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# Male Hormonal Contraceptives in Comprehensive Family Planning: Policy and Implementation Pathways to Advance Equity in Reproductive Rights

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## Abstract

Male contraceptive options remain largely limited to condoms and vasectomy, while family planning services and monitoring indicators often prioritize women, contributing to inequities in contraceptive responsibility. This review examines how future male hormonal contraceptives (MHCs) could support more equitable, rights-based family planning, and what policy and implementation pathways are needed for responsible integration. We conducted a narrative synthesis of peer-reviewed studies and policy/advocacy guidance on male engagement in family planning and on MHC development (searches in PubMed/Scopus/Google Scholar and key organizational sources; 2000–May 2025), focusing on acceptability, service-delivery readiness, governance, and potential system impacts. Evidence indicates substantial interest in MHCs among men and women in hypothetical studies and trials, but highlights persistent barriers: gender norms, limited routine sex-disaggregated data on men's participation, provider and service constraints, and insufficient public/private investment. Model-based analyses suggest that novel, reversible male methods could avert unintended pregnancies (with larger effects in settings with lower baseline contraceptive uptake) and that preventing unintended pregnancies can yield cost savings to health systems. Ethical discussions increasingly emphasize a dyadic perspective on risk and decision-making, alongside safeguards for autonomy and rights. We conclude that coordinated policy action—linking regulation, financing, service delivery, communication, and monitoring—is needed to expand couple-focused counselling, reduce stereotyping in care, strengthen indicators, and accelerate implementation pathways for MHCs while safeguarding women's options and agency.

**Keywords:** male hormonal contraceptives; family planning; equity; reproductive rights



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## 1. Introduction

For generations, effective contraception that can be initiated by men (and other people who produce sperm) has been largely limited to two options: condoms or vasectomy [1].

Because vasectomy is typically intended as permanent contraception, condoms remain the only widely available male-controlled method that is non-permanent and immediately reversible when used correctly. In contrast, women and other people who can become pregnant can choose from a wider range of reversible contraceptive methods [2,3]. The unmet need for contraception remains high [4–6]. This inequity is shaped by population growth, limited availability of comprehensive family planning services, and the scarcity of contraceptive methods for people who produce sperm [7]. Consequently, many family planning programmes have been designed primarily to serve women and other people who can become pregnant [5,8,9]. Pregnancy—whether intended or unintended—typically involves at least one partner who produces sperm and one partner who can become pregnant, yet global monitoring frameworks often capture contraceptive use only among women [10]. For example, United Nations reporting on global contraceptive use and family planning indicators commonly relies on measures such as the "Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern method" [8]. Although sex-disaggregated reporting is recommended [11,12], many institutions continue to rely predominantly on women-centred indicators [8,13]. This practice limits the visibility of men and other people who produce sperm in family-planning data and discourse, reinforcing inequities in access to information, services, and shared contraceptive responsibility.

These global measurement choices matter because international indicators and guidance inform national family planning strategies, procurement decisions, service packages, and training priorities. When men and other people who produce sperm are not routinely captured in monitoring frameworks, their needs remain less visible in policy agendas and in service delivery—reinforcing a cycle where family planning continues to be treated as primarily a "women-only" domain.

In this paper, we use policy to refer to formal commitments and governance mechanisms (e.g., laws, national strategies, budgets, accountability and monitoring requirements). We use implementation strategies to refer to the practical programmatic approaches that operationalize those policies (e.g., service-delivery channels, provider training, communication campaigns, and monitoring tools).

Men can play three roles in family planning: (a) clients and beneficiaries, by receiving methods or counselling on male-controlled methods; (b) supportive partners, by communicating and negotiating contraceptive use; and (c) agents of change, by advocating for policy reforms and gender equality to improve sexual health outcomes for all [14]. In many settings, contraceptive use and family planning participation are constrained by gender norms and religious influences [4,15–18]. In some regions, men frequently act as key decision-makers regarding whether contraceptive methods are used by women and other people who can become pregnant [19,20], whereas in other contexts men may reject involvement in family-planning decisions altogether [17]. Where people who can become pregnant face limited bodily autonomy and restricted access to information and services, the burden of contraception can fall disproportionately on them, undermining informed and empowered decision-making.

