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Highly precarious general and sexual health conditions of young domestic servants: results from a qualitative exploratory study and perspectives for community-based research in Bamako, Mali

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ABSTRACT

Most domestic servants (DS) in Mali are very young female migrants living in precarious conditions. We aimed to understand their living and working conditions in relation to their general and sexual health. Seven focus groups (53 participants) were conducted by the DS community-based organization ADDAD. Narratives were thematically analyzed using an inductive method. The dominant emerging theme was DS' strong dependence on their employers. Employers' attitudes regarding DS workload, the provision of food, water and hygiene products, housing conditions, and healthcare cover, appeared decisive for DS' physical and mental health, and the type of healthcare they used (self-medication, traditional care, healthcare facilities). Psychological, physical and sexual violence in employers' households was frequent. HIV/STI prevention knowledge was poor. These results highlight the serious risks for DS in terms of HIV/STI and unwanted pregnancies. DS were interested in receiving healthcare from ADDAD; this was motivated by the organization's trusting and understanding community-based environment, and DS' fear of discrimination in healthcare facilities. This study highlights the relevance of tackling the defense of rights and sexual health promotion for DS at the community level. Its findings can help identify research questions to evaluate the extent to which DS constitute a key HIV population.

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Domestic servants; migrant girls; sexual health; violence; Mali

Introduction

Seasonal and temporary labor migration from rural to urban areas in West Africa mostly concerns populations with a low socioeconomic status. Motivated by the need for financial autonomy, discovery of the outside world, and social recognition of transition to adulthood, migration has dramatically increased in recent decades among children and young persons, especially among girls and young women (Juárez et al., 2013; Temin et al., 2013). Compared to girls who remain in rural hometowns, migration for labor may constitute a material and social capital for these migrants' future lives, and improve their health management, educational, and domestic skills (Castle & Diarra, 2003; Garnier et al., 2003; Hertrich & Lesclinigand, 2011;

Jacquemin, 2011; Temin et al., 2013). Girls in rural West Africa mostly migrate to work as domestic servants (DS), which reflects the existing division of labor type according to sex. This places them at the bottom of the social and familial ladder in the urban households where they work (Feldman, 2013). Young DS face multiple and interacting vulnerabilities, because of poverty, young age, lack of experience, discrimination and stigma, as well as social and familial isolation. These vulnerabilities lead to high exposure to exploitation and violence (Azanaw et al., 2019, 2020; Juárez et al., 2013; Temin et al., 2013). In the absence of government policy to protect this vulnerable population, community-based organizations advocating the defense of the rights of young migrants and DS (Dottridge & Feneyrol, 2007;

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Jacquemin & Tisseau, 2019; Thorsen, 2012) provide training, legal aid, and social support (ADDAD [Association de Défense des Droits des Aides-Ménagères et Domestiques], n.d.; GRADEM: Groupe de Recherche Action Droits de l'Enfant Mali, n.d.; RIDDEF [Réseau Ivoirien pour la Défense des Droits de l'Enfant et de la Femme], 2019).

In Bamako, the capital city of Mali, the median age of female DS is 17 years, and 90% are aged between 10 and 19 years. In 2009, they were estimated to represent 5% of the Bamako resident female population (Pilon et al., 2019) (the latter being estimated to be 900,000 [Traore et al., 2011]). Several studies have investigated the social drivers and adverse implications of female labor migration for domestic work in Mali in recent decades (Bouju, 2008; Castle & Diarra, 2003; Feldman, 2013; Hertrich & Lesclingand, 2011; Ined, 2012; Lesclingand, 2004; Lesclingand & Hertrich, 2017; Thorsen, 2012). However, data on their knowledge, behaviors and status of sexual health and general health (i.e. Health conditions not related to reproductive or sexual health) are lacking. This is particularly true for data on HIV and sexually transmitted infections (STI) knowledge, prevalence and risk factors (Diallo, 2011). As sexual risk-taking and mobility is more prevalent in young migrant populations, and because of stigma and discrimination against DS, this sub-group may constitute a key HIV population in Mali (Barr et al., 2021; Juárez et al., 2013; Lydié & Robinson, 1998; UNAIDS, 2018).

The need to better understand health needs of DS, and to explore the feasibility of implementing a tailored community-based healthcare offer adapted to their age, vulnerabilities, living pace and constraints, led to the development of the community-based research and intervention project ANRS-0005s 2DM2 K ('Dou Dèmè Muso Ka Keneya' or "The health of DS" in the Bambara language).

The present article describes the first step of the project, which was an exploratory qualitative study conducted in 2021. The study aimed to provide an overview of Malian DS' health conditions and needs according to their specific living conditions.

