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Article

From training to practice: the impact of ENGAGE, Ireland's national men's health training programme

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Summary

Ireland's National Men's Health Policy recommended developing training programmes tailored to the needs of those working in health and allied health professionals and ENGAGE was developed to meet that recommendation. This study evaluated the impact of ENGAGE on frontline service providers' self-reported knowledge, skills, capacity and practice up to 5-months post training. Between 2012 and 2015, ENGAGE Trainers ($n = 57$) delivered 62 1-day training programmes to 810 participants. This study was conducted on a subset of those training days ($n = 26$) and participants. Quantitative methodologies were used to collect pre ($n = 295$), post ($n = 295$) and 5-month post ($n = 128$) training questionnaire data. Overall, participants were highly satisfied with the training immediately post training (8.60 ± 1.60 out of 10) and at 5-month follow up (8.06 ± 1.43 out of 10). Participants' self-reported level of knowledge, skill and capacity in identifying priorities, engaging men and influencing practice beyond their own organisation increased immediately following training ($P < 0.001$) and, with the exception of improving capacity to engage men and influencing practice beyond their organisation, these improvements were sustained at 5-month post training ($P < 0.001$). The vast majority of service providers (93.4%) reported that ENGAGE had impacted their work practice up to 5-month post training. The findings suggest that ENGAGE has succeeded in improving service providers' capacity to engage and work with men; improving gender competency in the delivery of health and health related services may increase the utilisation of such services by men and thereby improve health outcomes for men.

Key words: men's health, gender sensitive services, training of trainers, sustainability

INTRODUCTION

Background

Most epidemiological indicators suggest poorer health outcomes for men compared to women across the lifespan (White *et al.*, 2011) and these 'health inequalities' have leveraged much support for increasing the spotlight on men's health in recent years (Richardson and Carroll, 2009). Poorer health outcomes for men have been attributed to a range of factors, including

biology (Kraemer, 2000), lifestyle behaviours (Denton *et al.*, 2004; McCartney *et al.*, 2011), social factors (Scholz *et al.*, 2014) and gender (Oliffe *et al.*, 2012; Evans *et al.*, 2011). In particular, questions have been raised about men's under-utilisation of health services and this has been identified as a principal issue associated with improving health outcomes for men (Galdas *et al.*, 2005; Robertson *et al.*, 2008).

Despite the popular stereotype however, that men access health services less than women do, evidence suggests that men are willing to engage in self-care and take responsibility for their health. For example, evidence from Ireland indicates critical transition points in men's lives, such as fatherhood, ageing and the experience of a health crisis, typically coincide with men having a heightened sense of responsibility for their own health (Richardson, 2010). Previous studies have also shown that when men have been diagnosed and are undergoing treatment for an illness, a comparable level of self-care exists between the sexes (Galdas *et al.*, 2005; Wang *et al.*, 2013). However, significant differences exist in the way men and women seek help about health (Robertson *et al*, 2008). Many men delay using services in the course of an illness and this is associated with delayed diagnosis and treatment and ultimately poorer health outcomes (Doyle, 2001; Banks, 2001). In Ireland and elsewhere, and across all ages and all socioeconomic groups, men utilise general practitioner services, the gatekeepers to further services within the health care system, less than women (Central Statistics Office, 2011; Wang *et al.*, 2013). Furthermore, when men seek professional help, it has been suggested that they ask fewer questions than women do (Courtenay, 2000).

