintained by the communes they serve.³⁴ This lack of financial support from the central government has resulted in severely deteriorated conditions at community health centers where renovations are often put on hold³⁵ and equipment, supplies, personnel supervision, and management of care are grossly inadequate.³⁶

Furthermore, because the communes differ in their levels of prosperity and the willingness of their members to contribute to health-care costs, there is significant variation in community health centers. There is thus uneven enjoyment of health care across the country. The functioning of health-care facilities may also be affected by economic developments that have a particular impact on certain parts of the country. For example, a recent cotton crop crisis in the south led to a failure to pay the salaries of local health-care workers and a subsequent decrease in the quality of health care.³⁷

The number of health-care facilities is inadequate to serve the needs of the population, which is dispersed widely in rural areas. Only 32% of rural women live within five kilometers of a community health center.³⁸ Only 38.7% live within 15 kilometers of such a facility.³⁹ Hospitals are even further out of reach for rural women, with only 2.5% living within five kilometers of a hospital and 2.7% living within 15 kilometers of one.⁴⁰

b. Material shortages

Where community health centers do exist, they have been ill equipped to meet the primary health-care needs of women.⁴¹ The prerequisites for providing care—such as proper lighting, the means for sterilizing equipment and refrigeration—are lacking.⁴² Without such basic materials, the technical capacity of these facilities is low.⁴³ In the rural commune of Loulouni in the region of Sikasso, for example, the community health center is in dire need of basic equipment and materials. The state certified nurse overseeing the health center, from his small, dusty, and dimly lit consultation room, lists what is needed: an examining table, a delivery table and beds.⁴⁴ While norms of service provision require that women stay in health-care centers for 48 hours after giving birth, the structure in Loulouni is not equipped to meet the needs of women for a period of that length. It lacks such basic necessities as electricity and mosquito netting.⁴⁵

The situation is not much better in a community health center near Bamako, the capital city. The physician in charge points out that the center relies on solar power because there is no electricity. The delivery room is small and lacks ventilation. There is no room designated for newborns. The center lacks medicines and equipment, as well as the means for sterilizing equipment.⁴⁶

The capacity of these health-care centers to handle emergency treatment is even more limited.⁴⁷ Not only are medications for emergency care inaccessible, but there is not enough blood for transfusions⁴⁸ and there are limited means for ensuring the safety of the blood that is available.⁴⁹ In addition, a referral system—and corresponding community insurance program—has not been firmly established in every commune. As a result, local health personnel may not know where to send women who are experiencing complications, particularly when these women lack the means to pay for services or transportation to larger hospitals.⁵⁰ Not only are local providers not trained to identify warning signs,⁵¹ there are often no ambulances or other means to get women to emergency care in a timely manner.⁵² And where exactly these women would go even if they could afford to get there is unclear.

The success of any referral system depends upon the existence of a well-equipped health facility that can meet the needs of women with complications.⁵³ Yet even state-funded hospitals in Mali—facilities that the national government

INSIDE THE MATERNITY WARD

At the regional hospital in Ségou, women sit on the ground outside the door of the maternity ward, many visibly pregnant, some holding babies. To fight the heat, the doors to the front office are wide open, and a layer of dust covers the floors, walls and sparse furniture. More women sit on the floor inside. In the examining and delivery rooms, the midwife points out leaks in the ceiling and dilapidated equipment. The single delivery room has three birthing tables—all of which, says the midwife, are commonly in use at the same time. The supervising obstetrician tells us that she needs basic materials, like new birthing tables and medications. The midwife continues the list of what is missing: antiseptic, delivery kits, cesarean kits, rolling beds, a medical cart, emergency medications, cupping glasses, and more. In the darkened recovery rooms, where at least a dozen women lie, the thin mattresses are covered by an assortment of fabrics and blankets that women have brought from home. There are not enough beds, and one woman lies on the floor.

directly oversees—lack basic materials. One regional hospital in Ségou is illustrative of the problem. The hospital is severely under-equipped: medications, gloves, examination tables, and qualified staff are all in scarce supply.⁵⁴ Our fact-finding revealed similar material shortages at a nearby hospital in Markala, where a midwife told us that she needed delivery kits, a speculum, a stethoscope, medical trays, cleaning fluid, gloves, syringes, and needles.⁵⁵

One of the most severe material shortages in Malian hospitals is the lack of blood for transfusions.⁵⁶ The government of Mali has not established an effective system for ensuring an adequate supply. One provider recounts the story of a woman who came to the hospital hemorrhaging and in a state of shock following delivery. She died because the hospital lacked the blood she needed for a life-saving transfusion.⁵⁷ A hospital director notes that he faces serious difficulties acquiring an adequate supply of blood. Even when women are facing hemorrhage, he says, members

of their families often refuse to serve as blood donors. In addition, it is illegal to pay people for their blood, so the hospital has a limited ability to collect blood from the general public. The resulting shortage forces the hospital director to go to the local military base and offer soldiers 1,000 CFA (approximately USD 1.50) in cash for their blood. The practice is illegal, but it is done out of necessity.⁵⁸

c. Lack of human resources

The government has acknowledged that there is a shortage of needed trained medical personnel.⁵⁹ In 1997, there were only 543 physicians, 1,594 nurses and 343 trained midwives in the entire country.⁶⁰ One explanation for the shortage of personnel is the low salaries for medical professionals.⁶¹ As one physician in private practice says, "people have to be able to eat." Often, she says, doctors spend more time worrying about making ends meet than thinking about their work.⁶² Moreover, morale among health-care providers suffers where facilities are unequipped to meet patients' needs. As one trained midwife says, the government needs to "place people in proper working conditions."⁶³