Methods

The ANRS-0005s 2DM2K project

This ANRS-0005s 2DM2 K ongoing project (2021–2023) is a liaison between the expert knowledge of the Malian community-based organizations (CBO) ARCAD Santé PLUS and ADDAD, and the research team SanteRCom, which specializes in community-based research on key HIV populations. ARCAD

Santé PLUS is involved in the fight against HIV/AIDS in most known key HIV populations, but also against tuberculosis, malaria, and extended its mission to the promotion of sexual health. Previous to ANRS-0005s 2DM2 K, it did not work with DS (ARCAD Santé Plus, n.d.) 26. ADDAD is the main CBO for DS in Mali. It provides social support and training (ADDAD (Association de Défense des Droits des Aides-Ménagères et Domestiques), n.d.). ADDAD highlighted the problems which DS face to ARCAD Santé PLUS, specifically their restricted and poorly adapted access to healthcare in medical facilities (in terms of geographical mobility and working hours) and related discrimination and stigma. ARCAD Santé PLUS and SanteRCom then agreed to collaborate with ADDAD to jointly develop the ANRS-0005s 2DM2 K project. Aim and details of each four step of the project are provided in Supplementary material.

The ANRS-0005s 2DM2 K project received approval from the Ethical Committee of Mali on the 19th July 2021 (N°2021/180/CE/USTTB), which was renewed on the 5th April 2022 (n°2022/79/CE/USTTB).

The exploratory qualitative study

The exploratory qualitative study was the first step of the ANRS-0005s 2DM2 K project. It aimed at providing an overview of Malian DS' health conditions according to their specific living conditions, in order to identify their health needs, and to prepare the next steps of the project.

This study used an interpretive descriptive qualitative approach, which enables us to understand participants' experiences (Thorne et al., 1997). This methodology does not use a pre-existing theoretical framework; accordingly, it provides more flexibility in the study of multiple and complex realities (Thorne et al., 1997, 2004). The SanteRCom researchers together with ADDAD community workers – all of whom were former DS – decided to use focus groups (FG), as this tool creates excellent conditions for discussion and debate between peers. Together we developed and translated (from French to Bambara) two FG guides in close cooperation, in order to ensure that the topics and terms tackled would be understood in the same way in both languages. The first guide focused on exploring DS' (self and peers) general and sexual health and living conditions in Bamako, and their acceptability of a proposed tailored community-based health support program (see above) (Table 1). It was used in six FG to ensure that heterogeneous information was collected. Participants in these FG were divided either according to age class or to the number

Table 1. Focus groups: guides, groups and participant numbers.

Focus group guide	Recruitment criteria for focus groups (FG)	Number of participants
<ul style="list-style-type: none"> Global and sexual health & living conditions of DS working in Bamako 	FG 1: Age 12–14 y	10
Hygiene and housing conditions	FG 2: Age 15–17 y	6
Current illness, injury and pain	FG 3: Age \geq 18 y	7
Health behaviors and access to care	FG 4: First experience in Bamako and length of stay <3 months	7
Sexual, physical, and psychological abuse	FG 5: First experience in Bamako and length of stay 3–12 months	9
Sexual and reproductive health: knowledge, risk perception and related health problems	FG 6: More than one experience in Bamako and/or length of stay > 12 months	8
<ul style="list-style-type: none"> Acceptability of a potential community-based health support program 		
Preference for a healthcare facility-based health offer		
Preferred conditions for the community-based health program		
Interested in paying into a health solidarity fund		
<ul style="list-style-type: none"> Pregnancy, delivery, post-partum in DS 	FG 7: Pregnancy at least once while working as a DS	6
Circumstances and social implications of the pregnancy		
Pregnancy, delivery, post-partum: access to care, working conditions, social support		
Access to care for baby		

of experiences/total length of stay in Bamako. The second FG guide was used in one additional FG which comprised DS who had a pregnancy while working as DS. It was created to help the FG facilitator specifically explore the health and living conditions of DS during and after their pregnancy.

Participant recruitment and data collection

ADDAD facilitators provided information about the study to DS currently using the NGO's services and other DS through its network of focal points. Study inclusion criteria were as follows: (i) female (ii) working in Bamako as a DS (i.e., Employee paid in money or in kind for domestic work (Pilon et al., 2019)), (iii) speaking one of the most frequent languages in Mali (Bambara, Dogon, French), (iv) aged \geq 12 years, (v) had read or had been read an information letter on the study, and provided signed informed consent to participate. For participants <18 years, ADDAD also signed the consent form as a supporting moral person. FK, a specially recruited female facilitator who was studying sociology at the University of Humanities, Arts and Human Sciences of Bamako, conducted all seven FG in Bambara during evenings in August 2021 (i.e., After DS' working hours), assisted by ADDAD.

Data management and analysis

All data were audio-recorded and were anonymous. Under the supervision of a senior researcher (AC),

three Malian students in sociology from the University of Humanities, Arts and Human Sciences in Bamako transcribed and translated all the discourses from Bambara to French.

