African Population and Health Research Center

Countdown to 2030
Women's Children's & Adolescent's Health

Contraceptive Discontinuation and the quest for Sustainable Family Planning Financing in West Africa

Summary

West Africa has made notable progress in expanding access to modern contraception, yet high levels of contraceptive discontinuation continue to undermine program effectiveness, financial sustainability, and women's reproductive autonomy. Despite steady increases in modern contraceptive prevalence (mCPR)—with Burkina Faso, Ghana, and Senegal reaching 25–30%—overall use remains modest, and unmet need for modern methods exceeds 20% in several countries. While unmet need has gradually declined since 2000, persistent gaps between demand and actual use signal structural weaknesses in service quality, method availability, and continuity of care.

Discontinuation within 12 months of contraceptive use remains alarmingly high across the region, ranging from 23% in Burkina Faso to over 60% in Guinea, with high rates also observed in Nigeria, Ghana, and Liberia. Short-acting methods—particularly injectables and pills—account for the majority of discontinuations, while long-acting reversible contraceptives (LARCs) demonstrate substantially higher continuation. Countries dominated by short-acting methods face repeated re-initiation, greater commodity waste, and higher service delivery costs, while contexts with stronger uptake of implants show improved satisfaction, continuity, and cost-efficiency.

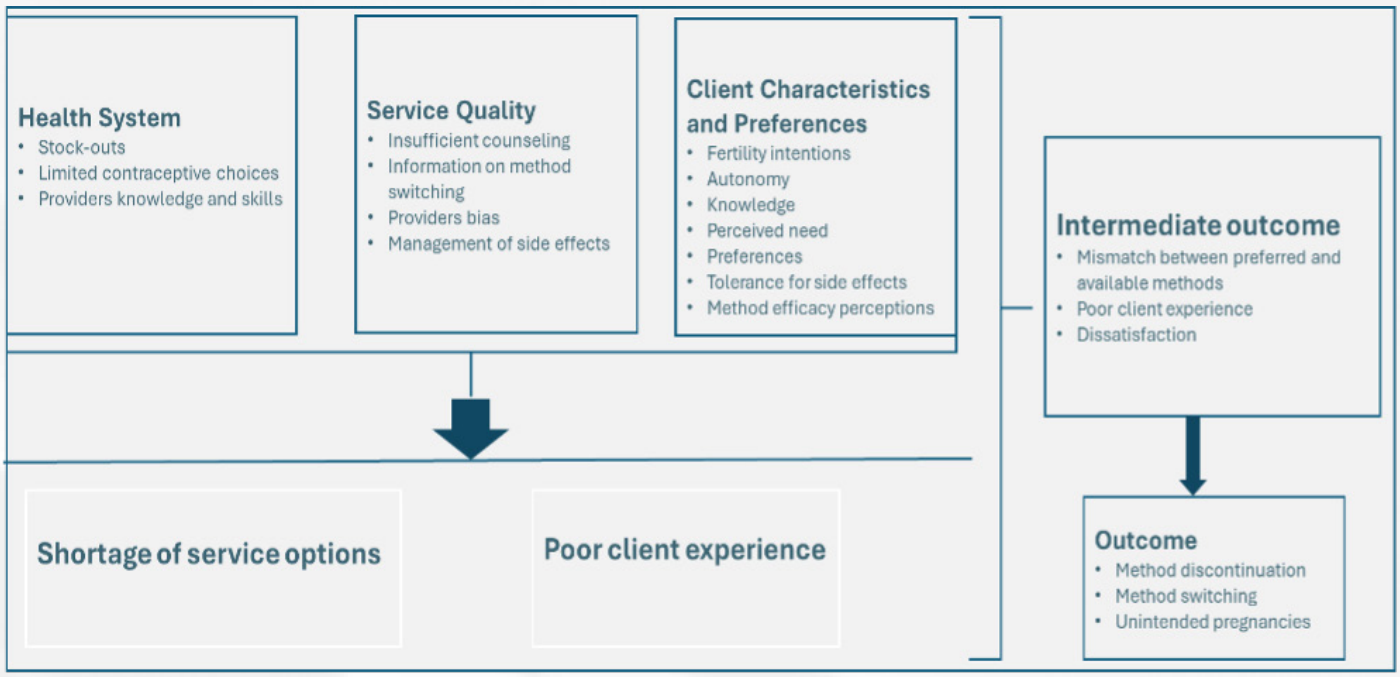
Reason-specific analysis reveals that side effects are the leading cause of discontinuation—exceeding one-third of instances in Guinea, Liberia, and Ghana. Other contributing factors include method failure, partner opposition, and access or cost barriers. These reasons point to systemic deficiencies in counseling, follow-up care, and male or community engagement. Financial realities compound these challenges. Domestic financing for family planning (FP) remains insufficient and uneven across the countries. Countries such as Côte d'Ivoire invest over US$5 per woman of reproductive age, while others—including Burkina Faso, Mauritania, and Sierra Leone—invest less than US$0.40, with Sierra Leone as low as US$0.15. Similarly, the share of domestic health spending devoted to FP ranges from 1.9% in Liberia to 0.10–0.12% in Burkina Faso, Mauritania, and Sierra Leone. These disparities highlight significant fiscal vulnerability and heavy reliance on external donors.

