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Engaging Men: Results of the MenCare+ Gender Justice Program in Indonesia

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Abstract

Indonesia is facing crucial gender gap issues, as is shown not least by high maternal mortality and violence against women, on one hand, and by the low level of male participation in the family planning program, on the other. These issues are partly the results of gender politics that marginalize men. The MenCare+ program is relevant. This study measures the changes in knowledge, attitudes, and behavior of men, married and unmarried, who receive the MenCare+ program interventions, and compares the knowledge, attitudes, and behavior of married men and young unmarried men. The study was conducted in Lampung Province, Indonesia, on 209 participants. The *t* test measured changes in the participants' results. In general, there were positive changes in participants' knowledge (GEM Scale), attitudes, and behaviors, after participating in the MenCare+ activities.

Keywords

gender justice, men's engagement, masculinity, manhood, caring

Introduction

During the last 15 years, the United Nations has called for the involvement of adult and young males in gender equality efforts. The International Conference on Population and Development (ICPD) in 1994 in Cairo noted the importance of involving men in promoting sexual and reproductive health, and emphasized the need to increase male involvement in childcare (World Health Organization [WHO], 2007). Across the globe, there is growing interest in men's roles in fostering gender equality (Flood, 2007).

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Currently, the programs for the development of gender equality and the elimination of violence against women are much more focused on women than on men. It follows that gender issues, violence against women, maternal and child health, and family planning are often perceived as "women's business." On one hand, these situations make men increasingly alienated from gender issues and violence against women. On the other hand, gender justice and equality and the fulfillment of women's rights—such as the right to reproductive health and the right to be free from violence—are difficult to achieve. This difficulty is evident from the persistently high gender gaps in many countries in the form of subordination, double burdens, stereotype labeling, and violence against women. The 2013 Global Gender Gap Report (World Economic Forum, 2013) stated that, globally, gender gaps occur across the areas of health, education, economic participation, and political empowerment.

Thinking about masculinity and men's roles in working toward gender equality is becoming more common in the development field (Greig, Kimmel, & Lang, 2000). Although still limited in scale, work with men to achieve gender equality is occurring on every continent and in many countries (Peacock, Stemple, Sawires, & Coates, 2009). There are solid theoretical and empirical bases for men's engagement. Flood (2007) identifies four essential reasons for engaging men in building gender equality:

1. Men are gendered, not generic, citizens;
2. Many men maintain gender inequality;
3. Men would benefit from gender equality; and
4. Excluding men excludes precisely those whose behavior we are trying to change.

Programs conducted with the aim of enhancing men's role in health care and reducing violence against women have varying results. Many studies find barriers to changes in men's knowledge, attitudes, and behavior, while a number of other studies show success. Malcher (2009) identifies these five societal barriers to men's engagement:

1. stereotyping of men's attitudes to their own health, including a belief that it is unmanly to worry about one's own health;
2. failure to recognize the importance of appropriate education of young unmarried men;
3. service provision not reflecting men's views and changing roles;
4. a dearth of men's programs and workers in community health, including indigenous health; and
5. the marginalization of boys and men by an education system that fails those not suited to conventional educational models.

Funk (2008) identifies two more factors: first, that men have personal handicaps, such as feeling isolated at work and feeling that there is little male support or acceptance, and second, that men face a disconnect between their attitude to women and all other forms of violence, oppression, and social injustice. Other factors include the belief that pregnancy is a "woman's affair" (Nkuoh, Dorothy, Pius, & Nkfusai, 2010),

the mismatch between available services and traditional masculine roles emphasizing self-reliance, emotional control, and power (Addis & Mahalik, 2003), and the traditional masculine beliefs that violence is justified as a way to protect oneself, that having sex is part of a male's role in a relationship, and that males should handle health issues by themselves (Marcell, 2003).

