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## The Globalization of Maternal Healthcare in Western Africa

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**Description**

Maternal healthcare is one of the most important global issues in today's world, reflected in its inclusion in the Millennium Development Goals. Globalization, through increased acceleration and movement, has improved maternal healthcare in Western Africa, as observed through the spread of Westernized medicines and treatments and improved technology in prenatal and obstetric care. Another remarkable effect of globalization is the hybridity manifested in both women's healthcare choices and in the pluralistic training of midwives. However, the same forces of movement and exchange can also bring negative consequences, visible through health-access inequalities, brain drain, and the exploitation West African countries.

**Location**

Science Center 300

**Disciplines**

African Studies | Community Health | Public Health | Women's Health | Women's History | Women's Studies

# **The Globalization of Maternal Healthcare in Western Africa**

**Maura Magistrali  
GS 440 Globalization Studies Capstone Project  
Gettysburg College  
May 7, 2014**

## **Revision Memo**

Most of the revisions I made for this final draft addressed the flow and cohesiveness of the paper, as well as polishing up the language.

In the introduction, I took your recommendation and added an “I argue” right before my thesis statement to make it clear that I was presenting my own arguments. I also eliminated subheadings and molded the paragraphs together, as you suggested. For the rest of the paper, I did several read-throughs to make sure everything moved together in a comprehensible way, and I added a few transitional phrases as I deemed necessary. I made sure to properly cite my own ISP work, which I had not done before. That was a good learning experience in how to reference one’s own work in another paper. In the conclusion, I added a line about Giddens to incorporate globalization scholars, as you recommended. I think that addition does make for a more appropriate conclusion.

Considering the paper as a whole and how it has changed since the first draft, I noticed a major difference in the development of the content. I went from a specific focus on research conducted in one country (ISP in Cameroon) to a more holistic view of the many large-picture processes of globalization in maternal healthcare in Western Africa as a region. Shifting to a big-picture viewpoint certainly improved the paper and reflects my own research and learning process.

## **Introduction**

Maternal healthcare is one of the most important global issues in today's world, as reflected in its inclusion in the Millennium Development Goals. In 2000, the United Nations (UN) hoped to reduce the maternal mortality ratio by three quarters between 1990 and 2015 and achieve universal access to reproductive health by 2015 (MDG Report, 2013). We have made considerable progress in accomplishing these goals, as the UN recently reported that maternal mortality has nearly halved since 1990 (MDG Report, 2013). Despite these gains, there is a large amount of work left to be done, especially in sub-Saharan Africa, a region with some of the highest maternal mortality rates in the world (Skolnik, 2012). In Western Africa, maternal mortality rates range from as high as 690 deaths per 100,000 live births in Cameroon to as low as 300 deaths per 100,000 live births in Burkina Faso (WHO Country Profiles, 2011). This range is especially devastating when one recalls that maternal mortality in most Western countries is about 8-20 deaths for every 100,000 live births (WHO Country Profiles, 2011). In this analysis, I argue that globalization has improved maternal healthcare in Western Africa, as can be seen through the spread of Westernized medicines and treatments and improved technology in prenatal and obstetric care. However, these changes also bring forward important questions about the loss of culture, increased global disparities, brain drain, and exploitation. I hope to bring some clarity to this issue through my own evaluation of both the positive and negative consequences of globalization in maternal healthcare.

Before delving into this topic, I would like to highlight why this topic is important, both for Western Africa and for me as a student, and clarify some key concepts. An understanding of maternal healthcare is essential to make strides towards reducing maternal mortality. In 2010, maternal mortality in Africa was 480 per 100,000 live births, the highest among all of the WHO

regions and more than double the global average of 210 per 100,000 (WHO, 2010). From a human rights standpoint, not to mention the economic and social damages that result from the loss of so many mothers, this issue deserves our attention and consideration. As a feminist and an advocate for women's rights, I was drawn to this topic, and was also eager for the chance to build on research on maternal healthcare I carried out as a study abroad student in Cameroon.

