Intersect, Vol 19, No 3 (2026)

WHO's Going To Do It?: Reflecting on the Absence of Hormonal Male Contraception

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I was in seventh grade when I first spotted my mother's Ortho Tri-Cyclen blister pack sitting on her bathroom counter. Intrigued, I opened the pink envelope and ran my curious fingers over the Monday and Tuesday labels. These twenty-eight mysterious pink pills looked like candy. Fast-forward to March 2023. That same little pack was delivered in the mail, but in place of my mother's, the label read my name. Opening the package, I found that the instruction manual expanded into a 24" x 24" pamphlet. The insert detailed warnings, instructions, and side effects in size six font. Suddenly, this blush blister pack did not look like a pouch of delicious DOTs, not something baby-pink and feminine. Rather, the pack felt like a burden in my palm. I was nervous, but I knew that this was my job. Or at least, my mom and doctor have told me that this is my responsibility. Despite my reservations, I push and break the seal, swallowing my first pill.

At this very moment, approximately 50% of the world's population is male (United Nations [UN], 2024). Nonetheless, out of twenty approved birth control methods featured on the World Health Organization's (WHO) website, only two rely on men: condoms and vasectomy (WHO, 2022). Biological women may be the only ones who can physically carry a child during pregnancy; however, the responsibility of contraception and family planning does not have to be held by mothers alone. As a young woman, I felt this burden of responsibility. Little did I know that beginning in the mid-1960s, American women had already asked the question that was only nagging in my brain back then. Now, in 2026, I and billions of other women demand an answer to that same question, but this time, we are more analytical: why is the onus primarily on us, and where is innovation for male birth control?

This absence of innovation is contextualized through the political, social, and economic climate during the mid to late-twentieth century. Many factors influenced those pursuing male and female contraceptive research, and therefore, progress in the field of fertility. First-wave feminist and obstetrical nurse Margaret Higgins Sanger's advocacy for female birth control in the 1950s is one pioneering example of a successful contraceptive movement. For Sanger, women's liberation manifested as

bodily autonomy. This purpose fueled her mission, resulting in the United States Food and Drug Administration (FDA) approval of the birth control pill in 1960. Conversely, stakeholders developing male birth control in the 1970s failed overwhelmingly due to a lack of Sanger's unstoppable determination. The Population Council (PC) and the UN were primarily concerned with fertility research as a means to control demographics in the Global South. The WHO was the first agency to conduct clinical research into male physiology and contraception. However, the WHO prioritized researching female over male birth control methods, as altering a woman's reproductive physiology proved biologically easier than a man's. Lastly, pharmaceutical companies chose to allocate their resources to female contraceptives, which was a growing industry that seemed less risky. Pharmaceutical companies were the only ones with sufficient funds to bring a male birth control method to fruition, and they prioritized profit over innovation. All of these parties, the PC, UN, WHO, and pharmaceutical companies shared something in common: emotional detachment from male birth control as a progressive social movement. Thus, male contraceptive research lost momentum and was suspended in 1979. The success of female birth control is indebted to Sanger's tenacity despite adversity. The two narratives demonstrate how the inspiration of those who conduct research—be that gender equality, population control, physiological practicality, or profit—impacts the outcome.

The current dearth of male birth control is not a result of scientific failure, but rather, it is reflective of the lack of dedication and ingenuity of those who pursued research. There were three distinct time periods leading to the eventual 1979 suspension of male birth control research. Sanger's historical narrative is reflective of women's rights and the suffrage movement that were surging during this period, and it is a good lens for understanding the discrepancies between male and female contraceptive development.

1914-1953: Women's Liberation vs. Population Policies

Margaret Sanger's fight for women's reproductive liberation took shape in an era defined by puritanical politics, where the cultural and legal treatment of contraception made it synonymous with indecency. Congress passed the Comstock Act in 1873, an anti-obscenity bill drafted by devout Christian Anthony Comstock that regarded family planning as promiscuous, ruling that "no obscene, lewd, or lascivious. . .thing designed…for the prevention of conception …nor. . .by what means either of the things before mentioned may be obtained" (Comstock Act, 1873). The aftermath of the Comstock Act not only promoted a culture that demonized female sexuality for another century, but it also precluded the conversation around contraception. However, in 1914 Sanger challenged that silence directly when she published *Family Limitation*. In sixteen pages, she taught women about their menstrual cycles, methods of contraception including sponges, chemical douches, condoms, and