A thematic analysis on the full corpus of data using an inductive method was initiated using QDA Miner by AC. It was subsequently revised and completed using NVivo software by MF. This consisted in identifying themes in order to develop a coding scheme, and then applying this scheme to meaningful units of narratives (Appendix – Coding tree). Data coding and

Table 2. Characteristics of participants ($n = 53$).

	N or median [IQR] (min-max)
Sociodemographic characteristics	
<i>Region of origin</i>	
Kayes	
Koulikoro	1
Ségou	25
Sikasso	24
	3
Age (years)	15 [14–17] (12–26)
<i>Educational level</i>	
No school or coranic school	40
Primary level	12
Secondary level	1
Working conditions	
Working day duration (hours)	16 [15–17]
<i>Domestic work activities *</i>	
Cleaning	48
Child sitting	13
Cooking	25
Laundry	40
Selling	4
Have a rest-day	11
Have an employment work contract	13
Monthly income (USD)	15 [15–19] (11–45)

*Multiple answers.

IQR: Interquartile range; USD: US dollar.

analysis were discussed between researchers and community-based facilitators from ADDAD and ARCAD Santé PLUS throughout the analytical process.

Results

53 DS participated in the seven FG. Basic sociodemographic characteristics and working conditions of participants are presented in Table 2.

Highly precarious living and housing conditions: general health conditions and behaviors very dependent on employers' attitudes

Living and housing conditions

Most participants lived at their employer's (understood here as the family employing them) house. DS who slept in a dry, clean room, with a mosquito net and a mattress declared they were satisfied with their housing conditions. These were priority features, while a fan was welcome but not a priority. Many participants however were very disgruntled about their housing as not all these features were available. These DS feared getting skin rashes, respiratory diseases, and malaria because of mosquitos and humidity. Some employers allowed DS to sleep in their (i.e., DS) relatives' homes if they were not able to provide a decent room.

If water gets inside and the room is humid, it can cause disease, such as a cold or malaria.(...) They [employer] always say that they'll fix it, but so far nothing. I said to myself that they don't care because they're not the ones who have to sleep in there. And when it starts to rain, you start to worry. (FG stay 3–12 months)

Many participants mentioned restricted access to water or soap, a lack of free time, and fatigue related to work overload. DS were concerned about hygiene during their periods, as they lacked money to buy sanitary towels/tamppons and the time to change makeshift alternatives.

When you finish your soap for washing, some bosses don't give you more soap. Sometimes, you don't have a place to sleep peacefully. Sometimes, you go looking for water to wash yourself, but you don't have easy access to it. (FG age 15–17 y)

You often don't wash because you don't have time, because it's up to you alone to do all the housework. So, sometimes you have to work until nightfall. (FG age 15–17 y)

Some women of the house – usually the woman overseeing domestic organization and who took on the DS (hereafter female employers) – looked unfavorably on them when they took care of their own hygiene

(washing themselves, their clothes, doing their hair, etc.) and interpreted this as an attempt to seduce the men of the household. The fear of displeasing these female employers was a major barrier to DS hygiene.

Some bosses don't like when you wash yourself properly (...) Some will see you as a prostitute because of that. Some may even fire you because if you wash yourself properly and wear nice clothes, their husbands may fall in love with you. (FG age ≥18 y)

Health issues and behaviors

Malaria, stomach cramps from periods, other physical problems from workload and the severity of work (back and feet pain), dermatological issues from the repeated exposure to water and to detergents like potash soap, as well as problems healing cuts, were the ailments most frequently mentioned. Many DS indicated they had no time or money to go to a healthcare center, that they were afraid of being stigmatized as a DS in such centers, and even that their employer forbade them to go to one. As they couldn't go to a center, they mostly self-medicated, buying drugs in the street from “pharmacies on the ground” (Malian expression), especially paracetamol and tetracycline, which they used to treat many kinds of illnesses.

I had malaria; I'm not totally cured yet. My boss didn't take care of me. They [employer and employer's family] didn't bring me to the healthcare centre; they didn't buy me drugs, so I had to get by on my own ... I asked some people for advice about the names of some drugs. I went to the store to buy the one called “banaségin” [lit. 8 diseases]. (FG stay >12 months)

To a lesser extent, DS sought out traditional healers and phytotherapy. Some of the oldest and most experienced declared their employers were understanding, and gave them paid sick leave and covered the cost of drugs and healthcare center visits. In contrast, some employers denied the DS had health problems, in order to keep them working. Sometimes DS received financial support for healthcare from their own relatives.