Some explanations of key terms are helpful. For this evaluation, I make use of the definition of maternal health from the World Health Organization (WHO): "maternal health refers to the health of women during pregnancy, childbirth and the postpartum period" (WHO, 2014). Globalization is more difficult to define, as scholars agree that it is a multidimensional notion. Anthony Giddens, in his book, *Runaway World*, maintains that globalization "is a complex set of processes, not a single one. And these operate in a contradictory or oppositional fashion" (Giddens, 2003). He writes that globalization can initiate a nation's higher involvement in the global playing field, but may also result in "the revival of local cultural identities" (Giddens, 2003). This cultural piece is of particular interest in my exploration of this topic because traditional maternal healthcare methods continue to be used in many Western African countries. The interaction of these kinds of practices with more Westernized health approaches is one subject I wished to investigate.

In his 2007 book, Thomas Eriksen outlines the main ideas of globalization, highlighting acceleration, interconnectedness, mixing, and hybridity, among other elements. He upholds that "globalization entails both the intensification of transnational connectedness and the awareness of such an intensification" (Eriksen, 2007). This is similar to the short definition offered by Manfred Steger, who asserts that "globalization refers to the expansion and intensification of social relations and consciousness across world-time and world-space" (Steger, 2009). With

recognition of these academics of globalization, I attempt to mold my own definition.

Globalization is a set of processes that increases connection and exchange between the people of the world in physical, economic, social, and other ways, while also making people more aware of this interconnection. I also add that globalization is strongly tied to Westernization, and has such a connotation in this paper. These global exchanges and connections are changing maternal healthcare in Western Africa, resulting in mixing and hybridity, as discussed later.

Lastly, it is essential to specify what is meant by “Western Africa.” Scholars who refer to “Western Africa” do not always include the same countries. This has made it challenging to identify precisely which nations I have included in this analysis. I attempted to limit the focus on French-speaking countries, including Cameroon, Mali, Senegal, Côte d’Ivoire, and Burkina Faso, though this was not always possible when using work from other academics who incorporated different combinations of countries in “Western Africa.” Focusing on this area also allowed me to integrate my research from Cameroon. Through this examination, I hope to gain a more holistic view of maternal healthcare in the identified region of Western Africa.

### **Social, Infrastructural, Financial, & Cultural Barriers to Receiving Maternal Healthcare**

A multitude of physical, emotional, and cultural variables contribute to the severity of maternal mortality in Western Africa. Some major barriers to maternal healthcare are: woman’s failure to recognize when and where they should seek care, the absence of suitable infrastructure, insufficient financial means to pay for services, and cultural constraints relating to gender (Akinrimisi, 2003). Judith Timyan, Susan J. Griffey Brechin, Diana M. Meashan, and Bisi Ogunleye, in their chapter of *The Health of Women: A Global Perspective*, provide a comprehensive overview of the major barriers to care facing West African mothers. Since their

article draws conclusions from several countries of Western Africa and covers many of the key topics commonly discussed in literature on maternal healthcare in this region, I will pull heavily from their work.

Women may not acknowledge an ailment due to its prevalence in their community or because they may not recognize the gravity of the situation. Pregnancy is not always seen as necessitating a visit to a health center, unless a problem occurs. In addition, if a woman acknowledges her pregnancy before showing visible signs, she is thought impolite and inviting bad luck. A woman's lower status in society can also prevent her from pursuing care. Timyan et al. note that "low self-esteem leads to the belief that suffering is women's lot, discouraging them from seeking, and others from taking them or encouraging them to seek, care when problems arise or persist." (Timyan et al., 1993)

Infrastructure and distance are also impediments to access to both general and maternal healthcare. It can be difficult for women to travel even short distances to health centers because they may not have access to transportation vehicles, and even if they do, many roads may be impassable. These limitations are all the more challenging for a woman in labor, who may need transport in an ambulance. Distance can largely influence whether a woman seeks care in a health center or not. A study conducted in Senegal found that health huts built to serve four to six villages were utilized more by women who lived in the villages where the health huts were located than by those who lived in neighboring villages. Such research emphasizes the considerable impact even small differences in distance can have on women's healthcare usage (Timyan et al., 1993)