In addition, health-care providers are not evenly distributed throughout the country, thus creating great disparities in the quality of care.⁶⁴ In 1997, 57% of the country's physicians resided in Bamako, as did 41% of its nurses and 64% of its trained midwives.⁶⁵ The absence of trained midwives outside of Bamako has particularly troubling implications for women giving birth. The entire region of Ségou had only 22 trained midwives, while Sikasso and Mopti had a mere 18 and 16, respectively.⁶⁶ Low salaries and trying working conditions make it difficult to attract providers to rural areas or even to keep existing personnel in place.⁶⁷

The government's Ten-Year Health and Social Development Plan (Ten-Year Health Plan), adopted in 1998, states that the community health centers should include one doctor, one state registered nurse, one obstetrical nurse, a dispensary supervisor, and a laboratory technician.⁶⁸ The policy itself recognizes that only an estimated 5% of these centers will be staffed accordingly by 2007.⁶⁹ At a minimum, the government has called for community health centers to be staffed by one state registered nurse, one *matrone* (birth attendant, distinct from a trained midwife) and one dispensary supervisor.⁷⁰ Indeed, for most women, *matrones* and traditional practitioners are the first contacts during pregnancy and delivery.⁷¹ While *matrones*,

Personnel Attending Births in Mali⁷³

	Doctor	Nurse or Midwife	Matrone
Bamako:	5.8%	86.4%	2.9%
Mopti:	1%	12%	7.1%
Sikasso:	6%	13.1%	32.1%
Ségou:	1.2%	14.8%	6.7%

unlike traditional practitioners, have had basic training and met basic educational requirements,⁷² they are not considered “skilled attendants” according to international standards.

While there is general agreement that more trained midwives are needed to oversee deliveries, there are not even enough *matrones* to meet the demand.⁷⁴ At the community health center in Loulouni, for example, we learned that not only were there no trained midwives in the vicinity, there were only three *matrones* serving 22 neighboring villages.⁷⁵ Similarly, in the village of Niena, the 35 to 50 births that take place in the community health center every month are attended entirely by *matrones*.⁷⁶

One of the primary reasons for the uneven distribution in personnel is that the communes are not able to offer job security to the providers they employ.⁷⁷ Salaries are often paid late and positions can be unexpectedly terminated.⁷⁸ Health-care workers are often discouraged by the fact that they work alone in difficult conditions where essential materials are lacking and new technologies are unavailable.⁷⁹ Furthermore, the communes are not able to offer housing and vehicles to their personnel, and often fail to pay a living wage.⁸⁰ These factors frequently lead local health-care personnel to abandon their positions for more secure jobs with the state.⁸¹ It is especially difficult to attract married, trained midwives to rural areas, where jobs may not be available for their spouses. Often, trained midwives live apart from the rest of their families.⁸²

Personnel problems are not limited to the providers of health care. One hospital director told us that he does not have a single paid custodian on staff. Instead, a number of the people who work at the hospital are unpaid “volunteers” who do var-

ious tasks and rely on tips from patients.⁸³

2. Accessibility of Care

The Economic, Social and Cultural Rights Committee has addressed the various dimensions of accessibility.⁸⁴ Services should not be denied on discriminatory bases, they should be physically accessible and affordable, and information about those services should be accessible.⁸⁵ Information accessibility implies “the right to seek, receive and impart information and ideas concerning health issues.”⁸⁶

a. Physical accessibility

Most of Mali is rural, and the health centers are often far away from the villages in which women live.⁸⁷ Roads may be unpaved or not well maintained and villages may be separated from health-care facilities by rivers.⁸⁸ In addition, ambulances are not available in most areas and the majority of women do not have access to vehicles of any kind—they either must walk or be carried by bicycle or donkey cart.⁸⁹

More community health centers are needed in order to decrease the distance women must travel for care.⁹⁰ While most women interviewed for this report said they did have access to prenatal care, those without access cited distance from the health center as the primary reason for not seeking care.⁹¹

b. Affordability

With health sector reform in the early 1990s, user fees were imposed upon women seeking obstetric health care. The cost of this care is out of reach for most women in Mali.⁹² Not only are women asked to pay the providers’ fees, but they are often asked to pay for supplies, such as gloves and urine tests.⁹³ Just getting to the health-care facilities may entail additional costs for rural women.⁹⁴ As one provider notes, “sometimes women arrive without a penny; they don’t have the means.”⁹⁵

Some communes have established a special fund, or “*mutuelle*,” to subsidize women’s access to emergency care during childbirth.⁹⁶ An estimate is made of the number of special procedures (such as cesareans) that will be needed in a given year, based on past demand. Financial contributions are made by various actors, including residents of the commune, health-care centers and NGOs. The resulting fund enables a woman to cover the costs of the special procedure and the hospital stay.