As global FP funding becomes more uncertain, countries with low domestic investment face heightened risks of stock-outs, service disruptions, and declining contraceptive use. Strengthening continuation through high-quality counseling, LARC availability, and responsive service delivery can improve cost-effectiveness—but these measures cannot fully compensate for chronic underinvestment. Sustainable progress requires deliberate increases in domestic financing, stronger supply chain systems, and improved quality of care. Addressing discontinuation is not only a public health priority but also a financial imperative: each episode of discontinuation represents wasted commodities, inefficiencies in service delivery, and reduced return on FP investments.

Introduction

Contraceptive use is inherently dynamic across the life course. Individuals start, stop, and switch methods for a variety of reasons throughout their reproductive years. For instance, a young woman may begin using contraception, discontinue to become pregnant, and later resume use—often with a different method. Others may stop due to side effects, limited access, partner opposition, or dissatisfaction with a method's characteristics (Figure 1). Some individuals experiment with multiple methods before finding one that best meets their needs (Figure 1).

Figure 1: Modern contraceptive discontinuation pathways



Across West Africa, fertility levels remain among the highest globally, with women having on average between four and six children. While total fertility has gradually declined over the past two decades—from above 6.0 births per woman in the early 2000s to around 4.8 today—the pace of change varies widely across countries (UNDESA, 2023). Modern contraceptive use among married women has increased but remains relatively low (ranging from 10% to 35%), and unmet need for modern methods continues to exceed 20% in many countries. These patterns reflect persistent barriers related to service quality, sociocultural norms, and limited financing, which together contribute to high discontinuation and method switching. Understanding these dynamics is thus essential for designing effective and sustainable family planning programs across the region.

These changing patterns of contraceptive behavior are captured through two key measures: method discontinuation—stopping a method for any reason—and method switching—transitioning from one method to another. Monitoring these dynamics is essential to understanding contraceptive use trajectories and ensuring that family planning programs effectively respond to users' evolving reproductive health needs.

High rates of contraceptive discontinuation signal weaknesses in family planning programs, reflecting situations in which women's reproductive rights are not fully realized—particularly when they do not receive adequate information or support to choose methods that best align with their preferences, needs, and circumstances. Beyond these rights-based implications, discontinuation carries substantial financial and programmatic costs. Repeated stopping and re-initiation increases service delivery expenditures through additional counseling, resupply visits, and wasted commodities, while diminishing the efficiency and long-term returns on family planning investments. For countries facing declining external assistance, understanding and reducing contraceptive discontinuation is therefore critical both to strengthen reproductive autonomy and to ensure the cost-effectiveness and sustainability of national FP programs.

Analyzing discontinuation patterns provides valuable insights into which methods are most frequently abandoned and the reasons behind these decisions, thereby informing strategies to improve method continuation, satisfaction, and sustained protection against unintended pregnancies.

Objectives

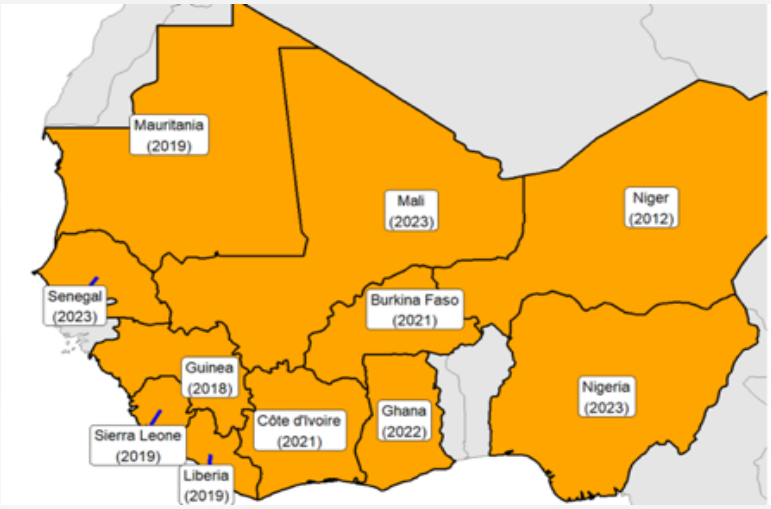
1. Measure and interpret contraceptive discontinuation patterns across diverse West and Central African contexts to identify which methods are most often discontinued and why.
2. Examine how discontinuation patterns relate to national method mix and program performance, highlighting opportunities to strengthen counseling, method choice, and quality of care.
3. Invest in robust data systems and implementation research to monitor service quality, equity, method continuation, and user experience—ensuring evidence-based decision-making and accountability in resource allocation.
4. Inform national and regional dialogue on sustainable FP financing, by linking evidence on discontinuation to policy actions that can optimize resource use, improve continuation rates, and reduce reliance on external funding.

Methods

This analysis focuses on 11 Countdown to 2030 (CD2030) countries in West Africa (Figure 2). We begin by examining the trends in modern contraceptive use and unmet need for family planning across West African countries. The study draws on women's contraceptive calendar data from the Demographic and Health Surveys (DHS) to estimate both method-specific and overall discontinuation rates. Employing a multi-state analytical framework, the analysis is based on 12-month episodes of contraceptive use, assessing the reasons for discontinuation, method switching, and duration of use.