Monetary resources may also inhibit women from seeking care, as I observed through my research in Batoufam, a village in the Western region of Cameroon. Participants I interviewed



often referred to poverty and a lack of financial means as obstacles that could prevent a woman from going to a hospital for prenatal care or to give birth. One woman, Colette, reflected, “*ce qui peut empêcher une femme d’aller à l’hôpital...on est au village, on n’a pas le moyens*”<sup>1</sup> (Magistrali, 2013). These financial constraints have been observed in other West African countries. In Senegal, researchers discovered that increased healthcare costs prevent more women than men from receiving care (Timyan et al., 1993). Another study conducted in Côte d’Ivoire revealed that patients requiring emergency operations, such as pregnant women in need of a Caesarean section, were not exempt from payment (Gohou, 2004). It is also important to bear in mind that healthcare costs include not only expenses on medicines and services, but also opportunity costs, as precious time is used up travelling to health clinics, waiting to be seen by a healthcare worker, and finally receiving service and treatment.

Finally, cultural factors can also act as preventatives to maternal healthcare. Culture comes into play in Western Africa with the question of gender. In Northern Cameroon, for example, men “are not allowed to touch other men’s wives, even for medical examinations or emergency treatment, without the husband’s authorization” (Timyan et al., 1993). This could understandably cause some problems. It is also difficult to resolve this issue by increasing the number of women doctors because social constraints prevent women from pursuing such careers.

## **Positive Impact of Globalization in Maternal Healthcare**

### *Spread of Western Knowledge & Technology*

Forces of globalization offer potential solutions to some of the outlined barriers to maternal healthcare. Characteristics of movement, acceleration, and interconnectedness, as

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<sup>1</sup> “What could prevent a woman from going to the hospital...we’re in the village, we don’t have the means.” Interview U.

highlighted by Eriksen, permit globalization the power to transmit complex ideas over vast distances in an infinitesimally small amount of time (Eriksen, 2007). This aspect of globalization can have a positive impact on maternal healthcare, by allowing new methods and technologies to spread quickly to the areas that need them.

This positive influence can be seen in Western Africa through the introduction and adoption of Western-oriented approaches to maternal healthcare. During my research in Batoufam, I observed the strong emphasis women placed on giving birth in a health center, where they had access to more resources and healthcare workers. Women assertively affirmed the obligation of going to a hospital before and during childbirth. The reply I heard again and again was, “*il faut aller à l’hôpital.*”<sup>2</sup> Another declared, “*tu vas toujours aller à l’hôpital. Il faut que tu attendes au moins trois, quatre mois, tu commences tes visites.*”<sup>3</sup> One even asserted that she went to give birth in the hospital “*pour sauver ma vie.*”<sup>4</sup> Participants showed a clear conviction that it was absolutely necessary to go to the hospital to reduce the risk of death or problems during childbirth. Several stressed that at the hospital, there was a sense of security and it was more “*sûr.*”<sup>5</sup> (Magistrali, 2013)

The reasons behind women’s trust and confidence in the hospital were related to the Westernized services provided there. Many mentioned the availability of devices, machines, and other resources at the hospital. As one woman told me, “*à l’hôpital, il y a les machines, pour qu’on puisse faire l’analyse, tout ça.*”<sup>6</sup> Women explained how it was important to see inside the mother’s body, to observe the position of the baby, and to monitor the development. Others

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<sup>2</sup>“You must go to the hospital.” Interview U.

<sup>3</sup> “you always go to the hospital. You have to wait at least three, four months and you begin your [prenatal] visits.” Interview O.

<sup>4</sup> “to save my life.” Interview F.

<sup>5</sup> “sure”

<sup>6</sup> “at the hospital, there are machines so that they can analyze everything.” Interview G.

mentioned the high quality examinations given at the hospital, and how the nurses there, “*veillent à tout*.”<sup>7</sup> Women respected Westernized health facilities for their technological resources (devices and machines), and felt safe and well-cared for there because of them. (Magistrali, 2013) These Westernized resources have become available through processes of globalization, and they are helping to provide healthcare that women value in Cameroon.