The money also makes possible the purchase of a radio system and an ambulance. A system of this type has been put in place in Loulouni. According to the director of the community health center there, the system is not yet perfect and requires further evaluation.⁹⁷ The success of these systems will depend upon the accuracy of estimated numbers of women with complications who require referrals and the availability of facilities that are able to meet the needs of these women.

c. Information about services

A number of those we interviewed during the fact-finding said that women needed to be made more aware of the importance of prenatal care and medical assistance during delivery.⁹⁸ Many women in Mali do not seek out prenatal care,⁹⁹ or wait to do so until the seventh or eighth month.¹⁰⁰ According to one NGO representative, often “the first consultation is made at the time of delivery.”¹⁰¹ Without care during the early stages of pregnancy, there is no opportunity to identify and manage potential problems, inform women of the warning signs for life-threatening complications, or assist women in developing an emergency plan in case complications arise during delivery.¹⁰² Many women start to give birth at home and rush to the community health center only if something goes wrong.¹⁰³ Some of those we interviewed talked about the difficulty of reaching women in rural areas. As one local official in Ségou says, “there are some places that information does not reach.”¹⁰⁴

The need for information goes beyond instruction on health. A member of the NGO community in Bamako did not think that most women lacked information. Rather, she felt that there was a failure of the health-care community to communicate in a way that would change pregnant women’s behavior.¹⁰⁵ Some stressed the importance of conveying one’s message in a manner that does not alienate women,¹⁰⁶ particularly on such sensitive issues as FC/FGM and family planning.¹⁰⁷ Sex, which remains a taboo topic of discussion in many communities, must be brought up with some caution.¹⁰⁸

The most recent Demographic and Health Survey found that only 11% of Malian women can be considered literate.¹⁰⁹ Most women are therefore limited in their ability to seek out maternal health information on their own.¹¹⁰ Health-care providers are often the primary source of information for these women.¹¹¹ Unfortunately, many health-care providers do not supply adequate information to

female patients, and may be insensitive to a woman's need for information during the prenatal period.¹¹² Women with whom we spoke attested to the poor conveyance of information during their pregnancies, saying that they received confused and contradictory advice from providers.¹¹³ Some said that when they came to the hospital complaining of pain, they were discharged without any explanation.¹¹⁴ They called for greater demystification of the pregnancy process.¹¹⁵ In some cases, providers have limited means to convey this information, and have expressed a need for posters, slides and other visuals that can reach more women.¹¹⁶

In the absence of solid medical information and effective communication from the health-care community, many women share various rumors and myths about maternal and child health. There is a host of misconceptions that prevents women from seeking the care they need. Some examples include the belief that if a pregnant woman crosses a river, her baby will die¹¹⁷ and the belief that taking iron pills will make one's baby yellow.¹¹⁸ At the same time, many women are not aware of the real risks associated with pregnancy.¹¹⁹ Often, when they begin to experience a complication, they believe that it is a normal part of pregnancy and they do not seek care,¹²⁰ or they think they should be courageous and not ask for help.¹²¹ Similarly, many women who have experienced childbirth once think subsequent births will be easier and therefore safe to carry out at home.¹²² Furthermore, few women know about the potential dangers to maternal health posed by FC/FGM.¹²³

Every community has its own myths about pregnancy, and practices vary accordingly.¹²⁴ One widespread practice involves hiding one's pregnancy until someone guesses that one is pregnant.¹²⁵ The belief is that announcing a pregnancy invites bad luck, so not only do women not tell people that they are pregnant, they also avoid seeking early prenatal care. Pregnant women are also subject to certain nutritional taboos, including some that apply to foods that are beneficial to a pregnant woman's health.¹²⁶ For example, women are told that if they eat eggs, their child will be mute.¹²⁷ Another practice harmful to maternal health is the use of an herbal ointment called *kana*, which induces labor.¹²⁸ *Kana* can lead to serious complications.¹²⁹

Women's lack of information is exacerbated by widespread distrust of many health care centers and hospitals.¹³⁰ One NGO worker in Bamako spoke of a "vicious cycle" in which women prefer to give birth at home because they believe

that women are more likely to die in health-care facilities. Those that experience complications may seek emergency care in facilities that are unable to save their lives. As other women learn of these deaths, the fear of organized health care is reinforced and they continue to stay away.¹³¹ Resistance to organized medicine may be reinforced by a widespread culture of fatalism when it comes to women's survival. In the words of one 51-year-old woman in Mopti, "everything depends on good God."¹³²

3. Acceptability of Care

The Economic, Social and Cultural Rights Committee states that "[a]ll health facilities, goods, and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals ... and communities [and] sensitive to gender and life-cycle requirements...."¹³³ In Mali, the fact-finding revealed widespread dissatisfaction with the treatment women receive from providers in public facilities.

