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Pharmaceutical industry's effect on socioeconomic development in sub-Saharan Africa in
relation to family planning accessibility

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Author's Note

Tessa Demarest is a student in the Honors College at Virginia Commonwealth University. She was advised by Professor Faye Prichard and her classmates. This paper is her final project for the class HONR 200, Rhetoric.

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Abstract

There is a large unmet need for family planning services in sub-Saharan Africa (Goodkind et al, 2018). Pharmaceutical companies contribute to the accessibility of medications in developing countries (Cottingham & Berer, 2011). If the pharmaceutical industry strongly affects access to contraceptives in sub-Saharan Africa, then it is possible that adjustments made to the industry would increase access to contraceptives.

I explored how contraceptives change the economic and social development of sub-Saharan Africa to determine if contraception benefits Africans enough for their shortage to be a serious injustice. This is followed by how the pharmaceutical industry affects access to and types of birth control available in the area. The potential solution of instilling more non-profit medical institutions to increase contraceptive availability is also probed.

It was concluded that access to reproductive health services in sub-Saharan Africa should be available due to their overwhelmingly positive economic and social benefits. However, the for-profit pharmaceutical industry creates obstacles for universal access, such as intellectual property rights and a profit-motivated model (Cottingham & Berer, 2011). Though a nonprofit pharmaceutical system and alternative medications may increase availability of reproductive health services, more research should be conducted as to how a more socialized form of medicine would increase universal access to contraceptives.

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Katz (2015) wrote an essay containing the following interviews:

Last month, Stembile Mugore visited a hospital in Togo, where she met a 24-year-old woman who had just given birth to her fifth child. Mugore is an advisor to Evidence to Action, USAID's global flagship for strengthening family planning, and she had come to Togo to follow up with a group of midwives who had been trained by USAID. The new mother's labor had been difficult, and she did not want to become pregnant again in the near future. But she also had no idea how to prevent it from happening.

“She didn't know anything about family planning,” Mugore recalled. “She'd never heard [of it]. She'd had these babies very closely spaced.” After discussing her options with a hospital midwife, the woman decided to receive an implant — a small, rod-shaped form of birth control that is inserted into the arm, and that lasts for up to three years.

“I remember very well the smile and the satisfaction on her face after she'd had this implant,” Mugore said. “And how she wished she had known [about it sooner].”

(para. 1-3)

In the same Katz (2015) essay, “Why 222 Million Women Can't Get the Birth Control They Need”, Upadhyay, the Head of Reproductive Health Commodity Security and Family Planning at the United Nations Population Fund, proclaims:

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“Family planning, it’s a human rights issue. It’s a prevention issue. It’s a women’s issue... How many women will have an unplanned pregnancy, and how many women will die because of that? [There] should be a movement all over the world.” (para. 15)

In some parts of the world, a woman cannot decide whether or not she has a child. Cottingham and Berer (2011) say between 700 and 800 million women and couples use contraceptives, while 215 million women who desire it are unable to obtain birth control. In the United States, conservative ideologies, financial inequalities, and other barriers to public health have prevented family planning services from reaching people in need. However, changing beliefs have led to a new movement, one which advocates for more women to be able to access reproductive and sexual health care. Though the current presidential administration plans to decrease funding for contraceptives, and is less supportive of socialized medicine than the previous administration, the United States population still has better access to family planning services than many other countries.

The countries of sub-Saharan Africa have a high rate of unmet need for contraceptives. (Goodkind et al., 2018). In an article by the Population Division of the U.S. Census Bureau, Goodkind, Lollock, Choi, McDevitt, and West (2018) show that of the 13 countries the United Nations projected to have the lowest met need for contraceptives, eight were countries in sub-Saharan Africa. Humanitarian aid from the United States government as well as international nonprofits goes to sub-Saharan Africa in the form of food, water, shelter, medicine, and more. However, while some aid is provided, universal access to family planning is still far from a reality. In the country of Southern Sudan, the demand for contraceptives which was met with modern contraceptive methods was only 6.1% in 2014, compared to 52.1% in the Philippines that same year (Figure 2).