The spread of Western types of healthcare through globalization also had beneficial results in Senegal and Mali. Alexandre Dumont and his team of researchers conducted a study in both countries to “assess whether a multifaceted intervention to promote maternal death reviews and training for emergency obstetric care in referral hospitals would reduce hospital-based [maternal] mortality” (Dumont et al., 2013). The intervention was education-based, with training and several certifications for healthcare professionals to update their knowledge on various issues related to maternal healthcare. The program also stressed the importance of conducting audits and reviewing the effectiveness of health centers and services. Since training and auditing are highly employed in Western healthcare practices, their usage in this intervention might be considered further evidence of the distribution of Western ideas through globalization. This is not to say that education is not valued among West African societies, only that the emphasis placed on education and surveillance in Western approaches to public health may be carried over to other countries through globalization. Untangling healthcare values and practices to ascertain which ones are Western-influenced and which are locally-based is a complex task beyond the scope of this paper. Dumont and his colleagues upheld that their intervention was beneficial, as hospital-based maternal mortality was reduced by 15 % in Mali and Senegal in the year after its implementation. This study can be viewed as an additional demonstration of the positive

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<sup>7</sup> “look over everything” Interview R.

consequences of globalization in maternal healthcare. Hybridity, discussed below, is another beneficial outcome of globalization.

### *Hybridity in Maternal Healthcare Choices*

Though globalization may be fostering positive changes in Western Africa, the major concern that arises with the influx of all of these Western ideas is whether the culture of West African countries is being dismantled in the process. Giddens discusses the reduced role played by tradition in modern society. He writes that “activities [like] work, exercise, food, sex—or even love...and other parts of life too, are much less structured by tradition and custom than once they were” (Giddens, 2010). Following this reasoning, it appears that maternal healthcare, too, might become less controlled by customs and traditions in Western Africa, with Westernized methods practices taking on more importance. Through my research, however, I observed a different outcome.

Loss of culture was not a problem I encountered during my studies in Cameroon. In fact, I was impressed with how easily women were able to combine both Westernized and traditional methods of healthcare to obtain the service that was best for them. During my many conversations with the women of Batoufam about maternal health care, I found an undeniable blending of both modern and traditional medicine. A majority of my sample population (65%,  $n = 20$ ) used both Western and traditional treatments during pregnancy, and nearly everyone I interviewed showed a respect for traditional medical practices, and a desire to preserve them. Traditional healers and hospital staff alike alluded to a partnership between the two sectors and shared with me how they work together in the healthcare environment of Batoufam. Evidently the people of Batoufam are finding ways to achieve a kind of hybridity in their health care practices. (Magistrali, 2013)

Using both modern and traditional treatments together before giving birth was a common practice I saw throughout my interviews with women. I also had the chance to discuss this subject with Professor Felicité Mbiapo, a retired professor of biochemistry who has also researched the benefits of herbal medicine. Mbiapo provided insight into the tendency for women in Batoufam to combine both modern and traditional practices:

*“Maintenant que les centres de santé sont implantés partout, elles [les femmes de Batoufam] font un effort, après avoir pris les médicaments traditionnels, d’aller également dans le centre de santé quand elles se sentent et je ramène même, quand ça ne va pas toujours au plan de la médecine moderne, elles mettent encore un accent sur le traitement traditionnel avec les plantes...elles combinent en général les deux aspects.”* (Mbiapo, 2013)<sup>8</sup>

This harmonious combination of modern (Westernized) and traditional healthcare is an excellent example of hybridity, as defined by Eriksen. He writes that, “*hybridity* directs attention towards individuals or cultural forms that are reflexively—self-consciously—mixed, that is syntheses of cultural forms or fragments of diverse origins” (Eriksen, 2007). Mothers in Batoufam are aware of using both types of care and service, and can navigate between them with ease. At least in one village in Cameroon, hybridity acts as a positive force, permitting women to have more options to meet their healthcare needs.