pessaries that she learned about while in France, and she sought to debunk myths regarding unreliable birth control methods such as nursing and withdrawal. The popular pamphlet underwent 18 subsequent editions and covered "more types of contraceptive methods than any other publication", educating a more progressive American woman (Embryo Project Encyclopedia, n.d.-c). In 1917, Sanger's work pivoted when she met wealthy Massachusetts Institute of Technology (MIT) researcher Katherine McCormick through the women's suffrage movement. They shared a vision of women in control of motherhood, which dictated their health, employment, and relationships. Sanger was arrested and served jail time for violating the Comstock Act with the opening of her first women's clinic in 1916. Undeterred, Sanger and McCormick together established the first medical contraceptive clinic in America in 1923, serving almost 18,000 women by 1930 (Smith, 1930). This successful prototype was the forerunner of Planned Parenthood.

Sanger's vision for women's health extended beyond the US. She quickly realized that to influence the global patriarchal leadership she had to promote family planning from a less overtly feminist angle. She appealed to the scientific community, finding an audience in those concerned with overpopulation. In 1927, she was instrumental in organizing the first World Population Conference (WPC) in Geneva, Switzerland. She strategically invited celebrated evolutionary biologist Julian Huxley and famed economist John Maynard Keynes. The gathering was triumphant, establishing the International Union for the Scientific Study of Population. The conversation "came perilously near mentioning the forbidden word Malthusianism," a theory promoted by clergyman Thomas Malthus who stoked fears of overpopulation which could be avoided with proper "moral restraint". Sanger's attempts to promote scientific birth control methods over behavioral restraint were "edged [out] like a bomb which might explode at any minute" (Sanger, as cited in *The Margaret Sanger Papers Project*, n.d.). The mob of opposition peaked as Sir Bernard Mallet, President of Britain's Royal Statistical Society, removed Sanger and her assistant's names from the conference program. In this pivotal moment, Sanger brought politicians and intellectuals together to further her agenda for female liberation, she floundered, and it was apparent that these eugenicists were interested in global population control but would be of no service to her goal. Discussing female autonomy was taboo. In spite of this obstacle, Sanger remained steadfast on her mission to develop female contraception.

Upon returning to the US, Sanger and McCormick funded projects promoting female birth control. Despite its illegality, this powerhouse team remained loud and radical in their promotion of reproductive rights. In 1953, the women joined forces with the experimental Harvard-educated biologist Dr. Gregory Pincus, a renowned international authority on matters of mammalian sexual relations (Lemelson–MIT Program, n.d). With Sanger's tenacity, McCormick's funding, and Pincus's medical

expertise, female contraceptive research gained ground. Their efforts culminated in the 1960 FDA approval of the combination synthetic estrogen and progestin oral contraceptive pill, called Enovid (Planned Parenthood Federation of America, 2015, p. 4). Quickly, hundreds of thousands of American women began taking oral birth control—the Pill. In 1965, the Superior Court case *Griswold v. Connecticut* officially overturned the rule of the Comstock Act. Finally, following years of campaigning and scientific benchwork, Sanger's vision of female reproductive liberation proved successful.

As Pincus and Sanger championed the Pill in the US, the UN/WHO contemporaneously led a birth control campaign once again addressing fears of global overpopulation, as a result of the 1927 WPC consensus. This was a branching point for family planning, with Sanger advocating female liberation through reproductive autonomy with the Pill vs the UN/WHO advocating fertility research for global population control.

The UN/WHO campaign officially began in October 1953 when the UN Department of Social Affairs Population Division produced the Population Bulletin. The UN wrote the Bulletin to provide "technical material" on "international interest relating to population trends and problems". These statistics were provided for "governmental agencies, scientific institutions, and scholars" concerned with overpopulation (UN, 1953). Although this target audience seems general, these concerns came predominantly from the UN's permanent members of the Security Council: China, France, Russia, the United Kingdom, and the US Article 16 of the UN's 1948 International Declaration of Human Rights stated that "the family is the natural and fundamental group unit of society and is entitled to protection by society and the State " (UN, 1948). Despite stating that individuals had agency over their own reproduction, the article was not applied uniformly. In actuality, the Security Council's self-aggrandisement as the powerful victors in World War II appointed themselves as decision-makers for the developing world. The global population, in their estimation, was imbalanced, with darker-skinned people and poorer economies reproducing at higher rates compared to the aging population in "Western civilization" (UN, 1953, p. iv). The UN Bulletin determined developing countries in Southeastern Asia and Latin America were the primary source of this burgeoning overpopulation problem, which required formal intervention.