Men's under-utilisation of services has been attributed to many factors. Men are more likely to delay seeking help for particular health issues such as physical disabilities (McKee, 1998), mental, emotional (O'Brien *et al.*, 2005) and sexual concerns (McKee, 1998). Poor symptom recognition (Addis and Mahalik, 2003), a general lack of awareness of health (Banks, 2001), a lack of engagement with and utilisation of health information (Ek, 2013), and a propensity to trivialise symptoms (O'Brien *et al.*, 2005) have also been associated with men's delayed help seeking. A growing body of literature indicates a significant role for 'masculine beliefs' in help seeking behaviour and health risk appraisal by men when they become ill (Oliffe *et al.*, 2012). Evidence suggests that men struggle to acknowledge their symptoms or illness to others and even to themselves, and avoid seeking help because of stigma (Oliffe *et al.*, 2012; Davies *et al.*, 2000) and to conform with a socially prescribed male role of being strong (Galdas *et al.*, 2005, Evans *et al.*, 2011). There is, however, evidence of ways in which men may maintain their masculinity in help seeking; Scholz *et al.* (2016) found that men may resist a stigmatised, feminised position on help seeking by constructing help seeking as responsible and wise and in fact a failure to seek help as 'stupid'. This is in keeping with O'Brien *et al.* (2005), who identified a 'hierarchy of threats' to masculinity with respect to help seeking; for men whose occupational role gave them access to a strong masculine identity (e.g. fire fighters) early help seeking, even for 'trivial' symptoms, was important to allow them to maintain their health and job; while for some men with sexual health issues, not being able to have sex posed a greater risk to their masculinity than seeking professional help.

Notably, there is a dearth of evidence in relation to men's use of non-health care services such as community based services. Such services typically promote social integration that may have both direct benefits to health and act as a stepping stone to traditional health care settings. Indeed, Ford *et al.* (2015) found that men's self-identification as part of a community group was a factor that made them more willing to take health advice and communicate about health issues. Considering the World Health Organisations' broad definition of health (World Health Organisation, 2005), health related services for men occur in a variety of settings and are provided by a broad range of service providers that ought to be considered within the wider context of men's help seeking behaviour and use of services.

Many service providers, however, view men as being 'hard to reach' (Carroll *et al.*, 2014; Zwolinsky *et al.*, 2012) and are unclear about the type of services that might appeal to or engage men (Hobbs, 1995; Barton, 2000). The absence of male practitioners and a preponderance of waiting room material for women and children have been associated with male environments and make many men feel unwelcome or unsafe (Banks, 2001). An Irish study found that a lack of capacity among service providers was a particular issue for male service users (Institute of Public Health, 2011). In a survey of the types of services available for boys and men, Monaem *et al.* (2007) reported that in the majority of cases [80–100%], service providers felt they did not successfully deal with their clients' concerns. In addition, lack of knowledge and skills among men was of particular concern to service providers in areas such as availability of services, communication and aetiology of diseases (ibid). Consequently, in order to reorient health and social services to effectively engage men, services providers need to be supported to adopt gender sensitive work practices. Specifically,

service provision needs to be informed by an understanding of men's beliefs, values and attitudes to ill-health and health and social services in terms of how messages are communicated and services are delivered to men (Galdas *et al.*, 2005).

Robertson *et al.* (2008) pose the question as to whether it is more effective to provide different services to men or the same services in a different way. Increasing evidence suggests that men will engage with gender sensitive services. For example, in the context of services designed to promote weight loss or weight management, we know that men are more reliant on exercise than nutrition to maintain a healthy weight (Robertson *et al.*, 2014) and prefer community settings (Carroll *et al.*, 2014) or sports clubs (Hunt *et al.*, 2014) to healthcare settings (Robertson *et al.*, 2014). Interventions are also more likely to be effective if they are based upon the behaviour change theory and include family and friends (Robertson, 2008). Other strategies that have been found to be effective in engaging men include; adopting strengths-based approaches that revolve around creating safety, trust, rapport, and meaningful relationships with men; using strong, positive messages that encourage men to engage with services without amplifying shame or blame; connecting positive masculine identities with being healthy and productive; reflecting the wishes of men to maintain control and to engage with services on their own terms and in their 'own way'; and sharing men's stories to show common challenges, to foster peer-support and to create a community of mutual help (Oliffe *et al.*, 2011; Lefkowich *et al.*, 2015; Grace *et al.*, 2016).

Notwithstanding the emergence of promising examples of effective practice in engaging men, there is little evidence to suggest that such practice is being adopted more universally. Indeed, White *et al.*, (2011; p93) reported that, within an EU context little was being done within member states to engage those men, in particular, who were most in need of services. The authors found:

'...few initiatives that were directly focused onto the needs of men, either in a form that men would use or in places that men would more easily access'.