A number of other studies indicate that male engagement has strategic roles in improving sexual and reproductive health rights (SRHR), maternal and child health, and reducing gender-based violence, as well as in building more equal gender relations. Dini (2007) showed that the successful outcomes from women activists' negotiation with men signify that cooperation between men and women is an essential factor in the women's ability to provide needed services to their communities and, in the future, rebuild their nation. Men's engagement in terms of gender equality has positive effects, for example, in children's social and emotional development (McKeering & Pakenham, 2000); in preventing and treating sexually transmitted infections (STIs; Shepard, 2004); in changing social practices that affect the health of both sexes, particularly in the context of HIV and AIDS (Peacock et al., 2009); in lessening men's adherence to the attitudes and values associated with sexual violence and increasing their emotional and moral compassion; and in encouraging men to intervene in the behavior of other men and reduce their future violence (Barker et al., 2011; Flood, 2004; Flood, 2011); and in broadening men's knowledge of maternal care (Nasreen et al., 2012).

There are many studies showing changes in men's cognitive, affective, and behavioral patterns as a result of involvement in gender equality programs (Barker et al., 2011; Crooks, Goodall, Hughes, Jaffe, & Baker, 2007; Flood, 2007; Nasreen et al., 2012), but the significance of those changes needs to be more deeply examined, as do the reasons why men participate in gender equality programs at all. Morrell and Jewkes (2011) identify two reasons for male involvement in domestic chores: (1) care work out of necessity (poverty associated with illness in the family and a lack of resources) and (2) care work as part of a commitment to making a better world. "Care" interpreted as a functional activity is not enough to either create or signify support for gender equity. Only when accompanied by emotional resonance does men's involvement show a commitment to gender equity (Morrell & Jewkes, 2011).

Men's roles in gender justice need a special approach (Crooks et al., 2007; Elsanousi, 2004; Englar-Carlson, & Shepard, 2005; Flood, 2010; Flood, 2013; Johnson, Huggard, & Goodyear-Smith, 2008; Scourfield, 2006; Wells et al., 2013). Peacock et al. (2009), for example, recommend moving beyond treating men simply as "the problem," and instead would engage men both as agents of change and as stakeholders, to the ultimate benefit of both women and men. Human rights and other policy interventions must avoid regressive stereotyping, and successful local initiatives should scale nationally and internationally.

Studies of specific age groups and of marital status are rare. There is a dearth of research on best practices in successful intervention programs for men such as the MenCare+ program. This study aims, as we said, to measure the changes in knowledge, attitudes, and behavior of men, married and unmarried, who receive the MenCare+ program interventions, and to compare changes in the knowledge, attitudes, and behavior of married men and young unmarried men.

Overview of the MenCare+ Program

The program, a collaboration of Rutgers WPF and Promundo-US, seeks to engage men aged 15 to 35 years as caregiving partners in maternal and child health (MCH) and SRHR. The aim is to

1. improve maternal and child health,
2. improve decisions about reproductive health, and
3. facilitate gender equality, and
4. lessen violence based on gender relations (domestic and marital violence).

The following are the four areas of focus of the MenCare+ program:

First, young unmarried men and caregivers are better informed and better able to make healthier choices regarding their sexuality, relationships, maternal health, and caregiving. Second, young unmarried men and women have greater access to contraceptives, including male and female condoms, to promote good health. Third, public and private clinics provide better sexual and reproductive health care services, including countermeasures to domestic violence. Fourth, there is greater respect for the sexual and reproductive health rights of people to whom these rights are still in many cases denied. The targets of the program are married men aged 25 to 35 years and young unmarried men aged 15 to 25 years.

The uniqueness of the MenCare+ approach is its full set of complementary and integrated interventions, having a bigger effect than the only one or two interventions of the global MenCare campaign (as distinct from MenCare+, "MenCare Plus").

The MenCare+ program integrates the following six interventions:

1. Group education of young unmarried men on SRHR and caregiving (Program H)
2. Fatherhood group education (Program P/M, "One Man Can")
3. Community MenCare+ campaigns
4. Health sector training in SRHR and MCH, including pre- and postnatal care, for fathers
5. Perpetrators' counselling to stop intimate partner violence
6. Engaging men in SRHR and MCH and stopping sexual and gender-based violence (SGBV), through legal advocacy at the district, national, and international levels (Rutgers, 2014).