One time, I had a toothache. I told my boss, but she said “you're not sick; you just don't want to work”. [In general] I got by on my own, buying drugs when I could (...). We don't have the choice; you have to get by on your own to work in these conditions. We don't have any other solution. (FG stay >12 months)

One time in Bamako, I had a pain in my hand too. For six days, I couldn't work. My boss did the housework herself; she went to the market and everything. She didn't deduct anything from my salary. She paid me. After that, I had a stomach ache and she gave me drugs. (FG age 15–17 y)

Relationships with female employers and exposure to abuse

DS qualified a good relationship with their employer in terms of their expectations that (i) the employer would fulfill their basic needs (water, food, hygiene products, bedroom, covering fees related to work-related health issues), (ii) they would not be discriminated against in terms of sharing meals and using the same bathroom as their employer, and (iii) that they would have a “mother-daughter” kind of relationship with their female employer.

When I came to ADDAD for the first time, a woman had travelled from Kati to take me to her house. This woman never hurt me. She treated me well, we used the same bathroom, we ate together, and slept in the same bedroom. She had taken me on to take care of her child. She bought me clothes, and every week she braided my hair. (FG stay > 12 months)

With the exception of the youngest DS (12–14 y), many indicated being a victim of various forms of non-sexual violence, mostly by their female employer, but in some cases by other members of the house. The types of violence most cited were the latter’s refusal to provide decent food, and even depriving them of food. Some DS also mentioned verbal and physical violence (insults, work overload, harassment, humiliation, and beatings). They expressed the psychological impact of this violence (sadness, a strong sense of rejection, and helplessness), but were often told by their families to endure it and to keep working.

It happened when I was in my third year there [in Bamako]. She used to wake me up at 3 in the morning to do the laundry, and once I finished hanging it out, she’d put the clothes back in the water and say to me that they were still dirty. She used to give food to her children, but not to me. I felt very belittled, I often cried. (FG age ≥ 18 y)

We are victims of abuse, lots of abuse. Some treat us like dogs, because we have no relatives. They have no consideration for us, we disgust them. If you come near them, they say to you ‘No! You can’t come close to me’. They don’t agree to us eating from the same plate as them, they only give us leftovers. They beat us, they insult us and our parents; they tell us that we came to get money and that we have to endure all that.(...) “It [abuse] made me really hate my boss. Every time I saw here, I hated her from the bottom of my heart. (FG > stay 12 months)

In the meantime, I had a fight with her [the employer’s] daughter. She took a knife and cut my hand. Like that. So I decided to leave my job. When I told my sister about this, she told me to stay, that it would all end some day. Then I called my dad to explain; he told me I couldn’t stay, and that her kids would harm me and their mother would not look after me. But my big brother

didn’t agree to my leaving the job; he told me to endure it and to keep working. I’ve been at her place been 3 months and 17 days. (FG stay > 12 months)

Poor HIV/STI knowledge and high exposure to sexual violence

Sexual and reproductive health knowledge

DS were globally aware that some diseases are sexually transmitted. They mentioned itching and sometimes stomach ache as symptoms of STI. They cited sharing bathrooms and washing the clothes of someone infected as transmission modes for genital infection. The youngest DS (<14 years) had no knowledge about STI or genital infections, and even less about transmission modes. When asked about HIV/AIDS and hepatitis, DS mainly associated these diseases with non-sexual modes of transmission, for example a lack of hygiene.

If you sleep with a man who has the ‘stomach’, you can be infected through him ... Your belly hurts sometimes; your genital parts can be itchy. (FG age ≥ 18 y)

We domestic servants, can be infected by washing the clothes of an infected person. (FG age ≥ 18y)

Participants had limited knowledge about how to prevent and treat STI. Some mentioned that ritual (i.e., according to Islam Janaba) washing prevented STI. No participant quoted condoms as a prevention tool against HIV/AIDS or other STI.

If you know how to clean yourself properly (as recommended by Islam, Janaba), it can protect you from these diseases. (FG age 15–17 y)

DS were more aware of the risk of unwanted pregnancies than of the risk of HIV/STI infection. Some DS >15 years understood what hormonal birth control methods are used for, and some expressed interest in getting more information about them. However, only a few DS reported using or having used birth control methods. Their perceptions of side effects could be inaccurate (sterility) or related to a negative experience. In some cases, this led to them stop using these birth control methods. Again, condoms were never mentioned as a tool to prevent unwanted pregnancies.

When you can’t refrain from having sex, you can use these methods [hormonal birth-control methods] to prevent pregnancies. Some use them to space pregnancies. (FG stay 3–12 months)

I once heard that there’s an implant, pills, injection. (FG age 15–17 y)

I never used it, but we would like to know much more about these methods, in case we'd like use them in the future. (FG stay > 12 months)

The implant is not a good method, because if you use it too long, it may make you sterile. (FG stay >12 months)

Although none of the participants declared ever having an abortion, some mentioned that peers had had one when they became pregnant outside marriage, mainly to preserve their family's honor. Abortion methods were mostly non-medical (tetracycline, Coca Cola, plant decoctions), and traditional abortion; one DS mentioned that a healthworker had provided an abortion for a peer (although DS often do not know to distinguish between professional health workers and traditional).