Some people commented that women are treated poorly by health-care providers.¹³⁴ Health-care personnel often treat low-income women and adolescents in a particularly insulting manner.¹³⁵ Several women who had experienced childbirth commented on the disrespectful treatment they received in the hospital.¹³⁶ According to one 26-year-old woman in Bamako who has given birth twice, midwives need to be advised "to take an interest in the women they care for."¹³⁷ As one NGO representative noted, providers do not always tailor their care to address the needs of individual patients. For example, a provider might write down the time of a patient's next appointment, despite the provider's knowledge that the patient is illiterate.¹³⁸

The results of our fact-finding also suggest that some health-care providers routinely demand supplemental payments from women, supposedly to cover the cost of supplies.¹³⁹ And though it is illegal for trained midwives to deliver babies at home, some agree to do so at a steep price. These midwives often ask for substantial "gifts" after the delivery, making it clear that their availability for the next birth will depend upon the woman's willingness to pay.¹⁴⁰ Services in some public hospitals are also conditioned on extra payments to providers. One private practitioner notes that "the hospital has become private," meaning that the unofficial costs of giving birth in the public hospitals now mirror the fees of private clinics.¹⁴¹

The testimonials of several women suggested that care in the private clinics was of higher quality. One NGO worker who had herself given birth twice at a private clinic and three times at the public hospital noted the superior care she received in the private clinic.¹⁴² At the clinic, which was staffed by both gynecologists and trained midwives, she was received respectfully and the facilities were clean. In the public hospital, she received care from the same physician she had had in the private clinic. However, when the physician was not present, she found the midwives inattentive to her needs. When she informed them that she was experiencing pain, for example, they were either slow to attend to her or they failed to help at all.¹⁴³

In contrast to the testimonials of women who have experienced giving birth, providers often cited the comportment of patients when discussing causes of maternal mortality. Many said that women who were able to receive regular prenatal care and give birth in a health-care center or hospital were spared significant problems during birth.¹⁴⁴ According to these providers, maternal deaths occurred when women came to the hospital at the last minute, already hemorrhaging or suffering from an infection.¹⁴⁵

4. Quality of Care

The Economic, Social and Cultural Rights Committee has stated that “health facilities, goods and services must ... be scientifically and medically appropriate and of good quality.”¹⁴⁶ Ensuring quality of care requires, among other things, “skilled medical personnel [and] scientifically approved and unexpired drugs and hospital equipment.”¹⁴⁷ Quality of care has suffered in Mali for multiple reasons. In many settings, various elements of the health system do not function well or lack coordination. Such elements include the training and capacity of health personnel.

a. “Health Systems” evaluations needed

Quality of care in Mali could be improved with greater evaluation of the capacities and failures of the existing health system, particularly when maternal deaths or serious complications occur. One effort to improve the health system’s capacity to handle obstetric complications in Mali is the “Near Miss Program,” a test program that in 2000 was being applied in two hospitals in Mali (Point G and Commune 5)¹⁴⁸ in cases where a woman’s life has been at risk during a delivery due to such complica-

tions as eclampsia, infections and severe hemorrhages during delivery or post-partum.¹⁴⁹ In these cases, an internal study is performed to examine what steps should have been taken and where there were problems in the care provided.¹⁵⁰ The woman herself is interviewed in order to see how the quality of care could have been improved. All personnel are then asked, in a confidential setting, how they think they could have performed their jobs better. All employees are part of this process—from the physicians to the ambulance drivers.¹⁵¹ Responses are synthesized and then a resolution for future action is adopted.¹⁵² Thus, from each “near miss,” lessons are drawn on how to improve the quality of care. It is hoped that this program will be replicated in other districts.¹⁵³ Similar programs are in place in Benin, Mali, Morocco, and Ghana.¹⁵⁴

b. Lack of training

There is a general need for improved training for health-care providers, with an emphasis on building practical skills.¹⁵⁵ Training programs for providers need to offer better supervision and feedback and provide an opportunity for hands-on learning.¹⁵⁶

A number of providers spoke of their need for more continuing education¹⁵⁷ opportunities, which have been inadequate or nonexistent.¹⁵⁸ Continuing education could come in the form of training seminars,¹⁵⁹ educational scholarships¹⁶⁰ or exchange programs allowing personnel to see how care is delivered in other countries in the region.¹⁶¹ Currently, training opportunities are offered on an ad hoc basis. For example, in Niena, a midwife spends 15 days per year training *matrones*. This training is sponsored by a French charity, and does not reflect an official government policy with broader geographical scope.¹⁶² While Malian and international experts agree that the priority is to staff health centers with more highly skilled providers, including doctors, nurses, and trained midwives,¹⁶³ many interviewees pointed out that the community health centers are currently staffed by *matrones*, who could benefit from increased training.¹⁶⁴ In addition, because much of the population continues to trust traditional practitioners and seek their services, several of those with whom we spoke endorsed efforts to improve the skill level of those providers.¹⁶⁵

Many of those interviewed emphasized the importance of training all

providers—from traditional practitioners to physicians—to recognize the warning signs of possible complications during childbirth.¹⁶⁶ At a minimum, if providers at any level can identify complicating factors, they can refer the patient to a health-care facility with greater competence.¹⁶⁷ Those whom we interviewed stressed that providers should be trained to create an effective medical team that allows each provider to play a crucial role but also encourages a division of labor based on a recognition of differing levels of expertise.¹⁶⁸

Training is necessary not just for building the capacity of health personnel, but also for ensuring compliance with national norms and procedures for quality of care.¹⁶⁹ The Ministry of Health has initiated training around the country on national norms and procedures.¹⁷⁰ This effort has been assisted by UN agencies and international donors including UNFPA, UNICEF and USAID.¹⁷¹ Most of the providers based outside of Bamako with whom we spoke said that they had received at least initial training on these new procedures.¹⁷² One midwife said that she had attended a ten-day training session for providers in the region that was designed to enable participants to train other personnel.¹⁷³ Nine months after the release of the norms, not all providers had received training.¹⁷⁴

c. Lack of regulation

Accountability for health-care personnel is lacking, due in part to inadequate regulation. This lack of accountability has led to instances of negligence in health-care facilities as well as a failure to ensure compliance with national norms of service provision. Greater accountability among health-care providers would promote higher quality of care.