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The examination of how a lack of access to and types of birth control available in sub-Saharan Africa has changed the social and economic development of that area is important in understanding the seriousness of this issue. Goodkind et al. looks at how the rate of met demand defined as “percent of demand for family planning satisfied with modern contraception” (p. 1) affects socioeconomic development. There are multiple possible justifications for sub-Saharan Africa’s low rate of met need for contraceptives, including; social stigmas, a lack of knowledge on contraceptives, financial limitations, and regional or landscape boundaries. Regardless of the cause, the lack of these goods and services may lead to hardships for women. A woman without effective contraceptives may have an unplanned, unwanted pregnancy, which can lead to the birth of a child she does not have the means to support. On the contrary, access and use of contraceptives positively correlate with the sexual empowerment of women, the likelihood of a woman joining the labor force, and the chance that a woman’s child or children will attend school (Crissman et al., 2012; Goodkind et al., 2018; Longwe & Smits, 2013).

However, there is adversity pertaining to increased access to family planning. Hynie and Lydon (1996) suggest that a high positive sexual attitude, which is positively correlated with the sex education that family planning programs may offer, can promote unsafe sex. This increases the chance of STI transmission and unwanted pregnancy. According to Obianuju Ekeocha on *BBC World News*, who is a pro-life advocate from Nigeria, believes Western involvement in Africa’s reproductive and sexual health care is a form of ideological colonization of women who do not desire birth control. With many differing opinions on increased access and use of family planning in Africa, an in-depth examination of contraceptives’ socioeconomic influence is necessary to decide if a lack of access is a serious problem.

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With almost infinite possible barriers to universal access to family planning, creating a concise, informed answer for why there is a large unmet need for contraception is nearly impossible. For that reason, this article examines the root of medication and vaccines: the pharmaceutical industry. The pharmaceutical industry is responsible for the invention, production, and distribution of medications and vaccines. In the United States, large pharmaceutical companies are paid by the government, individual consumers, and nonprofits for their products. In Africa, pharmaceuticals are also administered by the public sector, the private sector, and the nonprofit sector (Tumlinson et al., 2011). For my research, I examined how for-profit pharmaceutical companies affect women and families' access to reproductive health services, as well as how it alters the types of reproductive goods and services available. There are many laws and policies surrounding the pharmaceutical industry, such as those preventing unethical drug trials (Moon, 2012). United Nation guidelines pressure ethical business practices within the pharmaceutical industry (Moon, 2012). Nevertheless, products are still largely unavailable from economic failures. Due to a lack of success in access to contraceptives, this article concludes with the possibility that a larger prevalence in nonprofit pharmaceutical suppliers or public pharmaceutical suppliers may increase access to family planning products and services.

Due to overwhelming positive economic and social development created by family planning goods and services, sexual and reproductive health services in sub-Saharan Africa should be made more accessible. However, the for-profit pharmaceutical industry creates obstacles for universal access, such as intellectual property rights and a desire to make a financial profit. This research aims to come closer to a solution for how women who desire family planning can receive it, regardless of social or economic status.

Social and Economic Effects

Pharmaceuticals can decrease mortality, improve health, and increase social and economic development. This section studies the social and economic effects of contraceptives in sub-Saharan Africa. In particular, it discusses the demographic population shift, the sexual empowerment of women, increased educational opportunities, and possible negative effects of increased family planning.

Goodkind, Lollock, Choi, McDevitt, and West (2018) claim that increasing the rate of met demand for family planning would alter the demographics of 13 tested countries, providing positive effects for these countries. Goodkind et al. defines the term *met demand* as “percent of demand for family planning satisfied with modern contraception” (p. 1). The selected countries were 13 that the United Nations projected as being the furthest away from the benchmark of 75% met demand.