We also examine the patterns and shifts in contraceptive method mix across countries to contextualize these discontinuation dynamics. The analysis of modern family planning discontinuation is based on the most recent Demographic and Health Survey (DHS) data available between 2012 and 2023 (Figure 2). Data on health sector expenditure was got from World Band repository, while data on Family Planning Financing was got from FP2030 repository.

Figure 2: West Africa – Recent Survey Years



Results

1. Overview

Beyond individual behavior, contraceptive discontinuation reflects deeper structural challenges in settings where investments in family planning access, counseling, and appropriate-use interventions remain limited. High discontinuation often signals unmet needs for quality information, method choice, and effective management of side effects—gaps that undermine women's ability to use contraception in ways that align with their preferences, life circumstances, and reproductive intentions. These programmatic shortcomings also have downstream implications for national FP performance, including increased unmet need for FP, wasted commodities, and slower progress toward national targets. Nevertheless, the core rationale for addressing discontinuation is to strengthen women-centred, rights-based FP services that support informed choice, satisfaction, and continuity of use.

When countries invest in improving access, counseling quality, and method availability, they not only better meet women's contraceptive needs but also generate broader societal benefits. High-quality, rights-based family planning services support women to plan and space births according to their preferences, which is associated with improved health, increased participation in education and the labor force, and enhanced household and national productivity. At the systems level, such investments also lead to more efficient and sustainable use of scarce FP resources by reducing unnecessary repeat visits, commodity wastage, and program

inefficiencies. These findings highlight the need to view discontinuation not only as a behavioral outcome but also as a financial and system performance indicator for countries seeking to strengthen domestic FP financing.

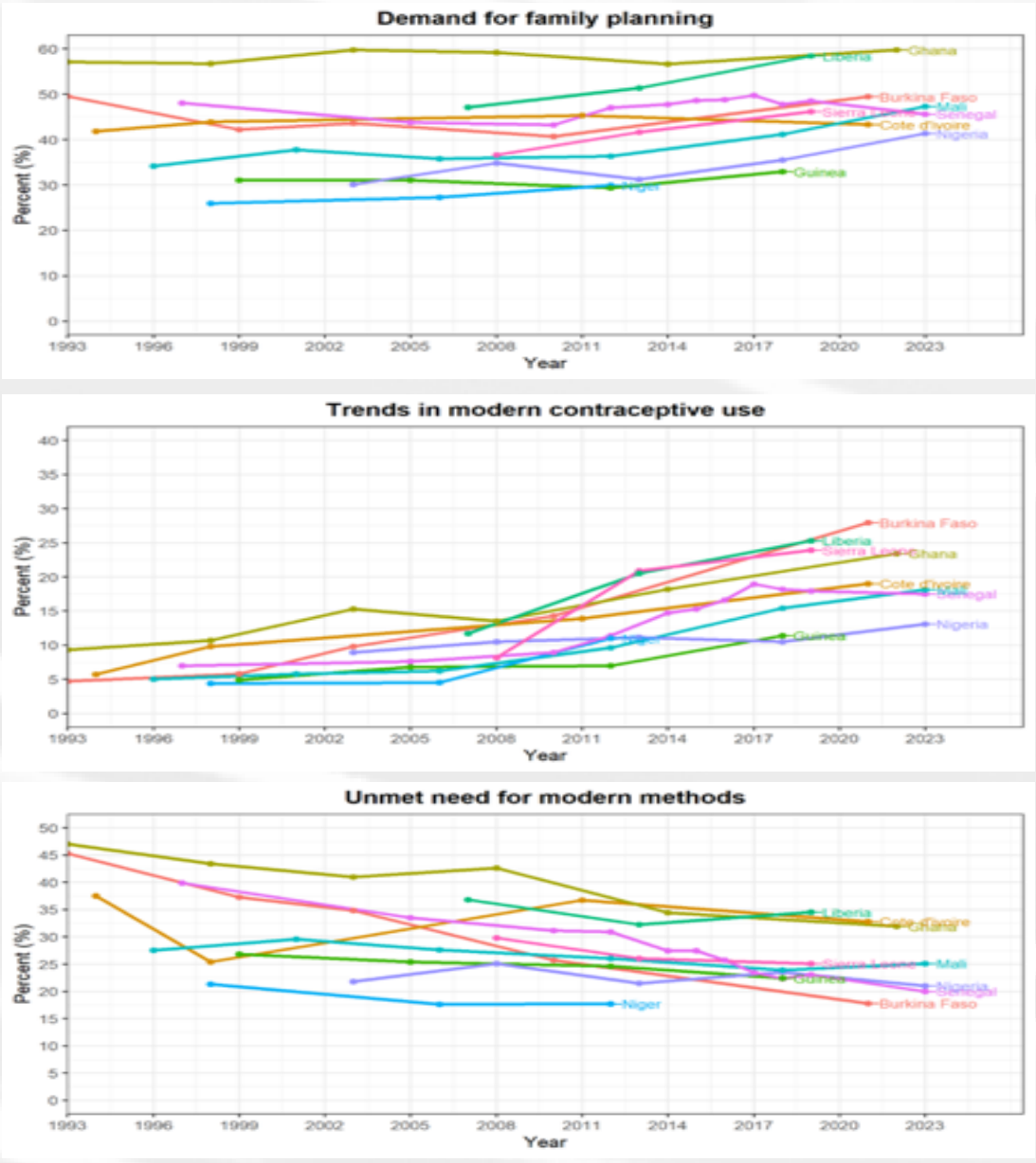
2. Trends in modern contraceptive use and unmet need

Across West African countries, the use of modern contraceptive methods among married women has shown a steady upward trend over the past two decades (Figure 3). The most notable increases were observed in Burkina Faso, Ghana, and Senegal, where modern contraceptive prevalence surpassed 25–30% in recent years. Moderate but consistent growth was also recorded in Liberia, Côte d'Ivoire, and Nigeria, while Mauritania, Guinea, and Niger experienced slower progress. Mali remains an outlier, with persistently low use of modern methods—below 10% even in the most recent surveys.

