MOVEMBER®

MEN'S HEALTH EDUCATION PROJECT

FINAL REPORT - NOVEMBER 2023

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Australian Psychological Society

Migration Council of Australia

Australian Association of Social Workers

Australian Health Promotion Association

Royal Australian College of General Practitioners

Australian Primary Health Care Nurses Association

Australian College of Rural and Remote Health

Allied Health Association of Australia

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Conflict of interest

This project was awarded through a competitive Australian Government tender process. The tender application declared that Dr Zac Seidler, funded by Movember, developed Men in Mind, a digital continuing professional education training program for mental health care professionals, which is referenced in Sections 2 and 5 of this report.

Statement of intent to disseminate findings

To support knowledge dissemination, the authors have reproduced parts of this report and submitted (Appendix A), or plan to submit, for peer-reviewed academic publications and conference presentations.

Suggested citation

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Movember: movember.com

Movember is the leading global men's health charity changing the face of men's health. Movember unites experts from around the world to collaborate on projects that will fundamentally change the way men in need are treated and supported.

Movember acknowledges the Traditional Custodians of Country throughout Australia and their connection to land, sea and community. We pay our respects to their Elders past and present and extend this respect to all Aboriginal and Torres Strait Islander peoples today.

FOREWORD

I write in support of the findings of this report from Movember, as Federal President of the Australian Medical Association (AMA). My other roles relevant to this report are as Professor of Reproductive Medicine at the Australian National University, and a principal committee member of the National Health and Medical Research Council. Across my professional career, I have provided care to men – often at a low ebb in their lives; for example, when they are about to undergo cancer treatment or when they are discovered to have health issues that leave them infertile. These conditions not only affect the body, but also the mind, often threatening what it means to them of being a man within their culture and society more broadly.

There is close alignment between the work of Movember and the aims of the AMA: to improve the health and wellbeing of our community. One of the rewards of my work as AMA President, has been to learn more about the work and impact of the Movember organisation. Movember's mission resonates with me deeply and I have been a strong advocate for men's mental health after my own experiences as a young man. Indeed, as I have worked with the Movember organisation, I have discovered its extraordinary achievements in connecting men and their communities at a global level in a way that has been, and will continue to be, transformative.

Compared to when I was young, we are, as communities, now able to talk more openly, acknowledge and confront the gendered pressures on men and the resultant barriers to effective help seeking. However, once men seek care, they need to be met with practitioners who can challenge their own gender biases and practically apply a gender lens to effectively connect with men and respond to their health and wellbeing needs. I certainly was not exposed to this in my formative medical training. Without dedicated training, it is not something that comes naturally, and it may or may not come after years of working with men.

As highlighted in this report, the gender lens is critical to person-centred care. If we do not embed this education into the training of our health workforce, men will, as the report refers to, continue to "slip through the cracks". I have been intimately involved in policy, education and accreditation initiatives that are critical to improving health care delivery and outcomes. I chaired the College of Obstetricians and Gynaecologists guidelines committee, and in this role synthesised the evidence to develop the clinical guidance underpinning reproductive health care in Australia and New Zealand. I also had the privilege of running the specialist examinations for several years and am proud that this work led to a whole generation of newly qualified young specialists going out into the community. With this experience, I feel confident to attest to the importance and potential broad reaching impact of the proposed education initiative described in this report.

Australia is, without doubt, a leader in men's (and women's) health, being one of the few countries to have dedicated men's health and women's health strategies. The Strategies acknowledge that more needs to be done, particularly to address health inequities experienced by sub-populations of people. This in-depth report responds to the Men's Health Strategy by presenting critical evidence and mapping a pathway to deliver curricula content to educate emerging and upskill current health practitioners on gender-responsive health care to meet the needs of all men. Importantly a gender focus in practitioner education will not only improve care for men but for women and people of all genders. There is receptivity by educators and practitioners for, and opportunities to, enhance curricula.

The breadth of the critical peak and professional bodies involved in the Consortium guiding this project is testament to the commitment of the health sector to move forward in this regard. I look forward to seeing the mainstreaming of gender-responsive health care into practice starting with the education initiative proposed.

Sincerely

Professor Steve Robson MPH MD PhD
Federal President, Australian Medical Association
Nov 2023

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Australian National Men's Health Strategy 2020-2030 aims to drive policy and practice improvements to reduce the burden of ill health and premature mortality of boys and men living in Australia, and address health inequities. The Strategy's goals align with Movember's global mission, as a leader in men's health, to change the face of men's health by helping create a future where all men, and therefore their communities, live healthier and longer lives.

Gender-responsive health care is vital to men's health, necessitating the integration of gender competencies into health care student and practitioner education. Objective 2 (action 2.1) of the National Men's Health Strategy therefore calls to improve the knowledge and capability of the health workforce to deliver holistic male-centred services across the life course and reinforces the importance of a gender lens to the approach.

In response to this Strategy objective, the Movember Men's Health Education Project was initiated. The main purpose of Phase 1 of this project was to undertake a landscape analysis of Australian health education curricula and programs to understand the gaps in content pertaining to key elements of men's health and methods for effective engagement with men and boys, and through stakeholder engagement, scope the need, receptivity, and opportunities for a future men's health education initiative. This report describes the series of studies undertaken and the key findings and offers a recommended framework for the future initiative.

For the project, a consortium of stakeholders and experts was established to guide and facilitate all aspects of the project. The landscape analysis involved formative reviews of Australian online continuing professional education (e-CPD) programs and tertiary health education curricula and surveys and consultations with educators and medical students from across universities. The landscape analysis was followed by a comprehensive scoping review of the literature, alongside in-depth focus group discussions with a diverse range of men, to collate evidence on best practice approaches for engaging with men in health care. The evidence was synthesised with input from health care practitioners and other expert members of the project consortium, to propose a men's health education innovation and develop an implementation plan.

The landscape analysis underscores the need for holistic men's health education that extends on existing offerings pertaining to disease-based competencies, particularly in gender-responsive health care which is currently lacking in existing programs. Stakeholders were receptive to e-CPD and enhancing tertiary curricula with men's health content to ensure the workforce readiness of emerging health care practitioners and the upskilling of current practitioners to effectively engage with men in practice. Incorporating gender competency into accreditation standards as a long-term systemic change strategy was also recommended. Stakeholders expressed receptivity to dedicated e-CPD and feasibility of enhancing tertiary curricula with men's health content delivered through a centralised suite of multi-modal, flexible e-resources to accommodate for a variety of pedagogies. While some barriers exist to curricula enhancement, educators and students offered solutions to such barriers.

Stakeholders emphasised the importance of co-design and involving men's lived experiences in education. This is to sensitise students and practitioners to men's health needs, and to develop a practical understanding of the gendered and interacting socio-cultural factors influencing health, health care access and outcomes. While further research is required to accommodate for contemporary masculinities and gender diversity, the literature review and input from men themselves collectively offers guidance on best practice education content, that has interdisciplinary application across public health and health care settings and scenarios.

Based on the synthesised evidence, an interdisciplinary online men's health education gateway, referred to as "the Hub," is proposed. The Hub will offer e-CPD programs for health care practitioners, e-resources for educators and students, and a community of practice portal. It will build on Movember's successful "Men in Mind" e-CPD program for mental health practitioners, which will be adapted for various health professions, settings and pedagogical approaches. The content will be tailored for priority population groups, such as culturally diverse men and Aboriginal and Torres Strait Islander men.

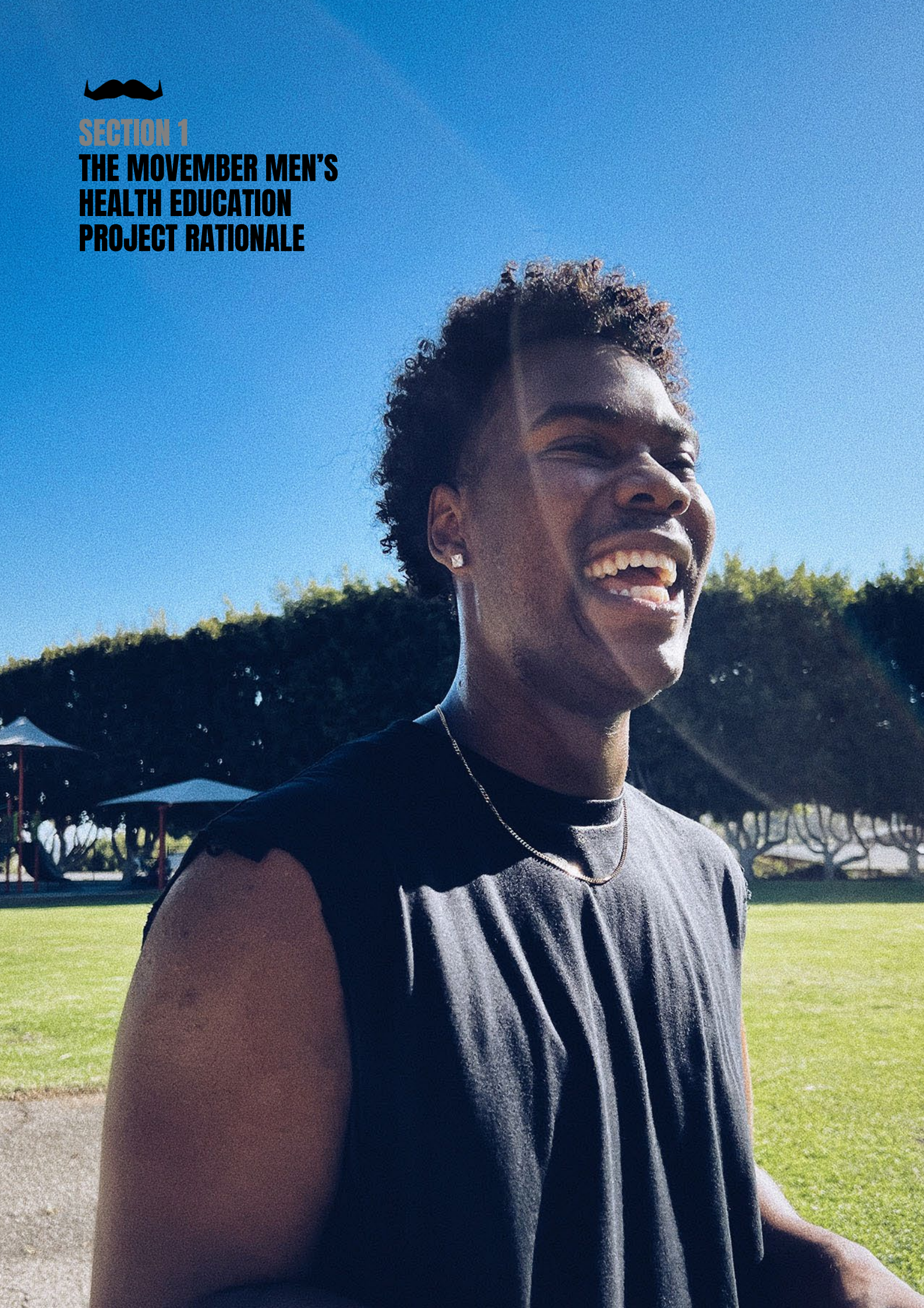
The Hub's implementation plan spans four stages: development, piloting, launch, and ongoing monitoring and evaluation. Strategies are outlined to address potential implementation barriers, ensuring effective integration into real-world education settings.

The Movember Men’s Health Education Project aims to revolutionise men's health education, bridging existing gaps, and enhancing health care practitioners' ability to engage effectively with men to better meet their needs. The evidence and proposals presented in this report lay the foundation for a comprehensive and innovative approach to men's health education and gender-responsive health care.

> "As a clinician - there are increasingly more men reaching out for services, but students are not being trained on the nuances of working with men.”
>
> University Social Work undergraduate curriculum Coordinator

SECTION 1

THE MOVEMBER MEN'S HEALTH EDUCATION PROJECT RATIONALE



SECTION 1

OVERVIEW

Section 1 outlines the background and rationale, stages, aims and framework of the Movember Men's Health Education Project. The project responds to a key objective for men's health set out in the Australian Government's National Men's Health Strategy 2020-2030 (NMHS 2020-30) that is focused on health workforce education to improve the quality of care for boys and men[1].

> "Critical questions are not being asked and important conversations are not being initiated by health professionals when men and boys are in contact with the health system. Opportunities to engage proactively with men and boys, to assess risk, provide health education and undertake health promotion across a range of issues are not being fully explored and represent an area of significant potential to address".
>
> NMHS 2020-30

BACKGROUND

The status quo

Globally, inequities in health care access, care received, and health outcomes exist for men, women, and gender diverse people in different contexts[2]. For men living in Australia, like in nearly all countries, they have, on average, a life expectancy four years shorter than women, a higher burden of disease for several health conditions (e.g., cancer, cardiovascular disease, injuries), and a higher total burden of disease[3]. Men are less likely to be engaged in preventative health, and more likely than women to die from preventable causes. Critically, Aboriginal and Torres Strait Islander men and men who are socially, economically, and geographically disadvantaged, experience a higher burden of ill-health than the rest of the population.

Premature mortality

On combining the 10 leading causes of disease burden in 2019, there were more than 907,000 years of healthy life lost from death and illness for males living in Australia, 50,000 more than those for females. The greatest contribution to this burden were males dying prematurely from preventable causes, whereas for females, the greatest proportion of burden of disease was from living with poor health and disease[3]. To give this premature mortality data more context, four out of every five deaths under the age of 65 years due to heart disease are male, three out of every four suicides are by males, three out of every four road deaths are male, and 93% of workplace deaths are male.

The impact of poor boys and men's health on the health and wellbeing of women, children and our broader communities cannot be underestimated[4]. The economic and societal impact of men leaving the workforce, and their families and their communities, prematurely due to death and disability has yet to be systematically quantified in Australia but would undoubtedly be staggering.

These statistics are accompanied by a pervasive narrative of men's common reticence in seeking care. This is despite long-standing evidence that most men are interested in their own health. Macdonald et al. (2022), in their review of the Australian and international literature, shed light on the barriers that prevent boys and men from gaining timely and effective access to health care and the opportunities to improve health system access for implementation in health promotion programming[5]. The barriers to timely access to health services can be contextualised alongside the finding of health practitioners' reports of challenges of engaging and working with men in care once men do seek help[6-8].

Gender-responsive health care

Gender is a major determinant of health, and as highlighted by the Lancet Commission on Gender and Global Health, the greatest advances in the health of our communities will be achieved through gender-responsive health systems[9]. Within this, gender-responsive health care for men is one that is attuned, responds, and adapts to the depth and diversity of men's gendered health care needs and experiences to optimally engage with them around their health and wellbeing.

> The global goal of equality on the basis of gender is an integral part of other global struggles for inclusive, rights-based, respectful, equitable systems, structures, and communities.
>
> Hawkes et al., 2020

The power of engagement

When men receive care tailored to their needs, their positive outcomes reflect these efforts. While the 'what' of men's health care (e.g., to achieve treatment efficacy) remains paramount, the 'how' (e.g., engagement) has been relatively overlooked. Effective early engagement fosters a lasting rapport between men and their health care practitioner (HCP), building trust, empowering men, and motivating them to remain in care to achieve optimal outcomes[10,11]. However, the essential aspects of tailoring care and cultivating person-centered engagement skills, though foundational education and training of future health care professionals, must be taught and amplified through a gender-sensitive lens to meaningfully address health inequities experienced by individuals of all genders [11-13].

Gender competency through education

Proponents, largely borne out of the women's health sector, have advocated for more than two decades that integration of gender competencies into education and workforce training is critical to mitigate gender disparities and biases in the health care system[14-16]. While considerably more work still needs to be done, gender-responsive health care and services for girls and women have positively impacted their health[17]. The men's health sector has corroborated this call for better integration of gender competencies into health education curricula, along with the need for tailoring of health promotion strategies to better connect with men[18-21]. Some progress has been made in the tailoring of public health programming for men, although not at a systems level[22,23]. Regrettably, there is minimal evidence to suggest that emerging and current HCPs are receiving the requisite education and training in men's health and gender competency needed to effect substantial improvements in men's health and health care outcomes.

THE MOVEMBER MEN'S HEALTH EDUCATION PROJECT

The Movember Men's Health Education project was established in July 2022 to directly respond to Action 2.1 of the Australian National Men's Health Strategy (NMHS 2020-30) that calls to:

> "Improve the knowledge and capability of the health workforce to deliver holistic male-centred services across the life course".

The overall mission of the project is to develop and implement best practice education and training curricula that will support emerging and current health practitioners in optimally engaging with boys and men around their health and health care needs. A particular focus of the training will be on reaching those men who, for gendered and intersecting sociocultural reasons, may face barriers to effective health care engagement. This mission aligns with the extended goal of the Strategy which is to "empower and support all boys and men to optimise their own and each other's life course health and wellbeing" as well as Movember's global mission as a leader in men's health to:

> "Change the face of men's health to create a future where all men, and therefore their communities, live healthier and longer lives."

Furthermore, by establishing a gender-responsive health care education agenda, we aim to continue to build the evidence base for improving boys' and men's health and wellbeing (NMHS 2020-30 Objective 3) and establish an Australian best-practice benchmark of men's health education to inform a global approach.

Project objectives

The objectives of this Movember Men's Health Education Project (Phase 1) were to undertake a comprehensive landscape analysis of Australian health tertiary education curricula and continuing professional development programs to:

- understand gaps in existing education offerings on key elements of men's health and methods for effective engagement with men and boys, and

- to gain insights from the literature and men themselves on best practice approaches to engaging with men in health care.

The further objective was to combine the findings of this landscape analysis to inform a men's health education innovation and implementation plan.

Project framework

The project framework aligned with that promoted by the NMHS 2020-30 to meet its goals and objectives. This includes a multi-pronged approach, and engagement and collaboration with a wide range of stakeholders across the health, men's health research, education and training sectors, peak bodies, professional associations and non-government organisations, as well as men as health consumers.

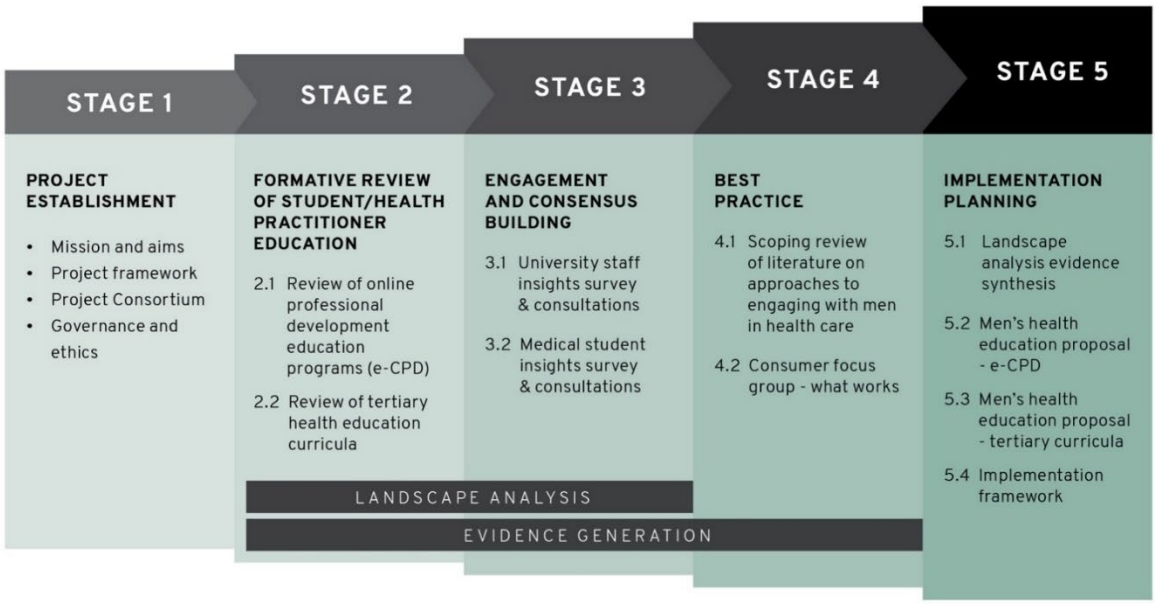
Stages of the Movember Men's Health Education Project

Evidence generation

The 5 stages of the Movember Men's Health Education project are shown in Figure 1.1. A landscape analysis (Stages 2 and 3) was first required to collate evidence on the gaps in men's health education across the Australian tertiary health education and professional education sectors. Important insights were also garnered during this landscape analysis from a range of stakeholders on gaps in education and perceived need, receptivity to, and opportunities for, men's health curricula enhancement.

The evidence generation also involved collating health practitioner and consumer informed best practice approaches for engaging with men in health care, by a review of the peer-reviewed literature, and through focus group discussions with men themselves (Stage 4).

Figure 1.1. Project stages



Evidence synthesis and implementation planning

The evidence generated by the project (Stages 2-4) was synthesised in Stage 5 to propose and identify the likely determinants (barriers and enablers) of an evidence-based men's health education innovation. From this, the project adopted the implementation research logic model (IRLM)[24] as the framework to roadmap how the proposed innovation is to be developed and implemented. The IRLM links the determinants of a proposed education innovation (identified in each stage of the landscape analysis), to strategies that support a structured and rigorous approach to successful implementation and outcome (Section 5.5).

Project stages - Aims

The specific aims for Stages 2 to 5 of the project were:

Stage 2

- To undertake a formative review of Australian online continuing professional development (e-CPD) programs and tertiary health education curricula, to understand
    - the gaps in key understandings of men's health and methods for effective engagement with men and boys in health care, and
    - potential opportunities for integration of key understandings on men's health and engaging with boys and men in health care into education through curricula enhancement and as new e-CPD programs.

Stage 3

- To engage with University staff responsible for health curricula and medical students to explore the need, receptivity, and potential barriers and enablers (determinants) to integration of men's health education content into tertiary curricula.