The first step in the study by Goodkind et al. was translating contraceptive use into probable fertility rates of the 13 selected countries. The study used the equation:

$$TFR = [Cm * Cc * Ci * Ca * Cp * TF]$$

TFR stands for the number of expected births per woman. This is meant to result from the multiplication of several different factors, including the proportion of women aged 15- 49 who are married (Cm), the index of contraception (Cc), the index of postpartum insusceptibility (Ci), the index of abortion (Ca), an index of infecundity or pathological sterility (Cp), and total fecundity (TF), which was estimated at roughly 15 births per woman. Data from the Census Bureau (2014) was used, as well as projected data for 2030 to come up with the projected increase of the modern contraceptive prevalence rate (MCPR). Goodkind et al. (2018) uses these

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differing rates to start the second step: “incorporating fertility estimates in cohort component population projections” (p. 4).

Using this equation and data, Goodkind et al. (2018) were able to predict the population size and ages if the 75% benchmark met demand for contraceptives was obtained by 2030.

This study found that a higher met demand would cause a slower population growth. This in turn would shift the countries' demographics, including a lower percentage of children, and a higher percentage working-age individuals. A decrease of dependent youth (children who need to be taken care of) and an increase of economically productive people (people who can work and hold jobs) allows for more men and women to enter the labor force. Goodkind et al. (2018) infers this would make it easier for developing countries to provide sustainable infrastructure and increase economic development.

Goodkind et al.'s study illuminates the positive economic development from met family planning needs. Research by Crissman, Adanu, and Harlow (2012) studies the positive social aspects of contraceptives.

Crissman, Adanu, and Harlow (2012) hypothesize that a lack of sexual empowerment among women imposes a barrier on their access to family planning methods and reproductive health. It defines women sexual empowerment as a woman's “perception of the right to self-determination in sexual relations” as well as the right to make sexual decisions (p. 202). Through using the 2008 Ghana Demographic Health Survey, the authors found that increased sexual empowerment of women is correlated with an increase in the use of birth control. Crissman, Adanu, and Harlow conclude that the issue of sexual empowerment, especially among low-income women, should be further researched and addressed in order to achieve universal access to reproductive health services.

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Those selected for the study were randomly selected from 412 geographic clusters within Ghana's 10 geographical regions, and 4,917 out of 5,094 eligible women completed the survey. Out of the 4,917 women, 2,104 identified as being married, not pregnant, not wanting to get pregnant soon/within the next three months, and not missing key components for the analysis. Out of that sample, 589 women were using contraceptives while 1,515 were not. The women for the Crissman et al. (2012) study were given a questionnaire consisting of the following questions:

- Can you say “no” to your husband/partner if you do not want to have sexual intercourse?
- In your opinion, is a husband justified in hitting or beating his wife if she refuses to have sex with him?
- Could you ask your husband/partner to use a condom if you wanted him to?
- If a wife knows her husband has a disease that she can contract during sexual intercourse, is she justified in asking him to use a condom when they have sex?
- Is a woman justified in refusing sex if she is tired/not in the mood? (p. 203)

The results found that sexual empowerment is different from other forms of empowerment, such as empowerment found through wealth and education, though these forms of empowerment are positively correlated. A major factor which was discovered in result of this survey was the religious connections in Ghana to birth control use. For example, Muslim women were much less likely to use contraceptive methods than Christian women. There is a higher concentration of Muslim women in Northern Ghana, so this data could be slightly related to a lack of access in Northern Ghana. However, after controlling for demographic differences, use is still statistically lower in Muslim women.