While these trends reflect overall progress, the uneven pace of growth suggests that some countries are struggling to maintain continuity and equity in service delivery—often linked to underfunded supply chains and limited outreach investments.

Despite these gains, unmet need for modern methods remains high, exceeding 20% in several countries. In 2000, unmet need levels were above 30% in most countries, with Liberia, Sierra Leone, and Burkina Faso among the highest. Over time, unmet need has declined gradually, though the pace of reduction varies. Persistent gaps between demand and use imply inefficiencies in both service coverage and financing allocation. Countries investing heavily in demand generation but underinvesting in continuity of use may see only marginal improvements in outcomes.

Figure 3: Trends in use and unmet need for modern contraceptive



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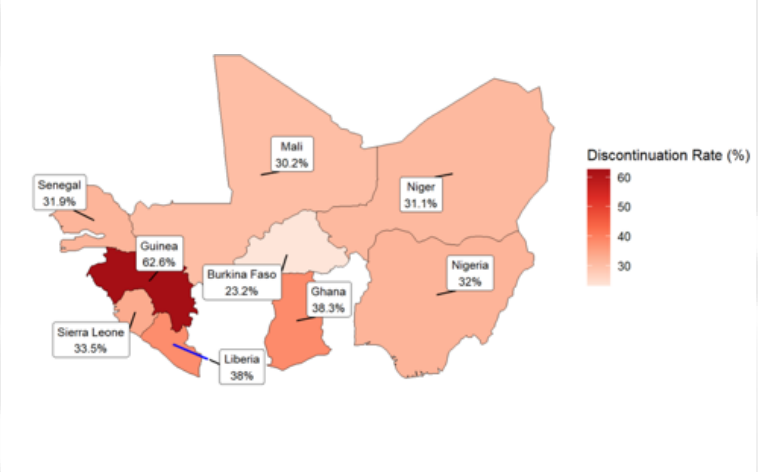
3. Contraceptive Discontinuation within 12 Months

The analysis of discontinuation within 12 months of contraceptive use reveals substantial variation across West African countries (Figure 4).

Discontinuation rates range from 23% in Burkina Faso to as high as 63% in Guinea, indicating wide disparities in method continuation and user satisfaction across the region. Countries with higher discontinuation rates— Guinea (62.6%), Nigeria (39.2%), Ghana (38.3%), and Liberia (38.0%) —may face increased financial inefficiencies, with resources mainly spent on initiation rather than sustained protection (Figure 4). In contrast, Burkina Faso (23.2%), Niger (31.1%), and Senegal (31.9%) exhibit comparatively lower discontinuation rates (Figure 4).

Programmatic implication: Maintaining continuity of use can reduce the cost per "effective user" of contraception, enhance predictability of commodity needs, and strengthen the case for domestic budget allocations to family planning.

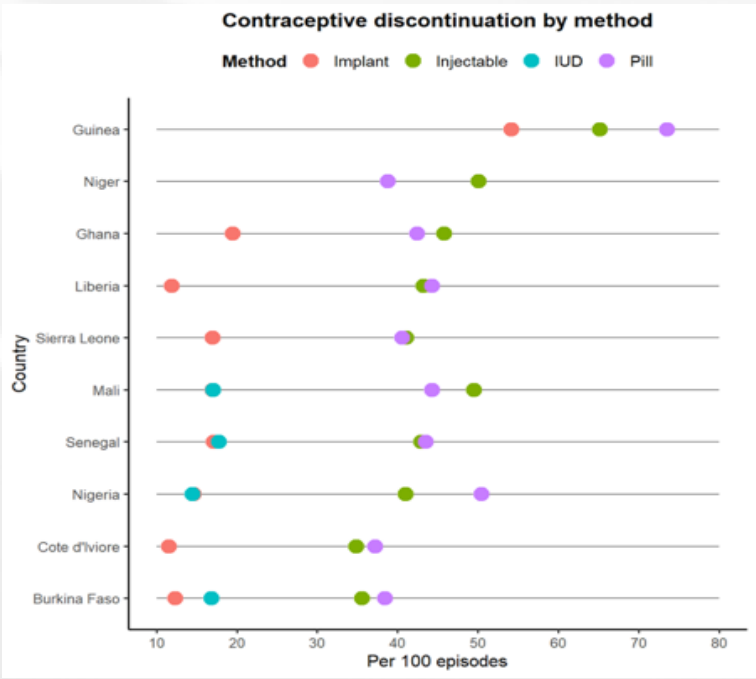
Figure 4: modern family planning discontinuation



4. Discontinuation by methods

Short-acting methods consistently show the highest discontinuation rates while long-acting methods such as the implant and IUD to have much lower discontinuation rates, frequently below 25.

