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Enhancing Public Participation Through Strategic Vasectomy Program Management in Riau

Deffy May Ayu[1], *Jeni Wardi[2], Agus Seswandi [3]
[1]Magister Management/Graduate School/Universitas Lancang Kuning
[2]Magister Management/Graduate School/Universitas Lancang Kuning
[3]Magister Management/Graduate School/Universitas Lancang Kuning
Correspondence*: Jeni Wardi
e-mail: jeniwardi@unilak.ac.id

Abstract

Male involvement in family planning remains critically low in Indonesia, particularly in conservative regions such as Riau Province. This study explores how strategic program management—through the lens of the POAC (Planning, Organizing, Actuating, and Controlling) framework—affects public participation in vasectomy services. Drawing from qualitative fieldwork, in-depth interviews, and document analysis, the research reveals that institutional planning is disconnected from the socio-cultural realities of the target population. Organizational fragmentation, lack of human resource capacity, and insufficient coordination between stakeholders further weaken program delivery. Actuation efforts are hindered by ineffective outreach strategies that fail to resonate with men, reinforcing widespread misconceptions about vasectomy. Additionally, the controlling function is reduced to bureaucratic data reporting, without adaptive learning mechanisms to recalibrate program strategies based on community feedback. Sociocultural barriers—such as gendered perceptions of masculinity, religious ambiguity, and entrenched misinformation—compound these structural weaknesses. The study argues that increasing male participation in vasectomy requires a paradigm shift from technocratic planning toward a participatory, culturally grounded model of reproductive governance. This includes involving religious leaders, male role models, and community stakeholders in message development and service delivery. By reimagining vasectomy not merely as a clinical procedure but as a symbol of shared reproductive responsibility, the program can achieve broader legitimacy and effectiveness. The findings offer valuable insights for policymakers, public health managers, and development practitioners seeking to enhance equity and inclusion in reproductive health programs.

Keywords: vasectomy, public participation, strategic management, family planning, male involvement

1. Introduction

Population growth remains one of the most pressing socio-economic and environmental challenges confronting developing nations in the 21st century. Indonesia, as the fourth most populous country in the world, has continuously sought effective strategies to address the rapid increase in population and its multidimensional implications. Family planning (FP) policies and reproductive health programs are central to these strategies. Among the spectrum of contraceptive methods, vasectomy—a male sterilization procedure—has emerged as a viable long-term solution, albeit underutilized due to a confluence of socio-cultural, religious, and systemic barriers. In the context of Riau Province, Indonesia, strategic management of the vasectomy program by local government agencies represents a critical point of intervention for enhancing male participation in family planning initiatives and, subsequently, increasing overall community engagement in population control efforts.

The Government of Indonesia, through national mandates such as Law No. 52/2009 on Population Development and Family Development, has institutionalized the need for equitable and sustainable family planning mechanisms. However, in practice, the implementation of such programs remains heavily skewed toward women, both in terms of service delivery and community outreach. This gender imbalance has perpetuated the cultural perception that family planning is predominantly a woman's responsibility. Consequently, male participation—especially in adopting vasectomy as a contraceptive method—has remained significantly low. The Riau Provincial Office for Women's Empowerment, Child Protection, Population Control, and Family Planning (DP3AP2KB) has acknowledged this disparity and has embarked on a series of strategic interventions aimed at increasing public participation, particularly among men, in vasectomy programs.

Despite the availability of modern contraceptive technologies and concerted efforts to promote gender equality in reproductive health, the uptake of vasectomy services in Riau remains suboptimal. Recent statistics indicate that less than 1% of new contraceptive users in the province opt for male sterilization, compared to the overwhelming majority who rely on female-focused methods such as implants, IUDs, and hormonal injections. These figures highlight a critical gap in public health policy and service delivery, underscoring the necessity of a robust strategic management approach that addresses both supply-side and demand-side constraints.

From a strategic management perspective, the effective implementation of vasectomy programs necessitates a comprehensive approach grounded in the POAC framework: Planning, Organizing, Actuating, and Controlling. In Riau, the planning phase entails identifying key demographic segments—such as couples of reproductive age (Pasangan Usia Subur)—and tailoring messages that resonate with male audiences. Organizing involves the deployment of trained personnel, community leaders, and healthcare providers to act as agents of change. Actuating includes conducting outreach activities, counseling, and free vasectomy services through collaboration with hospitals and civil society organizations. Lastly, controlling is reflected in monitoring and evaluation systems that assess the efficacy and coverage of the program.