*Terminology Note*

We distinguish sex (biological attributes) from gender (social roles/identities). When discussing biological mechanisms of contraception and clinical eligibility, we use capacity-based language (e.g., "people who produce sperm," "people who can become pregnant"). When discussing social norms, roles, and policy engagement, we use gendered terms (e.g., "men," "women") consistent with the constructs in the cited evidence. We recognize that trans and non-binary people may produce sperm or become pregnant; implementation

and monitoring recommendations should therefore be inclusive of diverse gender identities while still enabling clinically meaningful sex-disaggregated reporting where relevant. In monitoring systems, we recommend capacity- and service-use indicators that are inclusive of gender diversity, alongside sex-disaggregated reporting where clinically relevant, to maintain clinical interpretability without erasing trans and non-binary users.

## 2. Methods

This article is a narrative review with a structured search and document-analysis approach. We aimed to synthesize evidence and policy guidance relevant to (i) men's engagement in family planning (FP) and (ii) the development and prospective introduction of male hormonal contraceptives (MHCs), with an emphasis on implementation, equity, and rights-based policy considerations.

### *2.1. Design and Scope*

Given the diversity of evidence relevant to MHCs and men's engagement (e.g., trial acceptability reports, qualitative and survey research, ethical analyses, modelling studies, and implementation/policy guidance), we used thematic synthesis rather than meta-analysis. The review focused on implementation-relevant domains, including acceptability and social drivers, service readiness and delivery channels, governance and regulatory issues, market and financing barriers, monitoring indicators, and potential unintended consequences for women's access and autonomy.

### *2.2. Information Sources*

We searched peer-reviewed literature in PubMed and Scopus. To capture interdisciplinary contributions (e.g., ethics, health policy, and gender studies) and recent working papers, we complemented database searches with Google Scholar. We also reviewed grey literature and technical guidance from major sexual and reproductive health (SRH) organizations, as these sources frequently describe programme models, monitoring frameworks, and policy recommendations not consistently indexed in bibliographic databases.

### *2.3. Search Strategy*

Searches covered January 2000 to May 2025. We combined keywords and, where applicable, controlled vocabulary related to male contraception and FP implementation. Core concepts included: (1) male contraception ("male contraception", "male hormonal contraception", "androgen", "progestin", "testosterone", "contraceptive injection/gel/implant"); (2) FP and SRH service delivery ("family planning", "contraception services", "counselling", "service delivery", "primary care", "sexual health clinic", "STI services"); (3) uptake and social determinants ("acceptability", "attitudes", "masculinity", "gender norms", "couple dynamics", "trust"); and (4) policy/implementation ("policy", "governance", "regulation", "financing", "market", "pharmacovigilance", "monitoring indicators", "equity", "reproductive rights"). Reference lists of key papers were screened, and forward citation checking was used selectively.

### *2.4. Eligibility Criteria*

We included: peer-reviewed reviews and primary studies (qualitative, quantitative, and mixed-methods); clinical publications reporting acceptability, discontinuation, or user experience relevant to implementation; modelling studies addressing potential population impact or health-system implications; and policy, programme, or advocacy documents discussing men's engagement in FP, implementation considerations for male methods, monitoring/accountability, and equity or rights-based frameworks. We excluded sources focused solely on basic science/pharmacology without a clear link to implemen-

tation or contraceptive responsibility, and materials not relevant to FP delivery, equity, or policy pathways.

### *2.5. Study Selection and Data Charting*

Sources were screened for relevance to the review questions. For each included item, we charted publication type, setting/population (when applicable), method or policy focus, and key findings related to: (a) acceptability and social drivers; (b) service delivery and health-system readiness; (c) governance/regulatory and market barriers; and (d) monitoring and equity implications. Where evidence was context-specific, we retained key contextual descriptors (e.g., baseline contraceptive prevalence, service-delivery platform, or target population) to avoid overgeneralization.

### *2.6. Synthesis Approach*

Findings were synthesized thematically to map heterogeneous evidence to implementation-relevant domains. Where modelling studies reported quantified projections, we treated estimates as scenario- and context-dependent and interpreted them alongside key assumptions (e.g., uptake, switching, and continuation), rather than as uniform "global effects".