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This study by Crissman et al. (2012) displays how a Ghanaian woman's level of sexual empowerment is associated with contraceptive use. The debate exists as to whether contraceptive use increases sexual empowerment, or if a higher level of sexual empowerment increases a woman's likelihood to use contraceptives. It could possibly be both: having control over the spacing and number of their children can be empowering, while being empowered may cause one to want to have power over the spacing and number of their children. Either way, this type of empowerment offers a solution to increase contraceptive use without pushing ideologies onto Ghanaian women.

On the contrary, evidence shows heightened sexual empowerment in women may decrease their use of birth control. Hynie and Lydon's (1996) article discusses the possible low use of birth control in women with a positive sexual attitude. This differs from the previous viewpoint that women with a negative sexual attitude are less likely to use birth control.

Hynie and Lydon (1996) based their study on two hypotheses. First, that there would be a quadratic relationship between the Sexual Opinion Survey (SOS), a survey commonly used to project sexual attitude, and contraceptive behavior. This means that women with negative sexual attitudes would be poorer contraceptive users, but also that women with an extremely positive sexual attitude would be poorer contraceptive users than women with fairly positive sexual attitudes. Second, that women would be more likely to report effective contraceptive behavior in global behavior measure rather than measured by a daily diary. Global measurement is predicting the contraceptive methods they would use in the upcoming week, while diary entries were written after each intercourse session to establish what method of contraception was used.

The study included 62 women who were sexually active at least once in the five weeks during the study. Women were asked to rank their contraceptive effectiveness 1-7, 1 being the

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most effective (a birth control pill with a condom) and 7 being the least effective (no contraceptive used). Contraceptive consistency was also measured by calculating the percentage of intercourse where a reliable method of birth control was used.

The study showed that women with very high SOS scores used significantly less effective methods of contraceptives than women with moderate scores. Women with high SOS scores were also less consistent in their contraceptive behaviors. There was a decrease in effective contraceptive use from the first reported month and the methods predicted for next month. Also, a bias was found in the global measures, with women documenting more effective contraceptive use than what was actually performed. Finally, a quadratic relationship was found between sexual attitude and contraceptive consistency, confirming the hypothesis.

However, high levels of arousal only interfered with contraceptives which were coitus dependent, such as a condom. Methods such as the pill or an IUD were not interfered with significantly in relation to a high positive sexual attitude. This study was also performed with Canadian college students and adults. Since this article is related more to coitus independent forms of contraception, and involves women in Sub-saharan Africa, it is not believed that this study has a close enough relation for me to consider positive sexual attitude as a threat to contraceptive use. Therefore, the hypothesis still stands that sexual empowerment should be implemented into family planning practices in this area.

Educational opportunities and an educated population are important for social progress as well as economic development. For this reason, it is important to understand the educational effects of contraceptive use in sub-Saharan Africa.

Longwe and Smits' (2013) article articulates the need for an increase in the knowledge of contraceptives, as well as access to family planning practices in Africa. Their claims rest on how

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a lack of family planning continues the cycle of poverty – increasing fertility rates which reduce women's opportunities, as well as reduce the educational opportunities for their youth. They claim that with contraceptives, educational opportunities are more available for both younger and older children, because older children are able to go to school for longer if they do not have to take care of their younger siblings. They also include that with fewer children, women have an improved opportunity to enter the labor force. Through their data and findings, Longwe and Smits want to convince policy makers that funding family planning education and practices will be socially and economically rewarding.

Longwe and Smits' (2013) evidence includes an analysis of family planning practices and their outcomes on educational participation. The data includes both urban and regional areas of 233 subnational regions within 25 African countries. The study covers almost two decades; from 1992 to 2009. They used this data to answer three focus questions:

- What is the extent to which birth rates relate to primary school participation?
- What is the extent which birth rates relate to contraceptive use?
- What is the extent which contraceptive use is related to knowledge and acceptance of contraceptives?

The article also contains a web diagram to illustrate how the data found correlates to each other. Called "The Input Path Diagram of the Conceptual Model", it states "Change in acceptance of FP" (FP = family planning) comes first in the cause and effect chain, followed consequently by "Change in contraceptive use", "Change in number of recent births", then "Changes in primary school participation" (p. 25).