Stage 4

- To undertake a scoping review of the published literature for best practice strategies for communicating and engaging with men in primary health care settings, and to sense check these strategies by undertaking focus group discussions with a diverse group of men, for them to share their experiences of what works when engaging in health care.

Stage 5

- To synthesise the evidence to generate a consolidated framework and propose strategies for future implementation of a health student and practitioner men's health education initiative (innovation) in a Phase 2 of the project.

Movember Men's Health Education Project Consortium

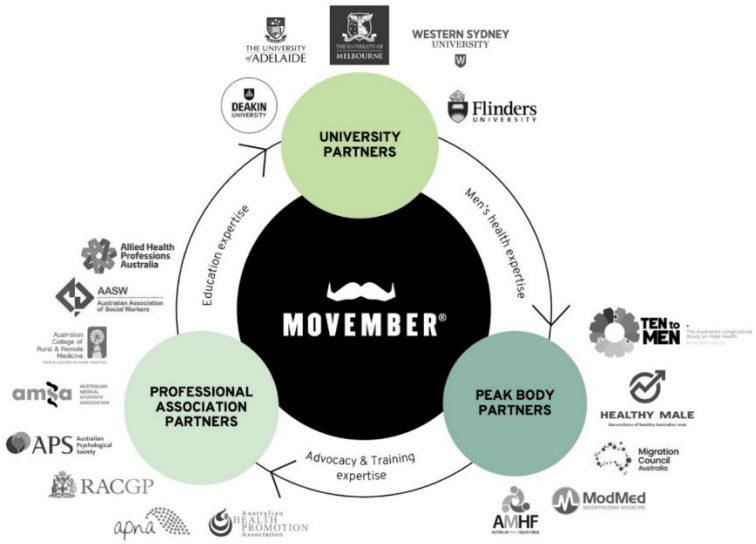
To support all aspects of project delivery, Movember convened a multidisciplinary national project consortium. The Consortium guided the development of the scope of work to be undertaken, ensured that the work and outcomes reflected diversity and inclusion across priority population and priority health areas, and ensured that the input of all relevant stakeholders were captured. The breadth and depth of the Consortium provided collective leadership to galvanise the sector and build consensus and momentum to bridge the outcomes of Phase 1 (Stages 1-5) of this project to a future implementation Phase 2.

The Consortium comprised three partner groups (Figure 1.2)

- **University (academic) partners:** leading academics with expertise in the biomedical and social aspects of boys' and men's health, and clinical services and public health program delivery.
- **Peak Body partners:** representatives of peak bodies in boys' and men's health who bring an intimate understanding of the men's health sector and who will also facilitate co-design processes and embed lived experience throughout the project.

- **Professional Association partners:** representatives of leading practitioner training organisations, medical student association, consumer health bodies, and professional associations who may not necessarily focus on boys' and men's health but do deliver education solutions and represent practitioner, education and consumer lived experience.

Figure 1.2. Consortium members by partner categories



Functional working groups were established (Figure 1.3) to streamline oversight and Consortium consultation across Stages 1-5 of the project.

- **A Working Group** providing regular expert advice, guidance, and oversight of all project activities.
- **An Advisory Group** advising on high-level project processes, and facilitation of consultations with relevant stakeholders.
- **A Reference Group** offering advice and guidance regarding acceptability, feasibility and sustainability of education innovations developed during the Implementation planning stage of the project .

Figure 1.3. Consortium members by functional groups

Ethics and governance

Research throughout this project was undertaken in compliance with The Australian Code for the Responsible Conduct of Research, 2018, and the National Statement on Ethical Conduct in Human Research 2007 (updated 2018)[25]. Where applicable, the research aimed to adhere to Sex and Gender Equity in Research (SAGER) guidelines[26]. The project protocol and all amendments were approved by the Bellberry Human Research Ethics Committee (Protocol No. 2020-04-318).

In accordance with the National Statement 4.4.1, project monitoring and evaluation was the responsibility of the project lead Dr Zac Seidler, and the Project Manager and Research Coordinator. Movember was responsible for organisational governance and the Working Group had independent governance oversight.

Project surveys used the Movember licenced Qualtrics survey online software and platform (XM Qualtrics full licence) that utilises TLS encryption in the transmission of all data, is ISO 270001, ISO 27017, ISO 27018 and SOC 2 Type II certified and has achieved HITRUST certification. (www.qualtrics.com/privacy-statement). Qualtrics complies with applicable data privacy laws. and the Qualtrics data is stored in Australia. All study related data and documentation are stored in files on a restricted access file directory on a Movember (Australia) hosted server. Access to data will be considered on request, provisional on research ethics approval.

Definitions	
Continuing professional development (CPD)	Education programs for professionals in order to acquire knowledge and skills to improve their professional competence in a specific area which, in the case of health professionals, aims to improve patient care and outcomes[27].
Gender	Gender refers to the characteristics of women, men, girls and boys that are socially constructed. This includes norms, behaviours and roles associated with being a woman, man, girl or boy, as well as relationships with each other. As a social construct, gender varies from and within societies and can change over time[28].
Gender-responsive health care	Gender-responsive health care identifies gender differences and inequalities in women, men and non-binary people regarding their health and health care experiences, and sets about addressing them through system-based change[29].
Health care engagement	The "processes of building the capacity of patients, as well as health care providers, to facilitate and support the active involvement of patients in the care process, in order to enhance safety, quality and people-centredness of health care service delivery"[30].
Health care professional (or practitioner) (HCP)	Professionals delivering health and social care to people including medical, paramedical and nurse practitioners, and allied health practitioners, pharmacists, public health practitioners and Aboriginal health workers, and students and trainees working in direct contact with patients/clients.
Interdisciplinary curricula integration	An approach to curriculum integration that generates an understanding of themes and ideas that cut across disciplines and of the connections between different disciplines and their relationship to the real world. It normally emphasises process and meaning rather than product and content by combining contents, theories, methodologies and perspectives from two or more disciplines[31].
Men	A broad term used to describe boys, adolescent and adult men. Consistent with that described in the National Men's Health Strategy 2020-2030[1], "men" is not intended to exclude males with diverse sexualities, intersex men and men with a transgender experience.
Men's health	A state of complete physical, mental, and social wellbeing as experienced by men and not merely the absence of disease or infirmity[32]; and a focus on how sex and gender intersects with other determinants of health to influence boys' and men's exposure to risk factors and interactions with the health system and health outcomes across the life course that requires dedicated prevention and care services[33].
Primary health care (Australian context)	Primary health care is the entry level to the health system and, as such, is usually a person's first encounter with the health system. It includes a broad range of activities and services, from health promotion and prevention to treatment and management of acute and chronic conditions[34].

SECTION 2

REVIEW OF AUSTRALIAN HEALTH PROFESSIONAL AND TERTIARY EDUCATION CURRICULA

SECTION 2

OVERVIEW

Section 2 provides an overview of a landscape analysis of Australian health education programs and curricula. This involved formative reviews of online continuing professional development (e-CPD) programs (study 2.1) and tertiary health education curricula (study 2.2) to assess the extent to which key understandings of men's health and methods for effective engagement with men in health care are offered to existing and emerging HCPs. Potential opportunities for integration of men's health content as e-CPD into existing or new curricula were also identified through this process.

These reviews served as gap analyses, with the evidence used to guide subsequent early stakeholder engagement (Section 3) the development of an innovation proposal and implementation framework for future men's health education curricula enhancement and CPD programs (Section 5).

2.1 REVIEW OF AUSTRALIAN CONTINUING PROFESSIONAL DEVELOPMENT PROGRAMS

Aim

- To evaluate the quantity, content scope and quality of e-CPD programs delivering men's health education for Australian health care professionals.

Methods

Search strategy

For the review, an online search was undertaken using the search terms "men's health" and "continuing professional development" (CPD) or "continuing professional education" (CPE) or "continuing medical education" (CME) to identify available programs collectively referred herein as e-CPD. Websites for men's health peak bodies, the health professional colleges, the professional associations and private medical education providers were also searched. The project consortium members also provided information on additional online CPD not appearing in searches (Table 2.1.1).

Table 2.1.1. Health care professions included in dedicated search for e-CPD

Primary health care setting	Professional organisation dedicated searches
General practice	
Medical general practitioner	Royal Australian College of General Practitioners
Medical rural generalist	Australian College of Rural and Remote Medicine
Nursing	Australian College of Nursing
Aboriginal health care worker	National Aboriginal Community Controlled Health Organisation
Paramedicine	Australian College of Paramedicine
Pharmacy	Pharmaceutical Society of Australia
Dentistry	The Australian Dental Association
Mental health	
General practitioner	Royal Australian College of General Practitioners
Psychology	Australian Psychological Society
Social work	Australian Association of Social Workers
Occupational therapy	Occupational Therapy Australia
Counselling	Australian Counselling Association
Other allied health	
Physiotherapy	Australian Physiotherapy Association
Exercise physiology	Exercise and Sports Science Australia
Dietetics	Dieticians Association of Australia
Orthotics	Australian Orthotic and Prosthetic Association
Public health	Public Health Association of Australia

Health care professionals of interest were defined as those providing primary health care. These included practitioners of general practice (general practitioners, nurses), paramedicine, pharmacy, mental health, dentistry, all allied health, and Aboriginal health care workers.

e-CPD program scope and quality

The e-CPD programs were classified according to the type of CPD program offered using a three-tier quality classification. Active CPD was defined as training through activities designed to enhance and test learning, as this is more likely to be retained and to lead to improvements in practice[27].

- **Tier 1.** Active CPD with a structured curriculum of study, dedicated e-learning resources and incorporates a formal assessment of competency and learning outcomes. The CPD is Professional Association accredited or endorsed or this is pending.
- **Tier 2.** Active CPD includes a semi-structured format delivering dedicated e-learning resources to support on demand, self-directed learning format. Competencies are not formally assessed. This CPD may or may not be Professional Association accredited or endorsed.
- **Tier 3.** Self-managed on-demand CPD that comprises e-learning resources only. This CPD is commonly delivered by private CPD providers and is not structured. The e-resources are not dedicated content but have general content obtained by external content providers. This general content includes lectures, talks, videos, webinars, and “explainers”.

Results

Three Tier 1 e-CPD men’s health curriculum-based programs were identified, and their scope was relatively comprehensive (Table 2.1.2). Of note, the Tier 1 programs provided by the Royal Australian College of General Practitioners (RACGP) and Movember feature learning outcomes that detail communicating with men in practice, managing practitioner gender biases relating to masculinity, and considering the influence of gender socialisation on the help-seeking, communication, and treatment preferences of male clients. Two Tier 2 e-CPD programs were identified, offered by Healthy Male and HealthCert Education, designed for general practitioners and other health care professionals.

The remaining four e-CPD programs were classified as Tier 3, with most relevant professional streams not offering a structured men's health e-CPD curriculum. The demand for these e-CPD programs was not assessed nor available and therefore is currently unknown. Where reference to e-CPD was noted, it is largely offered through numerous private e-CPD providers that deliver general content at cost. The content was largely biomedical in focus, aimed at enhancing understanding of male sexual and reproductive health, fathering, and other health conditions commonly seen in primary care. On occasion, topics regarding the therapeutic relationship and effectively communicating with men in clinical practice did appear in e-CPD content. The content in these Tier 3 offerings was derived, in some instances, from other providers (e.g., Movember, Healthy Male).

Table 2.1.2. Summary of the audit of Australian e-CPD with men's health content

Tier	Discipline	Provider	Details
1	General Practice Medical Practitioners	RACGP through elected training providers until 2023	Royal Australian College of General Practitioners (RACGP) training curriculum **MH16 Men's Health Contextual Unit offered as CPD**. On-line self-directed, supervised, group-based curriculum covering RAGCP curriculum competencies catered to the male patient. Accredited.
1	General Practice – Rural Generalist - Medical Practitioners	Australian College of Rural and Remote Medicine through elected training provider HealthCert Education until 2023	**Advanced Certificate of Men's Health** Understanding of men's health issues commonly seen in primary care, "male friendly" GP to develop a stronger rapport with their male patients to address common concerns, improve health outcomes and save lives. Accredited.
1	Psychology – *all Mental health practitioners	Movember	**Men in Mind** Practitioner training in men's mental health and working with men delivered as an online training curriculum. Evaluated via a randomised-controlled trial that demonstrated its efficacy in upskilling practitioners to better engage and work with men. Not currently accredited/endorsed.
2	General Practice, Medical & Nursing, Aboriginal Health Care Workers	Healthy Male	Short and day-long on-line training, including interactive training, case studies. Main focus on male reproductive & sexual health but also interactions with other chronic conditions common in men. Developed by reference groups and expert advisors.
2	Primary health care (medical, nursing & allied health)	HealthCert Education	Foundation Course in Men's Health; Professional Certificate of Men's Health; Primary Certificate of Sexual Health for Men. And Advanced Workshop. Men's health issues commonly seen in primary care, "male friendly" GP services.
3	Allied health (mental health)	Professional Development People	General content for allied health professionals with a particular focus on mental and behavioural health and human services. Two topics on Male friendly counselling. Australian Association of Social Workers directed portal for CPD
3	Mental health professionals	Mental Health Academy	General content for Nurse, Psychologist, Community worker, GP/Medical Practitioner, Psychiatrist) Australian Association of Social Workers directed portal for CPD. Content providers appear to be predominantly Universities.

3	Primary health care (medical, nursing & allied health)	Medcast, AUSmed, ThinkGP, CitiMed	General content across a broad range of topics on physical and mental health conditions and provision of care, fathering - with considerable variability in amount and quality of content. Medcast includes content from Healthy Male, and Black Dog. ThinkGP content providers include pharma. AUSmed is referenced by the Australian College of Nursing as a CPD provider. Citimed – RACGP approved content: andrology predominantly.
3	Pharmacy	Pharmaceutical Society of Australia	Limited men's health relevant content offered directly by Professional Association.

Evidence summary

The key evidence generated from the formative review of Australian e-CPD programs, that informed understanding of the gaps in men's health education was as follows:

- e-CPD programs delivering men's health education are available through a range of health discipline professional bodies (either directly or through education providers) but most deliver general men's health content that is biomedical in focus and the programs are not offered as structured, curriculum-based education (Tier 2 or 3 e-CPD).
- Two structured, curriculum-based men's health e-CPD programs (Tier 1) are available for Australian medical practitioners, both include limited content on gender-responsive health care for men.
- There is only one structured curriculum-based men's health e-CPD program (Tier 1), dedicated to developing gender-competencies of HCPs for when working with men (Men in Mind) but this is only offered in the setting of mental health care, but offers an important precedent and basis for expanded scope and implementation.
- Collaborative opportunities should be pursued with existing providers (e.g with RACGP, Healthy Male) for men's health e-CPD development initiatives.

Further research and stakeholder engagement is required to acquire an understanding of:

- Health professional bodies and primary care HCPs interest in, and receptivity to, dedicated men's health e-CPD (Tier 1 format), and;
- The demand for, and uptake of, men's health e-CPD (Tier 1 format) across health disciplines.

2.2 A FORMATIVE REVIEW OF AUSTRALIAN TERTIARY EDUCATION CURRICULA

Aim

- To undertake a formative review of existing Australian tertiary health education curricula for men's health content and,
- to scope the potential opportunities for future curricula enhancement with key men's health content.

Methods

Study design

The formative review protocol was developed based on a review of the curricula audit literature (Appendix B).

The review was undertaken on curricula from the disciplines of medicine, nursing, pharmacy, clinical psychology and social work. These were selected as the HCPs for these disciplines engage directly with patients/clients in order to deliver care. Public health curricula were also included given the profession's role in health service design and delivery, community health, health promotion and health policy.

The sample curricula for the review were selected using the top Universities listed by discipline in the Times Higher Education (2022) university and subject rankings[35]. Undergraduate degree curricula included nursing, medicine (MD, MBBS, BMedMD, MChD), pharmacy, public health, and social work. Included postgraduate curricula were psychology (clinical psychology), public health (Master of Public Health) and social work. For further industry context, professional accreditation standards for nursing[36], medicine[37]. Pharmacy[38], clinical psychology[39] and social work[40], were also reviewed. Public health does not have accreditation standards in Australia.

Course summaries and learning outcomes for the core and relevant elective courses within curricula were extracted from each selected university website and tabulated in Microsoft Excel. A curricula review framework and audit tool, adapted from Miller et al. (2013)[14] was developed to map men's health content found in these extractions to four learning categories; i) practitioner-patient communication and engagement, ii) biology and clinical practice, iii) preventative health and health promotion, and iv) social determinants of health and wellbeing (Table 2.2.1).

Table 2.2.1. Curricula review framework adapted from Miller et al. (2013)[14]

Learning category	Definition
Practitioner-patient communication & engagement	The communicative aspects of clinical/professional practice. Includes communicating, engaging and partnering with the male patient in the care process using a male-tailored approach.
Biology & clinical practice	Pathophysiology and biology of physical, mental and behavioural conditions that are exclusive to males, or for shared conditions where there are sex and gender related differences (e.g. heart disease, depression and suicide, substance abuse, trauma).
Preventative health & health promotion	Preventative health and health promotion strategies, including health literacy and self-care, access to care and services, screening, and lifestyle behaviours including risk taking and social networks.
Social determinants of health & wellbeing	Demographic and sociocultural determinants of health and wellbeing. These include gender, culture, education, income, life stage, and the interactions between these factors that influence health and wellbeing.

Instances of women's health and gender content were also mapped to these learning categories for comparison. Alongside the review for existing content, potential opportunities for men's health content integration were also mapped to these four learning categories. Integration opportunities were defined as avenues whereby curricula content could be augmented with gender-oriented considerations related to health and health care provision for boys and men (i.e., health care practices such as engagement approaches). The accreditation standards that inform curricula were also searched for references to men's health, women's health and gender and gender competency and examined for future curricula integration opportunities.

Data analysis

Curricula review data were analysed using descriptive statistics.

Results

The course information was reviewed for 1246 courses in 67 curricula from six disciplines, and 23 universities.

There were no dedicated men's health courses. Men's health was referenced in the course information for 10 of the 1246 courses (0.8%) in 8 out of 67 curricula (11.9%) (Table 2.2.2). No references to men's health were found in medicine, nursing, or clinical psychology curricula, with all content found in pharmacy, public health and social work curricula.

Men's health content in curricula

Five of the 10 instances of men's health content were in pharmacy curricula, with all content mapped to the biology and clinical practice category (Table 2.2.3). These references related to understanding and treating common conditions in male patients (i.e., reproductive health conditions). A men's health module (and women's health module) was included in one course, with the module among a series that focused on managing medical conditions and complications in specific patient groups. Three of the 10 instances were in public health curricula, with one reference in a course on 'mental health and ageing', and the other two in courses focusing on 'gender and health'. Course summaries included explanations of gender as a social construct, gender as a determinant of health across men, women, and non-binary people, and the need for gendered health care. The final two references were found in social work curricula where men's health was referenced in the context of masculinity and psycho-social problems.

Women's health and gender content in curricula

Women's health content was referenced in the information for 42 of the 1246 courses (3.4%) across 25 of the 67 curricula (37.3%). Most courses that referenced women's health were in nursing and medicine curricula, and in the context of obstetrics and gynaecology, reproductive and perinatal health, and child and family health. Two of the nursing curricula offered women's health as a dedicated elective and medicine and nursing curricula offered dedicated clinical rotations in women's health. The only discipline without any reference to women's health was clinical psychology.

Course information referencing gender in any context was found in 72 of the 1246 courses (5.8%), across 28 of the 67 curricula reviewed (41.8%). Of these 72 references, the majority (71%) were in public health and social work curricula (20 of the 28 curricula) that related largely to gender theory, gender as a social determinant of health, and implications for lived experience and practice considerations. Eight of 40 clinical discipline curricula referenced gender as a consideration for presentation and differential diagnoses.