Figure 5: Contraceptive discontinuation by method

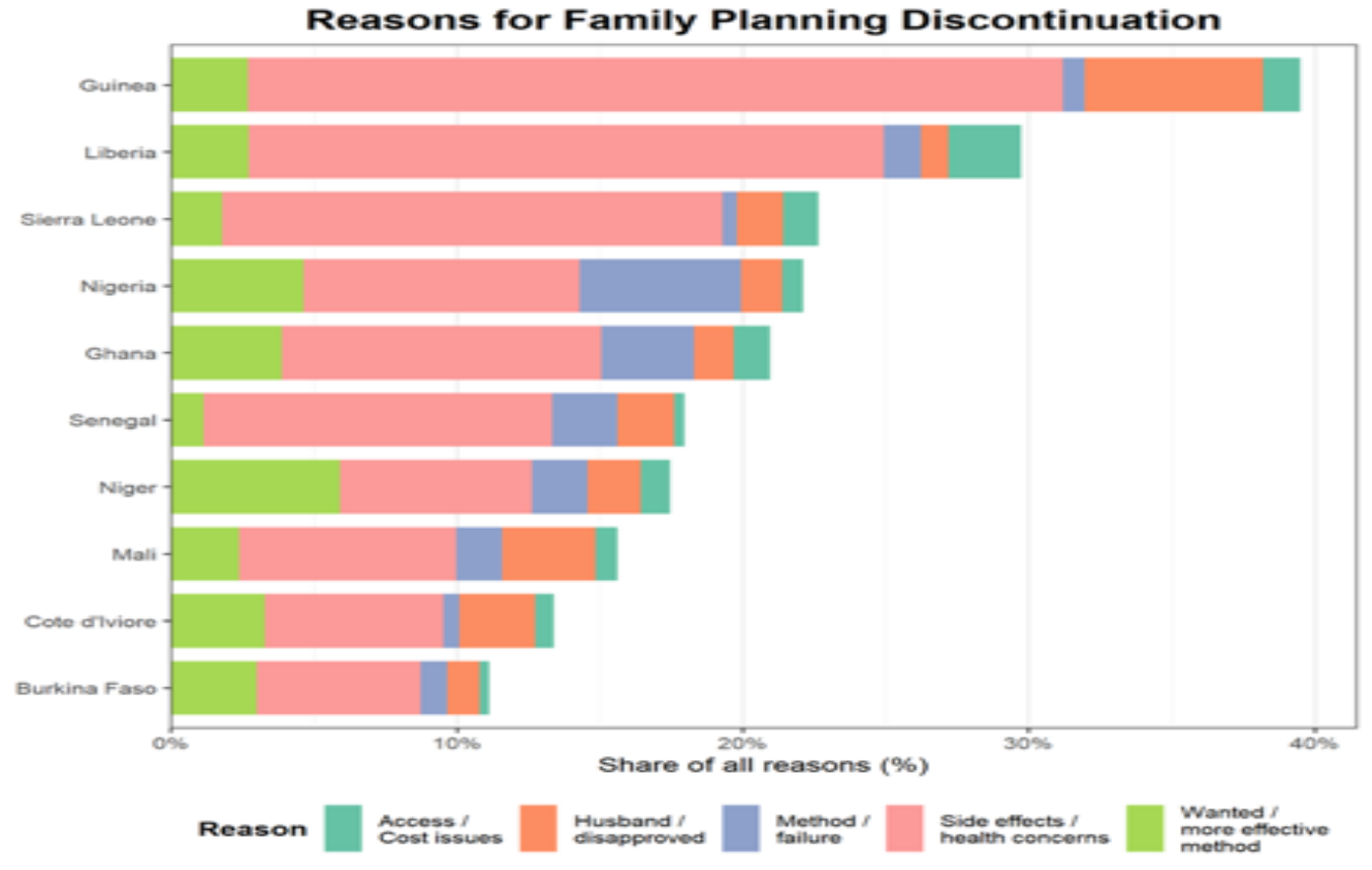


5. Reasons for Discontinuation and Financial Linkages

Across the region, method-related side effects emerge as the most frequently cited reason for discontinuation, especially in Guinea, Liberia, and Ghana, where over one-third of users stopped due to side effects (Figure 5). Other notable reasons include method failure, husband disapproval, and access or cost-related barriers, with varying prominence across countries. For example, Nigeria and Senegal report higher shares of discontinuation due to method failure, while Liberia and Côte d'Ivoire show greater sensitivity to partner opposition and access constraints (Figure 5).

This difference has clear financing implications: reliance on short-acting methods increases recurrent service delivery costs (repeat visits, commodity waste, and supervision needs), whereas investing in LARCs and sustained counseling offers greater cost-efficiency and longer-term coverage with fewer repeat expenditures.

Figure 6: Reasons for modern family planning discontinuations



Discontinuation rates exceeding 35%, as seen in more than half of the analyzed countries, underscore the need for programs to go beyond increasing uptake, focusing instead on ensuring sustained, informed, and satisfactory contraceptive use.

These behavioral and access-related drivers have budgetary implications:

- Method failure and side effects point to underinvestment in provider training and follow-up services.
- Access and cost barriers reflect funding gaps in outreach and equitable service delivery.
- Partner opposition and dissatisfaction signal missed opportunities for investing in community engagement and male involvement initiatives.