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The results showed that knowledge of contraceptives positively correlated with more contraceptive use and acceptance. More contraceptive use showed a decrease in births, as well as an increase in the number of eight to 12-year-olds attending school.

Pharmaceutical Industry Effects

The pharmaceutical industry can be viewed like any other for-profit industry: looking to make a profit, they must create a desired product, and they must follow governmental and NGO guidelines. However, unlike other businesses, pharmaceutical companies create products that are necessary for people to survive and develop.

With the necessity of pharmaceuticals comes unique guidelines and restrictions. The United Nations' legislation surrounding pharmaceuticals as well as the industry's for-profit nature decreases access to generic medications, new medications, and vital medications in Sub-Saharan Africa (TRIPS, 1994). In an article by Cottingham and Berer (2011), they elaborate on the claim that pharmaceutical companies are inhibiting the mass circulation of affordable family planning products in developing countries. The authors call for more public investment in essential medicine (which leads to increased access to generic, cheaper drugs) and strategic plans which will increase medications and technologies universally available for specific ailments.

Cottingham and Berer (2011) have multiple claims for their reasoning. First, pharmaceutical companies invest in products that will create a profit, which under-serves disadvantaged communities, as well as ignores negative side effects of certain products. To help improve quality of care, procedures and medications have been improved. These include safer abortions (manual vacuum aspiration and medical abortion pills), safer female and male sterilization and IUDs, new emergency contraceptives, oral pills that can be ingested less

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frequently, and new ways for hormones to be used and administered (p. 71). However, many pharmaceutical companies lack interest in deploying these new methods in developing countries because they lack profit when administered to people who would need to be charged a considerably lower fee than their Western counterparts.

Legal issues regarding marketing new essential medicines at prices where many people in developing countries would be able to pay for them is the second reason for the lack of access to family planning and medications. The Essential Medicines Programme (EMP) developed by the World Health Organization aims to help countries formulate national medicine policies, select essential medicines, and set up structures that allow for their availability. Essentially, the EMP hopes to create “affordability and rational use of good medicines that [are] safe, effective, and of good quality” (Cottingham & Berer, 2011). However, the program conflicts with pharmaceutical companies, primarily in the global battle for programs such as EMP to deploy generic, antiretroviral medicines. While pharmaceutical companies want to keep their patents on the drugs to sale more expensive name-brand drugs, both for-profit and nonprofit groups are trying to develop generic versions of the medications that are less expensive for more people to afford them, causing conflict between the two opposing sides.

Cottingham and Berer (2011) also reference the international patent system for pharmaceuticals and how it limits universal access to family planning. The Trade-Related Aspects of Intellectual Property Rights (TRIPS) grants a patent to the developer of a medicine for 20 years. Installed to protect the rights of the inventor, it initiates a possible monopoly on that medicine. A solution for some medications is compulsory licensing, where developing countries are given permission by the government to use the patented products so they can sell the drugs at

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lower costs to those in need. Yet Western countries “presumably backed by the pharmaceutical industry” are trying to enact stricter laws on compulsory licensing (p. 76).

The United Nations also recognizes pharmaceutical companies create a problem in regards to universal access to medicine, and in turn has created legislation to try to combat the issue. In her article discussing United Nations documentation surrounding the pharmaceutical industry, Moon (2012) discusses the challenges of TRIPS and a for-profit market in the pharmaceutical industry. However, Moon finds discrepancies in the work of the United Nations, calling for the Framework Convention on Global Health to include private for-profit entities and to create more regulations.