The program was implemented in Brazil, Indonesia, Rwanda, and South Africa. In Indonesia, the MenCare+ program was conducted in Lampung Province, East Java Province, and the Special Region of Yogyakarta, starting in 2013, and running to 2015. In each province, the program was conducted in two regencies. In each of those regencies there were two intervention subdistricts, and in each of those subdistricts there were two intervention villages.

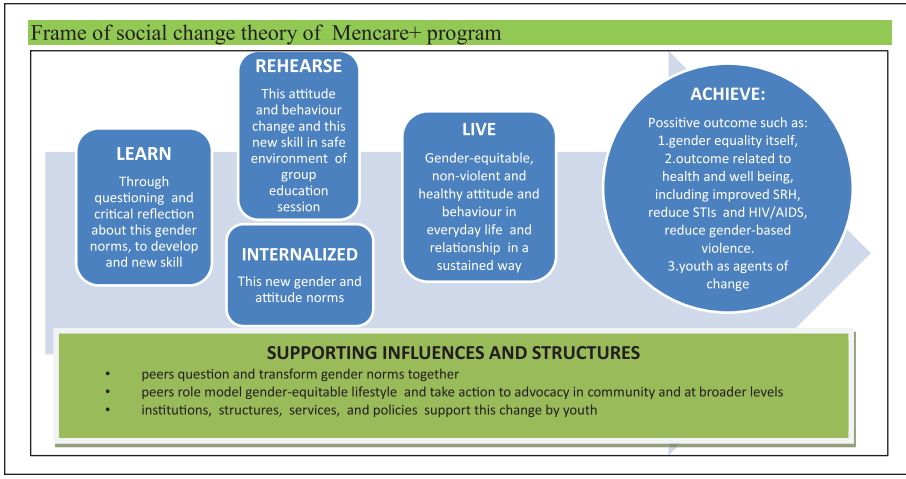

Figure 1. Frame of social change theory of MenCare+ program.
Source. Promundo, Instituto PAPAI, Salud y Género and ECOS (2013).
Note. STI = sexually transmitted infection.

Thus, there were a total of eight intervention villages in each province. The H and P/M programs (see Figure 1 above) were conducted through the main activity of fatherhood training in one session (13 topics) followed by weekly community discussions (10 times, 10 modules). The men for training and discussion were selected from each village, comprising between 10 and 12 for each group of married men and young unmarried men in one round (1 year). There were a total of three rounds corresponding to the 3-year period of MenCare+ intervention program. Each session of discussion lasted 2-3 h for one module. In addition, there were a number of other activities that strengthened the MenCare+ campaign, such as home visits, stakeholders workshops, community campaigns, media road shows, journalist forums, advocacy, and role play.

Method

Indonesia is the world's largest archipelago country with 13,466 islands and a land area of 1,990,250 million km^2 divided into 34 provinces. Indonesia is a multicultural country that has more than 350 ethnic groups. This study of the MenCare+ program is conducted in the two regencies (Bandar Lampung City and West Lampung Regency) in the Lampung Province that ran it.

A total of 209 men were involved in the present study, consisting of 105 married men and 104 unmarried men.

The study is longitudinal, using the cohort technique. Changes in knowledge, attitudes, and behaviors are measured by comparing the participants' pretest and posttest results. Data were collected between January 2014 and January 2016. The *t* test determines the differences in pre- and postinterventional conditions and the differences between groups.

Table 1. Respondents' Sociodemographic Background.

Characteristics	Category/ parameters	Married men group (%) (*N* = 105)	Young unmarried men group (%) (*N* = 104)
Age	<20 years	3	9
	20-25 years	13	84
	26-30 years	73	7
	31-35 years	10	0
Level of education	Elementary school	4	1
	Junior high school	24	15
	Senior high school	71	79
	University	2	5
Religious Orientation	Islam	95	96
	Christian	3	1
	Hindus	2	3
Marital status	Single	0	100
	Married	100	0
	Divorced	0	0

Results

Respondents' Sociodemography

The sociodemographic background of respondents was quite varied in terms of age, ethnicity, and education level (Table 1). In general, the education level of respondents from urban areas was higher than that of respondents from the rural areas. Most young unmarried men from Bandar Lampung are high school graduates or university students. Most young unmarried men from West Lampung have only junior high school education and few are high school graduates. Some from Bandar Lampung already have a job, but most from West Lampung work as farmers.