Not surprisingly, there have been repeated calls for greater provision of gender sensitive health related services for men. The Australian (Department of Health and Ageing, 2010) and Brazilian (Ministry of Health, 2009) men's health policies have prioritised improved access to health care for men through tailored initiatives and services while Ireland's National Men's Health Policy (NMHP) specifically recommended developing training programmes tailored to the needs of those working in health and allied health professions (Department of Health and Children, 2008; R7.2, p65).

Against a backdrop of i) men's under-utilisation of certain services, (ii) challenges from the service providers' perspectives in engaging men, (iii) increasing evidence in support of more gender-sensitive or 'men-friendly' services, and (iv) in response to men's health policy recommendations for the provision of training to service providers on how to effectively engage men, 'ENGAGE', Ireland's National Men's Health Training Programme, was developed. The ENGAGE training programme is a comprehensive 1-day training that aims to increase participants' understanding of best practice in engaging men with health and social services and ultimately seeks to address, what has been highlighted at a research and policy level as a deficit in gender sensitive service provision for men.

An overview of the ENGAGE programme and its implementation

The process of developing, delivering and maintaining the ENGAGE training has been outlined in detail elsewhere (Lefkowich *et al.*, 2016)). In brief, the ENGAGE training was overseen by the 'ENGAGE Team' ($n = 6$). Four organisations partnered to create the ENGAGE training; a facilitator from each organisation developed the training which was underpinned by research evidence and experience in practice. The facilitation team was responsible for the delivery and updating of the resources. An editor oversaw the production of the resources and was responsible for creating the online discussion forum. The coordinator fulfilled an administrative role and was responsible for communicating with the group of Trainers. In addition to these human resources, core funding of €35,000 was also required to implement the ENGAGE programme. ENGAGE was piloted over a 24-month period amongst a variety of sectors (see Figure 1) before delivery to Trainers.

A Training of Trainers (ToT) model of delivery was adopted to maximise the efficient delivery of ENGAGE across a wide geographical area. Whilst evidence pertaining to the process of delivering ToT programmes for maximum diffusion is limited, previous studies have shown that multifaceted, interactive ToT workshops can be an effective means of disseminating and implementing professional development curricula (Pearce *et al.*, 2012; Lai *et al.*, 2016).

Following a wide marketing strategy, Trainers were selected based upon the strategic relevance of their representative organisation to men's health, having a remit to deliver training, having facilitation experience and knowledge of men's health. As ENGAGE was defined as a national programme, Trainers within each training