Where care is of poor quality, it is often attributable to low salaries and the demoralizing conditions in which providers are asked to work.¹⁷⁵ However, there is also apparently a lack of regulation and supervision for providers,¹⁷⁶ and patients' practical ability to hold health-care personnel liable for malpractice is limited under the law.¹⁷⁷ Application of national norms and procedures is not uniform, and respect for these norms varies among institutions.¹⁷⁸ According to one NGO observer, for example, "in some health centers, equipment is not sterilized."¹⁷⁹

Negligence on the part of health-care personnel has been noted as a problem.¹⁸⁰

Women we interviewed in Sikasso, for example, observed shoddy care in the regional hospital.¹⁸¹ Several reported instances of midwives permitting untrained hospital volunteers to deliver babies and perform other procedures for which they were not qualified.¹⁸² A number of stories emerged of health-care personnel performing procedures far outside their areas of competence.¹⁸³ One provider commented that there are hospital janitors who give injections.¹⁸⁴ An NGO representative cited a case of a state registered nurse who performed surgery, causing the deaths of many people, but never faced prosecution.¹⁸⁵

The fact-finding suggested that pharmacists, in particular, needed to be better regulated.¹⁸⁶ There is great inconsistency in the pricing of medications.¹⁸⁷ In some cases, patients are required to pay for medications that should be provided free of charge.¹⁸⁸ This is a major barrier to health care, since women may barely be able to pay for the medical visits alone.

The professional associations of the different medical providers, such as the Order of Midwives, the Order of Physicians and the Order of Pharmacists, are in the best position to oversee quality of care.¹⁸⁹ These bodies are guided by ethical codes that set out standards for quality of health-care delivery. For example, the Code of Medical Ethics states that a physician must assist and care for all patients with the same dedication and without any discrimination, and is prohibited from practicing medicine under conditions that might compromise the quality of health care.¹⁹⁰ The medical orders are empowered to review violations of professional standards.¹⁹¹ With greater resources, they could potentially conduct periodic evaluations or inspections to ensure quality of care.¹⁹² They could also investigate complaints lodged by patients who were victims of medical negligence.

Several factors have impeded women's enjoyment of their right to health care that is available, accessible, acceptable, and of good quality. Availability of care is undermined by a lack of facilities and shortages in material supplies and human resources. Health-care accessibility has been hampered by women's lack of information and, relatedly, the prevalence of misconceptions and myths about pregnancy and childbirth. Acceptability of care has been compromised by health-care providers who treat women, particularly low-income women, disrespectfully and who are unresponsive to women's needs. Finally, quality of care has suffered as a result of a lack of needed health systems evaluations, inadequate provider regulation and continuing education.

B. RIGHT TO NON-DISCRIMINATION

Women's social status is a significant factor in determining their ability to survive pregnancy and childbirth. Widespread discrimination may be perpetuated by formal laws and policies. It may also manifest itself in harmful practices aimed at controlling women, particularly their sexual and reproductive lives. The Convention on the Elimination of All forms of Discrimination against Women (CEDAW) defines discrimination against women as "any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women . . . on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."¹⁹³ Where a distinction, exclusion or restriction jeopardizes a woman's life during pregnancy and childbirth, she is prevented from enjoying her right to life equally with men.

Although women constitute 52% of Mali's population,¹⁹⁴ gender inequity reflected in formal law as well as social and cultural practices prevent them from enjoying their rights. According to CEDAW, governments are responsible not only for refraining from acts of discrimination against women, but also for "modify[ing] social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women."¹⁹⁵ The government of Mali can be held accountable, therefore, not only for its own direct discrimination but also for failing to intervene in social and cultural practices that marginalize or harm women.

The Malian government has initiated a plan of legislative reform, particularly in the area of family law. If the proposed reforms are realized, women's legal status will be significantly improved and certain legal points raised in this section—including the age of marriage, a woman's duty of obedience to her husband, and recognition of bride price—will be amended. However, Malian NGOs have questioned the government's commitment to ensuring women's equality, as it allows severe *de facto* discrimination in the social, economic and political spheres to continue.¹⁹⁶ Politicians have not made substantial budgetary investments to accompany law reform and policy declarations aimed at promoting women's equality. In order for laws and policies to be effective, outreach and sensitization should accompany any legal reform aimed

at improving women's status.¹⁹⁷

Four manifestations of gender discrimination have a particular impact on women's ability to survive pregnancy and childbirth: women's weak participation in political life, the practice of FC/FGM, child marriage, and women's low status in the family.