When some get pregnant and don't want to go back to their village being pregnant, they get an abortion. They say that their dad would kick them out, and their mums would be humiliated. (FG age ≥ 18 y)

Among various potential sources of information about reproductive and sexual health, DS mentioned that for the most part they talked to older friends or went to healthcare centers, all the while underlining the fear of being judged or stigmatized because they were DS.

Perceptions of and exposure to sexual violence

DS were aware of their vulnerability to sexual violence and the difficulties to protect themselves from sexual violence because of their subordinate and low social status, isolation from their family, scant experience of living in the city, poor housing conditions, and threats of retaliation or death by perpetrators of violence. In particular, they feared men living in the household where they worked (members of the family or male workers who were employed as gardeners or chauffeurs for example), and expressed concern about the related risk of unwanted pregnancies.

Our bosses' children, and even our bosses' husbands can rape us. Especially our peers arriving from the bush, because they know nothing of the city. Sometimes, they will make love to you by force, and threaten to kill you if you tell anyone about it. Even if you get pregnant, you can't tell the name of who got you pregnant, or you may be killed. (FG stay > 12 months)

Many participants had experienced sexual harassment or abuse, their aggressors using physical force, or psychological pressure and blackmail. Some mentioned leaving their jobs, or telling their female employer (one DS whose employer then confronted her husband) as coping strategies to escape sexual violence. Overall however, they did not receive help for sexual violence or dare to ask for it.

I once was victim of sexual abuse in my job; it was my boss's husband. One night, he woke me up [to have sex] and I refused, I said that if he didn't stop, I would tell his wife. He answered that if I told his wife, nothing would happen. He said that if I told his wife, he would tell her that I was the one saying that I loved him. So I was scared to report him. Once, he went beyond the limits, and I couldn't sleep all night because of him. So in the morning I started to cry and my boss asked me what was wrong with me, and if her son had had sex with me. I told her that it was her husband that have asked me to make love with him for a very long time, that I always refused, and that that night I could not sleep at all because of him, and I had to leave the bedroom to sit outside. I was crying because if he forced himself on me some day, I would not have the strength to stop him. Then they were a fight between them, and I ran away to come here to ADDAD (...) I didn't scream, because he didn't use his force. When he came in my room, he woke me up and he was naked; he lay down next to me and showed me sexual positions, and offered me money (...) When I saw him, I was afraid, because I thought to myself 'Is he going to get me one day?'. (...) After that, when his wife was here and he tried to chat to me, I avoided him, because I feared that his wife might think I was interested in him ... I couldn't lock the door because the fridges were in my bedroom. (FG stay > 12 months)

Some participants blamed the behaviors of DS for being liable of sexual violence perpetrated against them, because of their behaviors, apparently having internalized stereotypes on victims of sexual violence.

You can go at a boss's house. He can desire you and declare his love, and if you don't accept, he can rape you. But it depends on our behaviors, us the DS. If they see some kind of things on your face, they will do that to you. Otherwise, if they don't see it on your face, they won't touch you. (FG age 15–17 y)

Pregnancy and post-partum experience as a DS

Among DS with children, most discovered they were pregnant in a healthcare center in their first two months. Wanted pregnancies were from husbands or long-term boyfriends; employers sometimes tolerated these relationships.

Because I needed a child, I was 26 years old, God gave it to me, thanks be to God. (FG mother)

Where she was working, she had three children with her employer's watchman. (FG stay >12 months)

Some reported unwanted pregnancies from rape perpetrated by a man from the household or a stranger. Pregnancies outside of wedlock compromised the relationship of DS with their own relatives. Most young female migrants in Mali get married through

arranged marriages in their villages; they migrate to work as a DS in order to earn money to buy their wedding trousseau for their future marriage.

I was not happy to be pregnant but I had no choice. It was already late when I found out, so I didn't want to get an abortion. My parents didn't know about it at first. [pregnancy from rape] (FG mother)

Here again, the employer's attitude was crucial for the course of the pregnancy. Some DS reported that their pregnancy did not jeopardize their relationship with their employer, especially if it were socially legitimized through marriage. Some employers lessened DS workload during pregnancies, looked after their babies or financially contributed to the delivery or to childcare fees. In contrast, other DS did not benefit from any change in working or income conditions on account of their pregnancy.