A similar hybridity is also apparent in Côte d’Ivoire, according to one native observer. Abou Bamba, professor of History and Africana Studies at Gettysburg College, noticed that the maternal healthcare choices made by the women in his family in Côte d’Ivoire were similar to those made by women in Cameroon. He explained:

“As far as maternal care [is] concerned, what you probably saw in Cameroon is what I experienced back home in Ivory Coast with my mom, with my aunties, with nieces...it’s the same. There is now a mandatory requirement to go to the hospital, but at the same

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<sup>8</sup> “Now that health centres are established everywhere, they [the women of Batoufam] make an effort, after having taken the traditional medicine, to go as well to a health centre when they feel and I would even bring up, when things don’t always go well in the framework of modern medicine, they still put an accent on traditional treatment with plants. They combine, in general, the two aspects.” Mbiapo, Felicité.

time, you have older women who know how to deal with pregnancies, for example, and post-pregnancy issues, and they will provide also their advice to the same person who has been to the hospital” (Bamba, 2014).

Professor Bamba’s comments provides further evidence of hybridity in maternal care in Western Africa. In both Cameroon and Côte d’Ivoire, mothers can use a hybridized version of healthcare, following Western treatments as well as more traditional ones as they see fit.

In Mali also, one can observe hybridity in maternal healthcare. In her book, *Monique and the Mango Rains*, Kris Holloway provides an excellent account of maternal care in Nampossela, Mali, where she served as a Peace Corps Volunteer for two years. Holloway worked closely with Monique Dembele, the midwife of the village, who was trained in Westernized methods of birth control, delivery, and post-birth care. Though the women of the village went to Monique for prenatal visits and to give birth, they also often employed traditional methods for their needs. Especially when seeking contraceptive tools, women turned towards traditional practices, as condoms and birth control pills could be difficult to access or utilize. As Monique tells Holloway, ““Many women here still use the old ways to avoid pregnancy. Sometimes they work and sometimes they don’t...They stay away from having sex for a while. They try different herbs, plants to drink, or to put up there.”” She pointed below her abdomen” (Holloway, 2007). Loss of culture, then, does not seem to be a problem in maternal healthcare in Western Africa, where, in a remarkable demonstration of hybridity, women comfortably use combinations of both Western and traditional forms of care.

### *Hybridity in Birth Attendants*

Examining the impact of traditional birth attendants and skilled birth attendants provides another window through which to observe hybridity through globalization in maternal healthcare. In a study on access to obstetric care in West Africa, Carine Ronsmans and her

research team evaluated factors that may compromise maternal health in a handful of West African countries: Senegal, Guinea-Bissau, The Gambia, Burkina Faso, Côte d'Ivoire, Mali, Mauritania, and Niger. The investigators found that a variety of health workers were involved at different levels of maternal care, with nurses and midwives providing basic obstetric care in health centers and skilled birth attendants providing birth services in health facilities. Some health centers in Senegal were even staffed by traditional birth attendants (TBAs) (Ronsmans et al., 2003). The presence of both trained and traditional birth attendants and the mixing of both traditional and Westernized training in West African obstetric is further evidence of hybridity.

Another example of hybridity amongst birth attendants is shown through Monique, the midwife of Nampossela, Mali. When Holloway asked Monique how she became the village midwife, her friend explained: “The *dùgùtigi* [chief] chose me, after the first year I lived here. I apprenticed with the *accoucheuses traditionnelles*—traditional birth attendants—for two years. I attended many births with them, then did my nine months of health training, and became Nampossela’s *matrone* and *aide soignante*—midwife and health worker” (Holloway, 2007). Later, Holloway learns that Monique received her nine-month training at a hospital in the city of Koutiala. Monique has experience with both traditional and Westernized forms of training, making *her* a form of hybridity. The pluralistic training Monique possesses makes her an invaluable midwife in Nampossela because she can have both Westernized tools to address maternal health problems and an understanding of the cultural attitudes of her patients. Monique provides prenatal care, regular baby weighing sessions, and educational programs on baby food, breastfeeding, family planning, and how to prevent diarrhea, among a wide variety of other services. Most significantly, she can offer relatively safe birth delivery in the village, as she is capable of dealing with hemorrhages and other complications, though not Cesarean section

surgery. This is an indispensable skill, given that the roads from the village to the hospital in Koutiala are only passable by motorcycle, impossible for a woman in labor to traverse. In addition to these abilities, Monique is accepted and trusted in her community because of her extensive training with TBAs. She is hybridized, possessing both Western and traditional knowledge of maternal health care. Because of this combination, Monique is an incredible asset to her community.