Table 2.2.2. Summary of curricula review findings

Discipline	Curricula	Courses	Curricula (Courses) referencing men's health	Men's health integration opportunities					Curriculum (courses) referencing women's health	Curriculum (courses) referencing gender
				Mean no. per curriculum	Mean % of opportunities by learning category*					
					COMM	BIOL	PREV	SOCD		
Medicine Undergraduate	10	157	0	23	36	22	16	25	8 (16)	2 (6)
Nursing Undergraduate	10	228	0	24	34	19	12	35	6 (7)	4 (7)
Pharmacy Undergraduate	10	203	4 (5)	13	47	23	15	15	2 (3)	0
Clinical Psychology (Postgraduate)	10	144	0	9	67	13	6	14	0 (0)	2 (2)
Public Health (Undergraduate/ Postgraduate)	5/10	217	2 (3)	9	13	8	33	46	6 (12)	10 (27)
Social Work Undergraduate/ Postgraduate	10/2	297	2 (2)	17	43	3	11	43	3(4)	10 (30)
Total [mean]	**67**	**1246**	**8 (10)**	**[16]**	**40**	**15**	**15**	**30**	**25 (42)**	**28 (72)**

*COMM: practitioner-patient communication and engagement; BIOL: biology and clinical practice; PREV: preventative health and health promotion; SOC: social determinants of health and wellbeing

Table 2.2.3. Curricula disciplines and courses with identified men's health content

Uni	Discipline	Year	Subject	Course summary or learning outcome
#1	Pharmacy	4th year	Core	Familiar and unfamiliar acute and chronic illnesses and determinants of health that are pertinent to women's and men's health as key patient population groups. (Learning category: biology & clinical practice)
#5	Pharmacy	4th year	Capstone	A men's health module and a women's health module in a final year capstone subject relating to integration of knowledge in pharmacology and pharmacotherapy to manage a range of medical conditions and complications in specific patient groups. (Learning category: biology & clinical practice)
#6	Pharmacy	1st year	Core	Physiology - Reproduction: nature and function of the female and male reproductive systems, hormonal regulation, common pathologies. (Learning category: biology & clinical practice)
#6	Pharmacy	2nd year	Core	Pharmacology: The pathophysiology and pharmacology relevant to endocrine disorders including; diabetes, thyroid disease, adrenal disease, osteoporosis, and male and female reproductive systems, including fertility. (Learning category: biology & clinical practice)
#8	Pharmacy	3rd year	Core	Apply their knowledge and understanding of the pathophysiology and management (pharmacological and non-pharmacological) of diseases to patient cases addressing men's health conditions, women's health conditions, urological conditions, rheumatology and pain. (Learning category: biology & clinical practice)
#1	Public Health (postgrad)	N/A	Elective	Mental health and ageing within a lifespan framework with an emphasis on both cognitive changes in later life and consideration of other challenges to mental health as people age, including inequality and marginalization, such as high rates of suicide among older men. (Learning categories: biology & clinical practice; social determinants of health & wellbeing)
#1	Public Health (postgrad)	N/A	Elective	Sex/gender as a social construct used to compare and contrast the health of men and women and critically analyse the explanations that have been offered for both the differences and similarities. Contemporary gendered practices of health care and the consequences for health (e.g., psychiatry, HRT use, cancer, heart disease and medical consultations), gendered public health programs and the consequences for health (e.g., screening programs, tobacco cessation). (Learning categories: social determinants of health & wellbeing; preventative health & health promotion)
#15	Public Health (undergrad)	2nd year	Core	Gender (non-binary) is a key determinant of human health globally. Men's and women's health are driven strongly by social constructions of gender performance across the life-course. Men live shorter lives, have higher cancer, cardiovascular disease, and higher suicide rates. Women suffer from higher rates of anxiety, depression, eating disorders, dementia, interpersonal violence, rape, and poverty globally. (Learning category: social determinants of health & wellbeing)
#3	Social Work (undergrad)	4th year	Core	Ideologies that inform psycho-social and political analysis; liberalism, critical feminism, critical masculinity, critical class theory, critical race theory, and adultism, and their explanations for psycho-social problems and proposals for change in relation to methods of social work practice. (Learning category: social determinants of health & wellbeing)
#8	Social Work (undergrad)	N/A	Elective	Men as gendered beings and the significance of masculinity to criminalised behaviours, victimisation and punishment. (Learning category: social determinants of health & wellbeing)

Opportunities for future curricula enhancement

Across all disciplines there was an average of 16 men's health content integration opportunities per curricula (Table 2.2.3). Opportunities were noted across each year of the curricula. Most integration opportunities were mapped to courses delivering education on practitioner-patient communication and engagement (40% of opportunities). This was particularly the case for the clinical disciplines and social work, with education opportunities relating to the gender considerations when engaging with men in care. The next most numerous opportunities (30%) for integration of men's health content were mapped to courses that covered the social determinants of health.

It was considered feasible to enhance existing courses with content on sex and gender as a major determinant of health. Specifically, content relating to the intersection of masculinities with other sociocultural determinants to understand inequities in men's health for sub-populations of men. Fifteen percent of men's health integration opportunities were mapped to biology and clinical practice learning categories and 15% were mapped to preventative health and health promotion.

There was no reference to gender (or gender competency) in the accreditation standards for nursing, medicine, pharmacy, and clinical psychology. Gender was referenced twice in the education standards for social work. These standards stipulated that gender identity should be considered in relation to human development/behaviour (standard 5.1: Education standards for social work), and that gender should be considered in the context of discriminatory structures and practices (standard 4.5: Education standards for social work).

Evidence summary

The key evidence generated from this formative review of a sample of Australian health tertiary education curricula to understand the gaps in men's health education, and thus the needs and opportunities to develop and implement a men's health education initiative was as follows:

- There were no dedicated men's health courses and no learning outcomes dedicated to men's health in any course. There are likely to be major deficits in tertiary health curricula for education of future health professionals in gender-responsive care for men.
- Apart from a few instances in Public Health curricula, the broader considerations of men's health, and of women's health, from a gender perspective, were rarely referenced.
- Men's health content integration opportunities were signposted to the learning category of 'communication and engagement' across most disciplines. This may facilitate an interdisciplinary men's health curricula enhancement strategy.
- Integration of men's health and gender-responsive health care practices for men would align with, and amplify, accreditation standards and best practice competencies relating to tailored engagement strategies to promote person-centred care.
- The addition of standards related to gender competency that recognise gender as a key intersecting determinant of health would ensure that men's health, along with women's and non-binary health are consistently taught across disciplines.

SECTION 3

STAKEHOLDER ENGAGEMENT - CURRICULA NEEDS ASSESSMENT

SECTION 3

OVERVIEW

Section 3 describes the conduct and outcomes of two stakeholder engagement studies that served to verify and extend the landscape analysis findings from the formative review of Australian tertiary health education curricula (Section 2). While the curricula reviews (study 2.2) found minimal evidence of relevant men's health content, a recognised limitation of the study was that the publicly available information may not have accurately reflected the actual content taught and the student learning outcomes. Based on the strengths and weaknesses of prior curricula audits (Appendix B), collaboration with staff and students was recommended to provide supplementary data sources to verify curricula offerings and provide additional valuable stakeholder insights from providers and users of tertiary education.

The two studies therefore included a university staff insights survey and consultations (study 3.1) and a medical student survey and consultations (study 3.2). These stakeholder data were used to establish initial guardrails around potential curricula content, and feasibility and approaches to curricula enhancement for consideration in the development of the education innovation and its implementation framework (Section 5).

3.1 UNIVERSITY STAFF INSIGHTS SURVEY AND CONSULTATIONS

Aim

To survey staff who coordinate and/or teach into Australian university health curricula to:

- determine whether or not men's health content was included in their curriculum or course,
- understand the types of content covered,
- determine the perceived need and receptiveness to enhancement of their curricula with men's content, including preferred format(s), and
- seek their insights regarding barriers and facilitators to enhancement for consideration in future implementation planning.

Methods

Staff survey

The target sample for the staff survey were staff members currently responsible for tertiary curricula or course delivery (i.e., discipline heads and deans) and teaching staff, listed online against the courses reviewed. Staff were invited to complete the survey via email and were asked to forward the survey to colleagues. Distribution to social work teaching staff also included the Australian Association of Social Workers newsletter and academic networks.

The survey consisted of 18 open- or closed-ended questions designed to yield data that served to validate and supplement the curricula review above. In order of appearance, questions sought data on i) the staff members' university, discipline, degree, position and, where applicable, course(s) taught; ii) the coverage of men's health in their course(s) and, if taught, a brief description of the content; iii) whether 10 specific men's health topics, selected by the expert project Working Group, were included in their course/curricula, iv) their perceived need for men's health content within their course/curricula, v) the preferred format(s) of the content, and vi) any perceived barriers and the facilitators to potential curricula enhancement.

Staff consultations

Survey respondents were then invited to participate in a semi-structured one-on-one or group consultation that sought to i) expand upon their survey responses; ii) workshop solutions to potential barriers to curriculum enhancement; iii) seek feedback on communicating and engaging with men as a focus for content; and to iv) gain pedagogical insights to inform resource development.

Staff were also asked for v) feedback on the concept of externally expert developed, housed and distributed education resources, and vi) the support necessary for teaching staff to access and use these resources.

Data analysis

Survey responses were analysed using descriptive statistics. Responses to the two open-ended items assessing barriers and facilitators were analysed using qualitative content analysis [41]. In brief, responses were coded to reflect distinct units of meaning, and codes were subsequently grouped based on similarity into higher-order themes.

Written notes of the staff consultations underwent a thematic synthesis using NVivo (Version 12), to identify recurrent and unique themes. Where relevant, themes from the survey responses were included.

Results

Participants

Survey responses were received from 70 university staff across 25 universities (Table 3.1.1). Medicine was the most commonly represented discipline (24.3%) and 'Course Coordinator' was the most common position held by respondents (57.1%). Most staff were responsible for one or more courses within a degree (64.3%).

Twenty-one of the 70 staff survey respondents from 10 universities, representing all of the targeted disciplines, participated in follow-up consultations with two researchers (Table 3.1.1). The consultations offered valuable insights that reinforce and build on the results of the staff survey.

Table 3.1.1. University staff survey respondent profile

Profile parameter	Staff survey n (%)	Staff consultations n (%)
Staff participants	70	21
Full response	60 (86)	N/A
Partial response	10 (14)	N/A
Disciplines represented	10	8
Participants by discipline		
Medicine	17 (24.3)	4 (20)
Nursing	12 (17.1)	4 (20)
Pharmacy	8 (11.4)	1
Psychology	9 (12.9)	4 (20)
Public health	13 (18.6)	4 (20)
Social work	7 (10.0)	2 (10)
Other	4 (5.7)	2(10)
Number of Universities	25	10
Role		
Dean/ Assoc Dean/ Head of School	12 (17.1)	2 (9.5)
Curriculum coordinator	7 (10.0)	3 (14.3)
Course coordinator	40 (57.1)	13 (61.9)
Other	11 (15.7)	3 (14.3)
Extent of staff responsibility		
Full degree curriculum	25 (35.7)	6 (28.6)
One or more courses within degree	45 (64.3)	15 (71.4.)

Men's health content in existing courses

Fifteen survey respondents (22%) reported no coverage of men's health content at all in their course, with 42 (60%) reporting generic men's health content only (i.e., content comparing health outcomes for men relative to women), and 13 (19%) reporting dedicated men's health content (i.e., content exploring men's health in-depth). Consistent with the curriculum review, most dedicated content detailed by respondents related to understanding and treating male sexual and reproductive health conditions.

Among relevant courses only, for seven of the 10 men's health topics, approximately half (46% -58%) of the respondents indicated that the topic was covered (Table 3.1.2). The most commonly reported topic covered (58%) was social determinants of health and wellbeing informing health equity approaches for men. The three topics covered least in relevant courses were i) tailoring of communication styles when engaging with men in practice (37%); ii) the role of masculinities and gender socialisation in men's health (36%); and iii) fathering and fatherhood (16%). Table 3.1.2 details participants' reported coverage of relevant men's health topics in their curricula.

Table 3.1.2. Staff reported coverage of men's health topics

Men's health topics (by order presented in survey)	Relevant to course/curriculum		Not relevant to course/ curriculum
	Yes included (% when relevant)	Not included	
Men's health help-seeking behaviours, service access and preferences	23 (47%)	26	11
Tailoring of communication styles when engaging with men in practice	18 (37%)	31	11
Tailoring of health literacy, health promotion and prevention programs for men (e.g. exercise/lifestyle, smoking cessation)	26 (51%)	25	8
The role of masculinities and gender socialisation in men's health	18 (36%)	32	9
Social determinants of health and wellbeing informing health equity approaches for men, including those from marginalised backgrounds (e.g., CALD, LGBTQIA+)	30 (58%)	22	7
Fathering and fatherhood	7 (16%)	36	15
Domestic and family violence	23 (50%)	23	14
Andrology - male reproductive system and urological problems unique to men.	22 (49%)	23	15
Priority health issues for men including conditions where men are over-represented (suicide, injury, addiction, diabetes, social isolation)	24 (56%)	19	6
Aboriginal and Torres Strait Islander male health and wellbeing	25 (46%)	29	5

Respondents indicated one or more preferred formats for men's health content, and findings were similar across disciplines. Forty-four (61%) respondents selected resource toolkits (lectures, readings, case studies), 30 (48%) selected online modules, 26 (42%) selected lecture or lecture series, 17 (27%) selected dedicated placements, and 6 (10%) selected dedicated electives.

Confirming results of the curriculum audit, staff consultations also highlighted that relevant gender and men's health content is being delivered sporadically in tertiary health curricula, particularly in social work and public health. For example, reference was made to topics pertaining to tailoring of health care provision and programming through a consideration of the role of masculinity and men's health experiences. A few staff admitted they had never given consideration to men's health content within their curriculum, while some staff confirmed that gender and health content in their curriculum largely equates to women's health.

> "Curriculum has undergone recent development with diversity being a big focus (in response to strong/active student voice) however there is no dedicated content on specifically working with men and this has never come up in the student voice - but keep in mind most students are females." (Clinical Psychology)

Receptivity to men's health content enhancement

Forty-four of 53 respondents to the survey question (83%) were receptive to future curricula enhancement with men's health content. Only five (9%) respondents indicated that men's health content was sufficiently covered in their course/curricula. A further 4 respondents (7.5%) of respondents indicated that men's health content was not relevant to their curriculum or course.

Throughout the consultations, staff were overwhelmingly receptive to curricula enhancement with men's health content. Staff offered numerous examples of opportunities to integrate communication and engagement content into existing courses. Staff agreed that in order for health practitioners and services to be responsive to men's needs, men's health content should be integrated into curricula as a key discipline.

> "It (men's health) has some relevance and could be better covered, I think, but there is a lack of will to do so - there is interest in women's health and women's issues but nobody really thinks about men's health in our program, even though in our area our populations of interest are most often predominantly male." (Public Health)

There was strong agreement regarding the need for a more structured and expert-informed approach to men's health education within and across disciplines.

Moreover, staff agreed this would align with established university goals regarding gender and cultural equity and diversity. Staff referred to their teaching standards, and the learning outcomes arising from these, include cultural competency. They noted the

opportunity for men's health content to be leveraged in their course/curricula to strengthen education and training for practice around intersectionality of gender and other sociocultural determinants to influence health.

Barriers and facilitators to curriculum enhancement

Staff were asked in both the survey and consultations for perceived barriers to, and facilitators of, curricula enhancement. As presented in Table 3.1.3, barriers to curricula enhancement noted by staff were typically balanced with at least one clear facilitator.

Staff reported that both undergraduate and postgraduate curricula are typically crowded and expressed concern around potential overwhelm for both students and staff resulting from new content. To overcome this barrier, they suggested integrating content into existing courses, which is an activity that course coordinators have autonomy over through an annual or biannual review process. In this regard, respondents referred to the '"fluidity" of their curriculum/course content, which would enable integration of new content.

Staff attitudes to men's health content, the perceived relevance of men's health to existing courses, and receptivity amongst educators was discussed. In particular, concerns were raised regarding navigating sensitivities around prioritising content on men's health over other priority groups. One staff member commented that there exists "a false narrative that men's health is already over-represented". A lack of interest in men's health content was also noted, as staff tend to include content based on their area of research interest and expertise. Widespread advocacy to clarify the meaning and value of men's health content was discussed as an avenue to addressing staff attitudes questioning the viability of men's health content. A broad dissemination strategy for men's health advocacy was recommended, spanning multiple channels such as social media, and including multiple stakeholders such as University Resource Librarians. Staff emphasised that the most impactful way to influence attitudes and standardise content delivery was through formal updates to competencies within accreditation standards. One participant cited "standards relating to cultural responsiveness and interprofessional education as successful examples of this". These represent a formal but longer-term approach to achieving widespread and standardised integration of men's health content into curricula and learning outcomes.

Table 3.1.3. Barriers and facilitators to curricula enhancement, with exemplar quotes

Barriers	Facilitators
Crowded curriculum "*There's only so much space for new content…something else will always have to be dropped*"	Integration of men's health content within existing courses *"[We are] definitely flexible to add quality content on an annual basis"*
Staff attitudes to men's health content "*The question of why we have focussed on men's health may be asked versus women's health focus*"	Advocacy on the need for men's health content *"[We] need to embed a fundamental understanding across the Faculty of 'what is men's health'."* Updates to accreditation standards as core competencies "*The most impactful way of changing the psychology curriculum at all levels is to include competencies in our accreditation requirements- this drives our curriculum*"
Staffing considerations: staff expertise, availability and funding *"[Limited] expertise to teach it (men's health)"*	Provision of free and easily accessible men's health resources *"If you provide free curriculum resources, including videos and class activities, from easily accessible promoted websites or via a respected health organisation … I would check them out."* Education and training for staff *"going into Uni with a workshop/seminar would be useful to upskill staff"*

Finally, while restrictions based on staffing considerations and limited expertise were noted, providing a free, widely accessible and versatile suite of curriculum resources was suggested as a worthwhile approach to generating staff buy-in. Numerous staff indicated that if there were teaching resources already available, they would enhance their curricula at their next course review. Education and training for staff was seen as an essential component of any curriculum enhancement. Workshops on men's health content for relevant course(s), and how to maximise use of any resources or education and training product were recommended. This could be supported

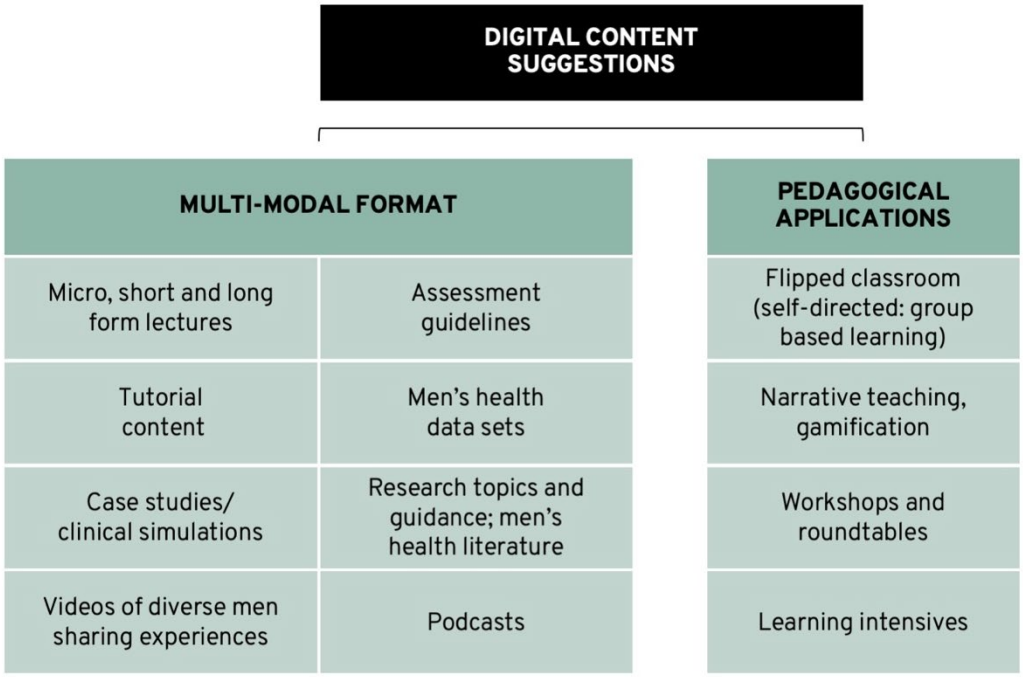
by dedicated champions, such as specific lecturers who could educate staff on content integration. Dedicated champions could also facilitate a feedback cycle to Movember from within the Universities, where new content can easily be piped into curricula. Some staff noted that an added benefit of education and training would be the development of men's health research expertise and capacity over time, offering research output benefits for universities.

Suggestions for content and pedagogical focus

In the staff survey, participants indicated preferred formats for men's health content. Findings were similar across disciplines. During consultations staff were asked to expand on their preferred format and characteristics of an online repository of expert-developed, free men's health education resources. As Figure 3.1.4 shows, staff were forthcoming in their suggestions for digital content offerings, based on current pedagogical approaches such as flipped classrooms or co-teaching, narrative teaching, gamification and group learning. Staff agreed that the resource hub would preferably include a suite of comprehensive, versatile, high-quality resources from reputable organisations. They suggested these could be selected based on pedagogy and compliance with learning outcomes and dropped into existing subject structures.

For most staff, traditional teaching resources were deemed sufficient for their teaching needs regarding men's health content. These included lecture material, readings, tutorial content and guidance documents for assessment of learning outcomes and competencies. Importantly, staff recommended the use of "*case studies that draw out issues relevant to men's health*" and "*the voices of men*" regarding their preferences around health service engagement. In addition, given the critical role of clinical/community placements in health curricula, clinical practice simulations for engaging with men in common clinical scenarios were suggested as being a useful resource. The need for accompanying videos and/or case study scenarios with a diversity of men was discussed here too. These would prepare students to effectively anticipate and adapt to the diversity and intersectionality of men's health.

Figure 3.1.4. Summary of staff suggestions for digital content and pedagogical applications.



Evidence summary

The key evidence generated from this university staff survey and consultations that confirmed the findings of the tertiary curricula reviews, and outlined the opportunities for curricula enhancement and the likely determinants of a successful men's health education initiative, was as follows:

- The majority of university staff surveyed acknowledged deficits in men's health content and were receptive to future curriculum enhancement with men's health content, recognising the need to improve students' workforce readiness as it related to gender competencies for effectively engaging with men in care.
- Staff favoured the concept of expert-developed, multi-format digital resources that could be accessed from a central resource, easily integrated into existing curricula and accommodate for varying pedagogies.
- Staff reinforced the value of, and need for, the lived experience voice from a diversity of men around their health care experiences, to cue students early, and that this be featured in education resources.
- While barriers to uptake were raised such as a crowded curriculum, staff attitudes to "men's health" and staff workloads, staff were also able to offer viable solutions.

3.2 MEDICAL STUDENT SURVEY AND CONSULTATIONS

Aim

The aim of this study was to undertake a survey of medical students attending Australian universities, to gain their perspectives on: (i) the extent to which men's health and gender-based medicine education is delivered in their medical school curricula; (ii) their perceived preparedness for engaging with men in clinical practice; and (iii) the particular men's health content they would have found useful during their training.

Methods

Participants and Procedure

As general practice is often the first entry point into the health system for men seeking care, and to date we have little understanding of the extent to which students receive men's health education that has a gender focus, nor whether medical students feel prepared and competent in engaging with and working with men in practice, medical students were selected for this stakeholder engagement study.

A 24-item online survey was co-designed by a multidisciplinary team that included a student representative of the Australian Medical Students' Association (AMSA). The survey was promoted by AMSA to its student representatives from each medical school, through medical student societies and to medical schools directly. Eligible participants were students in at least their fourth year of medical training, attending one of the 21 Australian Medical Council (AMC) accredited medical schools or recent graduates and who provided their informed consent to undertake the survey. The sampling goal was to have students representing at least 75% of the AMC medical schools undertake the survey.