I worked until the day I gave birth. Even the day I gave birth, I worked (...) Even the toughest work, I did it (...) It shouldn't be like that, but I am a DS. (FG mother)

I had a friend [another DS]; she was pregnant; her boss told her to go to the healthcare center. But her boss said that she couldn't pay for all of the drugs they prescribed to my friend (...). So my friend had money from a previous job, but it didn't cover all expenses. Her husband sent her money too. So she was able to give birth. She still works at her boss' house. The boss told her that she had to stay working in the house until all the expenses that the boss paid were paid off. So she has to stay working there until the money is paid back, before going back to the village. Otherwise she can't leave. (FG stay > 12 months)

Generally, DS reported only one prenatal visit to a healthcare center. DS mostly gave birth in a medical structure, accompanied by their employer or a woman from their circle of family and friends. A majority sought traditional medicine to treat post-partum-related pain and wounds. Immediately after the delivery, more than half got assistance with their child expenses (mostly to buy baby clothes or formula milk) from husbands, their own families or employers. The majority were back to work only one week after giving birth. Most breastfed, but not exclusively. Not all DS were aware of the recommendation to exclusively breastfeed until six months. In contrast to what they did for their own health management, most DS mentioned going to healthcare centers for their baby's healthcare, especially for vaccinations.

When I used to go at the healthcare center for my child's injections, healthcare workers had a talk with us; They said that until the baby was six months old, we shouldn't give it anything else than breast milk. (FG mother)

I didn't get help about that [breastfeeding information], during the visits. Healthcare workers told me to give fish sauce to my child. (FG mother)

Perception of a potential community-based health offer

Participants were asked about their preferences between the currently available facility-based health offer and a possible community-based general and sexual health program provided by ADDAD. Many DS expressed a preference for the latter, mostly for non-medical reasons including their expectation that it would offer a friendly, considerate and trusting environment between peers.

I want to get healthcare here, because there is cohesion and humanism. (FG age 15-17y)

This expectation was driven by their fear or previous experience of discrimination in healthcare facilities. Many DS complained about the long waiting times in healthcare facilities and said they were embarrassed to receive healthcare from men.

In the healthcare center, you can wait a very long time to be seen. And some healthcare workers belittle people. Others insult people. That's why I'd rather get care here. Because here, you are welcomed, and treatments are given the way they should be. (FG age 15-17 y)

They also insisted on the need to receive healthcare from someone with good medical skills, because of previous negative experiences in healthcare facilities. Furthermore, DS expressed their desire to be able to choose from a wide range of possible healthcare appointment times given their varied work schedules.

We might be embarrassed about getting healthcare from a man. With a woman, we understand each other. That's why I prefer to get healthcare from a woman (FG age 15-17 y)

I want the healthcare worker to be a woman who knows the treatments well. When you go to a health center, you get care from young women who don't know the drugs well; even for simple injections, they don't know how to do it. With some of them, you can't even sit on your backside. (FG age 15-17 y)

All the participants agreed with the idea of a health solidarity fund for DS, because of their difficulties to individually support their health expenses, and insisted on the need to have a trustworthy person to manage such a fund. They estimated they could contribute on average 500–1000 FCFA per month; the estimated amount varied depending on the DS. Participants said they preferred fund money to be collected on a weekly or monthly basis, rather than daily.

We love the idea to contribute [to a healthcare solidarity fund], and if someone gets sick, to use this money to help her. Which is good, because it's mutual assistance. (FG stay < 3 months)

Discussion

Multiple and interacting social and health vulnerabilities in DS in Bamako

General health

The present study highlights that the general health conditions of rural Malian DS who mostly live in their employers' households in the capital city Bamako, were highly dependent on the attitudes and behaviors of the employer in terms of workload, wages, access to food, drinkable water, safe housing and healthcare, and abuse. Specifically, participants frequently reported work overload and difficult work (causing pain, injuries, and skin issues), and not being given enough time for their own hygiene, sleep, healthcare or convalescence. They also reported verbal, psychological and physical violence (threats, discrimination and segregation within the employer's household, and employers belittling, insulting, and beating them), especially from female employers. High exposure to these various forms of non-sexual abuse, and their health adverse effects (stress, psychological disorders, physical pain and injuries) have been consistently reported in previous studies on DS in Mali (Bouju, 2008; Castle & Diarra, 2003; Lesclingand, 2004) and in other Sub-Saharan African countries (Ejigu et al., 2020; Jacquemin & Tisseau, 2019; Sene, 2021; Temin et al., 2013; Thi et al., 2022; Vidal, 2013).

Food deprivation because of employers was frequently reported in our study. Accordingly, DS in Mali may represent a group at particular risk of under-nutrition in a country where it is already a public health issue in the general population of adolescent girls (USAID, 2021). Food deprivation is therefore an important factor in the risk of adverse effects on growth and cognitive functions in DS, especially given the large nutrient requirements for adequate skeletal and brain growth during adolescence (Fiorentino, 2015).