Americans specifically exerted their power as politicians "became increasingly conscious that prosperity in North America or Western Europe depended heavily upon raw materials" from underdeveloped countries (Mass, 1974, p. 658). The UN's choice of location in New York in addition to officials' insistence that all "communications may be written in English, French, Spanish, Russian, Chinese or Italian demonstrated this exclusive attitude (UN, 1953, p. vi). North American and Western European influence on the future of global fertility was greatly determined by this Population Bulletin. The PC was their

subsidiary organization formed to investigate how to reduce reproduction in the developing world.

The PC first convened in June 1952 at the Williamsburg Conference in Virginia, organized on the personal initiative of John D. Rockefeller III, a renowned American philanthropist, under the official support of the National Academy of Sciences. Presided over by Rockefeller with the help of his executive vice president Fredrick H. Osborn, a UN deputy and known member of the American Eugenics Society, the conference gathered approximately thirty social and biological scientists to discuss the "effects of population growth on human welfare." However, similar to the UN, council members "agreed that the problems of the underdeveloped countries were of a very different kind from those of the United States," directing their attention at the Global South. The conference placed a particular focus on India, which Rockefeller and his colleagues feared was losing "the 'race' between production and population," stressing the urgency of reducing India's rural birth rate "prior to the transition to an industrial and urbanized society" (Rockefeller, 1977, pp. 494–495). This language significantly reveals that the PC did not position itself as an ally to Indian women seeking reproductive autonomy, but as an external authority intervening in a country it perceived as a demographic issue. The contraceptive research it would go on to fund was never designed around liberation. Once again, the fertility conversation shifted away from women's liberation and reproductive autonomy and toward eugenics and control.

In a 1972 editorial in *Science* titled "Ethics and Population Limitation", PC member Dr. Daniel Callahan, PhD, considered the balance between the good life and the human right of "procreative freedom". He pondered how much bodily freedom "should be given up in order to ensure the security-survival of a nation or a community" that is threatened by overpopulation (Callahan, 1972, pp. 488–489). While Sanger and her supporters marched in the streets promoting reproductive freedom, men in the Council sat in conference rooms discussing the importance of population control in countries thousands of miles away. In an astonishing convergence of disparate goals, the PC's concern for overpopulation in developing countries inspired the WHO in the 1970s to begin clinical research into new birth control methods. It was the WHO that would pioneer most research in the field of male fertility.

1965-1979: Sperm vs. Egg

The WHO thus launched male fertility research on a global scale seeking demographic management. The 1962 Fourth World Congress on Fertility and Sterility was overseen by WHO's Director-General Dr. Marcolino Candau. Candau's commitment to fertility research and eugenics was unequivocally intertwined with US scholars, foundations, universities, and the PC.

Beginning in 1965, the establishment of the Human Reproduction Unit (HRP), led by American endocrinologist Dr. C. Alvin Paulsen, symbolized a pivotal juncture in the progression of male birth control research. From 1966 to 1971, the WHO laid the groundwork for 20th-century andrology investigation through targeted task forces and clinical trials at select global research centers. HRP director Dr. Adam Kessler asserted that fertility research protocols must be standardized and scrupulously analyzed to make the outcomes reproducible across diverse populations in the developing world (Kessler et al., 1972). In accordance with this meticulous approach, the Statistics and Data Processing Unit backed the program.

In the WHO's 1972 report titled the "Expanded Programme of Research Development and Research Training in Human Reproduction", the HRP detailed the implementation, budget, and regulation of thirteen task forces during its first year of operation. The disproportion was striking: twelve teams were centered around the female reproductive system, whereas only one of these task forces was concerned with interventions in male fertility, formally called the "methods for the regulation (in the male) of fertilizing ability of sperm," later nicknamed the Male Task Force (WHO, 1972). It is difficult to read this imbalance as purely coincidental, and funding allocation solidifies such discrepancies. In the HRP's first year of operation, the male task force received just $108,200, less than every other task force listed, and less than a third of the $375,000 Prostaglandins task force alone (WHO, 1972, Appendix A, p. 6). Female physiology presented a more convenient target for hormonal intervention. Women release one egg per month in a predictable cycle, thus allowing contraception to be achieved through the suppression of the LH surge that triggers ovulation—a single hormonal event. Men, by contrast, generate between 100 and 300 million sperm per day. Suppressing spermatogenesis would require the sustained disruption of the hypothalamic-pituitary-gonadal (HPG) axis while simultaneously replacing testosterone to preserve health, making it a more complex albeit not impossible biochemical challenge.