Measures

Following completion of demographic information, medical students responded to quantitative and open-text qualitative questions across four topic blocks: (i) understanding of men's health, sex- and gender-based medicine and coverage of men's health and sex and gender based medicine during their education; (ii) preparedness for men's health practice using measures adapted from prior medical student research; (iii) preparedness for women's health practice; and (iv) reflections on learning and opportunities for men's health education in their training.

Data Analysis

Quantitative data were analysed using descriptive statistics. Responses to the open-ended qualitative questions were analysed using inductive content analysis [41]. This consists of three phases (preparation, organising, and reporting) where data are coded and overlapping categories developed to represent the dataset as a whole.

Results

Eighty-three students completed the survey (75 students responded to all questions; 8 students partially completed the survey; Table 3.2.1). Participating students represented 17 of the 21 (76.2%) AMC accredited medical school programs. The qualitative and quantitative item results are presented together for each of the four survey topic areas.

Table 3.2.1. Student survey respondent (n=83) profile

Characteristic	Values
Mean age - years (SD, range)	23.9 (2.6, 21-36)
Gender - *n* (%)	
Male	40 (48.2)
Female	42 (50.6)
Self-identified gender	1 (1.2)
Country of birth - *n* (%)	
Australia	66 (79.5)
Other country	17 (20.5)
First nations identity - *n* (%)	
Yes	2 (2.4)
No	81 (97.6)
Year of medical degree - *n* (%)	
4th year	34 (41)
5th year	28 (33.7)
6th year	6 (7.2)
Gap year/research year	2 (2.4)
Recently graduated	13 (15.7)

Topic one: Understanding and coverage of men's health

Most students reported their level of men's health understanding as 'somewhat' (n=40; 48.2%) or 'moderate' (n=37, 44.6%), with few reporting 'thorough' (n=3; 3.6%) understanding. For sex and gender-based medicine, the majority of students reported their understanding as 'minimal' (n=32; 38.6%) or 'moderate' (n=38; 45.8%), with only a few rating their understanding as 'thorough' (n=3; 3.6%). Content analysis of open-text responses from 80 students revealed a wide range of definitions of men's health. The most commonly identified (26.3%, n=21) definition of men's health referred primarily to male-specific health conditions, including sexual, urological or reproductive health (e.g., "Health issues faced by men, usually relating to the male urinary and reproductive systems.").

No students reported thorough coverage of men's health in their medical education. Twenty-nine students (34.9%) reported moderate coverage, 48 (57.8%) reported there being minimal coverage and six students (7.2%) reported no coverage at all. Only 8 of the 76 responding students (10.5%) recalled having the opportunity to take a men's health elective or placement compared to 45 students (59.2%) who recalled the opportunity to take a women's health elective or placement. Content analysis of open-text responses from all 80 students supported these findings, with students often reporting "*no formal teaching*" when asked to recall their education on men's health.

Where men's health content was mentioned, andrology (male sexual and uro-reproductive health) was the most frequently reported men's health education content, recalled by 50 students (62.5%), with conditions of the prostate specifically being recalled by 32 students (40%). While overall coverage was limited, some students nevertheless reported an over-representation of certain diseases and age groups of men, with one male student commenting on how they were taught "*common physical conditions in older men such as benign prostate hyperplasia. That's all.*"

Only five students (6.3%) recalled some limited content on gender norms or masculinities and men's health, including in relation to help seeking behaviours. A key trend appeared across these five responses, where students reflected being taught "that men have a decreased likelihood of seeking help for medical concerns - decreased likelihood of opening up or seeking help for mental health". This gendered stereotype was perpetuated across university teachings for these students, with another female student recalling how "in the rural program there was a single lecture involving a discussion of how men might be less likely to present with mood disturbances or health issues in general due to stoicism."

More than half of the students reported that sex and gender differences and considerations for clinical practice were covered minimally or not at all for 9 of 14 different areas of medicine (Figure 3.2.1) and for 6 of 10 specific clinical scenarios (Figure 3.2.2).

Figure 3.2.1. Student recall of coverage of sex and gender differences and considerations for clinical practice for different areas of medicine

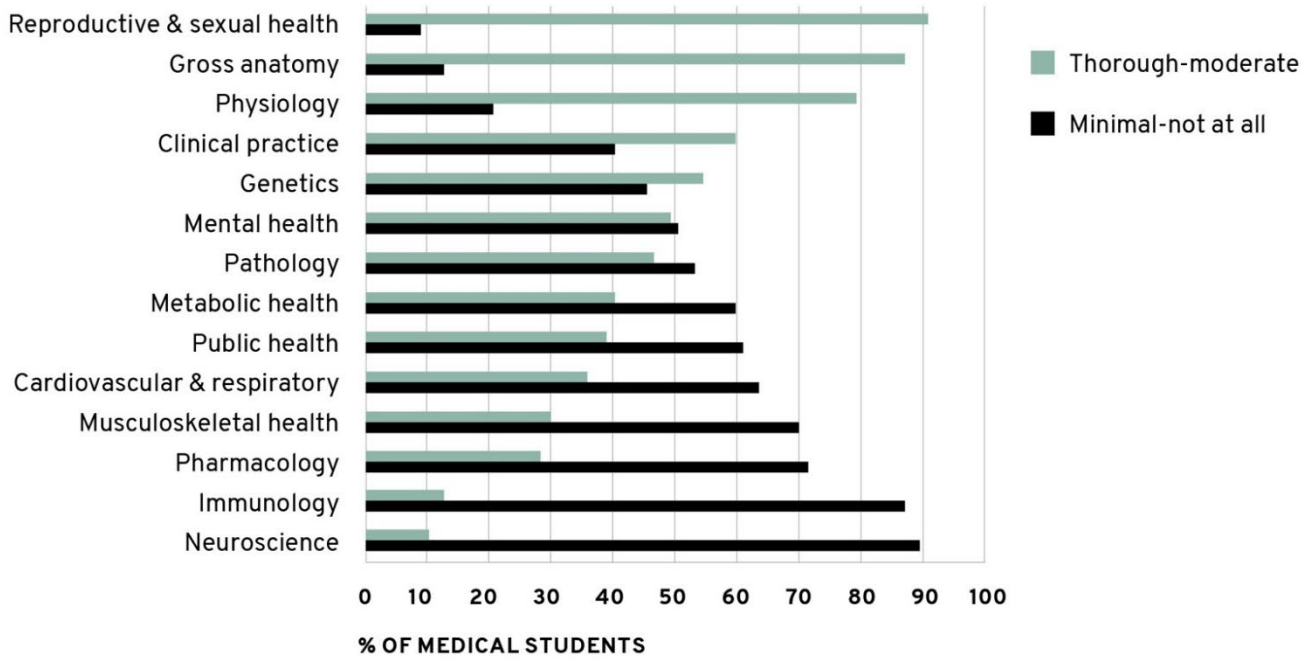
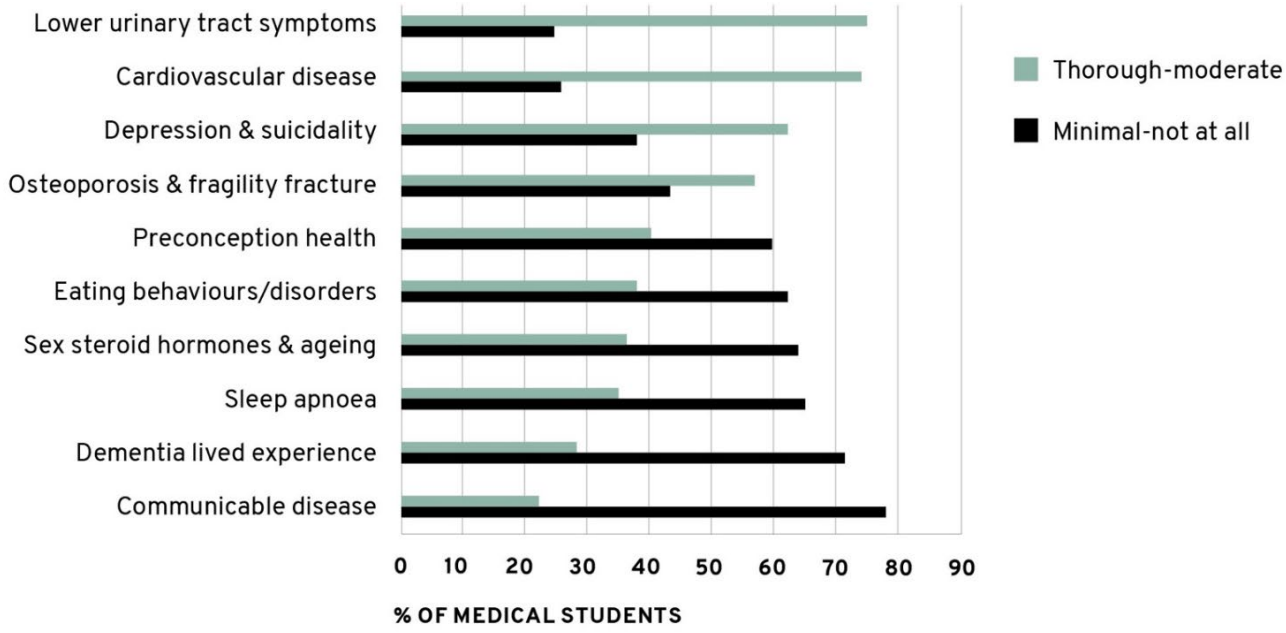


Figure 3.2.2. Student familiarity of sex and gender differences and considerations for clinical practice for different clinical scenarios from medical school education



Topic two: Preparedness for men's health clinical practice

A majority of the medical students (n=56, 63.9%) felt that they were 'moderately prepared' for working with men in clinical practice, with only a minority (n=6, 7.2%) feeling 'thoroughly' prepared. By comparison, 24 students (30.4%) felt thoroughly prepared for working with women in clinical practice (Table 3.2.2). Importantly, more than 60% of students surveyed felt minimally or not prepared for exploring interaction between men's experiences of masculinity and their health, and applying strength-based care when engaging men.

Table 3.2.2. Medical students self-rated preparedness

Item	Not prepared (*n*, %)	Minimally prepared (*n*, %)	Moderately prepared (*n*, %)	Thoroughly prepared (*n*, %)
Working with men	1 (1.2)	23 (27.7)	56 (63.9)	6 (7.2)
Working with women	0 (0)	7 (8.9)	48 (60.8)	24 (30.4)
Exploring interaction between men's experiences of masculinity and their health	13 (15.9)	37 (45.1)	31 (37.8)	1 (1.2)
Applying strength-based care when engaging with men	13 (15.9)	44 (53.7)	21 (25.6)	4 (4.9)
Understanding the impact of gender socialisation on men	7 (8.5)	35 (42.7)	35 (42.7)	5 (6.1)
Reflecting on your own gender assumptions	6 (7.2)	23 (27.7)	44 (53.0)	9 (10.8)

Thirty-eight students provided further open-text insights regarding their clinical preparedness for men's health. Students reiterated feeling unprepared for clinical practice, particularly in relation to applying a gender-based framework to optimally engage men, with students commenting that "*it's often difficult to approach and we have had no formal teaching except for being told "men are difficult consumers" and that "the only specific training we have had is grossly generalised and often placed the problems with men's health with the patient*". A clear gap in training was outlined with some directly advocating "there needs to be a part of the medical curriculum solely on men's health - definitely lacking at this point." Masculinity and its intersections with health were frequently cited as gaps in students' knowledge (e.g., "While we usually do have males as patients in our cases, the relationship between masculinity and health is rarely, if at all, explored".

> "As a woman I feel that while I may understand the clinical side of men's health, I lack the insight to comfortably approach it with men and I feel that thus far my medical education has not filled this gap. I feel as though my male peers are much more prepared for women's health than I am for men's health."

For students that did report feeling prepared, they usually did not gain this preparedness through formal curriculum: "*A lot of these things weren't inherently or explicitly taught in medical school, but I think I learned passively through experiences on clinical placement…*" Even those students who did feel as though they had been taught appropriate information felt they "...would struggle to apply this in a clinical context."

Topic three: Student interest in further men's health education and training

The vast majority of students (n=65; 85.5%) reported they would have liked more education and training on men's health. In comparison, 40 students (53.3%) reported they would have liked more education and training on women's health.

Regarding men's health topics that students would have found useful, the three most common were men's mental health (n=33), gender, masculinity, and sociocultural aspects of men's health (n=25) and how to specifically engage and communicate with men (n=22). Specific student suggestions included: "*...more specific teaching about approaches to male patients that accounts for barriers to care like reduced help-seeking and different forms of communication*". In addition, content covering "*clinical soft skills - strategies to broach difficult topics such as mental health etc.*", as well as "*mental health, gender identity, masculinity, lived experiences*" would have been useful to students. Reflecting a common finding that young doctors are overburdened with mental health presentations, one male student was emphatic that he wanted training to work with men effectively and "*how to actually make a difference*."

Student consultations

Two final year medical students (1 man, 1 woman) who completed the survey consented to a further consultation to gain additional insights on the need for, and the type of additional men's health content, in medical education, and the feasibility of integration of men's health into curricula and how this may be best achieved.

The students agreed that there was a medical need and imperative for better men's health education with a focus on gender competency so that graduates are confident and competent to effectively engage and respond to men in clinical practice. Such learnings would also serve to redress the stereotyping of men as difficult patients that both students had experienced during lectures and training. Specifically, the students recommended that content be delivered as i) men's health 1-week blocks starting early in degree, ii) round tables exchange with on-the-ground (non-academic) experts in men's health, iii) dedicated placements and research opportunities, and critically iii) men's lived experience heard from a diversity of men as health consumers. Furthermore, they felt that capacity exists within their current curriculum, and that the student voice through both formal and informal processes can be effective in advocating for curricula enhancement.

Evidence summary

The key evidence generated from this medical student survey and consultations, that confirm their men's health education needs and the focus of content for a men's health education initiative, was as follows:

- A majority of surveyed students from Australian medical schools reported minimal to no men 's health education beyond andrology related content; and were not familiar with sex and gender considerations for a number of common clinical practice areas and scenarios.
- Most of the students felt underprepared for men's health clinical practice, as well as, albeit to a lesser extent, women's health clinical practice. Students would have liked gender-responsive health care for men education with a common focus on masculinities and engaging and communicating with men in clinical practice, including for provision of mental health care.
- Practical education through men's lived experience from a diversity of men would support learning impact.

Further research and stakeholder engagement is required to acquire an understanding of:

- the men's health education experiences of students from other health and social care disciplines, and their perspectives on the need for men's health curricula enhancement to better prepare them for practice.

SECTION 4

BEST PRACTICE APPROACHES TO ENGAGING WITH MEN IN PRIMARY HEALTH CARE

SECTION 4

OVERVIEW

Section 4 describes the outcomes of two studies that aimed to collate evidence on best practice approaches for communicating and engaging with men in primary health care encounters; study 4.1: Approaches to optimally engaging men during health care encounters: A scoping review, and study 4.2: What works to engage men in health services? In-depth focus group discussions with a diverse range of men. These studies responded to evidence from the tertiary curricula and CPD reviews (Section 2) and the university staff and medical student engagement (Section 3) which identified a need and opportunity across disciplines to develop curricula resources on communicating and engaging with men in care, to ensure the gender competency and workforce readiness of HCPs to effectively work with men in practice.

4.1 A SCOPING REVIEW OF THE PEER-REVIEWED LITERATURE

Aim

- To synthesise, from the literature, recommended gender-responsive approaches used by health practitioners to optimally engage with men during primary health care encounters.

Methods

The research question developed to guide the review was: What are effective gender-responsive practices used by health care providers (HCP) for engaging men in primary health care encounters?

Eligibility criteria and sources

Articles were included in the review if: i) Adolescent and/or adult men were the target population, ii) articles provided recommendations for engaging men in health care and if iii) health care encounters related to a primary health care setting. Additionally, articles (including case studies, reviews, commentary or opinion pieces or editorials) were: iv) peer-reviewed, v) incorporated primary (original) data, vi) published in English language, and vii) published from 2000 to Feb 2023.

Articles were identified through four electronic databases (OVID Medline, CINAHL and EMCARE, and PsychINFO). The search strategy was prepared by the authors and conferred with an experienced University-based librarian.

The strategy for PsychInfo was

(*men/ or (male* or man or men or mens or father* or boy or boys or masculin*).ti,ab.)

and ((general adj1 practice*) or GP or (family adj1 practice*) or (primary adj1 care) or (primary adj1 health) or (primary adj1 healthcare) or (community adj1 health adj1 care) or (community adj1 healthcare) or counselling or counseling or psychotherapy or (mental adj1 health adj1 care) or (mental adj1 healthcare) or (family adj1 healthcare) or (family adj1 health adj1 care) or (allied adj1 health) or (allied adj1 healthcare) or (allied adj1 health adj1 care)).mp. and (relationship* or engag* or communicat* or connection* or rapport or alliance*).mp.
and limit 6 to (human and english language and "0100 journal" and yr="2000 -Current")

Two researchers independently screened titles and abstracts, and selected articles based on study eligibility criteria. Dual screening was performed on 30% of articles. Conflicts or uncertain screens were resolved by consensus with a third reviewer.

Data charting and results synthesis methods

The extracted data for charting included author(s), year, location of study, study design and type of evidence, primary health care setting, discipline or type of health care practitioner, population characteristics (sample size, average age, sub-population group), theoretical orientation of intervention (where applicable) and recommended engagement approaches/strategies.

Inductive thematic synthesis, guided by the principles described by Braun & Clark (2021)[42] was undertaken for data analysis. Inductive derivation of codes was guided by a previous scoping review undertaken by Seidler et al. (2018)[43]. Two researchers read and annotated all articles, coding for common content reflecting different facets of engagement practices with male patients or

clients. Categories of codes were progressively added as new themes were identified. Themes were iteratively discussed amongst the wider project team for consensus. Themes representing recommended engagement practices with men were derived and presented below with explanations and examples.

Results

The search strategy generated 14,689 references. Manual screening of reference lists yielded a further 88 potentially relevant abstracts. Following full-text review, 90 articles met the inclusion criteria and were included in the analysis. An overview of the screening and inclusion process is provided in Appendix C. The included articles (*n*=90) were published between 2001 and 2023 and included 81 unique first authors. Half of the studies (n=45; 50%) were from the United States of America (Table 4.1.1).

Synthesis of evidence

The approaches for optimally engaging men in health care encounters were coded to three interrelated themes; 1) Tailoring of communication to *reach* men, 2) Purposefully structuring treatment to *respond* to men in care, and 3) Centering of the therapeutic alliance necessary to *retain* men in care until outcomes are achieved (Table 4.1.2). The term 'therapeutic' is inclusive of all types of care delivered including both therapeutic and, or preventative.

Communication (to reach and understand men)

Tailoring of communication, centred on language style and elements of health care encounters. The use of informal language to enhance rather than obfuscate a health message was recommended to facilitate a perception of practitioners as "*down-to-earth*"[52], with a "*laidback and respectful manner*"[53]. Non-medical or lay terminology is also important to "*ensure information is understood*", and minimises power dynamics, especially with men who live in marginalising conditions and/or communities[54].

The use of 'male-relevant' metaphors (e.g., "*bringing it home, knocking it out of the park, taking one for the team/family"*)[49] was often recommended to bridge the language men ordinarily use to describe symptoms and experiences. Male-relevant language was however caveated in some articles with the need to ensure cultural responsiveness, recognising the futility of an essentialist, one-size-fits-all approach to communicating with men. For example, when working with First Nations men, a "*less confronting, side-by-side communication with opportunities for silence and reflection*"[53] was favoured over "*direct and matter of fact style communication*" recommended elsewhere[55].

Moreover, practitioners who "*allow more opportunity to talk more about what else is happening in the man's life*"[56] provide space for the 'whole man' in the room and thus more holistic health care encounters. Insights gained through contextual information can afford opportunities for gateway conversations about other health or social welfare issues that men may otherwise see as peripheral to the primary health concern or be reluctant to raise during focussed health care encounters (e.g., violence, obesity, work-related matters).

Structuring treatment (to respond to men and their health care needs)

Practitioners should have a foundational understanding of the influence of gender socialisation (i.e. adherence to masculine norms) on men's symptom presentation and preferences for care. For example, comprehensively exploring "*the ways by which the traditional male gender role both inhibits and complicates*"[44] the expression of common conditions (e.g., depression). This ensures practitioners are better positioned to assess, diagnose and tailor health care processes and treatment.