Financing takeaway: Targeted investments that address these root causes can significantly improve continuation rates and overall cost-effectiveness of FP programs.

6. Method Mix transitions and efficiency implications

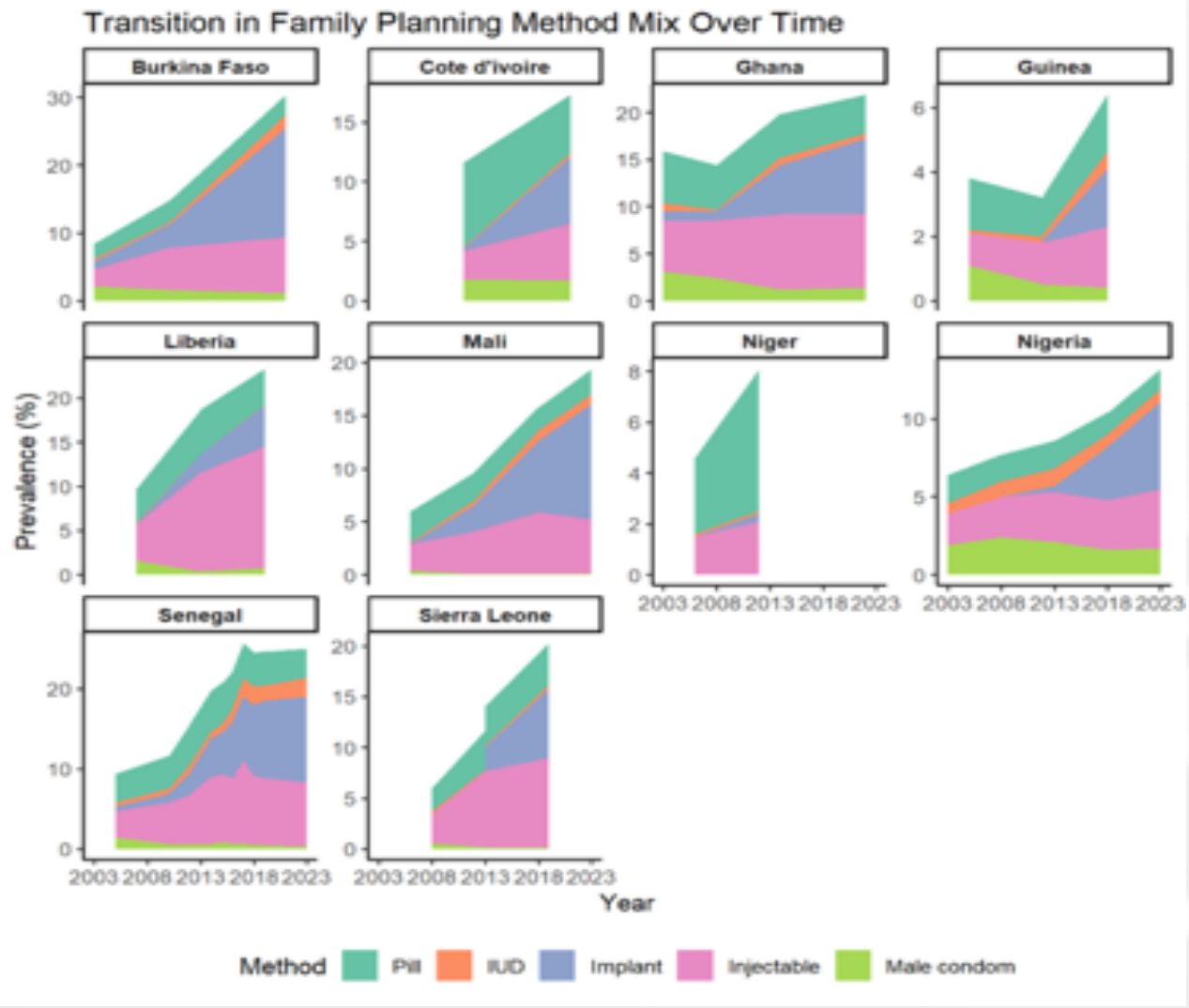
The changes in contraceptives method-mix over time (Figure 4) shows substantial shifts in contraceptive preferences across West African countries. Overall, there has been a steady diversification of modern methods, with notable increases in the use of implants and injectables, which now dominate the method mix in most countries. The use of the pill has either plateaued or declined, while IUDs and male condoms remain relatively low across the region. However, these methods mix dynamics are closely intertwined with the observed patterns of discontinuation.

Countries where injectables account for a large share of contraceptive use, such as Liberia, Sierra Leone, and Guinea, also exhibit the highest discontinuation rates, underscoring the cost of short-term protection. Each episode of discontinuation requires additional commodities, consultations, and counseling time, thereby increasing per-user costs.

Conversely, countries that have experienced greater uptake of long-acting methods such as implants (e.g., Burkina Faso, Ghana, and Senegal) tend to report lower discontinuation rates, suggesting that strategic investment in longer-term methods can improve both service quality and financial sustainability.

Policy message: Transitioning financing strategies toward reliable LARC procurement, provider capacity building, and quality counseling can yield high-impact, cost-efficient FP outcomes even amid declining external funding.