Moon addresses two United Nations mandates to educate the reader, then scrutinizes what the documents fail to address. The first mandate of the two discussed by Moon is Paul Hunt's *Human Rights Guidelines for Pharmaceutical Companies in Relation to Access to Medicines* (2008), which instructs pharmaceutical companies on ethical practices. Hunt elaborates on the idea that the practices of pharmaceutical companies may prevent states from providing the best health care (p.18). Some examples he uses is how pricing, research, and medical practices of the company may interfere with state practices, hurting public access to medicine. Hunt declares that more state control of medicine is better than for-profit providers; however, since that is not always the case, pharmaceutical companies have several social responsibilities. This creates “right-to-health responsibilities”, such as how the patent holder to a life-saving medicine should have the responsibility to disperse the medicine ethically (Moon, 2012).

The second mandate written from what Moon discusses is *The UN Guiding Principles on Business and Human Rights* (2011) by John Ruggie, created to address issues surrounding

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business interference and human rights (the Ruggie Principles). The document cites respect as the baseline expectation for businesses. This includes businesses cannot harm the public with their practices, and that their own practices must come secondary to the actions of the state. The document also includes specifics regarding pharmaceutical companies, such as requiring clinical trials to be ethical and respectful of human rights and allowing countries to use compulsory medicine for better access to medicine. The Ruggie Principles then discuss remedy, which claims those who feel wronged by the company have the right to come forward with their issues and receive remediation. It also views transparency as vital, calling for pharmaceutical companies to make their objectives known to the public, as well as disclosing their lobbying actions and ties with political parties, trade associations, and other key opinion leaders. However, Moon (2008) believes that holding companies to these standards is unrealistic without binding state standards.

Both of these mandates believe businesses, including pharmaceutical companies, have responsibilities to maintain as holders of patents for medicine and providers of necessary medical procedures. They also believe separation from public medicine should not undermine desirable donations and contributions from pharmaceutical companies, but it should come second to the actions of the state. However, Moon (2008) believes there are still many discrepancies within these mandates. For example, TRIPS can cause for large medicine monopolies that would inhibit people from getting medications and vaccines, yet the documents do not account for these complications. The documents also do not supply money for research for non-commercial diseases. A symbiotic relationship between states and pharmaceutical companies is still unable to be created. Through describing these declarations, Moon argues there needs to be more public policy to insure pharmaceutical companies are acting with respect and ethics, as well as to help

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subsidize medicine for disadvantaged people. For these reasons, she asks for the Framework Convention on Global Health to include private for-profit entities to create more regulations.

Moon (2008) believes more regulations need to be put on private pharmaceutical suppliers to promote universal access to family planning. Moon, Hunt, and Ruggie also believe state suppliers of pharmaceuticals are better for the overall development of areas receiving donated or paid for private goods. However, the article fails to discuss nonprofit medical systems.

Possibility of a Nonprofit Solution

A nonprofit organization runs on a similar business model as a for profit business; however, profit generated by the nonprofit must be reinvested back into the organization's mission, not to stakeholders. Though there can still be corruption within a nonprofit, more money is meant to go towards the beneficiaries of the organization, rather than the creators. For this reason, a nonprofit medical system that contains nonprofit pharmaceutical providers may allow for the best universal access to family planning. A major nonprofit family planning provider is the International Planned Parenthood Federation.

The International Planned Parenthood Federation (IPPF) is an offshoot of the American nonprofit, Planned Parenthood Federation of America. Claeys (2010) illuminates the positive work of the IPPF in her article, using it to support sexual and reproductive health rights and the NGO. She includes the European Region's launch of the *IPPF Charter on Sexual and Reproductive Rights*, creating international legislation in regards to sexual and reproductive health. Its goal was to create a standard for judging sexual and reproductive health violations. In 2008, the IPPF published *Sexual Rights: an IPPF Declaration*, declaring reproductive rights as a

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human right. It is also mentioned that the United Nations, after urge from the IPPF, created a resolution exclaiming it is a right for parents to “decide freely and responsibly on the number and spacing of their children,” as well as to have “adequate education and information” (p. 73).