One of the fundamental barriers to vasectomy adoption in Riau is the entrenched patriarchal culture that reinforces rigid gender roles. In many communities, decisions regarding reproductive health are either delegated entirely to women or made unilaterally by men without adequate dialogue. The stigma associated with vasectomy—often conflated with emasculation or loss of virility—further compounds the reluctance of men to participate in the program. Religious interpretations also play a role, as some conservative voices equate sterilization with interfering in divine will, thereby discouraging men from undergoing the procedure. These cultural and religious dynamics require sensitive yet strategic engagement from government

agencies, involving religious scholars, community leaders, and past vasectomy acceptors as advocates.

Another significant constraint lies in the lack of accessible and user-friendly information. Many men in rural and peri-urban areas remain unaware of the benefits, safety, and reversibility of vasectomy. The absence of targeted communication campaigns, compounded by logistical challenges such as limited service points and lack of trained providers, hinders the program's scalability. The DP3AP2KB's strategic response has involved increasing visibility through local media, deploying mobile outreach teams, and integrating vasectomy awareness into broader family health initiatives. Nevertheless, these efforts require sustained coordination, adequate funding, and community buy-in to be effective.

In examining the vasectomy program in Riau, it becomes evident that public participation cannot be reduced to mere service utilization. Participation encompasses a broader spectrum, including awareness, dialogue, acceptance, and ownership. Thus, strategic management must go beyond bureaucratic mandates and embrace participatory models that empower communities to become co-creators of health solutions. One such model is the community-based approach (CBA), which facilitates grassroots mobilization through focus group discussions (FGDs), peer education, and localized advocacy. Involving male role models—such as respected elders, religious figures, and satisfied vasectomy users—has proven particularly effective in normalizing the discourse around male contraceptive responsibility.

Moreover, institutional capacity remains a critical determinant of program success. The DP3AP2KB has undertaken organizational reforms to streamline interdepartmental collaboration, improve data collection mechanisms, and allocate resources more efficiently. However, these reforms are still in nascent stages and face challenges such as bureaucratic inertia, staffing shortages, and inconsistent policy support at the district and village levels. Effective management of the vasectomy program thus requires not only technical competence but also political will and intersectoral synergy.

The regional development plans (RPD) for 2025–2026 underscore the strategic priority of achieving balanced population growth through reduced fertility rates and enhanced reproductive health services. These plans set measurable targets, including increases in male contraceptive prevalence rate (mCPR) and broader utilization of GDPK (Family Development Guidelines). Within this framework, the vasectomy program is positioned as a linchpin for realizing gender equality in family planning and addressing the underrepresentation of men in reproductive health discourse. The DP3AP2KB's alignment with these strategic objectives necessitates a recalibration of its programmatic approach—emphasizing inclusivity, evidence-based policymaking, and community ownership.

In sum, enhancing public participation in the vasectomy program in Riau is not merely a technical or medical challenge—it is a deeply sociocultural endeavor. It demands a nuanced understanding of the intersecting factors that influence individual behavior, community norms, and institutional practices. Strategic program management, anchored in POAC principles and informed by ground-level realities, offers a pathway to overcome these barriers. By fostering male engagement, dismantling stigma, and creating enabling environments, the Riau provincial government can not only improve health outcomes but also advance the broader agenda of gender justice and sustainable development.

This study explores how strategic management—implemented by the DP3AP2KB—can enhance community participation in the vasectomy program. It aims to analyze the planning, implementation, and evaluation strategies used, identify barriers to effectiveness, and propose actionable recommendations based on empirical findings. In doing so, the study contributes to the growing body of literature on male involvement in reproductive health and offers a replicable model for other regions facing similar challenges. The following sections will

elaborate on the theoretical framework underpinning strategic management in the public sector, outline the methodological approach employed, and present a detailed analysis of the findings.