1. Women's Political Participation

Women's lack of political participation is visible both nationally and locally. Fewer than 10% of elected public officials are women.¹⁹⁸ In 2000, there were only 18 female members of Parliament out of a total of 143, and only 11 female mayors out of 701.¹⁹⁹ Three of Mali's 22 ambassadors were women, and out of 52 public prosecutors, there was not a single woman.²⁰⁰ Such low political participation and representation illustrates the social barriers women continue to confront in both the public and private spheres.

In the context of health-care delivery, women are given little voice in the management decisions of community health centers. As a result, the gender impact of certain policy decisions may not be taken into account.²⁰¹ One community development worker noted that "in the context of health care, women have greater needs, but the community health centers are run by men."²⁰² Some called for outreach campaigns to raise people's awareness of the role women can and should play in managing community health centers.²⁰³

2. FC/FGM

There are a number of harmful practices that affect women's safety during pregnancy and childbirth, including FC/FGM, which affects the lives and well-being of 94% of women of childbearing age in Mali.²⁰⁴ FC/FGM is the collective name given to several different practices that involve the cutting of female genitals.²⁰⁵ It is practiced in all regions in Mali, with nearly equal prevalence rates in both cities and rural areas.²⁰⁶ A recently adopted executive order creates a national government program aimed at preventing FC/FGM through research, education and outreach, but does not envision legislation banning the practice.²⁰⁷ While the government has, in the past, supported education and outreach activities to stop FC/FGM, these efforts have not resulted in a notable drop in the practice.²⁰⁸

Although not mandated by any major religion,²⁰⁹ FC/FGM is deeply embedded in Malian culture: 80% of women who were circumcised believe the practice should continue.²¹⁰ The age at which the genital cutting occurs has declined from 8.8 years for women currently aged 45 to 49 (only 4% of whom were circumcised after age 15) to 6.7 years for girls currently circumcised.²¹¹

A recent study in Mali found that women who had undergone FC/FGM were more likely to experience complications during delivery. The study also found that the likelihood of such complications was greater where the cutting was more severe.²¹² The forms of genital cutting practiced most commonly in Mali are Type I (excision of the prepuce, with or without excision of part or all of the clitoris) and Type II (excision of the clitoris with partial or total excision of the labia minora).²¹³ Type III (excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening) is rare in Mali, but does occur in small numbers.²¹⁴ While studies have found that Type III cutting is most commonly associated with obstructed labor, the complications associated with Types I and II can lead to problems during childbirth. These problems include vulval and vaginal scarring, which can obstruct delivery.²¹⁵ In addition, infection and inflammation may occur at the time of the cutting, leading to vulval adhesions that narrow or obliterate the vaginal opening. Again, the result can be prolonged or obstructed labor.²¹⁶ Not all health personnel have the capacity to deal with these problems.²¹⁷

3. Child Marriage

With the minimum age for marriage at 15 for girls,²¹⁸ the average age at first marriage for Malian women aged 25 to 49 is 16.5, and 25% of women are married by the age of 15.²¹⁹ By the age of 15, about 11% of young women have been pregnant. By the age of 17, 38% of women have already had one child or are pregnant, and by 19, more than two-thirds of women (69%) have begun their reproductive lives, with 61% having already given birth to at least one child.²²⁰ Young women in rural areas are even more likely to bear children during adolescence, with 49% of rural adolescents becoming mothers, compared with only 28% of adolescents in urban areas.²²¹

Early pregnancies entail a number of risks. Young girls who bear children before their pelvises are fully developed often suffer complications, including protracted labor.²²² Where these complications do not result in death, they may cause

chronic injury such as fistulae, or perforations in the birth canal that permit leakage from the bladder or rectum into the vagina.²²³

4. Women's Status in the Family

Women in Mali are generally undervalued in the family. They are appreciated primarily for their roles as wives and mothers—roles that are taken on at a young age. Under law, husbands are the heads of households²²⁴ and wives owe their husbands a duty of “obedience,” while husbands owe their wives “protection.”²²⁵ Polygamy is a legally sanctioned practice that is widespread in Mali, particularly in rural areas, affecting 43% of women and 24% of men.²²⁶ Only men have the right to choose whether a marriage will be monogamous or polygamous.²²⁷ By law, women's legal capacity may be limited by marriage contract.²²⁸

Early pregnancy, along with marriage, prevents many young women from pursuing higher levels of education. Enrollment in both primary and secondary schools is much lower for girls than for boys, but school enrollment for girls drastically drops from 33% in primary school to 7% in secondary school.²²⁹ Similarly, women constitute only 32.7% of the workforce.²³⁰ However, women typically work informally and are not paid,²³¹ despite a national minimum wage rate guaranteed under the Labor Code.²³² Women have few economic resources and a lack of access to credit, as well as limited access to professional training.²³³

Furthermore, traditional attitudes about the proper role of women relegate them to the home, and women who work outside the house are the exception.²³⁴ Despite guarantees of women's right to work, there is no law protecting women from sexual harassment in the workplace.²³⁵ Traditional attitudes, discrimination and the lack of legal protections hinder women's economic advancement and reinforce women's economic dependence on men. They are thus disempowered from voicing their needs and making independent decisions about their health.