### *2.7. Quality Considerations and Limitations of the Approach*

We did not conduct a formal risk-of-bias appraisal because the review integrates diverse evidence types to inform implementation and policy rather than estimate a pooled effect size. Instead, we interpreted findings cautiously—particularly where evidence was hypothetical, limited, or setting-specific—and triangulated across empirical studies and organizational guidance where possible. As real-world MHC introduction remains emergent, evidence on service delivery, continuation, and long-term outcomes is necessarily limited.

## 3. Results

### *3.1. How to Include Men in the Discourse on Contraceptive Responsibility Comprehensively?*

Three complementary strategies can strengthen men's engagement in family planning (FP). First, FP and contraceptive services need to provide high-quality, accessible, and acceptable care for men and other people who produce sperm [14]. In practical terms, "accessible and acceptable" care for men today typically means: clear entry points (primary care/family medicine, sexual health/STI services, community clinics, and in some settings pharmacies), confidential and stigma-free counselling, convenient opening hours, and providers trained to offer non-judgmental, rights-based information to men regardless of age, marital status, or parity. At present, men's contact points often focus on condoms and STI testing; expanding acceptability requires integrating counselling on shared contraceptive responsibility, couple communication, and referral pathways for additional methods. As MHCs become available, services will also need protocols for eligibility assessment, follow-up for side effects and adherence, guidance on reversibility timelines, and pharmacovigilance reporting—so that men can be supported as contraceptive users with the same standards of quality and informed choice expected across family planning. Second, programmes can foster men's role as supportive partners by promoting shared responsibility for contraceptive decision-making, prevention of sexually transmitted infections (STIs), and caregiving, including parenting responsibilities [14]. Third, men can be engaged as agents of change by advancing gender equality; promoting gender-equitable parenthood; supporting advocacy for non-discriminatory sexual and reproductive health laws and policies; and challenging gender norms that sustain inequality [14,15]. Despite clear guidance, these principles are often not implemented in national health policies, and only isolated initiatives have meaningfully involved men as agents of change [21]. Progress

is further limited by the lack of indicators and routine data capturing men's participation in FP [8,21], which restricts monitoring, quality improvement, and accountability.

Several organizations, including the World Health Organization, have published advocacy tools to support male participation in FP programmes [22–24]. A 2019 analysis indicated that household power dynamics shaping couples' contraceptive decisions become visible, and therefore actionable, when FP services adopt gender-sensitive measures [21]. Women's empowerment may be constrained when men and boys are not engaged as equally responsible partners in pregnancy prevention and contraceptive decision-making [14].

Service delivery can be expanded in settings that already provide condoms and STI testing by adding counselling on the full range of contraceptive options and shared responsibility, tailored to men and other people who produce sperm [25]. More broadly, FP and contraception should not be framed as women-only issues; this shift can be reinforced through comprehensive, gender-inclusive sexuality education. Early engagement of men and boys as FP/STI service users may also build readiness for the future integration of MHCs [26]. Evidence suggests that many men prefer receiving contraceptive counselling from their family doctor [15,25]. At the same time, studies report that, in some contexts, providers may restrict or steer FP options based on stereotypes about who is "appropriate" to use them [27–29]. When MHC become available, they should be offered alongside other methods to all eligible FP service users regardless of marital status within a non-judgmental, rights-based counselling approach.

Hormonal approaches to male contraception include oral, injectable, implant, and transdermal methods [30]. Across hypothetical studies and clinical trials, MHCs have been reported as acceptable to many women and men [31–40]. Market-demand estimates suggest a potential uptake comparable to that of several currently used female methods [41]. However, the National Institute of Child Health and Human Development and academic institutions currently provide more than 75% of funding for male contraceptive development [10], and limited investment from governments and the pharmaceutical industry continues to slow progress [10]. Policymakers can accelerate development by supporting sustained funding and clear implementation pathways for state-of-the-art male contraceptives.