2. Literature Review

Understanding the dynamics of public participation in health programs—particularly in the domain of family planning—requires a multi-disciplinary theoretical lens that encompasses strategic management, gender studies, behavioral change communication, and public health policy. This literature review explores key concepts and empirical insights related to strategic program management, male involvement in family planning, cultural barriers to vasectomy adoption, and community-based participatory approaches. It also integrates relevant models such as the POAC framework and stakeholder theory, which serve as foundational references for the present study.

2.1 Strategic Program Management in Public Health

Strategic management in the public sector refers to a set of processes that enable governmental institutions to define their long-term goals, align resources, and design action plans to address specific societal needs. According to Bryson (2018), strategic management involves the formulation and implementation of major goals and initiatives, based on consideration of resources and an assessment of internal and external environments. In the health sector, strategic program management ensures that interventions are not only technically sound but also responsive to contextual dynamics and stakeholder expectations.

The POAC model—Planning, Organizing, Actuating, and Controlling—is widely used to assess management effectiveness. Terry and Rue (2011) emphasize that each component of POAC plays a crucial role in ensuring program sustainability: planning identifies objectives and strategies; organizing allocates tasks and responsibilities; actuating motivates and directs personnel and stakeholders; while controlling evaluates outcomes and facilitates corrective actions. In reproductive health programs such as vasectomy services, the strategic application of the POAC model can determine the degree to which government agencies effectively engage target populations and mitigate implementation gaps.

2.2 Male Participation in Family Planning: A Persistent Gap

Historically, family planning programs have been predominantly oriented toward women, both in terms of policy focus and service delivery. This gendered approach has resulted in a marginalization of male involvement, reinforcing the misconception that reproductive responsibility lies solely with women (Greene & Biddlecom, 2000). Yet studies have shown that active male participation significantly enhances contraceptive uptake, reduces fertility rates, and improves maternal health outcomes (Kabagenyi et al., 2014).

Despite this evidence, male sterilization—particularly vasectomy—remains one of the least adopted contraceptive methods in many developing countries. According to UNFPA (2022), the global contraceptive prevalence rate for vasectomy is less than 3%, with even lower rates in regions with strong patriarchal norms. In Indonesia, while national policies support male involvement in family planning, actual participation is limited due to structural, cultural, and informational barriers. Riau Province exemplifies this trend, where male engagement in vasectomy services remains notably low, necessitating innovative management strategies.

2.3 Cultural and Religious Barriers to Vasectomy Adoption

One of the most frequently cited obstacles to vasectomy uptake is the cultural stigma associated with male sterilization. In many societies, vasectomy is perceived as emasculating or as a threat to male virility, leading to widespread resistance. This perception is often

reinforced by traditional gender roles, which associate masculinity with procreation and dominance in reproductive decision-making (Rothchild & Barnett, 2012).

Religious interpretations further complicate the issue. Some religious leaders interpret permanent contraception as a violation of divine law or as interfering with natural processes. In the Indonesian context, particularly in Malay communities such as those in Riau, these religious and cultural narratives hold significant sway over individual behaviors. As noted by Ahmad and Iskandar (2021), effective interventions must engage religious leaders and community elders as key stakeholders in reshaping public discourse around vasectomy and male responsibility.

2.4 Community-Based Approaches and Stakeholder Engagement

Research has consistently highlighted the importance of community-based approaches in promoting health behavior change. Community-based participatory approaches (CBPA) prioritize the inclusion of local voices in the design, implementation, and evaluation of health programs. These approaches are particularly effective in culturally sensitive contexts where top-down interventions often face resistance (Minkler & Wallerstein, 2011).

In the case of vasectomy programs, community mobilization strategies—such as focus group discussions, peer-to-peer education, and testimonial sharing by vasectomy acceptors—have been shown to reduce stigma and increase uptake. Involving community and religious leaders as agents of change is also essential. A study by Barone et al. (2016) emphasized that male-focused reproductive health campaigns that feature culturally relevant messages and community champions significantly increase the willingness of men to consider vasectomy.

Stakeholder theory provides a useful lens for understanding the roles and responsibilities of various actors in program implementation. As proposed by Freeman (1984), stakeholders include any group or individual who can affect or is affected by the achievement of the organization’s objectives. In the context of vasectomy programs in Riau, key stakeholders include not only health institutions and policymakers but also religious figures, community leaders, local media, and male family planning users themselves. Effective stakeholder mapping and engagement strategies are therefore central to strategic program success.