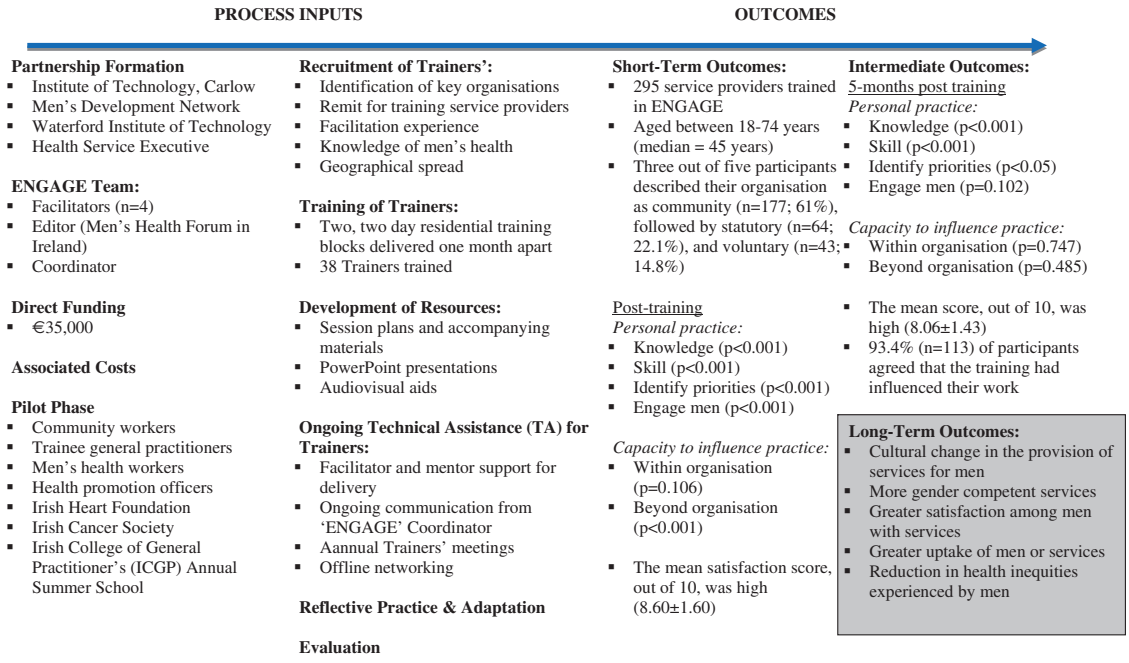

Figure 1.'ENGAGE', National Men's Health Training Programme: Logic Model and Indicator Results.

Note: Gray shaded areas are outside of the scope of this evaluation. Adapted from Dilley et al. (2009) and Pommier et al. (2011).

group represented a national geographical spread. Each Trainer was asked to commit to deliver three, 1-day ENGAGE training days to front line service providers.

All ENGAGE Trainers underwent two 2-day residential training blocks delivered one month apart. In keeping with best practice (Prior *et al.*, 2008; Grol and Grimshaw, 2003) experiential and interactive methodologies were used to deliver the five ENGAGE units which are as follows;

- Unit 1: Overview of Men's Health (including Gender and Social Determinants)
- Unit 2: Men's Health and You: Practitioner Values and Support
- Unit 3: Guiding Brief Interventions with Men
- Unit 4: The Rules of Engagement
- Unit 5: Establishing a Men's Development Group and Sustaining Engagement

Opportunities were created for Trainers to share their own knowledge and experience of working with men so that they could learn from and be supported by one another. Consistent with adult learning theory, Trainers were also given the opportunity to practice using the skills and information that they had received by co-facilitating a workshop to their peers on the second 2-day residential training block (Spencer and Jordan, 1999). Networking amongst the community of Trainers was encouraged via an online discussion forum and offline via the sharing of contact details.

Trainers were resourced with an ENGAGE training resource pack that comprised the 1-day training schedule; session plans, accompanying materials and a USB key with PowerPoint presentations and audio-visual aids. All resources were also made available online at a password protected site. While the effectiveness of including accompanying learning materials in a ToT programme is unclear (Pearce *et al.*, 2012), a number of studies have found that combining a ToT programme with learning materials to support Trainers after the training was more effective than the ToT programme alone (Tziraki *et al.*, 2000; Martino *et al.*, 2011). Trainers were also equipped with a promotional flier to support them to recruit service providers for their 1-day training, and all service providers who attended a Trainers' ENGAGE training received certification.

Post training, technical assistance was offered to Trainers in the form of co-facilitation with either a facilitator or later a mentor who was an experienced Trainer. There was ongoing communication from the coordinator and facilitators to encourage the uptake of

support for delivering training. Annual Trainer 'refresher' meetings were also hosted. Facilitators participated in ongoing reflective practice and consultation with Trainers. Updates were made available to Trainers by updating the online resource repository.

Findings from the ENGAGE process evaluation (Lefkowich *et al.*, 2016) suggest that the stringent selection process used to select Trainers, together with the post training bottom up (mentoring and peer networking) support of Trainers, were central to creating 'active' Trainers. However, the importance of top down (managerial) support to ensure the diffusion of training to front line service providers was also highly significant (Ibid).

From 2012 to 2014, a total of 57 Trainers were trained in three cohorts. At the end of September 2015, 62 training events had taken place and a total of 810 front line service providers were recipients of ENGAGE training. In the current study, the impact of the ENGAGE training on a subset of trainings [$n = 26$] and service providers [$n = 300$] was assessed up to 5-month post training. Specifically, this study sought to ascertain whether the ENGAGE training had an impact on service providers' practice when working with men in relation to the acquisition of knowledge, skills and capacity to engage men.