Table 4.1.1. Key characteristics of included articles (N=90)

Characteristic	n (%)
Country/region (lead author)	
USA	45 (50.0)
Australia	15 (16.7)
Canada	15 (16.7)
United Kingdom	7 (7.8)
Scandinavia	3 (3.3)
Other	5 (6.8)
Primary care discipline*	
Counselling/Psychology	58 (64.4)
General practice-Medicine	21 (23.3)
Social work	9 (10.0)
Nursing	8 (8.9)
Psychiatry	2 (2.2)
Pharmacy	1 (1.1)
Paramedicine	1 (1.1)
Not specified	2 (2.2)
Disease/condition focus*	
General mental health	32 (35.6)
Depression	18 (20.0)
Alcohol/drug problems	6 (6.7)
Domestic/family violence	6 (6.7)
Reproductive health	3 (3.3)
Obesity	2 (2.2)
Gambling	1 (1.1)
HIV/AIDS	1 (1.1)
No focus	28 (31.1)
Type of study/article	
Primary (original) research	45 (50.0
Commentary	21 (23.3)
Literature review **	18 (20.0)
Case study	4 (4.4)
Editorial	2 (2.2)
Primary research study design (n=45)	
Qualitative	31 (68.8)
Quantitative	8 (17.8)
Mixed methods	6 (13.3)
Primary research study population (n=45)	
Consumers	30 (66.7)
Practitioners	8 (17.8)
Practitioner & consumer	7 (15.6)
Subgroup of men in focus*	
Men in general	63 (70.0)
Young men	14 (15.6)
Veterans	5 (5.6)
Black American men	5 (5.6)
Older Men	4 (4.4)
LGBTQI+ men	3 (3.3)
Aboriginal and Torres Strait Islander men	2 (2.2)
Latino men	2 (2.2)

Table 4.1.2. Recommended engagement approaches by theme

Theme	Engagement approach	No. Papers	Exemplar quotes
Communication: to reach men and speak their language	● Use informal language (e.g., humour)	23	*"Engaging the male client in a more conversational and less clinical give-and-take at the very beginning of the first session can be helpful. This can be accomplished by inquiring about…superficial topics that will tend to 'warm up' the reticent male client…"* (Rabinowitz & Cochran, 2007)[44] *"It may be that football metaphor offers an alternative means of engaging men who find it difficult to talk about emotions and 'open up' about personal difficulties."* (Spandler et al., 2014)[45] *"Important to use any opportunity to engage men: for example…initiate a conversation relating to delicate topics such as sexual health and mental health as men may not volunteer problems in these areas." (Strange & Tenni, 2012)* [46]
	● Encourage and enable men to tell their story	17	
	● Raise issues directly	16	
	● Use male-relevant language	14	
	● Use alternative labels for treatment or symptoms	12	
	● Use culturally appropriate language	7	
	● Use metaphors	7	
	● Use gateway conversations	4	
	● Focus on non-verbal communication	2	
Structure treatment purposefully to respond to men	● Explore the influence of gender socialisation on men's service access and symptom presentation	28	*"An educational component was important to the participants. A straightforward explanation of the how and why behind interventions helped address suspicions of ulterior motives and appealed to men's desires to understand the process." (Kivari et al., 2018)* [47] *"[Ensure men] understand their role and are affirmed in their engagement, knowledge, and confidence to have and express opinions" (Rosu et al., 2017)* [48]
	● Collaboratively set goals for treatment	22	
	● Reinforce action oriented, solution focused, or activity-based treatment structure	21	
	● Allow for flexibility, timing and pace of treatment based on men's needs	17	
	● Seek opportunities to educate about treatment and health	17	
	● Transparently breakdown treatment options, structure and direction	15	
	● Explore expectations of roles and responsibilities	13	
	● Help men access and describe their internal emotional experience	10	
	● Build a male friendly space	8	
	● Build-in a treatment feedback process	6	

	● Employ masculine-sensitive assessment strategies	4	
Theme	**Engagement approach**	**Papers (n)**	**Exemplar quotes**
Centering the therapeutic alliance: to retain men	● Explore and emphasise the strengths and positive aspects of men's masculinities	39	*"Characteristics typical of men that can be valuable in therapeutic work include masculine camaraderie, discipline, rationality, and aggression."* (Dvorkin, 2015)[49] *"Health professionals actively addressing safety and power dynamics earlier on in health management encounters could be a strategy to start discussing a healthy and trusting clinical environment in their interactions with male patients."* (Kwon et al., 2023)[50] *[Practitioners] assess[ing] their own values and perceptions of masculinity*" and "*how masculinity and gender affect their conceptualisations of clients*" (Marasco, 2018)[51]
	● Validate, normalise and encourage men's personal experience	29	
	● Promote men's autonomy and empowerment	33	
	● Identify and respond to diversity within and between men	26	
	● Listen with empathy	23	
	● Meet men where they're at with their openness, motivation and willingness	23	
	● Self-reflect on practitioner gender socialisation and resultant biases	22	
	● Build collaborative non-directive relationship	20	
	● Create a non-judgemental environment	17	
	● Allow appropriate self-disclosure	13	
	● Reinforce confidentiality	12	
	● Convey confidence and competency	10	
	● Avoid challenging traditional masculine norms	8	

Seeking opportunities to educate men throughout health care encounters was raised as another recommendation, for example "*how diet affects physical appearance and personal functioning (e.g., sex, work, athletic performance)*"[57]. These opportunities to provide education builds men's capabilities to express their needs, while enhancing practitioner's abilities to understand men's health care concerns and develop individualised treatment plans and patient care pathways.

By summarising the treatment options early and transparently, practitioners can enable men to "*temper their expectations accordingly, thus engaging and empowering their client as an equal partner in treatment* "[58]. Men are likely to benefit from being involved in the decision-making processes and collaboratively setting expectations and goals by "*asking what the man wants to have accomplished in terms of success with respect to the challenges he identifies*"[59]. This approach responds to men's "*need to have tailored and holistic plans*"[60], allowing men to have a sense of autonomy and empowerment over what is often perceived as a passive treatment process. Several articles predicted that "*action oriented*" services could resonate more with men, with this framing of treatment "*more likely to make clinically significant and reliable change*"[61].

Therapeutic alliance (to retain men)

Men's likelihood for seeking help and engaging in health care was framed as contingent on "*critical characteristics*" of the practitioner, such as "*trust and confidentiality*"[62], especially if ailments are imbued with feelings of shame and vulnerability. During initial encounters, practitioners should display confidence and competence by "*leading the way*"[49] and adopting a "*concise, direct and to-the-point style for a trusting relationship*"*[48]*. Articles noted the value of practitioner openness and self-disclosure as a vehicle for building trust and establishing an "*equal relationship*"[63].

Also important to therapeutic alliances with men was the practitioner validating and, where appropriate, normalising experiences as common for men, for example, a degree of apprehension in seeking help (particularly in mental health service contexts). Universal norming statements such as "*many of my patients forget to…*", was suggested approaches to "*remove the embarrassment often associated with certain feelings and experiences*"[64]. This was discussed as particularly necessary when men were disclosing antisocial or risk-taking behaviours. Importantly, González-Prendes (2007)[65] highlighted the need to focus on "*building the therapeutic alliance by demonstrating empathy through the acknowledgment of the difficulties that the clients had experienced*", and in doing so avoid hastening to "*challenge clients' cognitions*".

A strength-based approach that aims to empower men for self-care and to be an active partner in the therapeutic alliance was commonly recommended. For this, practitioners can reinforce men's masculine self-worth by "*using solution-focused skills to pose constructive questions that elicit the man's taking responsibility to make things better for himself and others*"[59]. Relatedly, there is value in purposefully establishing a collaborative and non-directive alliance with men which can help overcome any sense of defeat (and associated shame) men might experience in health care settings.

It is recommended practitioners self-reflect on their own gender socialisation and resultant biases, "*assess[ing] their own values and perceptions of masculinity*" and "*how masculinity and gender affect their conceptualisations of clients*"[51], and consequently how this translates into their practices for engaging with men.

Evidence summary

The evidence generated from this first ever synthesis of current peer-reviewed, published literature on "best practice" approaches to engaging men in health care was as follows:

- Approaches to engaging with men may be condensed for education delivery for HCPs into three themes, that aim to better reach, respond and retain men in health care;
    - tailoring communication to reach men and keep them connected throughout health care encounters.
    - purposefully structuring treatment, improving HCP's ability to effectively respond to men's health care needs, and
    - centering the therapeutic alliance such that the HCP is receptive to, affirming and responsive to men's gendered patterns of health and help seeking in order to retain men in care.

While search criteria for sampling of the literature may limit the search outputs, only 90 articles from 2000 to 2023 were retrieved. During this time there has been marked evolution of the definition and scope of men's health with a shift in focus to gender and health equity. Further research and stakeholder engagement is required to acquire an understanding of:

- the approaches to engaging with men in health care that is responsive to:
    - the diversity of contemporary gender roles and masculinities, and
    - the intersection of gender with other sociocultural determinants, so that a future education initiative will have, as its focus, a goal of responding to the health care needs of priority groups of men, and
    - the specific clinical or social context for which men are seeking care, examples of which were limited in the published literature, outside of the counselling and psychology fields.
- to generate empirical evidence in future education initiatives and to operationalise these understandings and approaches for men into student and HCP education, and assess their impact.

4.2 WHAT WORKS TO ENGAGE MEN IN HEALTH CARE? IN-DEPTH FOCUS GROUP DISCUSSIONS WITH A DIVERSE RANGE OF MEN

While the scoping review reported in Section 4.1 yielded best practice approaches to engaging men in care, the source of these recommendations did not include dedicated studies involving in-depth discussions with men themselves. Understanding men's health care experiences and their perspective of what works and does not work for them during health care encounters with HCPs from a range of different settings is essential to developing consumer informed education content.

Aim

The aim of this study was to understand men's experiences with HCPs to identify practical, actionable consumer informed recommendations for inclusion in education curricula on gender-responsive health care.

Methods

Focus group methodology was selected as bringing men together in a group setting is a valuable approach to capturing collective group attitudes, norms and experiences, with scope to identify both agreements and inconsistencies[42].

Procedure

Participants were Australian men (18+ years) purposively recruited. Most were recruited from an existing database of men who had participated in previous research exploring their experiences of help-seeking in mental health services specifically. The researchers also shared the study information with relevant contacts for a snowballing recruitment in order to ensure a sufficiently diverse sample.

Consenting men completed a brief online demographics survey covering age, country of birth, Aboriginal or Torres Strait Islander background, cultural/ethnic background, estimated number of visits to a medical doctor per year (e.g., GP, specialists) and estimated number of visits to an allied health professionals in the past year. Among over 180 interested men, this data was used to purposely select a diverse group of men with varying socio-demographic and health service utilisation profiles, who were then invited to participate in the focus group discussions.

Data collection

For descriptive purposes only, participants were invited to complete a further survey of optional questions covering gender, sexual orientation, geographic location, education, employment status and relationship status. Participants were also asked to rate their overall health status and mental health status ("In general would you say that your health is excellent, very good, good, fair, or poor", repeated using the same wording for mental health; using the Australian Bureau Statistics National Health Survey, 2020-21 ABS)[66]. Participants were also asked to indicate from a list, which health professionals they had consulted in the last 12 months.

Eight FGDs (3-5 men per group) were conducted online during May and June 2023, each approximately 90 minutes in duration and co-facilitated by the same two project team members. A semi-structured interview guide with open-ended questions was developed to explore participants' interactions with health practitioners, asking them about positive and negative experiences, what makes them want/not want to return to a practitioner, what practitioners could do differently to better engage and retain them and what they would like all of their health practitioners to know and/or do when they are working with men. Participants were provided with a $150 gift card to acknowledge their time and contribution to the project. Each FGD was recorded and transcribed verbatim.

Data analysis

An inductive thematic analysis was undertaken following the principles of Braun & Clarke (2006)[42]. Transcripts were read by all team members to identify initial patterns and codes, developing a coding framework guided by the themes from the scoping review (Section 4.1 in this report). One researcher then proceeded with open coding of all transcripts using Nvivo (Version 12; 2018) adding new codes and categories as they were identified. The coding was reviewed by a second independent team member who grouped the codes into descriptive themes. The resulting themes were discussed by the team until consensus was reached.

Results

Thirty-two men aged between 18-70 years (M=39.4; SD=15.7) took part in the focus group discussions (Table 4.2.1).

Table 4.2.1. Focus Group participant profile

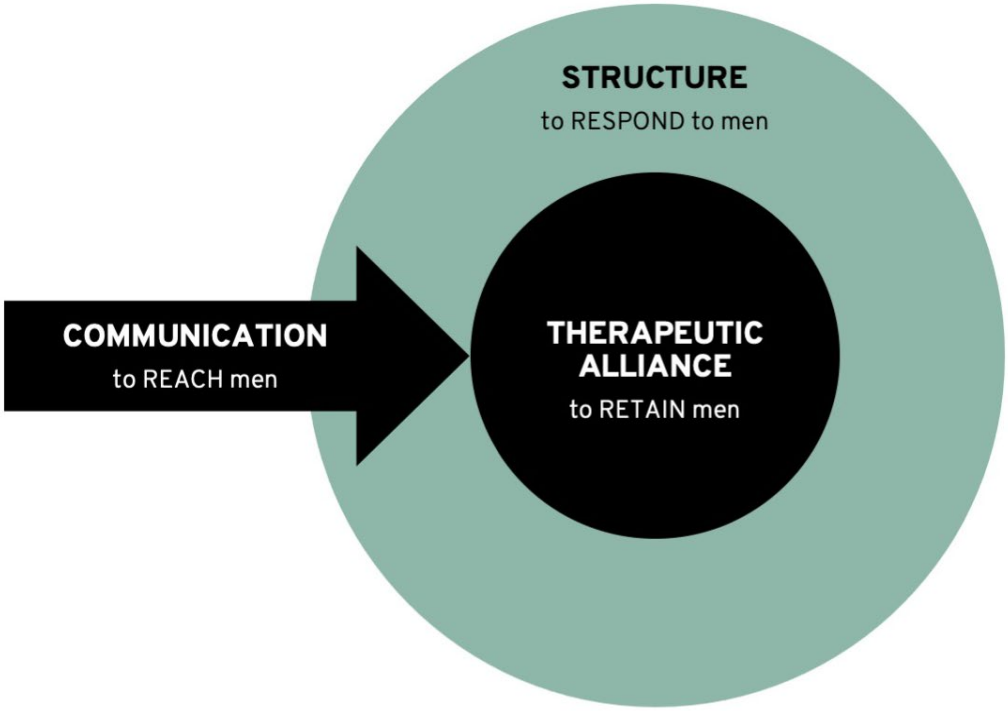
Characteristic	n (%)
Age group	
18 – 24 years	6 (18.8)
25 – 44 years	14 (43.8)
45 – 64 years	9 (28.1)
65 + years	3 (9.4)
Sexual orientation	
Straight	26 (81.3)
Bisexual	3 (9.4)
Gay	1 (3.1)
Not reported	2 (6.3)
Residence	
Metropolitan	19 (59.4)
Regional	11 (34.4)
Remote	1 (3.1)
Not reported	1 (3.1)
Australian born	26 (81)
Aboriginal and/or Torres Strait Islander men	2 (6.3)
Education	
High School	2 (6.3)
Trade Certificate or Certificate II or Diploma	7 (21.9)
Undergraduate degree	13 (40.6)
Postgraduate degree	8 (25)
Not reported	2 (6.3)
Relationship status	
Single	10 (31.3)
Partnered	20 (62.5)
Not reported	2 (6.3)
General health status	
Poor	0
Fair	5 (15.6)
Good	11 (34.4)
Very good	10 (31.3)
Excellent	4 (12.5)
Not reported	2 (6.3)
Mental health status	
Poor	3 (9.4)
Fair	8 (25)
Good	8 (25)
Very good	9 (28.1)
Excellent	2 (6.3)
Not reported	2 (6.3)

The majority were Australian-born, metropolitan based, partnered men with tertiary education qualifications. In terms of health, the majority of participants (78.2%) reported their general health to be good, very good or excellent while just over one third (34.4%) reported their mental health as poor or fair.

The majority of interactions described by participants were reflections on experiences with general practitioners. The remainder consisted of interactions with mental health professionals, along with a few experiences in hospitals and allied health professionals (mainly physiotherapists). In the past 12 months, participants reported a median of 5 medical care encounters (ranging from 1-26), and a median of 5 non-medical health care encounters (range 0-30+).

Three main themes were identified in focus group discussions concerning the factors from constituent of positive health service engagement by men. These were broadly classified across elements of health care engagement that men felt were useful in order for the HCP to **reach** and connect with them (e.g., communication styles, use of male-oriented language); **respond** to their needs (e.g., holistic, person-centred approach) and **retain** them in care (e.g., the necessary nature and substance of the therapeutic alliance). These findings build on and extend upon findings from the scoping review (Section 4.1), with first-hand accounts of men's experiences to add depth and weight to the complementary findings (Figure 4.2.1).

Figure 4.2.1. Key elements of gender-responsive approaches to optimally engaging men during health care encounters



Reach men: Communication strategies in health care encounters

Central to the level of engagement men experienced in their health care interactions was a focus on connecting through purposeful communication. Many participants shared how basic communication strategies to build trust and comfort were often overlooked, with the perception of genuine interest from the practitioner often tied to non-verbal body language:

> *"Don't be tapping on your keyboard, looking at your computer while you're doing it. Bit of eye contact. Make them feel like you're actually talking to them rather than it's just a, oh, I feel like I need to ask you because it's on my script. It has to be genuine."*

This notion of being genuine came from active listening, a 'soft skill' that the men themselves noted is hard to teach and difficult to discuss with a practitioner ("*sounds really trite*") but is often underestimated as a simple but fundamental element when ensuring practitioners get the most out of a male client. One participant noted that the makeup of the consultation environment can either

act as a barrier or facilitator to this level of connection so that "*you're actually sitting body to body. It's quite different to when you're across a desk*."

Masculine socialisation processes were implicated here too, and it was suggested by one participant that while "*some blokes might have grown up in households where it wasn't really a thing [to seek help] or where they just didn't feel supported*," this could be overcome by a "*medical professional who actually displays that they're listening to me and is open…I'll just keep talking. Compared to someone typing away on a laptop…I'll say the bare minimum, that's it*." This notion of free-flowing conversation being the marker of successful engagement amongst the participants was a consistent discussion point, such that once the client felt heard, understood and respected, there were few barriers to ongoing engagement.

As a means to streamline this process, a few recommendations were made by the participants. Male-relevant language, particularly around incorporating appropriate humour, metaphors and broader informal, colloquial language into initial interactions were repeatedly suggested. There was an underlying notion discussed amongst participants that health care interactions were inherently awkward or uncomfortable and so many reflected the value of "*a joke here and there just to release the tension*".

> *"It was the prostate exam which the first one was of course my GP and I'll never forget what he said to me. He said, "I don't enjoy this anymore than you do." So it was that little bit of humour that it literally broke the ice and it was appreciated because it was something just fills you with dread, something just slightly quirky and a bit of fun, just lightened the whole situation."*

These decisions by health care practitioners to humanise and make informal their language was well-received by the men and "*a friendly chat just encouraged me to open up more*." Indeed, there was a belief by one participant that this type of communication style was often a test and "*if you can handle [me saying] 'shit' or something stronger, you can probably handle listening to mental health issues or whatever I want to tell them*."

There was nevertheless a common sentiment across all communication recommendations promoting the importance of diverse interactions as "*I understand that maybe that doesn't work with everyone, so I guess read the room as well."* Personalising the communication style with metaphors that tapped into the male client's experience or interests was also welcomed: "*we always ended up talking about motorbikes to help with the problems that I was dealing with, she would be able to work that into it."* This quote typifies the need for practitioners to adapt and personalise their communication style according to the unique needs and stories of each male client.

Beyond the tone and approach for communication, the men also spoke to the 'what' of health care conversations with men, and repeated throughout discussions was the importance of the health practitioner asking questions, probing and investigating. Having a belief that the health practitioner was well-intentioned and was willing to "*go in light footed"* to start with, in order to build connection, gave way to an openness from some participants for practitioners to be blunt and direct: "*he knows I like that, he just gives it to me*."

Despite stereotypes suggesting men aren't willing or able to open up and discuss their health concerns, the current participants spoke to the power of empathic and broad-ranging questions in reducing anxiety and increasing their willingness to disclose:

> *"If I know that the health practitioner is probing a little bit into other things, into my personal life, into my social life, it's very, very quick. But it makes me feel that they're making the proper investigation, so my anxiety goes down and my level of trust goes up."*

Towards the end of health service interactions, participants also referred to the 'doorknob question' and how a practitioner genuinely and curiously asking "is there anything else?" (rather than as a formality) can overcome internalised stigma and increase engagement.

> *"I think you might need prompting because you're like, "They don't need to hear my crap." Well, but they are doctors. But you're just like, "I want to get out of here." Or they've got other people with bigger problems and some of us have a background of being told there's nothing wrong with you and things being minimised. I think that little prompt was a really useful thing for me."*

Respond to men: Structuring interventions in health care encounters

Present throughout the discussions was a consistent theme of the importance of practitioners purposely orienting services towards men and their needs. This orientation, or lack thereof, was often referenced in general practice settings where men described the negative experiences they had, detailing where they've been "*misunderstood… and sometimes misdiagnosed*" resulting in increasing "*likelihood of not visiting a doctor in the first place*". A lack of effective orientation of services towards men was evident in some participants' accounts, where some reflected on "*some pretty bad experiences with GPs before where I just haven't felt safe or haven't understood*", which culminated in them feeling that their needs were not being met ("*I couldn't get the help I needed*"). Participants also discussed that a lack of purposeful tailoring of services to men can give rise to an overriding sense of discontent which defined the interaction.