2.5 Institutional Constraints and Policy Gaps

While strategic planning is essential, its efficacy is often undermined by institutional constraints such as inadequate funding, poor interdepartmental coordination, and limited capacity for data-driven decision-making. According to Thomas and Grindle (1990), weak institutions in developing countries frequently face challenges in translating policies into effective service delivery. This is evident in Indonesia, where decentralized governance has created disparities in the quality and accessibility of family planning services across provinces and districts.

Policy implementation gaps are further exacerbated by gender bias in reproductive health programming. Despite Indonesia’s commitment to gender equality, resource allocation and service design often remain focused on women, leaving men excluded from the equation. As highlighted by the Indonesian National Population and Family Planning Board (BKKBN), efforts to involve men in family planning are still nascent and lack adequate institutional support. Addressing these gaps requires a paradigm shift toward inclusive and gender-transformative programming.

2.6 Vasectomy as a Cost-Effective and Safe Contraceptive Method

From a clinical and economic standpoint, vasectomy is one of the safest and most cost-effective contraceptive methods available. It involves a minor surgical procedure that permanently blocks the vas deferens, thereby preventing the release of sperm. The operation is

simple, requires minimal recovery time, and has a failure rate of less than 1% (World Health Organization, 2020). Despite these advantages, public misconceptions persist, including fears of sexual dysfunction, irreversible damage, or long-term health risks.

Educational interventions have proven effective in dispelling these myths. According to EngenderHealth (2017), targeted health communication campaigns that provide factual, user-friendly information significantly improve knowledge and attitudes toward vasectomy. These campaigns are particularly impactful when delivered through trusted sources such as healthcare providers, community health workers, or peer educators.

3. Method

This study employed a qualitative research approach to investigate the strategic management of the vasectomy program implemented by the Riau Provincial Office of Women's Empowerment, Child Protection, Population Control, and Family Planning (DP3AP2KB). Qualitative research was chosen due to its strength in capturing the depth and complexity of social phenomena, particularly the interplay between policy implementation, cultural perceptions, and community participation in reproductive health initiatives. By exploring participants' lived experiences, institutional practices, and community dynamics, this method enables the identification of both overt strategies and subtle barriers affecting male involvement in vasectomy programs.

The research was conducted through fieldwork in several districts across Riau Province where the vasectomy program has been promoted. Primary data were collected through in-depth interviews with key informants, including officials from DP3AP2KB, family planning field workers, healthcare providers, male vasectomy acceptors, and community leaders such as religious figures and local government representatives. These individuals were selected through purposive sampling to ensure that diverse perspectives relevant to program planning, execution, and reception were captured.

To guide the interview process, a semi-structured interview protocol was developed. This protocol consisted of open-ended questions aligned with the POAC (Planning, Organizing, Actuating, and Controlling) framework, allowing flexibility for respondents to elaborate on their experiences and observations. Questions focused on program objectives, outreach mechanisms, stakeholder coordination, socialization strategies, perceived challenges, and suggestions for program improvement. Each interview lasted approximately 45 to 60 minutes and was conducted either in person or via virtual meetings, depending on logistical feasibility and participant availability.

In addition to interviews, the study collected secondary data from institutional documents, strategic plans, program reports, media publications, and demographic statistics. These materials were used to triangulate the findings and enhance the validity of the analysis. Particular attention was given to the Riau Regional Development Plan (RPD) 2025–2026 and strategic guidelines issued by the BKKBN (National Population and Family Planning Board).

The data analysis followed a descriptive qualitative technique. All interview transcripts and documents were systematically coded using thematic analysis, identifying patterns and categories relevant to the research questions. Coding was done inductively, allowing themes to emerge organically from the data while maintaining alignment with the theoretical constructs of strategic management and community engagement. Thematic categories included program design, communication barriers, gender dynamics, institutional coordination, and community acceptance.

Ethical considerations were observed throughout the research process. Informed consent was obtained from all participants, and confidentiality was ensured by anonymizing personal identifiers in all transcripts and reports. Participants were also briefed about the purpose of the study and their right to withdraw at any point without any consequence.