Women are often seen as financial investments,²³⁶ a perception that is reinforced by legal sanction of the practice of bride price in the Code of Marriage and Guardianship.²³⁷ Women are generally expected to carry out their regular duties while pregnant or recovering from childbirth. They are thus overburdened with chores and further weakened prior to and after giving birth.²³⁸ The stress and fatigue associated with these tasks may contribute to their risk of complications.²³⁹ In many

communities, pregnancy is considered a rite that women must go through. Pregnant women are thus given no special treatment and are expected to be the first to get up in the morning and the last to go to sleep.²⁴⁰

Even while pregnant, women ensure that others in the family have enough to eat before they themselves eat.²⁴¹ Where nutrition is lacking, many women suffer from anemia, which can aggravate the severity and risks of complications during pregnancy, such as hemorrhage.²⁴² This is especially true of multiparous women and adolescent girls.²⁴³ Given the fragile state of the health infrastructure, this condition can contribute to women's risk of death during pregnancy and childbirth. It is illustrated in the story told by one provider of a 30-year-old woman in her third pregnancy who had not had prenatal care and was severely anemic because she had not been eating sufficiently. She started bleeding heavily during delivery, and no blood was available to perform a transfusion. She was transferred to a hospital, but she died on the way.²⁴⁴

In addition, domestic violence, which is also tied to women's status in the family, contributes to women's vulnerability when pregnant.²⁴⁵ One NGO representative told the story of a man he knew—a security guard—who beat his pregnant wife, causing her to miscarry. She subsequently died of complications.²⁴⁶

Discrimination against women in Mali takes several forms, all of which can be linked to women's vulnerability during pregnancy and childbirth. The exclusion of women from policy- and decision-making roles serves to marginalize women and reflects a lack of government responsiveness to women's physiological conditions and needs. Practices that are harmful to women, namely FC/FGM and child marriage, directly affect women's physical ability to endure childbirth. Finally, formal laws and policies, such as the early minimum age of marriage, and women's low status within the family further jeopardize their lives in a health-care context that is poorly equipped to address complications of pregnancy and childbirth.

C. RIGHT TO REPRODUCTIVE SELF-DETERMINATION

Support for the right to reproductive self-determination is found in human rights instruments that ensure autonomy in decision-making about intimate matters. Such provisions include protections of the right to decide freely and responsibly the number and spacing of one's children,²⁴⁷ the right to physical integrity (usually characterized as the right to security of the person),²⁴⁸ the right to liberty,²⁴⁹ and the right to privacy.²⁵⁰

Women's lack of reproductive self-determination has concrete effects on their health. Not only are they prevented from planning their pregnancies, which would allow them to reduce the risks associated with multiple and closely spaced births, but women who are pregnant may be inhibited from seeking the care they need.

1. Perception of Women as Mothers Only

Generally, there is a strong societal expectation that women will bear many children in their lifetimes, and many women continue to do so until menopause.²⁵¹ The average woman in Mali bears around seven children during her lifetime,²⁵² with the numbers slightly higher in rural areas (7.3) than in urban centers (5.5).²⁵³ Young women between the ages of 20 and 24 are the ones most likely to bear children in both rural and urban areas.²⁵⁴ It is estimated that the average interval between births is a little greater than two and a half years (32.3 months).²⁵⁵ Women who have experienced frequent pregnancy, childbirth and breastfeeding may not have the physical endurance to fight infection, blood loss or trauma during childbirth or the post-partum period.²⁵⁶ According to WHO, women who have given birth to at least five children are two to three times more likely to die during pregnancy or childbirth than women who have given birth only twice or three times.²⁵⁷ A recent study has confirmed that close birth spacing contributes to the risk of maternal mortality, finding that spacing births by three to five years can reduce that risk significantly.²⁵⁸

Family planning is disfavored by many families in Mali,²⁵⁹ and it is felt that women who do not produce many children risk losing their husbands.²⁶⁰ As one NGO representative said, "people think that women are baby-making machines."²⁶¹ One trained midwife told the story of a woman who died from a hemorrhage during her 18th delivery.²⁶² Another woman spoke of numerous acquaintances who had wished to limit their births, but whose husbands put pressure on them to continue

getting pregnant. A number of them died giving birth.²⁶³ This cultural value is reinforced by religious norms, which teach that a woman who dies in childbirth goes directly to heaven.²⁶⁴ In contrast, as one NGO representative noted, when a woman experiences a miscarriage, “she is considered a cursed woman who is being punished for some bad act.”²⁶⁵

2. Lack of Access to Family Planning

Lack of access to family planning also leads many women to have unwanted pregnancies. A recent statistical analysis estimates that 4,185 women died in Mali between 1995 and 2000 as a result of pregnancies that were unwanted.²⁶⁶ A mere 8% of women in Mali use any contraceptive method and only 6% use a modern method.²⁶⁷ Only 23% of women have used any contraceptive method at least once in their lifetimes.²⁶⁸ There is poor geographic distribution of family planning services in Mali, and little attention is given to family planning at health centers.²⁶⁹ Among adolescents, a lack of family planning information and inaccessibility of services contributes to the high rate of pregnancy. Overall, only 21% of young women know where to obtain modern contraceptives, but this knowledge differs dramatically for young women in urban and rural areas: 49% of young women in urban areas know where to obtain modern contraceptives, as opposed to only 10% in rural areas.²⁷⁰