Although this review focuses on male hormonal contraceptives, nonhormonal approaches are also advancing and may appeal to users who prefer to avoid systemic hormones. We emphasize MHC here because they are among the most clinically advanced novel, reversible male methods and therefore the most likely to raise near-term implementation and regulatory questions. Nevertheless, policy planning should anticipate that public perceptions may differ for hormonal versus nonhormonal methods (e.g., concerns about mood, libido, or metabolic effects for hormonal agents), which has implications for counselling, demand generation, and trust. A balanced policy agenda should therefore support both hormonal and nonhormonal development pipelines while preparing services for the first methods likely to reach the market.

Taken together, these service and education reforms create the social and health-system conditions needed for the effective introduction of male hormonal contraceptives (MHCs). Beyond implementation readiness, MHCs also have clear implications for reproductive health policy agendas in terms of equity, costs, accountability, and rights-based family planning.

### *3.2. How Would the Inclusion of MHCs Benefit Reproductive Health Policy Agendas?*

Building on these implementation priorities, the inclusion of MHCs in method mixes and FP strategies could strengthen reproductive health policy agendas in at least three

domains: population-level impact (e.g., unintended pregnancy reduction), health-system efficiency, and reproductive-rights equity.

Model-based analyses suggest that introducing novel, reversible male methods could avert unintended pregnancies, with estimates reaching approximately 30–40% under scenarios where uptake is substantial and baseline contraceptive use is comparatively low. Importantly, these figures are not uniform "global effects": they depend on modelling assumptions (e.g., method effectiveness, uptake, switching from other methods, and continuation/adherence) and on the population context. For example, modelling work comparing settings such as Nigeria, South Africa, and the United States illustrates that potential impact varies by baseline contraceptive coverage and patterns of method use [42]. In parallel, nonhormonal male contraceptive approaches are also advancing and may broaden choice for users who prefer to avoid systemic hormones [43]. From a health-system perspective, preventing unintended pregnancies can reduce downstream costs (e.g., pregnancy-related care), and economic discussions in the male-contraception literature often frame cost-effectiveness in terms of avoided healthcare costs and programme efficiencies, while acknowledging that results depend on the analytic perspective and assumptions [44].

From a health-system and policy perspective, averting unintended pregnancies may reduce downstream pregnancy-related care costs and improve allocation of FP resources; available economic analyses suggest that increasing male contraceptive use can be cost-effective in at-risk populations, while noting that results depend on modelling assumptions and analytic perspective [44]. Over time, broader access to male methods could also contribute to narrowing global health disparities by expanding the set of feasible contraceptive strategies across settings where women and other people who can become pregnant face constrained access, limited autonomy, or method-related side effects. Nevertheless, men's inclusion in FP remains marginal within many policy agendas, indicating a persistent implementation gap between guidance and practice [21].

A central policy challenge is that acceptability and uptake are not driven by biomedical performance alone. Peterson and colleagues highlight the importance of socially shaped perceptions that motivate men's interest in MHCs, implying that policy planning should address cultural norms, masculinity expectations, trust in health systems, and couple dynamics as determinants of real-world adoption [45]. Without attending to these "social drivers," even clinically effective methods may fail to achieve population impact. Therefore, the inclusion of MHCs should be framed not only as product introduction, but as a system-level intervention that reshapes responsibility, services, communication, and monitoring.

Policy readiness also requires explicit attention to trade-offs, safety, and governance. As with female hormonal methods, investigational male hormonal regimens may be associated with side effects in a subset of users (e.g., weight changes, mood symptoms, libido changes), and real-world continuation and adherence will shape effectiveness and acceptability. Regulatory pathways will need to define acceptable contraceptive failure rates, safety margins, and evidentiary expectations (including longer-term follow-up), alongside post-marketing surveillance and pharmacovigilance once products are introduced. These requirements should be paired with programmatic mitigation strategies: informed-consent procedures, clear guidance for managing adverse effects, referral pathways, and monitoring systems that detect inequities or unintended harms.

Safeguards should explicitly address the risk of reproductive coercion and intimate partner violence; counselling should include privacy-sensitive assessment, voluntary choice, and clear referral pathways where violence or coercion is disclosed or suspected.