4. Result and Discussion

Planning: Weak Strategic Foundation and Community Disconnection

The strategic planning of the vasectomy program in Riau Province reflects a fragmented approach that fails to sufficiently contextualize the cultural and behavioral nuances of the targeted population. Although formal documents such as the Regional Development Plan (RPD) 2025–2026 articulate goals to enhance male involvement in family planning, these are not accompanied by robust, field-based planning mechanisms. The program lacks localized behavioral assessments, segmented demographic targeting, or socio-religious mapping to inform planning. As a result, strategic priorities often remain aspirational rather than grounded in evidence or community insight.

Field interviews suggest that planning is largely directive and top-down, with limited involvement from grassroots actors, male stakeholders, or community influencers. This disconnection leads to programs that do not sufficiently address key deterrents to male participation, such as misconceptions, religious sensitivities, and masculinity norms. Additionally, the absence of gender-disaggregated goals or indicators contributes to the program's failure to recognize men as primary actors in reproductive decision-making. In essence, the program reproduces the feminization of family planning responsibilities despite rhetorical commitments to gender equity.

Furthermore, planning documents rarely identify vasectomy as a distinct priority, often subsuming it under general family planning efforts. This dilutes its strategic visibility and limits the allocation of dedicated resources. The lack of a focused, evidence-based plan for vasectomy dissemination severely weakens the foundation for subsequent management functions.

Organizing: Institutional Fragmentation and Operational Inertia

Organizationally, the vasectomy program operates within a decentralized bureaucracy characterized by poor horizontal and vertical coordination. While the DP3AP2KB is formally tasked with managing family planning efforts, it struggles to synchronize roles and responsibilities across agencies, such as community health centers (Puskesmas), hospitals, religious institutions, and field officers. As a result, program execution suffers from overlapping duties, insufficient accountability, and inconsistent implementation standards across districts.

PLKBs (family planning field workers), who are often the program's frontline representatives, report structural limitations such as lack of specialized training on male contraception, minimal decision-making authority, and inadequate operational budgets. Furthermore, many rural health facilities do not have qualified staff to perform vasectomy procedures, compelling potential users to travel long distances to urban hospitals. This geographical and institutional asymmetry creates significant access barriers, especially for low-income or rural populations.

There is also an evident disconnect between policy-level aspirations and field-level capacities. Bureaucratic compartmentalization hinders cross-sectoral collaboration, particularly between reproductive health and religious affairs offices, which is crucial in addressing normative resistance. The absence of integrated planning cells or interagency task forces dedicated to vasectomy promotion is a missed opportunity to strengthen internal coherence.

From an organizational theory perspective, this fragmentation reflects what scholars have described as "loosely coupled systems," where parts of an institution operate autonomously, without strategic alignment. Without institutional convergence and mutual reinforcement, organizational energy is dispersed, and program effectiveness suffers.

Actuating: Ineffective Communication and Cultural Blindness

Implementation of the vasectomy program reveals a significant failure in communication strategy and public engagement. Although awareness campaigns exist, they are irregular, generalized, and lack culturally tailored content for male audiences. Most campaign materials focus on the broader goals of family planning and maternal health, with minimal specific emphasis on male sterilization. Consequently, vasectomy remains obscure, misunderstood, and stigmatized.

Misconceptions about vasectomy are pervasive and deeply rooted in masculinity constructs. Many men in Riau perceive the procedure as emasculating or irreversible, believing it compromises their sexual performance or spiritual identity. These views are rarely countered through structured education or public discourse. The communication strategy has failed to directly challenge these myths through persuasive, empathetic, and relatable storytelling.

There is also minimal use of testimonial campaigns—an evidence-based strategy that humanizes the decision to undergo vasectomy through the lived experiences of satisfied users. Additionally, male community figures and religious leaders are rarely involved in outreach, despite their cultural capital and influence. The absence of religiously informed messaging limits the program's ability to neutralize doctrinal objections or reinterpret vasectomy within an acceptable ethical framework.

Moreover, community engagement is typically one-directional and event-based rather than dialogical and continuous. PLKBs and health workers report limited opportunities for sustained interaction with men in informal or trusted spaces such as mosques, workplaces, or local forums. This reflects a deeper failure to reimagine men not merely as targets of behavior change but as agents of reproductive responsibility.