METHODOLOGY

Cross-sectional surveys were administrated to all participants pre-training, immediately post-training and 5-month post training for the period May 2013 to January 2015. Data were collected 5 months post follow up to both allow practitioners sufficient time to integrate the training in their practice and to meet the timeframe of the evaluation. A sample population of 300 service providers was required for this study in order to detect changes in the variables measured while accommodating for the expected drop off in responses at 5-month post training (Dilley *et al.*, 2009). This was achieved in the first 26 ENGAGE trainings, however, five questionnaires were excluded due to a large number of missing values (final sample size = 295). Response rate at 5-month post training was 43% ($n = 128$). Pre, post and 5-month post training questionnaires were adapted from those used elsewhere (Dilley *et al.*, 2009). In addition to demographic data, participants were questioned about their personal practice defined in the context of this study as knowledge, skill and capacity to engage men. Likert scale questions were used to assess how participants rated (i) their level of knowledge of men's health; (ii) their level of skill in engaging men in their services; (iii) their capacity to identify priorities for men's health that could meet the needs of their organisations; and (iv) their capacity to engage men in their services in the future. Likert scale questions were also used to assess how participants rated their capacity to influence the practice of others, within and beyond their organisations, to prioritise men's health in their work plans in the future.

Ethical approval for this study was granted by Waterford Institute of Technology Research Ethics Committee [13/HSES/04] and Institute of Technology Carlow Research Ethics Committee [Ethics Reference No:95]. Written informed consent was provided by all participants and no participant refused consent. At 5-month post training, participants were emailed the final questionnaire. Those who did not respond were sent up to two further reminder emails followed by a final telephone/text reminder.

Statistical analysis

Questionnaire data were entered into the Statistical Package for the Social Sciences (SPSS V.22) for analysis. Initial analysis was conducted using descriptive statistics. Wilcoxon signed-rank tests were used to assess differences in personal practice and to assess differences in the capacity to influence the practice of others over the three measurement points (pre-training, post-training and 5-month follow up). Cases were selected so that analysis was carried out on the same people who responded in both pre and post training questionnaires and pre and 5-month post training questionnaires.

Mann-Whitney *U* tests were used to examine associations between the independent (knowledge, skill and capacity) and dependant (commitment to men's health work) variables at 5-month post baseline. No significant association was found between the variables so regression analysis was not pursued.

RESULTS

Participants were aged between 18–74 years (median = 45 years), with slightly more females ($n = 167$; 56.6%) than males ($n = 128$; 43.4%). When asked to best describe the organisation that they represented, three out of five participants described their organisation as a community ($n = 177$; 61%), followed by statutory (state-sponsored bodies) ($n = 64$; 22.1%), voluntary ($n = 43$; 14.8%), and other ($n = 6$; 2.1%). Three out of 10 participants (30%; $n = 88$) were 'health sector' representatives based within the community or statutory organisations. The majority of participants reported that their organisation worked within a local geographical

Table 1: Change (mean ± SD) in self-reported knowledge, skill and capacity immediately and up to 5-month post training

	Pre-training Mean (SD)	Post-training Mean (SD)	5-month post training Mean (SD)
Level of knowledge	5.58 (1.68) ($n=248$)	7.43 (1.36)* ($n=248$)	6.96 (1.58)* ($n=114$)
Level of skill	6.12 (1.70) ($n=267$)	7.20 (1.55)* ($n=267$)	7.03 (1.52)* ($n=116$)
Improving capacity in identifying priorities	3.34 (0.84) ($n=221$)	3.91 (0.70)* ($n=221$)	3.75 (0.67)** ($n=101$)
Improving capacity to engage men	3.84 (0.77) ($n=230$)	4.09 (0.66)* ($n=230$)	3.74 (0.71) ($n=106$)

*$P<0.001$; ** $P<0.05$.

area ($n=176$; 60.9%), with 21.8% working nationally ($n=63$) and 17.3% working regionally ($n=50$).

Overall, participants were highly satisfied with the training. The mean satisfaction score, out of 10, was high immediately post training (mean = 8.60; SD = 1.60) and at 5-month follow up (mean = 8.06; SD = 1.43). Of those who described their organisation's target population of service users ($n=265$), 21.1% ($n=56$) reported solely targeting men.