> *"Just an overriding feeling of you are not a human at times, you're just a statistic, you're in and out. All they're worried about is their 10-minute billing period, and then move you on sort of thing."*

In response to these negative experiences, some men noted the value of having a regular GP, who by nature of extended contact could appropriately tailor and target the structure of treatment for men. This led to a sense of confidence that when they went in, the treatment they receive would be relevant and geared towards them ("*because they've known me since I was a kid, so I do get that quite personal level of care, that they understand my history, and the things that are relevant to me when I go in there*"). For those who described their experiences in choosing a GP, a common thread was the choice of some practitioners to connect with their clients and enquire about their lives, in a holistic manner ("*asked me about my work… asked me just some personal questions, hobbies and that sort of thing*"). It was these moments that led some men to feel comfortable in the health service interaction, as they could identify practitioners' efforts to leverage and incorporate their strengths into the structuring of treatment that could ultimately feel more personalised towards them:

> "*You realise he's a human and he connected with me in the way of being like, "I'm not just a customer almost." He specializes his health treatments towards you a bit more I think is what I got the feeling of I reckon.*"

Many participants reflected on the clear value of purposeful structuring and delivery of treatment to meet their unique needs, lest they feel like just "*a person on the assembly line that needs to be fixed*". Importantly, this was developed through getting to know the man presenting to the service, by taking time to listen during "*the first two or three sessions*", with some men reflecting that "*if [practitioners] take the time to understand me, I'll usually project a lot more and tell them things without having them having to even work as hard."* These comments were central in men's desires to be seen under a 'whole person' approach, where a holistic view of their lives was taken into account with their treatment:

> "*He assessed my life and where I'd come from and why I was who I was. It was very helpful because I could go to him with anything that was more sort of abstract or something more locally bodily located. And he would be helpful because he just understood me on a much, much deeper level than just seeing the problem, I suppose. He saw me as a person and considered my worldview and we shared a similar worldview and that helped a lot.*"

Finally, a sub-theme noted in the discussions was the interactions between masculinity and health care encounters, with some speaking to the gendered bias that they've experienced in health service settings, while others noting generational differences that had alleviated any potential self-disclosing stigma for them. At times, men described their interactions with health care practitioners as reinforcing old, outdated sentiments to "*pull yourself up by your bootstraps*" , "*real men don't cry*", and "*You're a tough guy. You can deal with it. You can handle it",* which led to some feeling that they weren't being treated with care ("*you're not treated as delicately, I guess"*). This gender bias and complicity in perpetuating stereotypes on behalf of the practitioners could at times combine with the gender socialisation of the male clients, resulting in both a struggle to articulate the severity of their issues from the men's perspective, and an inability among practitioners to recognise the severity of men's concerns ("*Cause if you can't really tell them the severity of the issue, they're not going to really treat it as a severe issue either.*"). Promisingly, younger members of the group spoke to how the stigma around reaching out for help has lessened, compared to other, older generations of men, with more recent changes resulting in men typically "*putting their head down and making sure that they come out with the best health situation*". These findings speak to the need for practitioners to ensure timely and targeted service offerings for help-seeking men that aren't steeped in existing stereotypes about the ways in which men will, or will not, access care.

Retain men: Essential components of the therapeutic alliance

The final theme identified across focus group discussions pertained to the necessary nature and substance of the therapeutic alliance with men to effectively retain them in care. Key recommendations for practitioners from men were identified in terms of prioritising the building of a therapeutic alliance over time, without rushing, irrespective of his presenting problems or concerns. Importantly, the therapeutic alliance was often discussed specifically with reference to mental health service consultations (i.e., psychotherapy). Men highlighted the critical need for HCPs to prioritise the therapeutic alliance irrespective of their profession. They reinforced that their relationship with their practitioner is built on a genuine willingness to engage with them as a *person*, not just as a *patient*. Participants routinely noted the value of broader conversations around general life stressors they might be experiencing that can compound or complicate presenting health concerns, even if not directly related.

> *"It's more of a one-on-one, friendly chat, and talking about things like why you have high blood pressure and stuff, and how you can reduce it. And also stress and other things, and relationship issues that you might have. He could even always talk to him about that sort of stuff, and he'll always give you the best knowledge that he can give. He's probably not a professional, not a full on a mental health professional or anything like that, but he can sort of guide you anyway ".*

Participants also spoke of the value of an authentic connection with their health practitioners that influenced their willingness to stay engaged with services. For many participants this authentic relationship often went hand-in-hand with professionalism.

> "*He would be very professional and do his job at the same time… I always feel like I have to have that good connection relationship wise. I need to be comfortable. I need to be... Especially with physio because you're in a lot of pain while they're working away. So yeah, I do feel that it's important to have that connection. Or maybe mentally, emotionally, I guess*."

One participant also directly suggested a need for health practitioner training to prioritise engagement and connection with male clients, irrespective of health service setting. There was a strong sense that practitioners' capacity to manage illness in help-seeking men hinges ultimately on their capacity to connect authentically with their patient.

> *"But yeah, I think if there was something I could say to the people who were teaching the university students, I would say really focus on helping them become aware and connect well with the patient. And obviously if you're struggling you might have to go and recommend somebody else see them because you just can't make that connection/ because I just think that's paramount. If you can connect with a patient, you can help them with whatever they need. Any yeah, what they're there for, whatever."*

A range of other important components of the therapeutic alliance were noted by participants. These included openness, clarity and honesty with clients around the cost and structure of treatment. Allowing space for men to ask questions was also critical in establishing a therapeutic alliance typified by an 'even playing field' between client and practitioner; several participants noted negative experiences when attempting to clarify their treatment options.

> "*It was just the sheer fact that when I did ask questions, he was talking as if to say, 'And you're questioning my diagnosis or my treatment options,' or whatever. It was like that. All I was doing was asking questions and asking what the treatment options or whatever were. But he got really defensive. And he was a surgeon, and that made me feel a bit off*."

In addition, a focus on care, compassion, listening to clients wholly and building trust were all reported as central elements of therapeutic alliance irrespective of health profession. Focus group participants suggested in health service contexts, they can often readily identify genuine empathy and care in health practitioners, and the absence of this can be a key determinant of disengagement. Participants noted they can "*tell pretty quickly whether or not someone's got a genuine care for the situation [they're] in*", where one noted if they have "*a medical professional who actually displays that they're listening to me and is open, I'll just keep talking*."

Finally, results in this theme reflected a key emphasis on an equal therapeutic alliance that achieves the right balance between practitioner expertise and professionalism, with client's autonomy, empowerment, and strengths at the centre. Participants acknowledged the reality of time and resource pressures in many health service settings that can impact the extent to which practitioners will prioritise true engagement and connection. This was discussed particularly with reference to GP visits.

"*In terms of what they could do my big thing is take the time to properly understand. There seems to be such a rush with health practitioners to get you through and finish the job particularly within GP land [to] get you through the 15-minute slot that you paid for… quite often the main thing that you came in for are a crossover or not treated in this session we'll do that next session type of thing.*"

Yet given GPs are typically the initial point of contact for men seeking help irrespective of their health issue, it is critical that in this context, the therapeutic alliance is prioritised as much as possible to help retain men in care and ultimately improve their outcomes.

> *"I might come in and I might be really scared. And if they're going to meet me with, "I need to get you out the door to see my next patient." Well, that's going to really, really hurt. But yeah, for me, I think the judgement thing is massive. If I can just feel comfortable from the outset, I think that's huge."*

Evidence summary

The key evidence generated from this synthesis of what men report works for them when engaging with HCPs to inform a best practice men's health education initiative was as follows:

- Strong agreement between men's preferences for approaches to engagement used by their health care practitioners to that extracted from the literature, in that most men had a preference for their practitioner to have an upfront authentic, caring style of communication and connection with them that allowed them to legitimise and value their relationship for positive outcomes, and

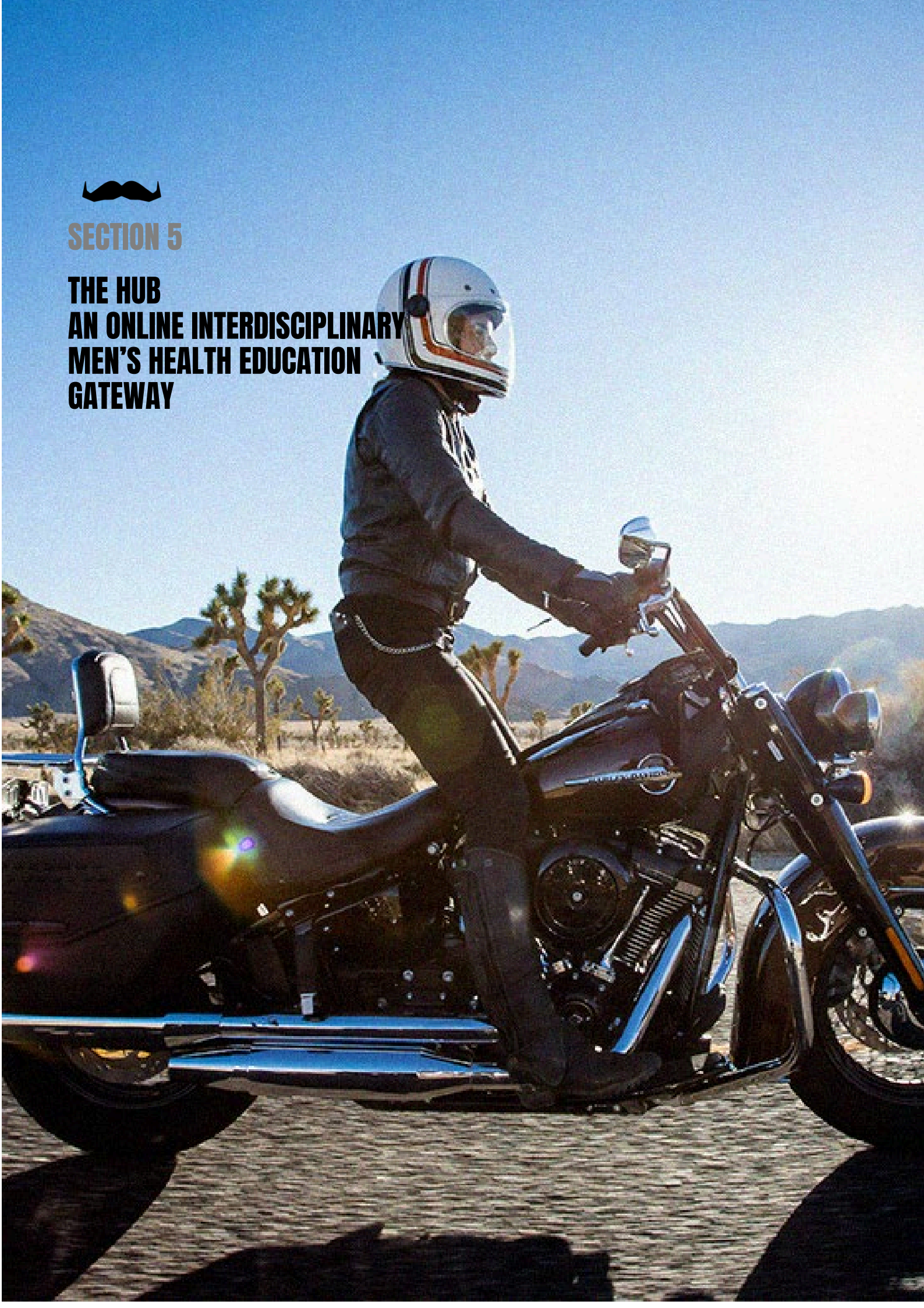
- men collectively acknowledged that there had been major generational shifts in regard to the eroding of stigma related to men reaching out for help and thus the focus of HCP education and training should be around optimisation of the care process so men "come out with the best health situation", and an important requisite for such being the removal of unhelpful stereotypes and gender biases around men and health care.

Further research and stakeholder engagement is required to acquire an understanding of:

- the experiences of men and preferences when communicating and engaging with health care practitioners in sub-speciality health and social care settings. While gender-responsive engagement approaches cuts through all disciplines and health care scenarios, this evidence will be important to tailor future education content to the range of student and HCP audiences.

SECTION 5

THE HUB
AN ONLINE INTERDISCIPLINARY MEN'S HEALTH EDUCATION GATEWAY

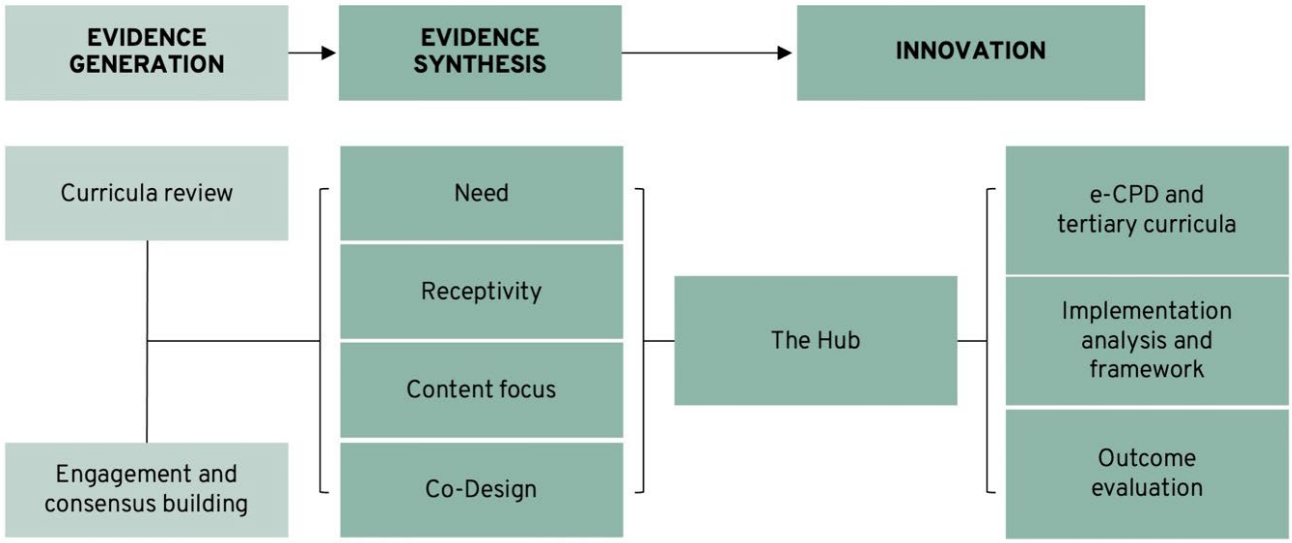


SECTION 5

OVERVIEW

Section 5 presents a synthesis of the evidence generated from studies throughout Stages 2-4 of this project. Grounded in an implementation science framework, a proposed initiative (the innovation) is detailed that addresses the identified opportunities for health curricula and e-CPD enhancement (Figure 5.1). This innovation will be a comprehensive interdisciplinary online men's health education gateway, hereafter referred to as "The Hub". Following this, an implementation plan for the development and launch of The Hub is outlined.

Figure 5.1: The evidence-based development of "The Hub": an online men's health education gateway



5.1 LANDSCAPE ANALYSIS EVIDENCE SYNTHESIS

This project involved 3 stages of evidence generation. First, a high-level review of Australian e-CPD programs was undertaken (Section 2.1), followed by a formative review of 67 Australian tertiary education curricula across 6 disciplines and 23 Australian universities (Section 2.2) to determine the gaps in men's health education. Next, 70 university staff across 10 health disciplines and 25 universities were surveyed (Section 3.1), along with 83 medical students from 17 of the 21 Australian Medical Council accredited medical schools to validate the findings of the tertiary curricula review and to undertake a stakeholder-informed needs assessment for curricula enhancement with men's health (Section 3.2). Finally, a comprehensive scoping review of academic literature was conducted (Section 4.1), alongside in-depth focus group discussions with a diverse range of men (Section 4.2), in order to collate evidence on HCP and consumer-informed best practice approaches for engaging and communicating with men in health care. Throughout the evidence generation process, all evidence and findings were supplemented by advice from HCP and other expert members of the project consortium.

Aim

The aim for this final stage of the project was to synthesise the evidence across each of the stages described above, to propose and construct a consolidated framework and identify the strategies for the future implementation of a men's health education innovation for university educators, students and HCPs. This plan would be implemented during a Phase 2 of this Movember Men's Health Education project.

Evidence synthesis summary

Opportunity for innovation

The evidence generated in this project presents opportunities to innovate at multiple levels to better prepare future HCPs, and support the upskilling of current HCPs, to optimally engage with men during health care encounters. Outlined below is the evidence used to propose and define the opportunity and potential utility of a men's health education innovation, according to need (*are there gaps in men's health education and do stakeholders consider there to be a need?*), receptivity (*will this content be received well by key stakeholders?*), content focus (*what should this content specifically detail?*) and co-design (*how to implement content that reflects men's lived experience and current health needs and discipline specific considerations?*).

Need

The formative review of existing education programs at a tertiary and CPD level, as well as feedback from educators and students, found a lack of suitable dedicated men's health tertiary education curricula content and CPD programs that focused on gender-responsive health care for men. The deficit in education content was accompanied by a focus in current curricula and CPD on disease-based competencies, rather than person centred, or individualised care, through a gender and intersectionality lens. Given tertiary education and CPD programs comprise the two formal pathways to HCP education, the gaps in content here highlighted the need for education reform. The outcome of extensive discussions with a broad range of HCPs across the program consortium reflected a need for this education and training across the health system and spanning multiple levels of health education and disciplines. These included general practice and speciality medicine, nursing, psychology, social work and public health practitioners at various career stages.

Receptivity

Closely aligned with need, there was consensus of receptivity amongst key stakeholders for tertiary curricula enhancement with men's health content, and that the content be delivered through centralised e-resources. Further, it was suggested e-resources be made freely available in flexible (multimodal) delivery formats in order to facilitate ease of integration into existing university curricula and pedagogies in the short-term. It was recommended that the long-term goal be formal integration of content through the inclusion of gender competency into education accreditation standards. While not reported here, engagement to date with representatives of the mental health sector (psychology, social work professional bodies) and those delivery postgraduate registration education, found strong receptivity for the e-CPD content via self-paced modules for HCPs or as learning intensives for students prior to or during initial clinical placements. Centralising these e-CPD programs and tertiary curricula resources into an easily accessible online central repository was also consistently recommended. Stakeholders reinforced that advocacy, marketing, and local champions would be key to driving access and uptake. Furthermore, successful precedents for this style of content and housing were noted, along with an increasing preference for these flexible education modalities in the education sector.

Content focus

The results of the e-CPD program and tertiary curricula reviews highlighted the lack of men's health education that went beyond the narrow biomedical confines of sex-specific conditions (e.g., prostatic hyperplasia) and disease-based competencies. The lack of gender-responsive health care content may reflect the absence of gender competencies within education accreditation standards for most disciplines. Where there was reference to gender within some standards or curricula, its translation into relevant education content on gender-responsive health care was inconsistent, and in most cases primarily focused on women's health. Gender is a major determinant of health, and men themselves and a review of the literature confirmed the importance of effectively reaching, responding, and retaining men with health care provision through gender-responsive engagement practices. This will be the focus of the proposed education innovation with broad interdisciplinary application. A critical element of gender-responsive health care is acknowledging and accommodating for the intersection of gender, culture, and other social determinants of health, to ensure health equity. These principles of intersectionality and equity are strongly upheld and align with current university standards. Consequently, a consensus emerged throughout this review for content that extends beyond a biomedical lens and instead includes a wide-reaching focus across disciplines on building the gender competency of emerging and current health care practitioners. Gender-competency extends, rather than replaces the person-centred (tailored) care model, that represents foundation learning of all HCPs, and may therefore be readily integrated into tertiary curricula. Indeed most opportunities for integration of men's health content within University curricula were signposted to courses delivering teaching on practitioner-patient communication and engagement where tailoring and person-centred care. This is the case for clinical disciplines, but the curricula reviews and stakeholder engagement

confirmed that gender-responsive practices have broader importance and application in public health programming. The content focus on engagement in a future education innovation is therefore highly feasible because of its broad interdisciplinary reach, but it can be tailored to accommodate for specific health and social care scenarios.

A gender-competency focus serves to benefit all genders

The women's health sector has, for some time, led the advances to date seen in gender-responsive health care and programming. This has resulted in the raising of important health and health inequity issues experienced by women and within groups of women. This has led to improved health care service and outcomes for women, but more investment and prioritisation is required to advance women's health and health equity, as is the case for gender diverse individuals. Indeed, references to women's health, including through a gender lens, was more often found in the tertiary curricula review, albeit infrequently, and included dedicated electives.

> "Women's health has traditionally been examined from a gynocentric or medical perspective as women have been acknowledged primarily for, and only in terms of, their reproductive function. However, issues surrounding women's health are broader than this and should be studied in the context of women's place in a patriarchal society at local, national and global levels. In this subject, students have the opportunity to examine, within a feminist framework, why women still need specialised services for women only and why the women's health movement continues to challenge the system providing mainstream health services."
>
> Undergraduate Nursing elective - Women's health elective summary

The benefits of an agenda and innovation in gender-competency focussed curricula (and eventually accreditation standards) for men will, importantly, act to drive concurrent considerations to the health practitioner competency training needs to improve gender-responsive care and outcomes for women and gender diverse individuals. The joining of sectors for a shared gender transformative health agenda will be embedded within the implementation framework for Phase 2.

Co-design

There was also a consensus from educators and students that one of the most powerful ways to sensitise students and practitioners to the importance of men's health, and gender-responsive care for men, is through exposure to the lived experience accounts from men themselves. This approach will empower the voices of Aboriginal and Torres Strait Islander men, and other priority population groups of men who experience health inequities in ways that orient HCPs to gender and intersecting sociocultural and gender considerations when providing care. This approach aligns with the principles for action of the NMHS 2020-30 being to *"embed active, meaningful, non-tokenistic engagement of men and boys in these processes with an emphasis on enabling diversity of representation".*

Innovation overview – The Hub

Based on this synthesis of evidence and established opportunity, Movember proposes to develop and host a dynamic, co-designed online men's health education gateway ("the Hub") that, in its first iteration, houses:

1. e-CPD education and training programs for health care practitioners
2. A dynamic suite of multi-modal education e-resources for guided use by tertiary-level educators teaching into health degrees, and for students
3. A community of practice portal.

The overall objective for the Hub is:

- To prepare future practitioners and upskill current practitioners across the health professions on men's health and best practice approaches for engaging with boys and men. The overarching goal is to better reach, respond to, and retain men in health care to meet their health care needs.

This innovation, directly responds to Objective 2.1 (Action #3) of the National Men's Health Strategy 2020-2030:

"Develop online training modules for key topic areas (in men's health and wellbeing across the life course) in an accessible format and widely promote among the medical, nursing and allied health community."

5.2 MEN'S HEALTH EDUCATION ENHANCEMENT PROPOSAL - e-CPD

The e-CPD programs will be designed to reach and upskill a broad range of health professionals who provide care to men. As described in Section 2.1, Movember has already developed the Men in Mind (MiM) e-CPD program (and gender competency learning outcomes) that is delivered through a learning management system portal. This provides a critical proof of concept for The Hub.