Most married men from Bandar Lampung are high school graduates and some are college graduates. Most married men from West Lampung, by contrast, junior high school graduates and only a few are high school graduates. Some from Bandar Lampung are professionals such as teachers, but most from West Lampung again work as farmers.

Attitudes Toward Gender Equality

In this study, attitudes toward gender equality are measured for both married and young unmarried men. We use 13 questionnaire items with responses of "agree," "somewhat agree," and "disagree."

Table 2 shows significant changes in Gender-Equitable Men (GEM) score for both groups. This means that the MenCare+ program interventions in the forms of training and serial discussions have positive impacts in terms of changing the participants' gender perspective. The biased gender perspective currently evident in

Table 2. Differences in Attitudes Toward Gender Equality Among Groups of Married Men and Young Unmarried Men.

No.	Items	Married men			Young unmarried men		
		Mean pretest	Mean posttest	*p* value	Mean pretest	Mean posttest	*p* value
1	The most important role of a woman is taking care of the house and cooking for the family.	1.7	2.9	<.001	1.8	2.8	<.001
2	Women who carry condoms are "sluts."	2.0	2.9	<.001	2.0	2.9	<.001
3	Changing diapers, bathing, and feeding of children are responsibilities of a mother.	1.9	2.9	<.001	1.8	2.9	<.001
4	In my opinion, a woman can suggest using condoms as a man can.	1.0	1.7	<.001	1.1	1.5	<.001
5	Avoiding pregnancy is the responsibility of a woman.	1.9	2.9	<.001	1.8	2.9	<.001
6	The final decision in the household must be made by a man.	1.9	2.9	<.001	1.7	2.8	<.001
7	A woman should tolerate violence to maintain the integrity of the family.	1.9	2.9	<.001	1.9	2.9	<.001
8	Selection of the type of contraceptives used should be decided by the woman and man.	1.0	1.7	<.001	1.0	1.3	<.001
9	A man may simply beat his wife if she refuses sex with him.	2.2	2.9	<.001	2.5	2.9	<.001
10	I would not have any friends who are homosexual.	1.6	2.9	<.001	1.7	2.7	<.001
11	If a man makes a woman pregnant, the baby is the responsibility of both.	1.2	2.8	<.001	1.0	1.1	.055
12	The presence of a father is important for the lives of their children, even if he is not with the mother anymore.	1.0	1.2	<.005	1.0	1.2	<.005
13	Real men have sex only with women.	1.0	1.4	<.001	1.2	1.5	<.001
	Overall pre- & posttest GEM scores	18.4	29.1	<.001	18.6	26.5	<.001

Note. GEM= Gender-Equitable Men.

society could be transformed into an equitable perspective through such discussions. In general, changes in cognition occur among participants after participating in these discussions. Furthermore, a *t* test of the groups of married men and young unmarried men shows a *t* value of 1.02 ($p = .055$), meaning that there is no significant difference in the changes for the groups of married men and young unmarried men.

Antenatal Care (ANC) and Postnatal Care (PNC)

ANC and PNC are an aspect of behavior expected to change after the MenCare+ program. ANC refers to a man's involvement in care as a companion to his wife at least four

Table 3. Comparison of Attitude Toward Contraception Among Married Men and Young Unmarried Men.

Items	Married men			Young unmarried men	
	Mean pretest	Mean posttest	*p* value	Mean pretest	Mean posttest
Men who use a contraceptive are perceived as weak compared with those who do not	2.9	4.2	<.001	1.8	1.9
Couples should talk about contraception before having sex	2.1	2. 6	<.001	2.2	3.1
Two individuals who have sex should use some sort of contraceptive if they are not ready to have a baby	1.9	2. 6	<.001	2.8	3.5

Table 4. Comparison of Pretest and Posttest Results for Groups of Married Men and Young Unmarried Men in Terms of Attitudes Toward Condoms.