Participants in our study also reported stigma and discrimination in healthcare services, poverty, and a lack of information as barriers to healthcare; these three factors are worldwide concerns for young migrant girls' health (Temin et al., 2013). We also highlighted that employers' attitudes are decisive in terms of DS access to healthcare, specifically whether or not they give DS time to go to a healthcare center, whether

they give them time to convalesce, and whether they pay for DS' medical fees or provide wages sufficiently high to enable DS seek care. Previous research in Mali reported that some employers refused to pay agreed wages, sometimes accusing their DS of stealing (Castle & Diarra, 2003; Thorsen, 2012), which constitutes another potential barrier to healthcare. Limited access to healthcare facilities led many participants to purchase drugs in the street and to self-medicate, which may have adverse effects at the individual and public health levels (Aslam et al., 2020).

Sexual and reproductive health

The present study suggests a serious lack of knowledge about sexual and reproductive health in Malian DS, especially regarding HIV and other STI. In particular, none of our participants mentioned that HIV can be transmitted sexually and condoms were never cited as a mode to prevent HIV/STI. This result is in line with what we believe to be the only other study on Bamako DS' knowledge of HIV. In that study, two thirds of 309 DS did not know how HIV/AIDS is transmitted and only 15% mentioned condoms as a mode of HIV prevention (Diallo, 2011). Consistently with previous findings in West African young migrants (Buchbinder, 2012), reproductive health knowledge in our study was slightly better than HIV/STI knowledge. More specifically, some DS were aware of the risk of unwanted pregnancies related to sexual intercourse, and the role of hormonal birth-control methods. However, condoms were never mentioned as a way to protect from unwanted pregnancies. Previous research in Mali and other Sub-Saharan countries showed that girls who migrate for labor have greater general and sexual health knowledge than those who stay in rural areas (Castle & Diarra, 2003; Jacquemin, 2011). Nevertheless migrant DS living in a city are still less educated than other urban girls (Erulkar & Ab Mekbib, 2007; Temin et al., 2013), including other marginalized young urban populations (Ngilangwa et al., 2016).

The present study found a high level of exposure and vulnerability to sexual violence which was reinforced by multiple factors such as social isolation and poverty, living in employers' houses, fear of retaliation by the employer, gender stereotypes and fear of jealousy of female employers. This is consistent with previous studies in Mali (Castle & Diarra, 2003; Thorsen, 2012) and in other Sub-Saharan countries (Ayimpam, 2014; RIDDEF [Réseau Ivoirien pour la Défense des Droits de l'Enfant et de la Femme], 2019; Temin et al., 2013). A lack of HIV knowledge and high

exposure to sexual violence may put DS at high risk of HIV acquisition. Previous research suggested that DS have earlier sexual debut (Temin et al., 2013) and are more likely to have unprotected sex with boyfriends (Castle & Diarra, 2003), compared to other girls. In 2016, the International Labour Organization warned that the aforementioned forms of vulnerability put female migrant DS at high risk of HIV acquisition (Torriente, n.d.). Although transactional sex was not mentioned in the focus groups in our study, it has been widely reported in previous studies in Mali (Bouju, 2008) and other Sub-Saharan countries (Ayimpam, 2014; Dambach et al., 2020) as a coping strategy to escape poverty and harsh working conditions, to complement or substitute working as a DS. Moreover, DS may represent a key population for HIV because of migratory cycles. This stresses the need for a comprehensive exploration of Malian DS' sexual behaviors, HIV prevalence, and migratory journeys in order to evaluate whether they constitute a key or bridging population for HIV.

The high exposure to sexual violence and the under-use of birth-control methods – including condoms – put DS at risk of unwanted pregnancies, something experienced by participants in the present study. The literature reports the high social risks related to out-of-marriage pregnancies in DS in Mali: dismissal, abandonment by their partner, and a jeopardized future marriage in their home village. The risk of banishment from one's family and village may lead to traumatic or dangerous events such as clandestine abortion, neonaticide, or child abandonment (whether at the DS' initiative or forced by family members) (Bouju, 2008). Pregnancies in adolescent girls in Mali also entail specific health risks for them and for their babies, especially in a context of prevalent malnutrition (Fiorentino, 2015). The present study explored the conditions of pregnancy and post-partum among DS who carried their pregnancy to term. We observed that while DS mothers had sought healthcare in medical facilities at delivery, follow-up visits and infant vaccination – none had prenatal visits, and none received post-partum care. Their low financial resources and lack of available time probably led them save their visits to medical centers for serious conditions, or for their child's healthcare rather than their own. DS mothers were highly dependent on their employers' attitudes and behaviors regarding their pregnancy in terms of covering expenses related to delivery and to the baby, lightening DS workload during their pregnancy or when breast-feeding, and accompanying them to a medical center for delivery. DS relied greatly on social and financial support from their relatives

after giving birth. They had only one week off work after delivery, which is at odds with the traditional Malian practice of “quarantine”, consisting in a 40-day post-partum rest period in the parental home (SANGARE, n.d.).