With the PC's depopulation goals in the developing world driving the research agenda, two main clinical trials began in 1973 (Waites, 2003, p. 2). Clinical Research Centers focused on treatments capable of either inhibiting spermatogenesis or interfering with sperm maturation. They tested an injectable androgen-progestin combination at seven centers in six countries and cyproterone acetate injections at institutions spanning Berlin, New Delhi, Sydney, and Chapel Hill, North Carolina (WHO, 1972, Appendix A, p. 9). The results were promising. Half of the male participants achieved azoospermia—a complete absence of sperm—and the majority of the remainder oligozoospermic, defined as fewer than 15 million sperm per milliliter, a threshold low enough to warrant further efficacy testing (Paulsen, 1986, as cited in Waites, 2003, p. 2). Crucially, the only major side effects noted were acne and weight gain, the same side

effects already deemed acceptable in female hormonal birth control, yet here they were treated as a cause for hesitation. Nevertheless, the Advisory Board suspended the Male Task Force in 1979.

The Advisory Board did not make this decision lightly. It consisted of a "distinguished group of 12" WHO-appointed scientist experts who maintained complete authority over both the continuation and fund allocations for all potential projects (WHO, 1972, p. 7). They employed mathematical simulations alongside the Programme Evaluation and Review Technique (PERT)—a management planning tool used to calculate the required time to complete a project. Following this systematic evaluation, and "in the light of the objectives, scientific merit, and funds available," the Board declared the male birth control research unnecessary (WHO, 1972, pp. 8-9). The majority of the twelve other female-centered task forces, by contrast, moved forward. The Board justified the suspension by citing a "perceived need for large-scale investment in basic science; the relatively few investigators in [the] area," and hesitations concerning the willingness of men to use male birth control (Kessler & Standley, 1976, as cited in Waites, 2003, p. 3).

These justifications were not neutral. In particular, the claim of too few investigators was unfounded, as by 1979, the number of researchers involved in the Task Force's activities had increased by more than fourfold from its founding (Waites, 2003, p. 3). The Board cited a shortage of talent while presiding over its rapid growth. WHO scientists found female physiology, specifically the prevention of ovulation, thickening of cervical mucus and thinning of the endometrial lining with cyclic estrogen and progesterone, easier to predict and manage, as "it [was] possible to interfere with the female cycle at numerous stages, starting with ovulation and ending with embryogenesis" (Djerassi 1970, p. 945). Biological complexity, however, is a design challenge, not a verdict, and choosing to treat it as the latter was a political decision—not a scientific one. The Advisory Board's own concern that men would not accept hormonal contraception was also later refuted by the WHO's own data. In the post-reinstatement efficacy trials, around 80% of men and their partners reported wanting to continue the male method regimen, and 83% of couples had enrolled specifically because of dissatisfaction with female methods (Ringheim, 1996, cited in Waites, 2003, p. 10).

Several of the HRP's female task forces successfully demonstrated a variety of contraceptive options such as medicated intrauterine devices and post-coital contraceptives. In comparison, the Male Task Force required further testing, requiring funding and time, in order to ensure azoospermia in all clinical trial participants. WHO researchers also anticipated the need for extensive social education campaigns reassuring men that azoospermia would not affect their virility and promoting the benefits of sharing the contraceptive burden with a partner. While the Male Task Force's scientific trajectory was upward, the journey proved more demanding. From 1955 to 1980, the total world fertility rate dropped

from 5% to 3.75%, largely due to the success and popularity of the Pill and other new female methods (UN, 2023).

From the 1979 suspension onwards, male birth control research became dormant across nearly every institution that had originally pursued it. Despite the Task Force's reinstatement in 1982, three years of stagnation proved ruinous. There was one exception. At the People's Republic of China's request, trials continued in 1979—the same year the Chinese government implemented the One-Child Policy, which has been described as "the most massive governmental attempt to control human fertility and reproduction in human history" (Embryo Project Encyclopedia, n.d.-a). In effect, China primarily encouraged abortions and sterilization toward this goal, which was enforced with heavy fines. Novel discoveries are not apparent, as IUDs and the Pill were the primary contraceptives encouraged by the government.