No.	Items	Married men			Young unmarried men		
		Mean pretest	Mean posttest	*p* value	Mean pretest	Mean posttest	*p* value
1	Condoms are an effective method for preventing the spread of HIV and other sexually transmitted infections	2.0	2.6	<.001	2.4	3.0	<.001
2	Condoms are less reliable for preventing pregnancy	2.7	4.2	<.001	1.7	1.9	<.001
3	Condoms interfere with the enjoyment of sex	2.7	4.2	<.001	1.8	1.9	<.001

times during pregnancy. PNC refers to male involvement as a companion in childbirth and in baby care until the baby is 1 year old. Changes in this aspect are measured only for the group of married men. During the pretest, there were nine respondents awaiting the birth of their child. Eight respondents reported accompanying their wife "several times" both for ANC and PNC. Six respondents said they "always" accompanied their wives and 81 respondents report "never" doing so. These figures do not change much at the posttest. A total of seven respondents say "several times," seven say "always," and again 81 say "never," Mean pretest is 0.333, mean posttest 0.323, and *p* value 0. This means that there is no significant difference in men's role in ANC and PNC between pretest and posttest.

Attitudes Toward Contraception

In this study, men's views on contraception tend to be negative early in the program, and the views change after intervention, to a more positive view. Table 3 shows changes for both groups. The only aspect not changing is Item 1, "Men who use a contraceptive are perceived as weak compared with those who do not," among young

Table 5. Comparison of Pretest and Posttest Results for Groups of Married Men and Young Unmarried Men in Terms of Sexual Satisfaction and Relationship Satisfaction.

	Married men			Young unmarried men		
Items	Mean pretest	Mean posttest	*p* value	Mean pretest	Mean posttest	*p* value
I think I am a good sexual partner	2.2	3.0	<.005	1.9	2.9	<.005
I am happy with my sexual life	1.6	1.9	<.015	1.0	2.3	<.001
I feel that my partner enjoys our sex life	1.2	2.8	<.001	1.5	2.9	<.001

Table 6. Pretest and Posttest Comparison of Division of Childcare Duties for the Group of Married Men.

	I do it all		I usually do it		It is shared equally or done together		My spouse usually does it		My spouse does it all	
Duties	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Taking care of children daily	1	0	24	0	56	104	8	1	16	0
Keeping a sick child at home	1	0	27	0	57	102	11	3	9	0
Picking up the kids from their schools or daycare	5	0	36	12	56	93	7	0	1	0

unmarried men. Otherwise, after *t* test, there are no significant differences in changes in attitude between the groups ($t = 1.03$; $p < .005$).

Training and serial discussions in the MenCare+ program emphasize changing the attitudes of the participants toward condoms (Table 4). The *t* test shows no significant differences between groups ($t = 1.00$; $p < .005$).

Sexual Satisfaction and Relationship Satisfaction

There is a change in a positive direction in general in the level of sexual satisfaction for both groups, as Table 5 shows. The *t* tests show that the change is greater for unmarried men than for married men ($t = 2.05$; $p < .001$).

Childcare and Sharing of Childcare

Men's role in childcare is an important component of the MenCare+ program, specifically aimed at the group of young fathers. Male involvement in childcare is a manifestation of men's responsibility for their family. The program encourages men to be more involved in childcare. It explains the various benefits through training and community discussions as well as various other events. Table 6 shows pretest and posttest

changes in the pattern of sharing of childcare duties among married men. Childcare duties among married men are those duties likely to be shared equally or done together flexibly by the husband and wife. The *t* test was 2.45 ($p < .001$), meaning that those changes are significant.