Claeys also supplies a large amount of statistics emphasizing the ability of the IPPF to be large and all-encompassing, such as with national affiliates in Japan, South Korea, Bermuda, and many more. She also includes after the International Conference on Population and Demand in 1994, chaired by the IPPF President at the time, that there was a need for “universal access to reproductive health by 2015” (p. 71-72). This started the groundwork for Millennium Development Goals in 2000, which worked to decrease maternal mortality rates and HIV/AIDS prevention.

Though those accomplishments are successes in the fight for universal access to contraceptives, Claeys (2010) briefly analyzes the counter arguments of promoting IPPF. This includes cultural differences internationally (for example, a higher concern in Africa about being infertile rather than pregnancy prevention) and the belief that ‘local people... provide the best response to local needs’ (p. 70). However, Claeys combats these claims by playing on the emotional and ethical appeals of her audience, proclaiming that “many governments... are still not valuing women's' lives” (p. 74) and that sexual right violations are continuing to occur due to lack of proper protection by people and organizations.

With Claeys (2010) being an employee of IPPF, there are numerous biases and opinions within the article. A person with the time and capabilities to write about an organization is likely to have ties within the organization; however, Claeys' includes how a major principle of the IPPF is that the implementation of practices should come from demands within the country, and that locals can provide better than outsiders. This counteracts the fact that as a business, their

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services will no longer be needed if local people have complete independence in relation to healthcare. However, it is clear in many ways, such as less reliance on donors, that a community having a successful, independent family planning system would be more beneficial than one dependent on international NGOs.

Not only is birth control security increased without outsourced family planning, but medical goods can also be provided for cheaper by the public sector. The concept that a state may provide better medical treatment than private corporations reappears in an article covering Sino-implant(II) by Tumlinson et al. (2011). Sino-implant(II) is a contraceptive implant which closely resembles that of other contraceptive implants, yet costs about 60% less than other implant methods (p. 88). This allows for states to pay for and provide this contraceptive without relying as heavily on donors.

Kenya receives a significant amount of donated contraceptives, and could benefit from less donor dependency and more birth control security. For this reason, Tumlinson et al. (2011) addresses this new technology in conjunction with Kenya and its family planning system. The authors discuss and analyze the idea that Sino-implant(II) could be a cost effective method for Kenyan women in comparison to birth control pills, IUDs, and other methods; they also look at the possibility that the cost of Sino-implant(II) could be self-sustaining in the public sector, for-profit sector, and not-for-profit sector.

The study included a sample size of 22 implant supplying facilities in Kenya. Eight of these facilities were public institutions, six were private, for-profit institutions, and eight were nonprofit institutions, affiliated with the International Planned Parenthood Federation. In the study, 293 contraceptive implant users were interviewed, the interview containing questions about why they choose the implant and how much the implant cost them (including the price of

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insertion and removal), and if they had been using the implant for six months or more. Out of the 293 implant users, 45% were from the public institutions, 13% were from the private-for-profit institutions, and 42% were from the private not-for-profit institutions. There was also an exit survey for those leaving the facilities of about 412 participants, which were interviewed about why they choose the method of birth control they did. It is important to note here that the contraceptive implants used in this case study were not Sino-Implant(II), for this implant had not been introduced into Kenya yet. However, similar implant products were used.

The studies and interviews conducted in 2007 outlined several findings. First, the self-reported median of prices for those with the implants from the public sector was US \$1.30, from the private for-profit sector was US \$13.30, and US \$20 in the private nonprofit sector. The removal of the implants followed a similar pattern, with the cost being US \$1.30 from public sources, US \$4.60 from private for-profit sources, and US \$17.30 from the nonprofit sector. The amount family planning donors were able to procure Sino-Implant(II) for was US \$8.00, allowing it to be cheaper than both the for-profit cost and not-for-profit cost of other implants.