Men in Mind (MiM)

MiM is an evidence-based online training curriculum that responds to the need to embed gender considerations into the education and ongoing training of mental health practitioners working with men[67,68] . It is a self-paced, interactive, 8-10 hour learning program. MiM has been successfully piloted among over 150 mental health practitioners and was subsequently the subject of a randomised-controlled trial with over 500 practitioners. The results of this trial demonstrated that MiM significantly improved practitioners' confidence and competence to engage and respond to male clients. As the world's only evidence-based engagement training framework in the field, insights from MiM's market roll-out will inform the implementation plan for this broader Hub, acting as a foundation for learning and future content creation. Importantly, MiM will provide early established brand reputation for men's health training that will be important to The Hub implementation and early uptake.

While MiM was designed for mental health practitioners, the evidence generated through our stakeholder engagement with educators, medical students, HCPs and the health professional training sector (Stages 2, 3 and 4) suggests the core tenets of MiM have broad reaching interdisciplinary application across health professions and disciplines. The MiM program was devised with a broad pedagogical framework and can be readily adapted into an interdisciplinary e-CPD offering for the priority front line health professionals that have been the focus of this project (i.e., medical, nursing, pharmacy, psychology, social work, allied health, and public health professionals). It may also be modularised for tertiary curricula integrations.

5.3 MEN'S HEALTH EDUCATION ENHANCEMENT PROPOSAL - TERTIARY CURRICULA

Clinical placement learning intensives

The e-CPD program described above would offer a timely education offering for health students prior to their mandatory clinical placements. Specifically, it is proposed that the e-CPD would be available through flexible delivery modalities to universities as intensives that precede student clinical placements or are made available during placements with the learning hours accredited to the placement. This will require formal integration as set content within curricula and will require working directly in partnership with university discipline representatives to offer the e-CPD program.

e-resources

Moreover, MiM and comprehensive future related content will be modularised and tailored to generate a flexible range of e-resources to accommodate different disciplines, pedagogical approaches and lecturer and student preferences. This will facilitate integration into existing tertiary curricula. The e-resources support both online and face-to-face delivery and are proposed to include:

- Educator Lecture packages:
    - lecture presentations; readings and relevant background evidence; tutorial guides
- Practice simulations as video vignettes (and discussion guide)
- 'Micro-learnings' resource - 1-page factsheets or evidence summaries
- Consumer voices – lived experience video vignettes (and discussion guide)
- Assignment (short-form) and research project (long-form) topics and materials and men's health datasets and assessment guides

- Podcasts
- Facilitated workshops and live round tables (fee for service; second iteration)

User support interface

The Hub will be developed with a best-practice user-friendly interface with alerts available for new opportunities for engagement as a means to attract new and retain existing users, and integrated support functionality provided by:

- Educator webinars
- An e-resource user guide that also offers course subject sign-posting recommendations for the e-resources, as recommended by university informants
- Troubleshooting Q&A for educators and CPD users.

Intersectionality focus

A focus of the e-CPD and tertiary curricula content will be its tailoring for priority population groups, such as for culturally and linguistically diverse men and those from other diverse backgrounds and those with varying lived experiences. For example, Section 4.1 highlighted the importance of tailoring HP's engagement approaches (i.e., communication strategies, structured treatment and therapeutic alliance) to the unique health care needs and preferences of Aboriginal and Torres Strait Islander men. Dedicated resources should therefore be co-designed with culturally diverse men to summarise and speak to the unique engagement considerations when working with specific sub-populations of men. In addition, the implementation of these resources should be tailored effectively according to the particular sub-population of interest.

A community of practice portal

Once fully implemented, the Hub will incorporate a community of practice offering an interactive environment for user-moderated exchange of education content and approaches, networking events and expert facilitated webinars, research updates and initiatives.

5.4 IMPLEMENTATION FRAMEWORK

A 4-stage implementation framework is proposed for the Hub, broadly outlined as:

- Stage 1 (12 months, 2024): Hub development, stakeholder engagement, monitoring and evaluation planning, adaptation of MiM CPD program into tertiary curricula resources
- Stage 2 (12 months, 2025): Pilot the Hub, develop advocacy campaign and engagement strategy
- Stage 3 (24 months, 2026-2027): Launch the Hub, advocacy campaign, monitoring and evaluation, community of practice learning collaborative integration
- Stage 4 (12 months, 2027): Monitoring and learning, marketing innovation (nudge), cycle 1 resource review and updates.

A time commitment of at least-four years is required to execute full implementation of a dynamic product that is subjected to an iterative cycle of monitoring and evaluation and continuous quality improvements. Ongoing marketing will be required to ensure widespread uptake.

The sections that follow outline the development of the implementation framework and the strategies required at each stage to facilitate implementation success.

Approach: The Implementation Research Logic Model (IRLM)

The Implementation Research Logic Model (IRLM)[24] provides a "roadmap" for how the Hub will be executed. It supports the description of linkages between determinants, strategies, mechanisms and outcomes (as defined below). The IRLM articulates a pathway through which the innovation (The Hub) can be effectively implemented into a real-world setting, by combining the *Theory of Change* and the *Theory of Action* into a single model.

- ***Determinants*** are factors that might prevent (barriers) or enable (facilitators) implementation success. The identification of relevant determinants was guided by the updated Consolidated Framework for Implementation Research (CFIR)[69]. Determinants are coded according to whether they are a barrier and have a negative impact (-), a facilitator with a positive impact (+) or are neutral in impact (+/-).

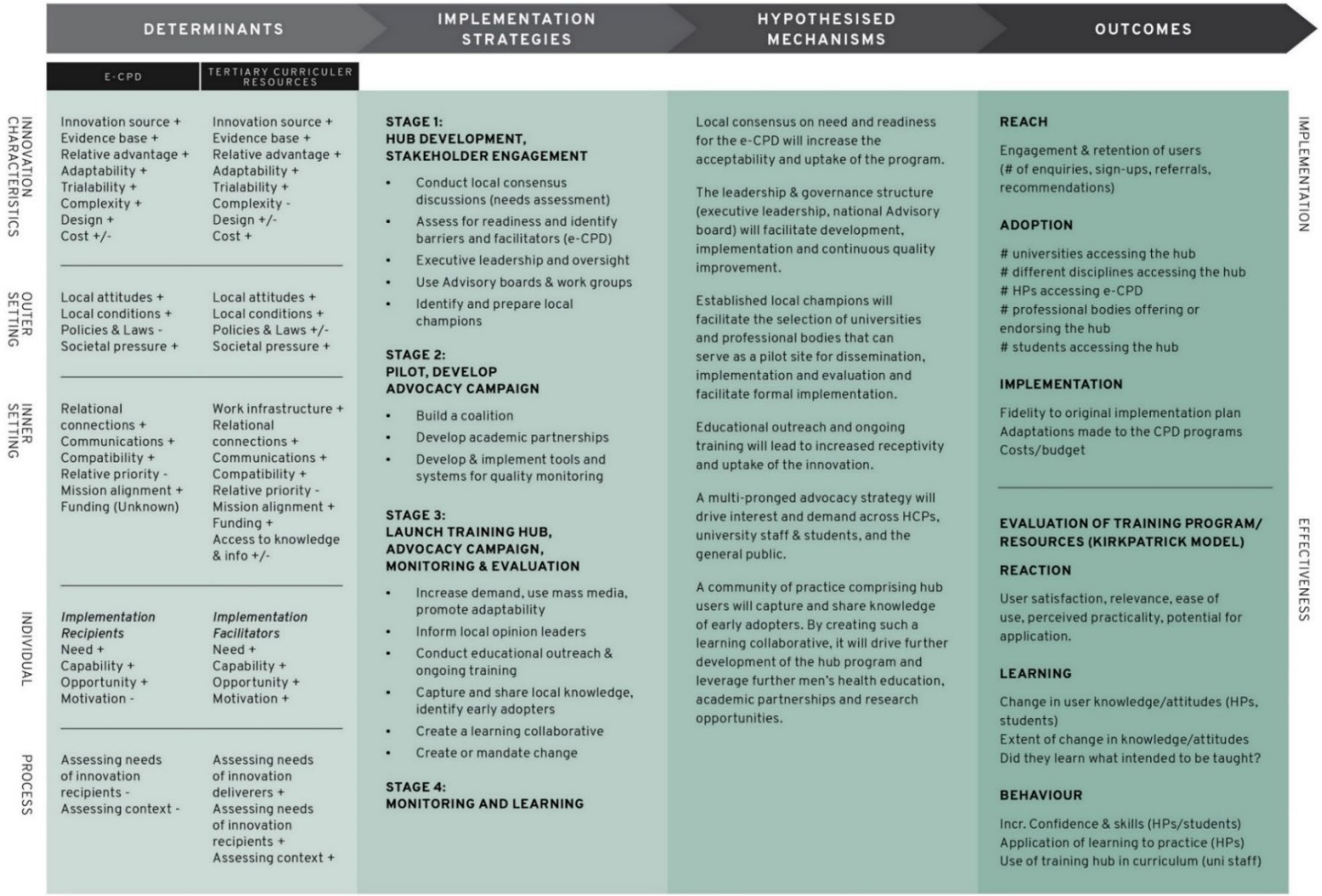
- ***Implementation strategies*** are actions to increase adoption of the innovation that will either attempt to overcome barriers or attempt to leverage facilitators. The Expert Recommendations for Implementing Change (ERIC)[70] was used to identify high-level implementation strategies to address the identified barriers.

- ***Mechanisms of action*** are the processes or events through which an implementation strategy operates to affect desired outcomes[71].

- ***Outcomes*** are the desired effects and impacts resulting from implementation of the innovation/project. Implementation outcomes are based on RE-AIM[72] and Kirkpatrick & Kirpatrick's (2016)[73] four-level model of training for specific learning outcomes, both very well-known and widely used frameworks for program and learning evaluation.

Figure 5.4.1 presents the overall Implementation Logic Model for The Hub. It outlines the proposed causal pathway from development of the innovation to the desired outcomes, both short, medium and long term, for (i) HCPs, (ii) health care educators and iii) students. Determinants are presented separately for the e-CPD program and the tertiary e-curricula resources given differences between the two. The most relevant strategies identified by the CFIR-ERIC matching tool[74] for both the e-CPD program and the tertiary e-curricula resources were the same and are listed according to the main project stages.

Figure 5.4.1: Implementation Research Logic Model for The Hub



Determinants of implementation success for The Hub

The below section details a comprehensive overview of all possible factors that may impact the successful implementation of The Hub. Table 5.4.1 defines the domains of a well-established implementation science framework, the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2022), followed by individual sections for each domain outlining determinants relevant to implementation success.

Table 5.4.1. Determinants of implementation success across five domains

Innovation domain	Innovation source, the evidence base, relative advantage, adaptability, trialability, complexity, design and cost factors.
Inner setting: where the innovation is implemented	Universities (tertiary curricula resources) and health professional bodies (e-CPD). Factors considered include work infrastructure, relational connections, communications, compatibility, mission alignment, relative priority, funding and access to knowledge and information.
Outer setting: the surrounding context or setting in which the Inner setting exists	Australian health system (e-CPD outer setting); tertiary education system and HCPs regulatory system (tertiary outer setting). Factors considered include local attitudes, local conditions, policies and laws and societal pressure.
Individual: the roles and characteristics of innovation end users and facilitators	Factors considered include the need, capability, opportunity and motivation of both implementation recipients and implementation facilitators.
Implementation process: the activities and processes that occur during implementation and influence outcomes	Factors considered included assessing needs and assessing context.

Determinants: Innovation domain

Most innovation characteristics have been identified as either facilitators or neutral for both the e-CPD and tertiary curricula e-resource components (Table 5.4.2). This is attributable to Movember's reputation and experience in men's health over the last 20 years along with the wealth of internal resources (e.g., marketing, design, information technology, monitoring and evaluation) to draw on to support all elements of the development process. The only identified barrier in the innovation domain is 'complexity' for the tertiary curricula e-resources. Covering multiple disciplines, priority groups, and learning modalities expands the diversity of content required. Both the initial development and the maintenance of accurate, up-to-date information across a broad scope of topics pose challenges that will need to be considered and addressed with adequate resourcing.

Table 5.4.2. Determinants in the Innovation domain

Construct name and definition	Evidence supporting innovation as a barrier (+), facilitator (-) or neutral (+/-)	
	e-CPD program	**Tertiary curricula e-resources**
Innovation source The group that developed and/or visibly sponsored use of the innovation is reputable, credible, and/or trustable	(+) Movember has a strong reputation in the men's health space. Co-funded in partnership with the Australian Federal Government	
Innovation evidence base The innovation has robust evidence supporting its effectiveness	(+) Hub content and approach is based on published evidence (scoping review, student survey, RCT of Men in Mind).	
Innovation relative advantage The innovation is better than other available innovations or current practice	(+) There is only 1 of 3 Tier 1 (structured, competency assessment) e-CPD programs on men's health for HCPs, that currently focuses on communication and engagement.	(+) The only online training hub for tertiary education providers focused on HCP education on communicating and engaging with men.
Innovation adaptability The innovation can be modified, tailored, or refined to fit local context or needs	(+) Both components will be developed for multidisciplinary application with adaptations for specific disciplines and settings. Modules can be updated as required and diversified for different disciplines.	
Innovation trialability The innovation can be tested or piloted on a small scale and undone	(+) Movember has extensive experience developing and trialling new products. Potential trial sites have been identified.	
Innovation complexity The innovation is complicated, which may be reflected by its scope and/or the nature and number of connections and steps	(+) Movember's existing online men's health e-CPD for mental health professionals will form the framework, much of the complexity is already known.	(-) Resources must be both generic to address interdisciplinary needs with discipline specific adaptations. Wide scope of topics to be included which increases the complexity of the development and maintenance.
Innovation design The innovation is well designed and packaged, including how it is assembled, bundled and presented	(+) Movember's existing online men's heath e-CPD for mental health professionals has been very well received (including its ease of use) and shown to be effective.	(-/+) While the design can be challenging, key stakeholders are engaged to work collaboratively to ensure the resources are designed and presented to meet the needs of the tertiary curricula.
Innovation cost The innovation purchase and operating costs are affordable	(+/-) Co-investment to be proposed to cover the cost of development. User pays model for e-CPD. Yet to establish what HCPs will pay for this product	(+) No cost to users of the tertiary curricula resources.

Determinants: Inner setting

Implementation science emphasises the importance of considering the "inner setting", in this case the universities, professional bodies and other organisations, that will access and promote uptake of The Hub among HCPs. The evidence synthesised by this report indicates that almost all of the determinants in the inner setting will act as facilitators to implementation (Table 5.4.3). This was due to evidence of receptivity for this content through consultations with staff within these inner settings, the existing education and professional structures and informal networks, and Movember's prior success with the MiM e-CPD program.

Table 5.4.3. Determinants in the inner setting

Construct name and definition	Evidence supporting innovation as a barrier (+), facilitator (-) or neutral (+/-)	
	e-CPD program	**Tertiary curricula resources**
INNER SETTING	Health Professional Workforce, Professional bodies for HCPs	University schools/departments teaching health professionals
Work Infrastructure Organisation of tasks and responsibilities within and between individuals and teams, and general staffing levels, support functional performance of the Inner Setting	Not relevant	(+) Lecturers and course coordinators report having autonomy to include new content/resources into courses on an annual basis.
Relational Connections There are high quality formal and informal relationships, networks, and teams within and across Inner Setting boundaries (e.g., structural, professional)	(+) Existence of professional bodies that mandate CPD, and endorse CPD. Existence of informal and formal health professional's networks e.g., ANZHPE, social media groups	(+) Multiple health disciplines within a faculty means strong networks and\or relationships
Communications There are high quality formal and informal information sharing practices within and across Inner Setting boundaries (e.g., structural, professional)	(+) Professional bodies and associations will share information. Informal and formal communication channels amongst health professionals e.g., newsletters, social media, webinars	(+) Multiple communication channels within Faculties, departments etc e.g., staff meetings, email updates
Compatibility The innovation fits with workflows, systems, and processes	(+) Movember's existing online e-CPD program has exhibited high demand and useability suggesting it is highly compatible with the setting.	(+) University staff indicated that they will use resources once they are available. Staff suggested preferred format for resources
Relative Priority Implementing and delivering the innovation is important compared to other initiatives	(-) Interest from some disciplines e.g., social work, but outreach to broader disciplines needed	(-) University staff report crowded curriculum, staff research interests, and competing priorities when it comes to gender, women's vs men's health.
Mission Alignment Implementing and delivering the innovation is in line with the overarching commitment, purpose, or goals in the Inner Setting	(+) In this setting the goal is to ensure HCPs engage in continuing professional development.	(+) Staff spoke about equity as an important goal.
Funding Funding is available to implement and deliver the innovation	UNKNOWN what the price point is to access the program and what HCPs are willing to pay.	(+) The training hub will be free to access in this setting
Access to Knowledge & Information Guidance and/or training is accessible to implement and deliver the innovation	Not relevant	(+/-) Guidance on how to access the resource hub will be provided to the institutions.

Of note, the 'relative priority' of The Hub was identified as the only barrier for implementation within the inner setting at both the e-CPD and tertiary levels. Given that accessing the training program and curricula resources are not compulsory, addressing this barrier will be critical to implementation success. While MiM confirmed a high demand amongst mental health practitioners for men's health content, demand amongst other practitioners in different health disciplines is unknown (especially given the crowded context of existing e-CPD offerings). Through consultations with university staff, a potential conflict in teaching gender-responsive health care was highlighted where teaching men's health may be perceived as competing with women's health. Therefore, careful consideration of gender-relations in curriculum development will be critical to implementation.

Of note, there was also an "unknown" relating to funding, where more consultation is needed with individual HCPs and professional groups to gauge a feasible fee structure for the e-CPD component of The Hub.

Determinants: Outer setting

The outer setting of the innovation would be the broader health system for the e-CPD component, while the tertiary education system and health care professionals' regulatory system would make up the outer setting for the tertiary curricula component of the innovation.

Evidence generated by the formative reviews and stakeholder consultations within this report indicated that local attitudes, local conditions and societal pressure within the health system will act as facilitators for implementation for both the e-CPD and tertiary components of the innovation (Table 5.4.4). These facilitators would grow stronger with current emerging awareness and political support for changes needed to address men's health.

'Policies and Laws' was noted as a barrier for implementation of the e-CPD component (as gender-responsive care remains absent from accreditation standards and mandates), and neutral for the tertiary component (as current accreditation standards will neither be a key facilitator or barrier to uptake of The Hub by course coordinators).

Table 5.4.4. Determinants in the outer setting

Construct name & definition	Evidence supporting innovation as a barrier (+), facilitator (-) or neutral (+/-)	
	e-CPD program	**Tertiary curricula e-resources**
OUTER SETTING	Health System	Health professionals' regulatory systems, tertiary education system for health professionals
Local Attitudes Sociocultural values (e.g., shared responsibility in helping recipients) and beliefs (e.g., convictions about the worthiness of recipients) encourage the Outer Setting to support implementation and/or delivery of the innovation	(+) Evidence from MiM of receptivity and interest from State health departments. Increasing acknowledgement of need for gender-responsive health care to advance gender equity and health	(+) University staff (inner setting) can implement some level of curricula content change without reliance on attitudes of the outer setting. Increasing acknowledgement of need for education and develop competencies in gender-responsive health care.
Local Conditions Economic, environmental, political, and/or technological conditions enable the Outer Setting to support implementation and/or delivery of the innovation	(+) The National Men's Health Strategy supports implementation of this innovation. Growing political interest in men's health.	(+) Universities already access online expert-developed teaching resources to support delivery of curricula.
Policies & Laws Legislation, regulations, professional group guidelines and recommendations, or accreditation standards support implementation and/or delivery of the innovation	(-) There is no mandate for men's health sub-specialty training. CPD is mandated but particular types of training are not mandated.	(+/-) Accreditation standards exist around communication with clients which informs curriculum content but will not be a key influence on staff use of the innovation.
Societal Pressure Mass media campaigns, advocacy groups, or social movements or protests drive implementation and/or delivery of the innovation	(+) Increasing interest in and awareness of the need to focus on men's health, driven by men's health organisations, given the perseverance over time of suboptimal health outcomes for men and health inequities experienced by sub-groups of men. WHO and Lancet Commission on gender and health calling for gender-responsive health systems to impact population health .	

Determinants: Individual

The Individual domain is about both individual roles and characteristics and is an opportunity to document key roles relevant to the project and characteristics applicable to those roles. We have focused on two roles in the Inner Setting namely the '*Implementation Recipients*' for the e-CPD component (the HCPs), and the '*Implementation facilitators*' for the tertiary component (the university staff; see Appendix D, Table D1 for more details).

Roles applicable to the Outer Setting, for example high-level leaders and opinion leaders, will emerge during Stage 1 of the Project and can be added to the IRLM. As recommended in the CFIR, it is intended that where relevant and feasible both Implementation Facilitators and Implementation Recipients will be invited to collaborate closely with the Movember implementation team.

Individual roles and characteristics for: e-CPD program

Health care professionals who are identified as the 'Implementation Recipients' have greater access and opportunity to complete the proposed e-CPD program, given existing professional requirements, technological literacy, and autonomy in choosing training. However, their motivation to prioritise this specific program compared to other CPD options is not yet known, representing a potential barrier. Further consultation is needed to understand motivators and incentives that would promote adoption of this e-CPD content by HCPs.

Individual roles and characteristics for: tertiary curricula e-resources

Consultations with university staff revealed they are capable, motivated, and willing to serve as 'Implementation Facilitators' for the training hub within their departments and schools. Multiple staff expressed interest in supporting rollout, indicating a strong opportunity to adopt the facilitator role in the inner setting. Additionally, staff are aware of gaps in current curricula regarding gender equity and men's health topics, indicating that a need exists to incorporate this new training. Overall, university staff are poised to effectively facilitate implementation and leveraging their enthusiasm and capabilities as facilitators will be a key element in the implementation strategy, noting time pressure and casualisation of the workforce may have an impact.