While the goal was the same, the process was different. Sanger employed both activism and medicine to promote female birth control. In comparison, the WHO task forces approached contraception as a technical problem, one of optimizing population outcomes—not advancing women's rights. Scientific research is not neutral. It is born into a social context and belief system, which is why it is critical who leads and thus influences the course of discovery. To research contraception without a framework of gender equity is to tacitly accept the existing distribution of reproductive burden, predominantly upon women. Unlike Sanger, Pincus, and McCormick who explicitly fought for the liberation of women, the WHO scientists treated their detachment as a virtue, and that is what enabled them to walk away when their goal was achieved. When the WHO closed the book on contraception after discovery of the Pill, it placed a moratorium on research which left a gap in the progress toward bidirectional gender family planning which has yet to be filled.

Post-1979: Male Contraception vs. The Pharmaceutical Industry:

The pharmaceutical industry played an important role in the WHO's finances and the fate of the Male Task Force. The HRP's 1971 "Report of a Feasibility Project" stated, "[expectations] that funding would come from governments and private foundations" (WHO, 1971, p. 22). Throughout the 1970s, the UN's Population Fund and Ford Foundation allocated significant funding for research on "family planning and the health aspects of population dynamics" (WHO, 1972, p. 3). However, the pharmaceutical funding as such was inadequate, and the task forces pursued philanthropic and non-government support. Carl Djerassi, also known as the Father of the Pill, was a Bulgarian-American pharmaceutical chemist who reflected upon the 1979 downfall of male contraceptive research as a financial decision.

In Djerassi's book titled *This Man's Pill: Reflections on the 50th Birthday of the Pill*, Djerassi claimed that the early 1950s were optimal for

the birth of new female oral contraceptives. The decade marked a "heyday of new drugs". In light of post-war industrialism, "every problem, be it a medical one such as tuberculosis or a social one such as the population explosion, seemed capable of a technological fix" (Djerassi, 2003, p. 282). However, in 1961, this excitement for new pharmaceuticals downshifted dramatically with the tragic thalidomide crisis (Kim, 2012). As a result of the severe limb deformities from thalidomide, Americans demanded better safety controls in clinical trials. Due to the liability and fear of legal entanglements, "extreme caution became the FDA's watchword", especially in the field of contraception. Even minor side effects, frequently associated with birth control products such as acne and weight gain, were presumed risky in the eyes of investors (Waites, 2003, p. 13). A greater proportion of the 17-year patent life of drugs was newly allocated to safety in clinical trials, leaving less time to recoup the cost of research, let alone make a profit. In 1970, an estimate of the "costs and amount of time necessary to bring a chemical compound to clinical fruition was $6.2 million over 10 to 15 years" (Djerassi, 1970, as cited in Wallach et al., 1977, p. 1275). However, in 1972, that estimate jumped to $25 million per year over 5 years (Paulsen, 1972, as cited in Wallach et al., 1977, p. 1275). The pursuit of more profitable drug categories used by geriatric, insured patients was yet another reason for the surrender of male contraceptive development. A 1988 survey of the international pharmaceutical industry indicated that "new human fertility control methods were not even among the top 35 on their list of research priorities" (Djerassi, 2003, pp. 285–286).

Both women and men benefit from reproductive control, and yet the outcomes proved askew. By 1979, the WHO had already achieved its goal of population control by prioritizing female methods. Likewise, pharmaceutical companies saw no need to produce a competitive new medication, as female methods were effective and dominated the contraceptive sector of the market. The contraceptive marketplace abandoned male research prematurely, unlike Sanger, who was unrelenting, soliciting New York investors to support her cause monetarily. In a talk on May 6, 1970, at the California Institute of Technology, Djerassi predicted this fate:

> . . . Unless some incentives in the area of contraceptive research are introduced soon, it is unlikely that the present rate of industry expenditure on research in this field will be maintained; indeed the rate is likely to decline, and it may reach a noncritical level in a short time. This would be a tragedy . . . (Djerassi, 1970, p. 949)

These two stories of contraceptive development demonstrate how gender equality, demographic control, biological practicality, and profit have the power to determine outcomes. And every difficult cause needs a fierce champion.

Then and Now: Where Are We in 2026?