Use of Sexual Reproductive Health (SRH) Services

The following were three questionnaire items relating to the use of SRH services to be answered only by the group of young unmarried men: "When was the last time that you sought health care for yourself in a clinic or hospital for sexual or reproductive health problems?" "What type of sexual or reproductive health care did you seek?" "Why were you comfortable with the service (if you felt comfortable) and why were you uncomfortable with the service (if you felt uncomfortable). In the pretest, only three (3%, $N = 104$) respondents use SRH to obtain information about sex, family planning, or STIs. In the posttest, the number increases to 30 respondents (29%). The types of examination include HIV tests (9), information about sex, family planning, or STIs (16) and others (5). This finding suggests that the MenCare+ program increases demand for SRH information among young unmarried men.

Use of Alcohol and Addictive Substances

At the time of the pretest there were only four people in the group of married men claiming to have used alcohol in the last 3 months. All participants reported never using either soft or hard drugs. At the time of the posttest, all participants claimed not to have used alcohol, or either soft (such as cannabis) or hard (such as cocaine and heroin) drugs. Four participants in the group of young unmarried men reported using alcohol within the last 3 months. One used soft drugs, and none used hard drugs. At the time of the posttest, three participants claimed to have used alcohol. Four participants claimed using soft drugs and none used hard drugs.

The *t* test shows a *t* value of 0.30 and *p* value of .015 for the group of married men and *t* value of 0.31 and *p* value of .015 for the group of young unmarried men. This means there is no significant difference between the pretest and posttest use of addictive substances for both groups. Thus, the MenCare+ program in this regard does not change the use of addictive substances. Only a small number of the participants use such substances at all. The low use is related to the prohibition by Islamic teachings and to the Indonesian government's policy of strict controls on the circulation of such goods.

(Risky) Sexual Behavior, Condom Use, and HIV Testing

Twenty (19%, $N = 105$) married men at the time of the pretest and posttest reported having had sexual intercourse with more than one partner in the past 3 months. Eighteen reported having had sex with three, four, or five partners, and two with more than 10 partners. Of the 20 respondents of the group of married men who

Table 7. Pretest and Posttest Comparison of Domestic Violence Prevalence Among Married Men.

Situation	% of respondents who abused at least once in the last 3 months		*p* value
	Pretest	Posttest	
Have you hit your partner with your hands or tools that could injure her one or more time in the last 3 months?	59	21	<.001
Have you forced your partner to have sex when she has not wanted it? (vaginal, anal, or oral sex) one or more time(s) in the last 3 months	7	0	<.005

reported to have had sexual intercourse with more than one partner, two used a condom, two used a condom occasionally, and the remaining 16 never used condoms. These numbers do not change post test. No respondent of the group of young unmarried men reported having had sexual intercourse in the last 3 months either at the pretest or posttest.

Of the 20 respondents of the group of married men who reported having had sexual intercourse with more than one partner, two respondents reported using a condom during the intercourse, two respondents occasionally, and the remaining 16 respondents had never used condoms. This condition did not change at the posttest. Of those respondents who reported having sexual intercourse with only one regular partner, condom use was also very low (only 4 respondents) both at the pretest and posttest. A total of 85 respondents had sex with only one permanent partner and, at the pretest, 62 of them claimed to have "always," 2 "often," 2 "sometimes" and 19 "never" used condoms. This condition slightly increased at the posttest in which 66 respondents admitted to have "always," 4 "often," 3 "sometimes," and 12 "never" used condoms.

Partner Violence/Sexual Assault/Domestic Violence

The questionnaire items related to partner violence/sexual assault/domestic violence were to be answered only by the group of married men. Table 7 shows changes in the positive direction in terms of domestic violence among married men. The most frequent act of domestic violence was physical violence, such as beatings either by hands or tools capable of injuring the partner. The *t* test showed significant changes with a *t* value of 2.3 ($p < .001$).

Discussion

Gender transformative programs aimed at promoting equality of gender relations constitute the most effective interventions among those programs addressing the

issues of gender equality (WHO, 2007). The present study confirms this finding. In general, the MenCare+ program improves the cognitive aspect and also attitudes and behaviors. The negative attitudes toward contraceptives, for example, become more positive. Similarly, those behaviors born of gender bias, such as domestic violence, are reduced in frequency and intensity. Married men share domestic chores and childcare, and young unmarried men more frequently seek SRH help.