Personal practice

As outlined in Table 1, there were significant improvements post training in participants' self-reported level of knowledge ($z=-12.082$, $P<0.001$), level of skill ($z=-9.683$, $P<0.001$), capacity to identify priorities for men's health ($z=-8.027$, $P<0.001$), and capacity to engage men ($z=-4.652$, $P<0.001$). These improvements were sustained in the 5-month post training follow-up for self-reported level of knowledge ($z=-6.388$, $P<0.001$), level of skill ($z=-4.445$, $P<0.001$), and capacity to identify priorities for men's health ($z=-1.991$, $P<0.047$). Improving capacity to engage men was not sustained in the 5-month post training follow up ($z=-1.637$, $P=0.102$).

In the 5-month follow up, 93.4% ($n=113$) of participants agreed that the training had influenced their work. Additionally, 39.2% ($n=47$) of participants reported having included men's health in their official work plans or having committed in some official way to conducting men's health activities.

Capacity to influence the practice of others

Participants' self-reported capacity to influence the practice of others within their organisation increased slightly, but not significantly, immediately post-training ($z=-1.615$, $P=0.106$) and no difference was found between pre and 5-month post training time points ($z=0.332$, $P=0.747$). Participants' self-reported capacity to influence the practice of others beyond their organisation increased immediately following training ($z=-5.451$, $P<0.001$), however, this increase was not sustained in the 5-month post training follow up ($z=-0.698$, $P=0.485$) (Table 2).

DISCUSSION

Men's under-utilisation or delayed use of health services in the course of an illness has been identified as a principal challenge and priority for improving men's health (Galdas *et al.*, 2005; Robertson *et al.*, 2008). Many service providers, however, view men as being 'hard to reach' (Carroll *et al.*, 2014; Zwolinsky *et al.*, 2012) and are unclear about the type of services to which men might respond (Hobbs, 1995; Barton, 2000). This deficit in gender sensitive service provision for men has also been highlighted at a men's health policy level (Department of Health, 2009). ENGAGE, Ireland's National Men's Health Training programme, was developed to address this gap. This study sought to ascertain whether the ENGAGE training had an impact on service providers' practice – in terms of knowledge, skills and capacity to engage men - up to five months post training.

Findings indicate that the ToT model adopted for ENGAGE was effective at diffusing training to front line service providers. Service providers were highly satisfied with the training immediately post training (8.6 ± 1.6) and at 5-month follow-up (8.06 ± 1.43). Significant ($P<0.001$) improvements were reported by service providers in terms of their self-reported knowledge, skill,

Table 2: Change (mean ± SD) in self-reported capacity to influence the practice of others within and beyond their organisation immediately post and up to 5-month post training

	Pre-training Mean (SD)	Post-training Mean (SD)	5-month post training Mean (SD)
Convincing within organisation	3.66 (0.84) ($n = 194$)	3.77 (0.83) ($n = 194$)	3.57 (0.85) ($n = 69$)
Convincing beyond organisation	3.16 (0.89) ($n = 161$)	3.58 (0.86)* ($n = 161$)	3.16(1.14) ($n = 73$)

*$P < 0.001$.

capacity to identify priorities for men's health and to engage men in their services, and these were sustained up to 5-month post training. The vast majority of service providers (93.4%) reported that ENGAGE had impacted their work practice up to 5-month post training, with 39.3% having formally committed to men's health in their work plans and/or conducting men's health initiatives within their services. These findings are consistent with Dilley *et al.*, (2009) who reported improvements up to 3-months post training in knowledge, skill, capacity, motivation and self-efficacy for achieving public health policy and systems change. McCullagh (2011) has also demonstrated the potential of delivering men's health training to increase public health practitioners' knowledge of men's health, and to promote the development of gender-sensitive services. Evidence suggests that service providers often struggle to engage effectively with men (Carroll *et al.*, 2014; Zwolinsky *et al.*, 2012; Hobbs, 1995; Barton, 2000; Banks, 2001; Monaem *et al.* 2007) and that this may be a factor in men's underutilisation of services and their health outcomes. However, there is a growing body of evidence that men will engage when the approach is right (Carroll *et al.*, 2014; Hunt *et al.*, 2014; Robertson *et al.*, 2014; Oliffe *et al.*, 2011; Lefkowich *et al.*, 2015; Grace *et al.*, 2016) and it is essential that this evidence is disseminated appropriately to build capacity among front line service providers to improve gender competency in service provision. Ongoing professional development training, such as ENGAGE, is one mechanism for building capacity among service providers and the findings from this study suggest that there is value in extending ENGAGE training to further increase awareness of men's health and influence the provision of gender competent services for men. Indeed the need for a short, multidisciplinary programme in men's health for both providers and commissioners of health has been called for elsewhere in order to promote equality of male access and, in turn, reduce the inequitable rates of chronic disease experienced by men (Banks, 2009).