The 2022 Supreme Court decision *Dobbs v. Jackson Women's Health Organization* reshaped the reproductive landscape for both sexes. In its immediate aftermath, the vasectomy rate among privately insured men increased by 26% when compared to 2014 (Huang et al., 2023). Most striking is the increase in vasectomies in young men under 25 without children, those with the least immediate stake in permanent sterilization. The numbers suggest that men, when confronted with reproductive uncertainty, are searching for means of control and reproductive responsibility, but in the absence of a reversible hormonal option, permanent sterilization remains the acceptable, reliable answer. The gap left by the 1979 suspension is still visible forty years later. A 2021 to 2023 survey of 12,000 men and 9,000 female partners conducted across seven countries, including six low- and middle-income countries and the US, found an average of 61% of men who indicated they would try a novel male contraceptive within its first year of availability (Kaur et al., 2024). Male Contraceptive Initiative (MCI), a nonprofit dedicated to funding nonhormonal reversible alternatives, frames the issue directly. Reproductive choices, it argues, "should be a shared responsibility" (MCI's Impact, 2026). Recently, scientists conducting clinical trials are more egalitarian as well. Dr. Regine Sitruk-Ware, a distinguished scientist at the Population Council's Center for Biomedical Research (CBR) in New York City, embodies this motivation by stating that "expanding male contraceptive options could help make family planning more of a shared responsibility between women and men" (Sitruk-Ware, as cited in The Lundquist Institute, 2023). Sitruk-Ware is working on NES/T (Nestorone®/Testosterone), the first hormonal male birth control to pass through phase III of FDA testing (National Institute of Child Health and Human Development, 2022). In addition, Your Choice Therapeutics produced a daily pill called YCT-529 that is a hormone-free male contraceptive blocking retinoic acid receptor-alpha, which is required for sperm production (Studies, n.d.). Another novel contraceptive, ADAM™, is a hydrogel injected biennially into the vas deferens that acts as a temporary, permeable filter to block sperm without affecting ejaculation or sensation (Contraline Product, 2024). This union between consumers, medical professionals, researchers, pharma, and our government, in the name of shared procreative destiny, gives me hope.

Intention vs. Outcome: Looking to the Future

Djerassi's 1970 prediction proved correct. The current absence of hormonal male birth control is not a result of medical failure. Rather, it is reflective of the limitations of those leading the male contraceptive project: the UN, the Population Council, the WHO, and pharmaceutical companies. These stakeholders for male contraception were motivated to reduce reproduction in developing countries and were indifferent to

gender equality, which led them to abandon male birth control development. Sanger's efforts to create a female method in the 1950s were distinctly characterized by her willingness to push past obstacles and logistical impracticalities. In the pursuit of women's reproductive freedom, she fought relentlessly despite scientific setbacks, and her impassioned commitment was the main factor that enabled the FDA approval of Enovid in 1960—the first oral hormonal birth control pill. If the Male Task Force had such a champion, male contraceptives, not only barrier methods, abortions, and sterilizations, might be available today. Though not explicitly pursued, successful male birth control could have simultaneously liberated men from reproductive uncertainty and redistributed the contraceptive burden more equitably between partners. The past fifty years have exhibited a tragic injustice where men do not have ample control over fatherhood while they are implicitly led to believe they are therefore not responsible for family planning.

I hold the little pink blister pack in my hand. What was once a symbol of liberation now feels complicated. But I am powerful. If the past teaches us anything, it is that a passionate advocate is what science needs to advance our societal objectives, and that is who I intend to be.

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Table 1
Contributions to WHO Expanded Programme (in US Dollars)

Year	***Contributor***	***Amount (USD)***	***Year Total (USD)***
1970	*Swedish International Development Authority (SIDA)*	*50,000*	*50,000*
1971	*International Development Research Centre (IDRC)*	*51,500*	
	Ford Foundation	*100,000*	
	SIDA	*3,000,000*	*3,151,500*
1972	*Ford Foundation*	*500,000*	
	IDRC	*100,000*	
	Norwegian Agency for International Development (NORAD)	*454,000*	
	Danish International Development Agency (DANIDA)	*200,000*	*1,254,000*
Total			***4,455,500***

Note. This table shows the allocation of funds from the Ford Foundation (row 3) to the HRP; Expanded Programme of Research, Development, and Research Training in Human Reproduction. From *Expanded Programme of Research, Development and Research Training in Human Reproduction* (p. 34), by WHO, 1972.