Controlling: Weak Monitoring and Lack of Adaptive Learning

The monitoring and evaluation (M&E) dimension of the program is largely mechanical and input-oriented. While DP3AP2KB collects quantitative data on family planning acceptors, including vasectomy users, this data is not systematically analyzed to guide learning or reform. There is minimal use of real-time dashboards, qualitative feedback, or disaggregated indicators to identify where participation is weakest and why. Consequently, the program lacks the capacity to learn from failure, adapt strategies, or replicate success.

Feedback mechanisms from field implementers are also weak. PLKBs report limited avenues to report implementation barriers or propose innovations. Evaluation processes tend to focus on compliance rather than performance improvement. This bureaucratic orientation towards monitoring—focusing on targets rather than insights—results in inertia and stagnation.

Crucially, the absence of post-procedure follow-up with vasectomy acceptors means that long-term outcomes, satisfaction rates, and community spillover effects remain undocumented. Without such feedback, policymakers are blind to the social and psychological impact of the program and are unable to amplify success stories or preempt emerging concerns.

The controlling function thus operates as a static audit rather than a dynamic feedback loop. This violates core principles of strategic public management, which emphasize responsiveness, adaptation, and iterative refinement. Without embedding mechanisms of reflective learning, the program cannot evolve in the face of complex, rapidly shifting socio-cultural terrains.

Synthesis: Misalignment of Strategy, Culture, and Governance

The findings across all four POAC dimensions converge on a critical insight: the vasectomy program in Riau fails not because of a lack of intention, but because of strategic misalignment between institutional design, cultural logic, and managerial execution. The program's structure does not correspond to the sociocultural complexity of male contraceptive

decision-making. Planning is generic and detached, organizing is fragmented, actuating is tone-deaf and inconsistent, and controlling is bureaucratic rather than strategic.

This misalignment reflects a deeper systemic issue—the tendency of public health systems to treat community participation as instrumental rather than relational. Male engagement in reproductive health is not merely a behavioral issue; it is a socio-political process that challenges gender norms, power relations, and collective identities. As long as strategic management remains insulated from these realities, interventions will continue to suffer from low uptake and limited legitimacy.

Ultimately, enhancing public participation in the vasectomy program requires a bold departure from managerial orthodoxy toward a more transformative model of reproductive governance. This model must center cultural dialogue, shared ownership, narrative persuasion, and participatory accountability. Only by integrating technical precision with cultural wisdom and institutional humility can strategic vasectomy program management truly achieve its intended impact in Riau and beyond.

5. Conclusion

The strategic management of the vasectomy program in Riau Province illustrates the persistent disconnect between institutional intentions and the complex socio-cultural realities that shape public health behavior. Although policies supporting male participation in family planning exist, their translation into practice has been undermined by fragmented governance structures, insufficient planning mechanisms, and culturally insensitive implementation strategies. These challenges are compounded by entrenched gender norms, religious misinterpretations, and misinformation, all of which contribute to the persistent exclusion of men from active roles in reproductive responsibility.

What emerges from this analysis is the urgent need for a reconfiguration of how public programs—particularly those addressing sensitive issues like vasectomy—are conceptualized, designed, and delivered. Enhancing public participation requires more than technical efficiency; it demands cultural empathy, strategic integration, and participatory leadership. Male involvement in family planning must be reframed not as a deviation from normative gender roles, but as a legitimate, responsible, and socially valued form of civic engagement.

Future efforts must prioritize inclusive planning that integrates local knowledge, strengthens coordination across sectors, and actively involves religious and community leaders. Outreach strategies should shift from episodic campaigns to ongoing dialogue, embedding narratives that resonate with men’s lived experiences, identities, and aspirations. Monitoring systems must evolve from static compliance checklists into adaptive learning platforms capable of capturing community feedback and facilitating continuous improvement.

By reimagining vasectomy not merely as a medical service but as a cultural and political dialogue about shared reproductive responsibility, program managers and policymakers can foster a more equitable and sustainable public health system. This paradigm shift will not only increase male participation but also strengthen the overall integrity and inclusiveness of family planning programs in Indonesia and comparable sociocultural settings.

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