This article offers a possible solution to medical cost recovery in Kenya. It also provides evidence that a state-run system may offer cheaper contraceptives than private and nonprofit companies. With a government medical system, sub-Saharan Africa could eliminate a private medical system. This way, intensive government control may insure ethical practices. Also, Sino-Implant(II) will not work for all women. Out of a sample of 412 women, only 6.5% of women choose a contraceptive implant, with the main leading factor being the fear of side effects, not excessive price. With a public system, alternate forms of contraceptives could be offered at reduced rates.

Negatives Effects of Contraception

Not all discussion on increased contraceptives in Africa is positive. The implementation of increased contraceptive access must be performed in a way which does not undermine the culture and beliefs of the people affected. However, it requires communication and compromise from both sides for the benefits of contraception as well as the beliefs of the people who would receive the healthcare improvements to be accepted. An example that illuminates the lack of communication and compromise is a 2017 interview with Obianuju Ekeocha. A BBC Worldwide News anchor interviewed pro-life activist Obianuju Ekeocha about her thoughts on access to birth control in Africa. Ekeocha professes that she finds increased access to contraceptives unnecessary, as well as a form of Western ideological colonization.

The BBC news anchor initiates the debate by claiming hundreds of millions of women do not have access to contraception, claiming access to birth control is a universal right. Ekeocha backfires, claiming that western groups offering abortion in Africa, an area where most people do not support abortion, is a form of ideological colonization. Ekeocha claims, "Contraception might be the tenth thing, if that..." on an African women's list of needs and desires. She believes instead women are asking for wood, food, water, and basic health care, so that should be the focus of foreign aid. Ekeocha also combats contraception implementation because of a lack of awareness towards their side effects.

The BBC interviewer suggests that contraceptive use can lead to the decrease of poverty, suggesting that women having access to a family planning program helps improve other factors in eliminating poverty. Speaking from experience as an African women who was able to get out of poverty, Ekeocha claims an unmet need for contraceptives is not the single indicator of poverty. In her own experience, education lead her out of poverty, and she believes Africans

need education rather than contraceptives to combat poverty.

Conclusion

Ekeocha's powerful interview straddled the viewpoints expressed in this article. While other articles stated how contraceptives empower women and cause more Africans to go to school, this video implies that contraception is demeaning African women and the focus of nonprofit aid is being turned away from education. Ekeocha portrays contraceptives as something most African women do not desire, and that its side effects are unknown and hurting African women.

A point of weakness for this viewpoint is Ekeocha's lack of sources for her answers. None of the examples and statistics she gives are backed up with evidence or in studies. The credibility of Ekeocha's claims are more rooted in the fact that she herself is an African woman who was born and raised in Africa. However, Dr. Abiba Longwe-Ngwira, co-author of, "The Impact of Family Planning on Primary School Enrollment in Sub-National Areas Within 25 African Countries", is also an African woman, yet believes in improving the sub-Saharan access to contraceptives (2013). Longwe-Ngwira's research also illuminates an increase in youth education opportunities when mothers use contraception.

But Ekeocha's point that Western beliefs of what is good and necessary can differ from African beliefs holds true. For example, Crissman, Adanu, and Harlow (2012) found that Muslim women in Ghana were less likely to use contraceptives, likely due to their belief system. Though contraception has many positive effects, the administration of medicine that is against one's faith would be a major injustice. For these reasons, while family planning should be equally accessible

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in the developing world as it is in developed countries, it should not be pressured on women who do not desire modern contraceptives.

There is overwhelming evidence of improved socioeconomics in sub-Saharan Africa through the implementation of contraception. These improvements are highly desirable, for they can improve the lives of millions of children, women, and families. However, they should be made accessible rather than forced, in order to not interfere with the beliefs of many African people. With the current structure of pharmaceutical companies, universal access to family planning is nearly impossible. However, by looking into more socialized medicine and the empowerment of women, better access to contraceptives may be attainable.

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