Combining the defense of rights and healthcare and support at the community level: perspectives for community-based research and support in DS

Many DS in our study reported multiple forms of control and/or abuse, while others declared satisfactory relationships with their employers. Employers were in a strong position of power and control over most aspects of their DS' lives, because of the latter's subordinate position, the fact that they lived under the employers' roofs, their young age, rural origin, lack of education, and low socioeconomic status. Employing a housemaid is a sign of social distinction for middle-class and high-class city dwellers, and is perceived as fulfilling a legitimate need to be served by someone (Jacquemin & Tisseau, 2019). Urban female employers rely heavily on DS for daily organization and family life, especially if the employer has a professional activity outside of home. For some employers, this interdependence within the privacy of their home, contributes to a strong desire to control, to exploit, and to abuse DS. DS seduction of husbands, theft by DS, and child abuse by DS (Buchbinder, 2012; Taiwo & Ajayi, 2013) are all stereotypes that may contribute to some female employers having negative attitudes about DS. In contrast, others may prefer to develop trustful relationships with their DS based on negotiation and concession (Nyamnjoh, 2005). To better characterize at-risk situations and households, and to target the most vulnerable DS, the attitudes and characteristics of abusive employers and of protective employers, as well as resilience and protection strategies developed by DS, need further exploration in the Malian context, as has already been done in other Sub-Saharan contexts (Azanaw et al., 2019, 2020; Thorsen, 2012).

Community-based programs to reach migrant adolescent girls and provide them safe spaces, practical skills and support has been recommended for over a decade (Temin et al., 2013). It is recommended that intervention programs aimed at young DS include a component on negotiation and advocacy with employers (Kyegombe et al., 2021). Community-based support for DS to date has mainly focused on the defense of rights, and the provision of legal and social support. A peer/mentor-based program in Burkina Faso showed improved HIV and sexual health knowledge and attitudes in young DS (Engebretsen, 2013; Kyegombe

et al., 2021). However, very few health interventions have been conducted to date in young DS in West Africa, despite their large – and possibly underestimated – number (Kyegombe et al., 2021), and none has investigated their multidimensional forms of dependence on employers in terms of their health.

The precarious living and health conditions of DS related to employers' behaviors highlighted in our study can inform future DS information campaigns in rural villages in Mali and in Bamako, especially regarding key messages on hygiene, general and sexual health, violence, and the existence of ADDAD in Bamako. Based on the results of the present study where DS indicated their preference for a community-based health and support service, a fixed and mobile community-based health service provided by female healthcare workers from ARCAD Santé PLUS, will be integrated into ADDAD's routine activities. We cannot generalize our study results because of its exploratory and qualitative design. However, they will be used to prepare the qualitative and quantitative survey tools for the next steps of the 2DM2 K research project (mixed-method study using exploratory sequential, explanatory sequential and convergent designs; see above). More specifically, socioeconomic, psychosocial, and behavioral data will be collected (1100 questionnaires and 25 in-depth semi-directive interviews) from DS partaking in ADDAD's routine activities who agree to participate in the mixed-method study. In particular, the study will explore the social and health consequences of various forms of abuse, employers' attitudes and working household characteristics as risk factors for poor health status in DS. It will also explore DS' individual and collective coping strategies. Medical data will provide data on the prevalence of HIV, HCV, HBV, STI, tuberculosis, and undernutrition (stunting, thinness, and anemia) in participating DS living in Bamako.

Conclusion

The present study's findings suggest that a lack of knowledge, precarious and harsh living and working conditions, and high exposure to psychological, physical and sexual violence, all jeopardize DS' general and sexual health conditions and access to health care, especially regarding the risk of HIV, STI and unwanted pregnancies. Our findings highlight the relevance of tackling both the defense of rights and sexual health promotion for DS at the community level in Bamako. The results might help to extend health community-based interventions for DS in other West African countries where ADDAD or its partners are active. The present study also brought new research questions to light which

could further understanding of how best to study and improve the general and sexual health of DS.

The triangulation of qualitative and quantitative data from the 2DM2 K project will provide new and wide-ranging information about the living conditions of Malian DS in relation to their health. It may highlight heterogeneous social profiles of DS (Vidal, 2013) with different health implications. The proposed community-based healthcare offer could therefore be adapted to their needs and possibly target DS with the highest social and health risks. This data will also help to evaluate whether DS or subgroups of DS may constitute a bridging population for HIV, in terms of HIV prevalence, sexual behaviors, sexual violence experience, discrimination and stigma, and cyclical migrations.

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