Interestingly, the training had very little effect on the capacity of service providers to influence the practice of others within their organisation to prioritise men's health in their work plans for the following year. While service providers were more confident immediately post training about their capacity to influence the practise of other service providers beyond their organisation, this confidence was not evident at 5-month post training. Organisational support, and in particular, managerial support is critical to instigate cultural change within any organisation (Kuppler, 2013). Evidence from the ENGAGE process evaluation (Lefkowich *et al.*, 2016) highlights the importance of a gender sensitive work environment with integrated gender sensitive practices. In the absence of organisational support for service providers, the integration of ENGAGE training in practice may suffer. Key considerations for future training needs to be a) the leveraging of support and buy-in from management in order to achieve genuine institutional and cultural change that distils down to a policy and strategic planning level and b) 'refresher' training for service providers. Future research ought to consider whether recruiting more than one service provider from an organisation might foster increased peer support among colleagues, thereby increasing the likelihood of enacting changes to work practices post training.

It is evident that ENGAGE training predominantly attracted locally based (60.9%) service providers from the community (61.0%) and voluntary (14.8%) sectors. While such services play an important role in supporting men's health both directly (e.g. through social inclusion and education initiatives) and indirectly (e.g. through referral pathways to traditional health settings), it was notable that health professionals were conspicuous by their absence. While occupation was not asked, only some 30% ($n = 88$) of service providers classified themselves as representing the 'health sector' and it is probable that not all of those were front line health professionals. Anecdotally, ENGAGE Trainers reported difficulties when trying to engage key health

professionals such as general practitioners, practice nurses and community nurses. Training was, however, delivered to trainee nurses over two half-days. Given the pivotal role that GPs in particular play within the health system, it is essential that health care professionals are targeted for such training. However, based on evidence elsewhere (McCullagh, 2011) and to the best of the authors' knowledge in an Irish context, men's health is not included on undergraduate or postgraduate training curricula for medicine, nursing, midwifery or other healthcare providers. In Ireland, some attempt has been made to address this shortfall; the Royal College of Surgeons in Ireland approved a Masters programme in men's health however, due to insufficient numbers this never ran. Workshops have also been delivered by the authors as part of the Irish Congress of General Practitioners accredited Summer Schools, however, these have been somewhat ad hoc. It is evident that consideration needs to be given to the targeting of health care professionals via integrating ENGAGE into undergraduate curricula within medicine, nursing and other health professional programmes and establishing links to health professional bodies and 'Continued Professional Development' training for health professionals. Adapting modes of delivery to meet the competing needs of health professionals e.g. online, case study, refined to meet the needs of particular practitioners (e.g. to include more clinical focus for GPs) such as the eLearning modules for GPs in male reproductive health offered by Andrology Australia (https://www.andrologyaustralia.org/health-professionals/gps/) should also be considered.

The findings of this study, however, should be viewed in the context of the following limitations; cases were selected so that analysis was performed on the same people who responded in both pre and post training questionnaires and pre and 5-month post training questionnaires; some of the scale variables contained 'don't know' and these responses were excluded to give a more accurate comparison of those who did rate the question.

ENGAGE, Ireland's national men's health training programme has been effectively diffused to over 800 service providers nationally via the ToT training model from a team of 6 facilitators and 57 ENGAGE Trainers and is ongoing. ENGAGE has been effective in improving self-reported knowledge, skill and capacity among service providers to engage and work with men up to 5-month post training and service providers have integrated their learnings into their work practices. While ENGAGE needs to adapt to the specific training needs of health professionals, ENGAGE currently meets the needs of the community and voluntary sector and many within the statutory sector. As a training model and resource, the findings from this study indicate that ENGAGE has been effective in influencing the development of gender sensitive service provision and has significant implications for practice elsewhere.

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