It appears that Westernized methods of maternal healthcare introduced through globalization are not having a detrimental effect on traditional cultural practices. In Cameroon, Côte d'Ivoire, and Mali mothers can easily make use of both Western and traditional forms of care, without one contradicting the other. Additionally, the spread of Western treatments and technologies through the acceleration and movement permitted by globalization have improved maternal healthcare. Though Western medicinal practices have become more widely used in Western Africa, their presence has not diminished the importance of traditional forms of care. Women in Cameroon, Côte d'Ivoire, and Mali are comfortable with using both, if they so wish. Finally, some birth attendants, like Monique in Mali, are trained in both Western and traditional methods of maternal care, further proof of the beneficial hybridity that can take place through globalization.

### **Negative Effects of Globalization**

Clearly, globalization can foster some positive outcomes in maternal care. However, the same forces of acceleration and exchange that allow for such beneficial effects can also have some harmful results for mothers in Western Africa. In addition to its advantageous and



favorable consequences, globalization can perpetuate inequalities, foster brain drain, and promote exploitation.

### *Unequal Access to Care*

As I mentioned above, increased acceleration and movement in the globalized world have allowed Westernized practices to become more widespread, helping to address maternal care needs and contributing to reducing rates of maternal mortality in Western Africa. However, access to these services is still not equal, with a number of variables creating barriers. Asim Kurjak and his colleagues highlight this point in an essay on the subject. They argue that, “the leap in science and technology in the industrialized world has led to a great gap between the situation facing pregnant women in Europe or North America and that of women in the developing world... A young woman in Ethiopia, for example, goes into the reproductive phase of her life with a one-in-ten chance that she will die as a result of pregnancy or delivery” (Kurjak et al., 2010). The high mortality rates observed in Western Africa, highlighted at the beginning of this paper, echo these remarks. No matter what gains globalization has allowed in the maternal healthcare realm, it is clear that the benefits are not distributed fairly. As long as there continues to be such a wide gap in maternal mortality between rich and poor regions, the overall positive impact of globalization remains in question.

### *Brain Drain*

Sadly, some of the same processes of interconnection and movement that permit the spread of Western methods and technologies to improve maternal healthcare are also forces that contribute to maternal mortality. This occurs through a phenomenon known as *brain drain*, whereby people from low-income areas, like Western Africa, move to high-income countries to become educated and trained. The problem arises when these highly skilled individuals choose

not to return to their home countries, because of low wages, unfavorable working conditions, or other reasons, and so do not bring their newly-acquired skills and expertise to help solve problems where they are most needed. Globalization has permitted brain drain by making it easier for people to move from place to place.

The negative effects of this trend are especially severe in the healthcare sector, where there is great need for doctors, nurses, and other health specialists leave their countries to help address low access to care, rampant infectious disease, and high mortality rates. I do not at all wish to accuse these individuals of abandoning their home countries to face these grave health problems on their own, but only to recognize brain drain as one part of the problem, and acknowledge the facilitating role globalization plays in its occurrence. Professor Bamba makes the connection between brain drain, globalization, and maternal healthcare clear: “less money is being given to doctors and nurses, many of them are leaving their countries...it can be seen as part of the globalization process, because...it’s easy to cross borders....we can see...the impact on the provision of service to mothers and children because the nurses have gone where they receive better pay for their services” (Bamba, 2014). By promoting increased and easier movement between continents as well as progressing rapid technological and educational advances, globalization is enabling brain drain to continue, certainly with some negative effects for maternal healthcare.