Behaviors reflecting traditional gender norms and inequalities foster HIV, STIs, and violence (Pulerwitz & Barker, 2008). Norms of male dominance, superiority, and masculine "honor" are widespread, reinforced by large-scale militarization of countries, a process which has devastating impacts on women through economic upheavals, cultural dispossession, and poverty due to loss of land or lack of employment (Becker, 2003). Transformations of gender norms toward gender equity thus help improve the situation of women. Implementing the MenCare+ program helps transform gender-equitable norms. Improved GEM scores for both groups of young unmarried men and married men reflect a positive (gender-equitable) shift, and this facilitates further changes, such as attitudes toward contraception, involvement in childcare and domestic tasks, risky sexual behaviors, and violence against women.

The MenCare+ program is part of a global campaign to promote equitable, nonviolent relationships between men, women, and children. It posits that men's involvement in domestic work, in maternal health care, in violence prevention, and as caregivers for children is a necessary and largely overlooked aspect of achieving gender equality. We show that male involvement in the MenCare+ program contributes to the establishment of more gender-equitable relations as indicated by, for example, a reduced level of violence against women. The MenCare+ program intervenes by, for example, counselling perpetrators, with the aim of breaking the cycle.

The international community is increasingly convinced that engaging men is crucial to achieving gender justice (Barker et al., 2011). According to the WHO (2010), work with men is the key to advancing gender equality and improving the health of women and men. Men can change. The patriarchal culture can be transformed. As in certain cultures men are the main decision makers, they are the key to changes in their own attitudes and behavior.

Many studies show that traditional masculinity has adverse effects: suicide (Braswell & Kushner, 2012), depression or hopelessness (Krames, England, & Flett, 1988), risky health behaviors and stoic denial (McCann, Stewin, & Short, 2010; Morioka, 2014; Odimegwu, Pallikadavath, & Adedini, 2013; Reed, 2013; Smith, 2006; Stern & Buikema, 2013; Wall & Kristjanson, 2005), difficulty in seeking counselling (Emslie, Ridge, Ziebland, & Hunt, 2006), and even crime (McFarlane, 2013). It's clear that traditional masculinity needs to be transformed into masculinity with a gender-equitable perspective. Interventions such as the MenCare+ program can benefit men, women, families, and communities. In addition, another lesson learned is that the scale of changes that occur in the community alone remains very limited. Therefore, there must be changes through a

variety of communication and advocacy efforts, at the local, national, and international levels.

This study has certain limitations: the limited population and sample, and our quantitative approach. The quantitative approach does not reveal the intentions and sincerity of men in making changes. A qualitative study, which we suggest as an option for future research, will reveal the emotional involvement in the male role, which, according to Morrell and Jewkes (2011), better ensures equality of gender relations. Furthermore, a qualitative approach will identify the key roles in the process of change in communities. We recommend using mixed methods in future evaluations of gender equality programs involving men.

Conclusion

The MenCare+ program implemented in Lampung Province changed gender relations in communities. Some indicators of success include the following:

- a more positive attitude toward gender norms and contraception,
- increased sexual satisfaction and relationship satisfaction,
- increased male involvement in childcare,
- increased use of SRH services (particularly young unmarried men), and
- a decrease in domestic violence.

We see no significant difference in the changes occurring among the group of married men and young unmarried men. This means that these two groups have been acting as effective agents of social change. Nevertheless, this program has not been fully successful in increasing demand for health care and counselling services.

The key to success is the involvement of men, taking into account the prevailing patriarchal culture. Changes in attitude and behavior begin with changes in critical awareness among men about the importance of gender equality in communities. Men feel the benefits of the changes that occur in themselves and their families. This confirms the findings of Barker et al. (2011) who state that men with a more gender-equitable attitude will be more likely to be happy, establish a harmonious relationship with their partner, and have a better sexual life.

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