Women who do not have the means to control the number and timing of their pregnancies are often forced to give birth despite the existence of risk factors such as physical immaturity; advanced age; high numbers of previous pregnancies; and the existence of medical conditions such as malaria, tuberculosis, anemia, and HIV/AIDS.²⁷¹ Many unwanted pregnancies end in abortion—a procedure that is illegal in Mali unless a pregnancy threatens a woman’s life and in cases of rape and incest.²⁷² The criminal ban on abortion renders the procedure more dangerous for those who seek to undergo it, particularly where it is performed in clandestine, unhygienic settings. While the latest Demographic and Health Survey makes no mention of maternal deaths resulting from unsafe abortion, such procedures have been cited as the cause of an estimated 5% of maternal deaths.²⁷³ One 24-year-old woman in Mopti recounted the story of her friend who at the age of 18 was pregnant for the first time and tried to have an abortion by taking a medication six months into preg-

nancy. She died as a result.²⁷⁴

In some cases, women's inability to control their reproductive lives has more subtle effects on their health during pregnancy and childbirth. Even women who are aware of their health needs during pregnancy and have access to care may suffer health consequences as a result of their lack of choices. One NGO worker, speaking of her own experience, said that she did not seek care during the first four months of her fifth pregnancy because she was unhappy about being pregnant and was in a state of denial.²⁷⁵

3. Third-Party Consent Requirements for Medical Care

As one NGO representative said, women are not in charge of what happens to their bodies.²⁷⁶ It is the established policy of the Ministry of Health that health-care providers may not require spousal authorization for most medical procedures. The recently adopted 2002 Reproductive Health Law specifies, however, that spousal consent is required prior to permanent sterilization procedures, unless such a procedure is necessary to protect a woman whose health would be jeopardized by a future pregnancy.²⁷⁷ It was also noted in interviews that adolescent girls need the permission of a parent in order to receive family planning assistance.²⁷⁸

4. Decision-Making within the Family

Decisions about a woman's health care are made not by the woman herself, but by more senior members of the household.²⁷⁹ Often, the head of the household has to approve the decision to seek care—both prenatal care and assistance during childbirth. The principal decision-maker may be the woman's husband or mother-in-law.²⁸⁰ The result is that the decision to come to the health center is delayed, and many women only come when they are already in a state of crisis. By then, it may be too late to save the woman.²⁸¹ As one trained midwife at a regional hospital noted, "it's always the man who decides, especially in rural areas, but it's not the man who suffers."²⁸²

Without their own sources of disposable income, women are dependent upon members of their households, who may or may not appreciate the value of health care during pregnancy and childbirth and who are often unaware of the warning signals that the pregnant woman herself may be experiencing.²⁸³ The reasons for

families' refusal to authorize health care are varied. One woman said that her husband would not let her leave her rural community to seek prenatal care because "he didn't want me to be away."²⁸⁴ In some cases, the family is unwilling to pay the fees for maternal health care, either because they are too high or because health care is viewed as a waste of money. In one extreme case, recounted by a doctor in a community health center in Bamako, a woman suffered from complications during childbirth. She had eight children already, and had not sought prenatal care. The doctor recommended transferring her to a facility that was better equipped. Her family refused, thinking that the care would be too expensive. She died of a hemorrhage following a premature detachment of the placenta.²⁸⁵

Among many families, there is a general distrust of "modern" medicine and a preference for the services of traditional practitioners. Many trust only practitioners that have assisted childbirth for other members of the family, sometimes across generations.²⁸⁶ One hospital director noted that "a family member often insists that 'the person who helped my cousin give birth will take care of my daughter.'" Others might say, "my cousin gave birth alone, so my daughter can too."²⁸⁷ Another provider remembered a man who said, "the women in my family do not give birth in the maternity ward."²⁸⁸ Attitudes such as these are found among families in the cities as well as in rural areas.²⁸⁹

Women who become pregnant outside of marriage are often in even greater danger. Not only do these women often die while undergoing clandestine abortions, but stigma and lack of financial resources may prevent them from giving birth under safe conditions.²⁹⁰ One NGO representative recalled a young woman he knew who was working as a domestic servant and who became pregnant. She attempted to give birth in secret and then began to hemorrhage. She subsequently died.²⁹¹ Even an unmarried woman who gives birth in a hospital may have her health jeopardized by other shortfalls in care. One 18-year-old woman in Bamako, who is unmarried, could afford to give birth in the care of a trained midwife in a hospital, but had had to forgo prenatal care for lack of funds.²⁹²

Women's lack of reproductive self-determination in Mali begins with societal perceptions of women as primarily mothers and nurturers. It is reinforced by women's lack of access to family planning. The law further undermines women's autonomy by demanding authorization for sterilization procedures from spouses and

requiring minors to obtain parental authorization for family planning. Finally, women's ability to seek care in the first place is impeded by their lack of decision-making power within their families.

The causes of maternal mortality in Mali are complex, varied and attributable to the actions and inactions of individuals in nearly every sector of society. Still, responsibility for the extraordinary risks faced by pregnant women in Mali lies with the government, which has pledged in international and national instruments to uphold all citizens' right to life. To give force to this right, the government must take steps to ensure women's real enjoyment of the rights to health, non-discrimination and reproductive self-determination. The next chapter examines in greater depth the international and national legal framework requiring the government of Mali to protect women's right to survive pregnancy and childbirth.