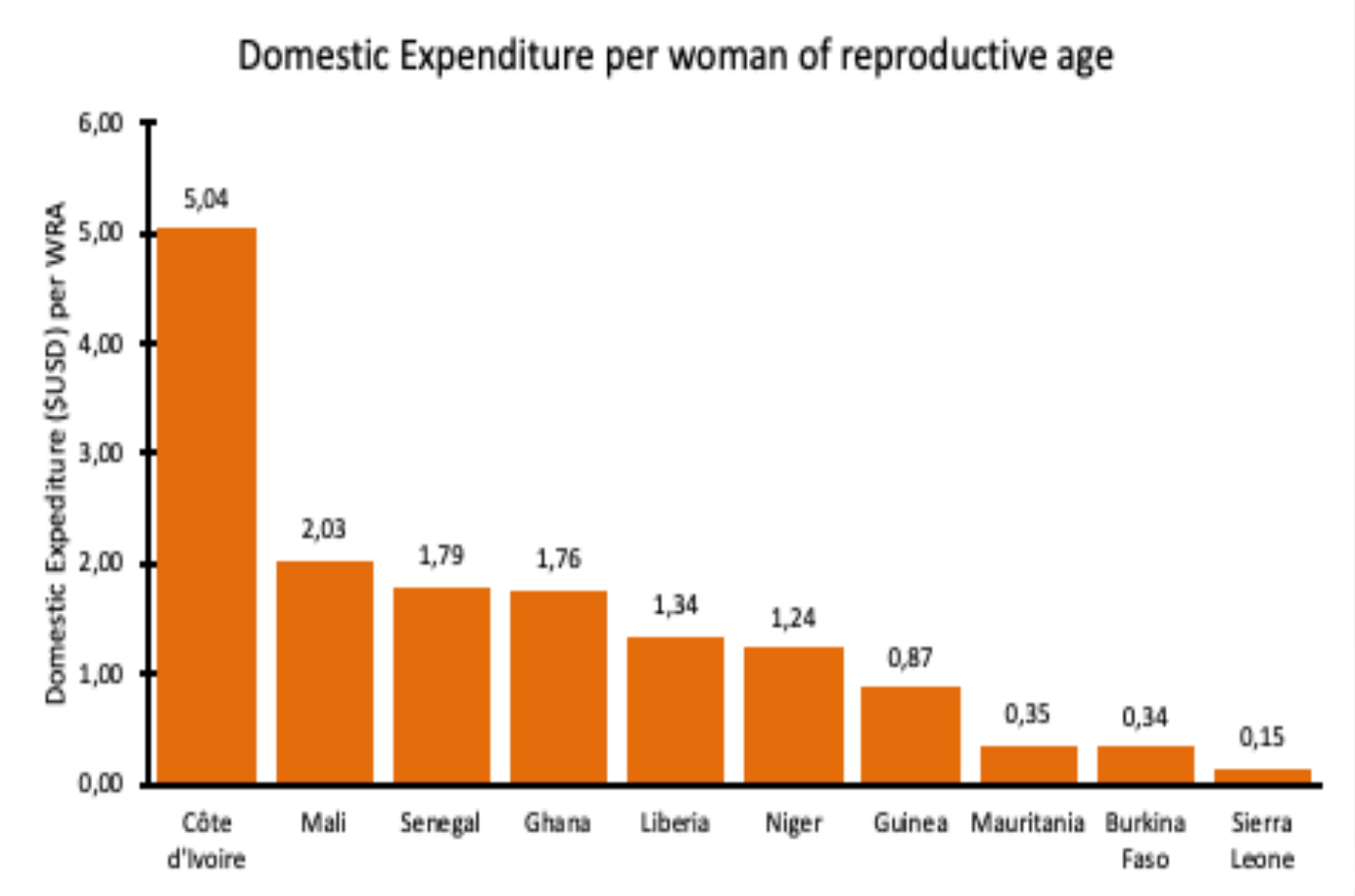
Figure 7: Method Mix transition



7. Domestic Expenditure

Domestic expenditure per woman of reproductive age varies substantially across countries, reflecting significant differences in government commitment to financing family planning (Figure 8). In 2021, Côte d'Ivoire demonstrated the highest domestic investment—spending approximately US$5.04 per woman aged 15–49—followed by Mali (US$2.03) and Senegal (US$1.79). Ghana and Liberia also showed moderate levels of government spending, at around US$1.76 and US$1.34 per woman, respectively. In contrast, several countries exhibited markedly low domestic allocations, including Niger (US$1.24), Guinea (US$0.87), Mauritania (US$0.35), Burkina Faso (US$0.34), and Sierra Leone (US$0.15).