### *Exploitation*

Finally, primarily through neocolonial movement and interconnection, globalization has permitted continuous exploitation of West African countries, with deleterious effects for maternal health. One of the prime examples of this exploitation can be observed through Structural Adjustment Programs (SAP). SAPs were developed by the World Bank and the

International Monetary Fund (IMF) with the supposed intention of helping low-income countries deal with their debt to wealthy nations. SAPs were permeated with Western-valued techniques and systems, including “trade liberalization, devaluation, the removal of government subsidies and price controls, ‘cost recovery’ in health and education, privatization, a credit squeeze, and increased interest rates” (Logie & Woodroffe, 1993). Though proclaimed to be beneficial for the poor and indebted, in reality, SAPs seemed designed to suit the needs of powerful Western countries. Western nations could exploit raw materials from low-income nations through liberalized market strategies and gain more control of their governments by reducing public spending and increasing privatization. The impact on healthcare were terrible. In Senegal, for example, health spending as a proportion of Gross National Product (GNP) decreased after the country implemented a SAP under the recommendation of the World Bank (Logie & Woodroffe, 1993). Professor Bamba also spoke of the disastrous effects of privatization in healthcare, especially for mothers:

“where before that medical care were much more accessible because [it] is a public good...with the Structural Adjustment Program, what you see happening in many of the countries, [is] the privatization of many of the facilities that provided...health and care, and with that, of course, privatization means those who are providing should make money...so with the privatization, it will be those who have more that will be able to acquire the most sophisticated medical treatment, that of course including...mothers and their children” (Bamba, 2014).

As Professor Bamba points out, the introduction of SAPs in West African countries made it more difficult for poor women to gain access to healthcare services. In addition, in the absence of public services, women are more likely than men to fill the gap and work for community needs, adding to their already-heavy work burden by decreasing the time available to dedicate to tasks at home (Timyan et al., 1993).

Unfortunately, the same interconnectedness and movement that permitted rapid exchanges of medical knowledge and technology to improve maternal healthcare are also the processes that allowed the IMF and World Bank to wield such control over low-income countries and take advantage of them. Globalization is, of course, two-sided, offering both good and bad consequences.

### **Conclusion: The Dual Influence of Globalization on Maternal Healthcare**

Globalization might be viewed as a two-faced friend: sometimes kind and generous, only to turn around with greed and spite. As I highlighted earlier, scholars have already pointed out the dual identity of globalization. To repeat, Giddens asserts that the forces of globalization “operate in a contradictory or oppositional fashion” (Giddens, 2003). This contradictory nature of globalization is certainly present with regards to maternal healthcare in Western Africa. On the one hand, acceleration and interconnectedness have allowed for the augmented flow of knowledge and technology in between various countries. The influx of enhanced medical methods and techniques has undoubtedly helped to reduce rates of maternal mortality and encourage better maternal healthcare in Western Africa. Another fascinating aspect of globalization is the hybridity it has permitted. Women in Western Africa need not give up traditional medicinal practices in the face of Western treatments, but can hybridize their choices by using both. Birth attendants are also becoming hybridized through globalization, as manifested by Monique Dembele, an inspiring midwife in Mali.

However, these beneficial consequences of globalization only give one side of the story. The same interconnectedness and movement that results in the spread of improved maternal healthcare methods can also have harmful effects. Women still do not have equal access to

healthcare. Brain drain from Western Africa is leaving many women without doctors, nurses, and birth attendants to care for them during pregnancy and childbirth. SAPs exploited West African countries, among many others, for the benefit of the Western world, leaving them less capable of providing needed maternal health services.

There is no doubt that globalization is making a positive impact on maternal healthcare in Western Africa, but its negative effects must also be considered. Our friend globalization offers both gifts and grievances. As the processes of globalization inevitably continue, it will be increasingly important to evaluate how to maximize the beneficial outcomes and minimize the damaging results.

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*I affirm that I have upheld the highest principles of honesty and integrity in my academic work and have not witnessed a violation of the Honor Code.*

*-Maura T. Magistrali*