Risk–benefit evaluation further illustrates why MHCs require a distinct policy lens. Because people who use MHCs do not bear the physiological risk of pregnancy, contraceptive risks are often assessed in a strictly individualistic way. However, in heterosexual

relationships, this framing can be incomplete. A dyadic perspective has been proposed in which benefits and harms are evaluated for both partners, acknowledging that pregnancy risk and many contraceptive consequences are shared within the relationship [46]. In this framework, "shared risk" refers to the combined risks to both members of a sexual dyad associated with contraceptive use by one or both partners, compared against the risk of unintended pregnancy for the dyad as a whole [47]. This conceptual shift matters for policy because it supports rights-based counselling and decision-making models that recognize mutual responsibility and the relational context in which contraception occurs.

As commercially available MHCs move closer to reality, policymakers and advocates have also raised concerns about possible unintended consequences—particularly whether introducing MHCs could divert resources, attention, or autonomy from women [21,44,46]. These concerns should be treated as governance questions rather than reasons for exclusion. Importantly, experts involved in developing new male hormonal contraceptives argue that, if the objective is to advance women's empowerment, policy agendas must explicitly include men and boys as equally responsible partners in pregnancy prevention and FP decision-making [44]. In other words, the policy goal is not substitution of women's methods, but expansion of options and rebalancing of responsibility, while safeguarding women's access, agency, and service quality.

Finally, policy design and accountability mechanisms determine whether these agendas translate into practice. Clear laws, budgets, and programme commitments enable public scrutiny when activities are not implemented or when promised resources are not allocated [14]. A supportive environment for men's constructive participation in sexual, reproductive, and family life should therefore be framed as a rights-based commitment to equity in reproductive health and shared contraceptive responsibility, with explicit implementation pathways and measurable indicators.

## Policy Implications and Implementation Priorities

To operationalize MHC inclusion within reproductive health policy agendas, the following actions are particularly relevant:

Table 1 summarizes priority implementation domains, responsible actors, and illustrative indicators to operationalize coordinated policy action for MHC integration while safeguarding rights-based FP principles.

**Table 1.** Operational priorities for responsible integration of male hormonal contraceptives (MHCs) in comprehensive family planning (FP).

| Action (What) | Responsible Actor/Level (Who) | Example Measurable Indicator (How Much) | Means of Verification (Where) |
|---|---|---|---|
| Include men's FP participation and MHC preparedness in national FP strategies with timelines [14,21] | MoH + National FP coordinating unit | Strategy includes objectives/timelines/responsible agencies and a budget line (Yes/No); implementation/expenditure report published annually (Yes/No) | Published national FP strategy; annual operational plans |
| Equity safeguards so MHC complements (not replaces) women's options [21,44,46] | MoH + procurement agencies + donors | No reduction in women's method availability or counselling quality after pilot introduction | Stock records; method mix monitoring; quality audits |
| Define service-delivery channels for men (primary care, SRH/STI clinics, pharmacies, urology) and referral pathways [14,45] | MoH service delivery directorate; regional health authorities | % of FP/SRH sites offering male-inclusive counselling package | Facility service package list; supervision reports |
| Provider training and minimum competencies for non-judgmental, rights-based counselling (including informed consent, side-effect management, and referral pathways) [14,45] | Training institutions; professional associations | % of providers trained; competency assessment pass rate | Training registers; pre/post assessments |

**Table 1.** *Cont.*

| Action (What) | Responsible Actor/Level (Who) | Example Measurable Indicator (How Much) | Means of Verification (Where) |
|---|---|---|---|
| Demand generation grounded in social drivers (including trust and couple dynamics) [45] | MoH + public health communication units | Reach of campaign; change in knowledge/attitudes indicators | Campaign analytics; surveys |
| Risk communication using a dyadic frame (including "shared risk" where appropriate) [46,47] | MoH guideline unit; ethics boards | % of users receiving standardized counselling + consent | Chart audits; counselling checklists |
| Regulatory readiness: guidance on efficacy thresholds, safety reporting, and pharmacovigilance | National medicines regulator | Pharmacovigilance protocol approved; reporting rate | Regulatory guidance; PV database |
| Measurement and indicators: strengthen routine data systems to capture men's FP participation and method use (sex-disaggregated where relevant) [21] | HMIS unit; national statistics offices | % of FP reports containing male indicators | HMIS dashboards; annual FP reports |

Note: Coordinated policy action refers to a defined national coordinating mechanism (e.g., an FP technical working group chaired by the MoH with participation of regulators, implementers, and civil society) with published responsibilities, timelines, and reporting requirements. Health Management Information System (HMIS) unit; Ministry of Health (MoH).