Figure 8: Domestic expenditure per woman of reproductive age

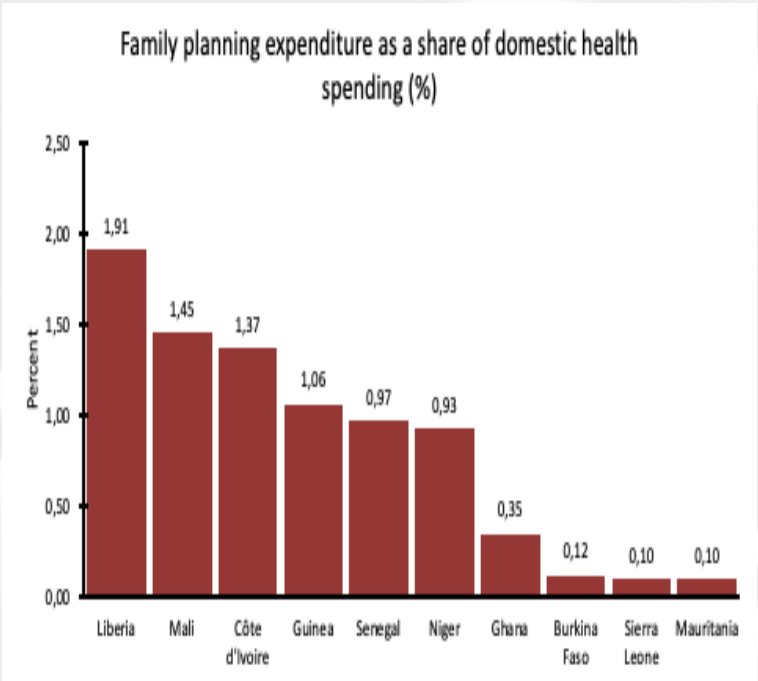


8. Domestic Expenditure

There is substantial variation in how much domestic health spending is allocated to family planning (FP) across the examined West African countries (Figure 9). Liberia allocates the highest share of its domestic health expenditure to FP (1.91%), followed by Mali (1.45%), Côte d'Ivoire (1.37%), Guinea (1.06%), Senegal (0.97%), and Niger (0.93%). These countries appear to prioritize FP relatively more within their limited health budgets. In contrast, Ghana (0.35%), Burkina Faso (0.12%), Sierra Leone (0.10%), and Mauritania (0.10%) allocate a markedly smaller proportion of their domestic health resources to FP. This suggests comparatively lower domestic prioritization of FP within national health financing structures. Despite generally low levels of FP spending across the region, the magnitude of differences—ranging almost 20-fold between Liberia and Mauritania—points to profound heterogeneity in policy emphasis, fiscal space, and the degree of reliance on external donor financing. Countries allocating a very small share may depend heavily on donors or may not yet have integrated FP as a core component of their domestic health agenda.

These disparities highlight persistent gaps in domestic financing for family planning across the region, with implications for the availability of commodities, the quality of services, and the sustainability of national FP programs as external donor support declines.

Figure 9: Family planning expenditure as a share of national health spending



Conclusions

The findings demonstrate that although modern contraceptive use has risen across the region over the past two decades, discontinuation remains a major and costly challenge. The composition of the method mix plays a decisive role in shaping these patterns.

Countries whose method mix is dominated by short-acting methods—particularly injectables and pills—face higher turnover and discontinuation, often driven by unmanaged side effects, stock-outs, weak counseling, and limited support for switching or continued use. In contrast, settings with greater uptake of long-acting reversible contraceptives (LARCs), especially implants, tend to exhibit lower discontinuation and stronger continuity of use, reflecting higher client satisfaction and more efficient use of program resources.

Reducing discontinuation is both a public health imperative and a strategic financing priority. Each episode of discontinuation represents a loss of earlier investments in commodities, service delivery, demand generation, and human resources. Yet many of its drivers—stock-outs, weak counseling capacity, limited method choice, and data gaps—are rooted in systemic underinvestment and chronic dependence on external financing, rather than isolated operational failures.

In countries with low domestic FP funding—especially amid global financing disruptions—this reliance on external partners leaves programs highly vulnerable to stock-outs, service gaps, and declines in modern contraceptive use if discontinuation remains high. Strengthening continuation is a critical, cost-saving strategy that helps safeguard service coverage under fiscal constraints, but it cannot fully compensate for chronic underinvestment. There is an urgent need to progressively increase domestic financing for FP to protect essential services, ensure commodity security, and reduce exposure to external funding shocks.

Stronger domestic financing systems and higher national allocations for FP are therefore essential to secure service continuity, improve cost-effectiveness, and build more resilient FP programs. By advancing both programmatic improvements to support continuation and financial reforms to reduce funding vulnerability, countries will be better positioned to accelerate progress toward FP2030 commitments, UHC, and SDG 3.7, while safeguarding the reproductive autonomy and wellbeing of women and couples.

Key Recommendations

1•Increase domestic financing and strategically leverage partner resources to ensure reliable procurement and distribution of contraceptive commodities—particularly long-acting reversible contraceptives (LARCs)—and to protect service continuity amid global funding disruptions.

2•Invest in human resources and continuous capacity-building to improve client-centered counseling, proactive side-effect management, and method-switching support, thereby reducing discontinuation and enhancing overall service quality.

3•Institutionalize sustainable and ring-fenced FP budget lines at national and subnational levels to reduce dependence on external aid, enhance predictability in financing, and enable long-term planning for FP commodities and services.

4• Strengthen supply chain systems through digital logistics monitoring, improved quantification, and performance-based financing mechanisms to prevent stock-outs, reduce commodity wastage, and ensure timely availability of a diverse method mix.

5• Support community engagement and male involvement initiatives to address sociocultural norms, misconceptions, and gender dynamics that contribute to discontinuation, switching, and underuse of FP services.

6• Invest in robust data systems and implementation research to monitor service quality, equity, method continuation, and user experience—ensuring evidence-based decision-making and accountability in resource allocation..