## 4. Discussion

This review highlights that integrating men meaningfully into comprehensive FP—and preparing for the introduction of MHCs—requires more than adding a new product to a method mix. The evidence synthesized across engagement programmes, acceptability studies, and policy guidance suggests a consistent implementation pattern: men's contraceptive participation remains under-measured and under-served, which reinforces women-centred service models and weakens shared responsibility in practice [14,21]. In this context, MHCs represent an opportunity to expand contraceptive choice and rebalance responsibility, but only if introduction is accompanied by rights-based service reforms, communication strategies that address social drivers of uptake, and governance safeguards that protect women's options and autonomy [21,44–47].

A core implication is that "readiness" should be treated as a health-system package. Service-delivery preparedness includes clear entry points for men (e.g., primary care, SRH/STI services and, in some settings, pharmacies), provider competencies for non-judgmental counselling, follow-up pathways for side effects and adherence support, and routine monitoring that makes men visible as users and partners rather than peripheral participants [14,45]. Regulatory and financing readiness is similarly decisive: sustained investment, clear evidentiary expectations, and post-marketing surveillance will influence whether MHCs can be introduced responsibly and scaled equitably [44].

### *4.1. Ethical and Counselling Considerations*

Ethical and counselling considerations warrant explicit attention. The "shared risk" framing and broader dyadic perspectives emphasize that contraceptive benefits and burdens often operate at the relationship level, which can support more balanced counselling approaches and shared decision-making [46,47]. At the same time, governance safeguards are essential to ensure that expanding male methods does not unintentionally displace resources, attention, or autonomy from women, and that all counselling remains grounded in voluntary, informed choice [21,44].

### *4.2. Limitations*

This article is a narrative synthesis designed to integrate heterogeneous evidence spanning clinical acceptability findings, social science research, and policy/implementation guidance. As such, it does not provide pooled quantitative estimates of effect and does not apply a formal risk-of-bias assessment. Evidence is also uneven across settings, and

implementation experience is more developed for male engagement strategies than for real-world MHC service delivery, which remains emergent [21,44].

## 5. Future Directions

Future work would benefit from (i) implementation research that tests male-inclusive FP service models across diverse health systems; (ii) longitudinal research on real-world uptake, continuation, adherence, and trust dynamics for MHCs once available; (iii) comparative work on communication strategies that address concerns and preferences related to hormonal and nonhormonal approaches; (iv) equity-focused monitoring frameworks that incorporate men's participation without reducing accountability for women's access and autonomy; and (v) policy analyses of regulatory pathways, pharmacovigilance systems, and financing mechanisms that can accelerate responsible introduction while safeguarding rights-based FP principles [14,21,44–47].

## 6. Conclusions

Further political and health-system action is needed to strengthen couple-focused education on shared contraceptive responsibility and to reduce prejudices and stereotypes that shape access to and counselling about contraceptive methods within family planning programmes. Removing structural and informational barriers to contraception can expand autonomy and informed choice, support more equitable decision-making, and improve sexual and reproductive health outcomes while reducing preventable costs for health systems. To advance comprehensive, rights-based family planning, policy agendas should treat investment in male contraception, particularly the development and future integration of male hormonal contraceptives, as a strategic priority. Coordinated commitments in funding, service delivery readiness, provider training, and sex- and gender-sensitive monitoring are essential to ensure that expanding male methods complements (rather than replaces) women's options and contributes to equity in reproductive rights.

Ultimately, introducing MHC should be treated as a health-system and rights-based implementation challenge—not only as product availability. Preparing services, regulation, financing, communication, and monitoring in advance can help ensure that expanding male methods increases contraceptive choice and shared responsibility while protecting women's access and autonomy.

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## Abbreviations

The following abbreviations are used in this manuscript:

| | |
|---|---|
| FP | family planning |
| STIs | sexually transmitted infections |
| MHCs | male hormonal contraceptives |

| | |
|---|---|
| MoH | Ministry of Health |
| SRH | sexual and reproductive health |
| HMIS | Health Management Information System |

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