Determinants: Implementation process

This domain considers the degree to which different processes will occur during implementation and may influence outcomes. Two processes have been identified as the most relevant for the current implementation planning stage as they have different impacts on the implementation of the e-CPD and tertiary components of the training hub (see Appendix D, Table D2 for further clarification of these constructs):

- ***Assessing needs*:** Collect information about the priorities, preferences, and needs of deliverers and recipients to guide implementation and delivery of the innovation
- ***Assessing context*:** Collect information to identify and appraise barriers and facilitators to implementation and delivery of the innovation

For the e-CPD program, needs assessment and contextual assessment are currently barriers to implementation, as consultations with HCPs across multiple health disciplines have not been appropriate to conduct prior to having a clear structure and format of the training product. Directly engaging end users across a diversity of health disciplines is the next step to assess the generalisability of uptake of the proposed e-CPD across disciplines and contexts.

In contrast, for the tertiary curriculum e-resources, the formative review in the university setting supplied evidence about innovation deliverers, recipients, and contextual needs. This knowledge of end user needs and environments will positively impact implementation.

Summary of barriers to implementation

Based on evidence gathered during the formative review, from the project consortium members and consultations with various stakeholders, almost all determinants (or contextual factors) specified in the CFIR can be considered as facilitators of implementation, or neutral for both components of the online training hub. Movember is well placed to develop and deliver this

innovation, and the evidence would suggest that there are many contextual factors in the settings in which it will be delivered that support implementation.

As detailed in Table 5.4.5, for the e-CPD program, the CFIR framework has identified a few select barriers and an unknown factor to consider, largely as result of less engagement with practising HCPs in this first phase of the project. Further work is to be done in assessing the needs of recipients and assessing the implementation context, which will provide evidence around funding and the individual needs and motivation of HCPs to utilise the program. In terms of 'Policies and Laws', the absence of a mandate for men's health sub-specialty training by health workforce regulatory or accreditation bodies is seen as a barrier and one that is closely related to 'Relative Priority'.

'Relative Priority' is identified as a barrier for both components and is considered the most significant barrier to implementation success given that use of the online training hub will be completely voluntary, and practitioners will have the option to undertake an assortment of other e-CPD offerings on other aspects of health.

Table 5.4.5. Summary of identified barriers and unknowns for training hub components

Determinant Domain	Barriers	
	e-CPD program	Tertiary curricula e-resources
Innovation characteristics	Nil	Innovation Complexity
Inner setting	Relative Priority	Relative Priority
Outer setting	Policies & Laws	Nil
Individual	Motivation	Nil
Implementation process	Assessing needs of recipients Assessing context	Nil
Unknown	Funding (Inner Setting)	Nil

Implementation strategies

Twenty-two key strategies were selected from the consensus derived Expert Recommendations for Implementing Change (ERIC) tool to best address the potential contextual barriers to successful implementation of the Hub innovation (Appendix E). This tool was systematically derived from consensus among experts in implementation science and provides a structured framework for implementing organisational change. These strategies will be initiated and operationalised within, and where relevant, across the four implementation stages. The key strategies that are collectively relevant to all components of the innovation, are described below by the Stage at which they are initiated.

Stage 1+ (Hub development, stakeholder engagement)

- Sector-wide **stakeholder engagement** and **needs assessment** will be ongoing to ensure that all considerations have been given to potential barriers to successful implementation. As such, readiness and receptivity to the program, and adaptability of the innovation in response to changes to local needs and internal and external settings, will be optimised.

- Governance structures will be put in place to ensure that there is executive and expert leadership to facilitate the development, implementation and continuous quality improvement of the Hub innovation. This will include consideration to principles of Indigenous data sovereignty, through overarching leadership and governance. Internal leadership and oversight will be the chartered responsibility of a Board of Directors and independent external leadership will be offered by a National Advisory Group of sector experts, that will include representatives of professional bodies and University Deans.

- Formalising existing and new relationships with **local champions** will be a key strategy to ensure that the innovation has access to universities and professional bodies available to pilot (including evaluation) incremental components of the Hub innovation. The nature of these champions will evolve as the market scope for the Innovation changes.

Stage 2+ (Pilot the hub, develop advocacy campaign)

- Throughout Stage 2 and beyond, a sector-wide **coalition**, that includes the above-mentioned champions, will be critical to a strategy that supports the subsequent marketing and implementation efforts and ensures that indifference or resistance to the intervention may be addressed and overcome in advance.

- An **academic partnerships** strategy will be developed as a related but separate implementation strategy to the coalition. This will serve to establish and build the scientific evidence base and credibility of the innovation to ensure it maintains a market leader throughout its lifespan.

- A **quality monitoring and evaluation strategy**, co-designed with academic partners, will ensure that the tools, systems and processes are in place to support each stage of the innovation's execution (piloting, advocacy, scale-up, the virtuous cycle of quality improvement, and sustainability programming through rigorous, comprehensive user experience and outcomes data). This is described in the next section.

Stage 3+ (Launch training hub, advocacy)

- A multi-pronged, targeted media and communications **advocacy campaign and marketing** strategy promoting gender-responsive health care training of emerging and current health care practitioners (and their educators) will be initiated and rolled out to ensure broad market awareness and receptivity that drives interest and demand. This will be maintained throughout the project so that the responsiveness and adaptability of the innovation is conveyed to the market.

- A sub-strategy that engages **opinion leaders** to promote and facilitate broad dissemination of the Hub to identified and new health practitioner and educator markets will form a component of the advocacy and marketing strategy and support a systems-wide improvement goal for the innovation.

- An **educational outreach strategy, including information forums and workshops,** built in as a core resource component of the Hub will ensure user confidence and competency in the use of the Hub and application of the materials to secure potential user receptivity and uptake. The strategy will, by necessity, be maintained throughout the life of the Hub to accommodate for evolution and innovation in the training and resources and the functionality of the Hub as the communities of practice, pedagogies, and digital technology evolves.

- With real world implementation of the Hub, a quality monitoring and evaluation sub-strategy (as outlined in the IRLM) that targets the purposeful capture and sharing of local knowledge and identification of early adopters, will support rapid response product optimisation. The outputs of this strategy will also inform the ongoing advocacy and marketing strategy.

- A strategy that is hypothesised to be a collective outcome of the above-described strategies will be substantial advancement toward standard integration of gender-responsive health care into education and training accreditation standards. This will ensure that, in the longer term there is a formal and sustainable demand for innovation in the longer-term.

Evaluation of outcomes

As outlined in the IRLM, both the RE-AIM framework and the Kirkpatrick model will be used to guide evaluation of the innovation, its implementation and its success in achieving desired training outcomes. Table 5.4.6 provides an overview of potential outcome measures based on the different elements of RE-AIM and Kirkpatrick's model. It should be noted that the final monitoring and evaluation framework will be developed in collaboration with Movember's Monitoring, Evaluation and Learning team.

RE-AIM (*Reach, Effectiveness, Adoption, Implementation, Maintenance*) is widely used in implementation science and program evaluation and has been incorporated into Movember program evaluation for some time. At this stage, evaluation of implementation outcomes will focus on *Reach, Adoption, Implementation* and *Maintenance* from RE-AIM and an expanded version of *Effectiveness* utilising Kirkpatrick's model for evaluation of training and learning outcomes which considers four levels of training outcomes, Reaction, Learning, Behaviour and Results.

Table 5.4.6. Potential evaluation outcome measures

RE-AIM	KIRKPATRICK
Implementation Outcomes	**Evaluation of Training Program**
Reach Engagement and retention of users (# of enquiries, sign-ups, referrals, recommendations)	**Reaction** User satisfaction, relevance, ease of use, perceived practicality, potential for application, motivation to learn more
Adoption # universities accessing the hub # different disciplines accessing the hub # HPs accessing e-CPD # professional bodies offering or endorsing the hub # students accessing the hub	**Learning** Change in user knowledge/attitudes (HPs, students) Extent of change in knowledge/attitudes Did they learn what intended to be taught?
Implementation Fidelity to original implementation plan Adaptations made to the e-CPD program & tertiary curricula e-resources Costs/budget	**Behaviour** Application of learning to practice (HPs) Use of training hub in curriculum (tertiary educators)
Maintenance Changes in standard of care practice Changes in curricula	**Results** Increased confidence and competency/skills (HPs/students). Impact on men accessing health care (satisfaction, retention)

5.5 RESEARCH OPPORTUNITIES

Objective 3 of the NMHS 2020-30 is to build the evidence base for improving the health of men and boys with objective 3.1 calling for an increase in, and prioritisation of, research investment.

The establishment of The Hub will create a unique opportunity to develop a national interdisciplinary men's health research program on gender-responsive men's health care education and practice that will be unique in both Australia and internationally. The research opportunities will be extensive, serving to:

- longitudinally map the demand for and uptake of gender-responsive health care education into tertiary curricula and e-CPD for the health professions,
- measure the impact of gender-responsive health care education initiatives in terms of practitioner competencies in provision of public, social and clinical health care for men,
- measure changes in clinical and public health programming,
- generate evidence on innovations in gender-responsive health care and its implementation into practice, including a focus on intersectionality of men's health and health equity and its build into training and curricula,
- monitor changes in accreditation standards for health practitioners over time and changes in best practice,
- measure public and patient perceptions regarding gender competencies of health services, and its association with the perceived effectiveness and outcomes of help seeking by men,
- describe and innovate in partnerships with the broader men's health sector, along with the womens' and LGBTQI+ sectors in gender-responsive health care and systems change.

5.6 CONCLUDING STATEMENT AND ENDORSEMENT FROM THE PROJECT'S WORKING GROUP

The Project Consortium was consulted throughout the project with members guiding and facilitating the work undertaken. Input from the Consortium was integrated into the planning of the innovation and into the development of the implementation framework. The Working Group reviewed and endorsed this report and approved its final submission.

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APPENDICES

Appendix A: Articles arising from the Movember Men's Health Education project submitted for publication

1. Seidler Z et al. "I'd have no idea how to go about this..." - A survey of Australian medical students' perspectives on their men's health education. Submitted to BMC Medical Education, May 2023.
2. Seidler Z et al. What does men's health education look like in Australian tertiary health curricula? A formative evaluation and future enhancement opportunities. Submitted to the Journal of Medical Education and Curriculum Development, August 2023.
3. Seidler Z et al. Approaches to optimally engaging men during health care encounters: A scoping review. Submitted to the American Journal of Men's Health, September 2023.

Appendix B: Abstract: Literature review to inform the curriculum audit tool and methodology

Literature review to inform the development of the Movember Men's Health Education project

curriculum audit tool and methodology

Movember, Australia.

Background: One of the first objectives of the MMHe project is to undertake a review of tertiary education curricula to identify gaps in key learnings in men's health. For this, a men's health, contextually relevant audit tool that can be used to formatively evaluate the breadth and depth of health and medical curricula in Australia is required.

Aim: The aim of this study was to undertake a review of the literature describing audits of health and medical tertiary curricula for men's health content to synthesise knowledge on i) core men's health content audited for in curricula reviews; ii) the framework against which the audit is undertaken; iii) the audit methods used and what methods yield the best returns in terms of quality of data to inform curricula enhancement strategies.

Methods: PubMed, Scopus, CINAHL, Medline, Embase, PsychInfo, and ERIC databases were searched for journal articles and dissertations published in English, using the terms "men's health OR "male health", "curriculum or curricula or syllabus" AND "evaluat* OR audit OR review". The search yielded 67 articles and these were supplemented by additional articles identified in reference lists and provided by consortium members. The abstracts were reviewed for relevance and selected articles were further reviewed for data summarising the education setting, the audit methods used, the men's health content and the educational framework against which audit data were analysed.

Results: Seven articles describing audits were selected. Three articles described audits of curricula for "men's health" content specifically, one audit was of a single Australian medical school (Holden et al., 2015), one of multiple United States pharmacy schools; (Young & Lempicki, 2015), and one of all United States public health and medical schools (Giorgianni et al., 2013). Taking a more expansive scope, a further four articles described audits of undergraduate medical curricula for both men's and women's health content delivered as part of a sex and gender-based medicine (SGBM) framework that focuses on gender-awareness in education with the goal of reducing gender disparities/biases in the health care system. Three audits were undertaken in United States (Henrich et al, 2008, Song et al, 2016; Rydberg et al, 2021), two of a single curriculum only and another of all 125 accredited medical schools (Henrich et al, 2008). The remaining article was an audit of a single medical school curriculum in the Netherlands (van der Meulen et al, 2017). Importantly, two of these articles described longitudinal follow-up audits that served to describe maintenance and acceptance of SGBM curriculum enhancement strategies (Rydberg et al, 2021; van der Meulen et al, 2017). Based on the strength and weakness of the audits, the key methodological considerations to inform an audit tool for formative evaluation of Australian curricula were summarized as follows:

- Men's health content for audits should reflect the broader sociological and pathophysiological definition of men's health and be analysed against a more contemporary SGBM framework.

- A collaborative approach, engaging early with tertiary institution leads is critical to gaining access to curriculum information for audit, and to coordinate timing of audits to ensure informant availability.

- An audit protocol that relies on one primary data collection method is important for high quality, quantifiable, reliable data. Access to curricula to map content yields the most comprehensive data for gap analysis.

- A student survey on core topic leanings and competency provides important supplementary data and is more likely to yield a good response rate when compared to institutional staff informant completed audits.

- Rating scales to supplement binary data enhance the sensitivity of audit data to measure change over time.

- A sequential mixed methods approach that uses a focus group to build on primary data and to provide important additional insights from providers and users of tertiary education could be considered.

- Health practitioner-patient communication is a core men's health topic included in all audits.

Conclusions: There are limited audits of tertiary health and medical curricula for men's health content, including in Australia settings. Nonetheless, given the broad scope of men's health content, employing a more inclusive and equitable SGBM framework may help scaffold a curricula audit tool. The audit process should be a collaborative effort with institutions involving staff and students to increases the likelihood of access to curricula for direct content mapping and additional student surveys on learning outcomes. As most audits reviewed were of medical curricula, considerations need to be given to adaptation of audit content for curricula of primary care disciplines including social work, psychology, public health, dentistry, and nursing.

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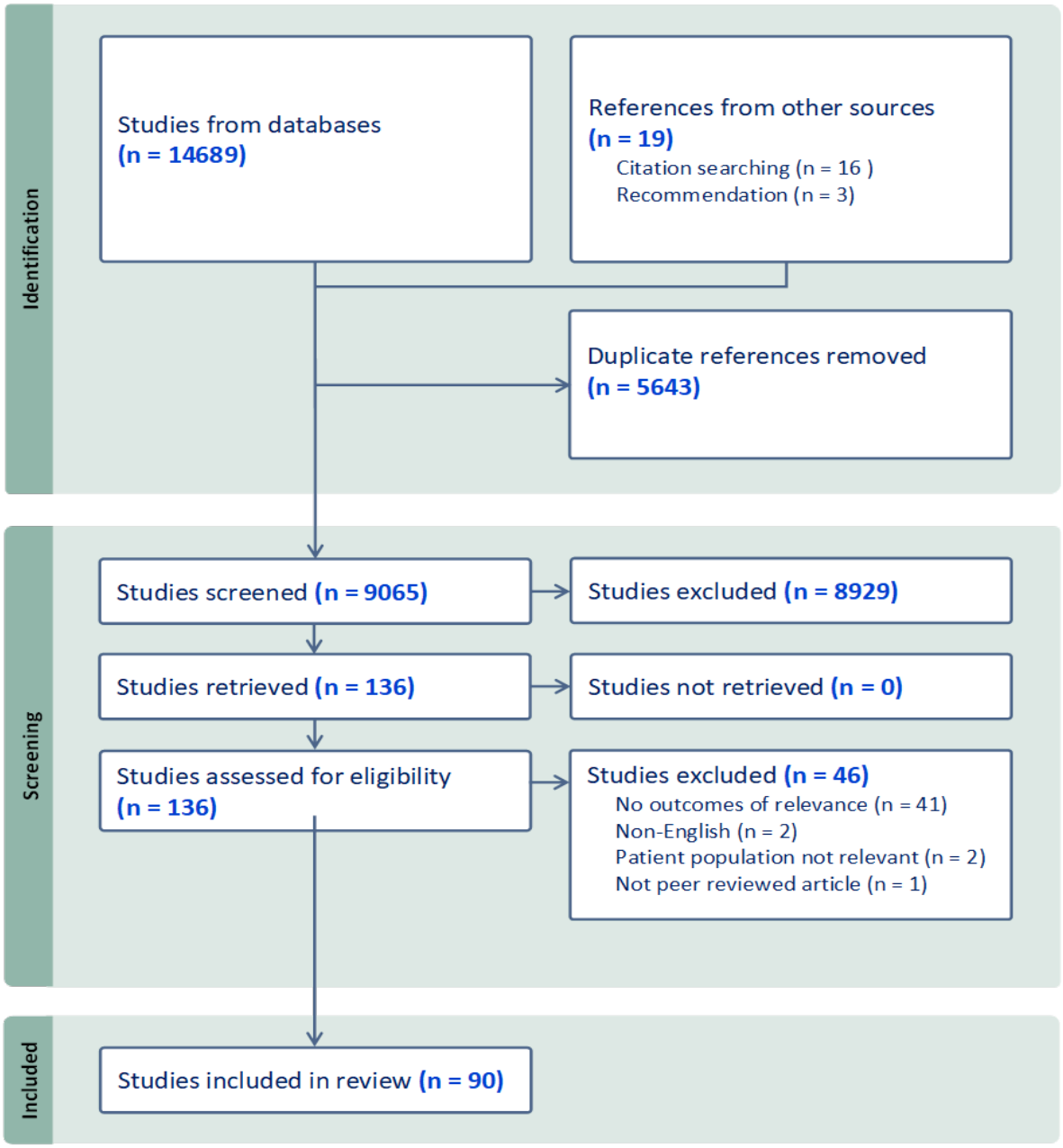
Appendix C: PRISMA flow chart for scoping review (Study 4.1, Section 4)



Appendix D: Tables of determinants in the individual and process domains of CFIR

Table D1: Determinants in the individual domain

Construct name & definition	Evidence supporting barrier (-), facilitator (+) or neutral (+/-)	
	e-CPD program	**Tertiary curricula resources**
INDIVIDUAL ROLES		
Implementation Facilitators (Inner setting) Individuals with subject matter expertise who assist, coach, or support implementation **Implementation recipients (Inner setting)** Individuals who are directly or indirectly receiving the innovation	**Implementation recipient**: HCP	**Implementation facilitators**: University staff
INDIVIDUAL CHARACTERISTICS		
Need The individual(s) has deficits related to survival, well-being, or personal fulfillment, which will be addressed by implementation and/or delivery of the innovation	**(+)** Broad understanding of sector is that gender competency is not comprehensively taught, suggesting deficits in knowledge and practice that will be fulfilled by the innovation	(+/-) Staff consults identified receptivity to curricula resources which indicate high level of awareness about the current gap in the curriculum.
Capability The individual(s) has interpersonal competence, knowledge, and skills to fulfill Role	(+) CPD is a requirement of HCP training and HCPs very capable of accessing online training	(+) Both university staff and students already access online learning resources
Opportunity The individual(s) has availability, scope, and power to fulfill Role	(+) HCPs have availability, autonomy and scope to undertake any compliant CPD	(+) University staff can make certain additions to their course content on an annual basis
Motivation The individual(s) is committed to fulfilling Role	**(-)** HCPs motivation to complete this e-CPD over others is not known, although MiM trial has demonstrated a demand in MH setting	(+) Evidence from staff survey and consults identified individuals willing to facilitate use of Hub in their Department/School

Table D2: Determinants in the implementation process domain

Construct name & construct definition	Evidence supporting barrier (-), facilitator (+) or neutral (+/-)	
	e-CPD program	**Tertiary curricula e-resources**
PROCESS		
Assessing needs of innovation delivers Collect information about the priorities, preferences, and needs of deliverers to guide implementation and delivery of the innovation	Not relevant.	(+) Curricula audit, staff survey and consults have confirmed a need and some level of receptivity for planned resources, and suggested formats for resources
Assessing needs of innovation recipients Collect information about the priorities, preferences, and needs of recipients to guide implementation and delivery of the innovation	(-) No evidence yet collected around the needs of HCPs from multiple disciplines.	(+) Survey findings showed evidence from medical students of demand for the planned resources
Assessing context Collect information to identify and appraise barriers and facilitators to implementation and delivery of the innovation	(-) No evidence yet collected across multiple health disciplines	(+) Staff consults have provided detail of the teaching context and what will be feasible for inclusion into existing curricula

Appendix E: Twenty-two key implementations (ERIC) strategies

Ref	ERIC strategies for innovation by category
1. Financial strategies	
1.1	**Funding and contract/**agreements
1.2	**Create a sustainable funding model** (incentive/ allowance structures /disincentives; user pays, free, subscription based, other).
2. Interactive and assistance	
2.1	**Recruit/designate human resources** and train for innovation effort.
2.2	**Develop support resources and capabilities**: technical assistance, facilitation.
3. Evaluation and iterative	
3.1	**Conduct local consensus discussions** with users/stakeholders for needs assessment, receptivity to innovation
3.2	**Assess for readiness and identify barriers and facilitators**
3.3	**Capture and share local knowledge** Capture local knowledge from implementation sites, including from pilot and early adopters, on how implementers and users made something work in their setting to learn from their experiences with the practice innovation and then share it with other sites.
3.3	**Develop and implement tools and systems for quality monitoring** Audit cycle – Quality monitoring and evaluation responsive audit and reporting framework and data systems.
4. Adapting and tailoring	
4.1	**Promote adaptability** Identify the ways an innovation can be tailored to meet local needs, pedagogies, and audiences and clarify which elements of the innovation must be maintained to preserve fidelity.
5. Stakeholder relationships	
5.1	**Identify and prepare local champions** who commit to supporting marketing, implementation, overcoming indifference or resistance that the intervention may provoke in their organisation.
5.2	**Inform local opinion leaders**
5.3	**Build a coalition:** Recruit and cultivate relationships with stakeholder partners in the implementation effort.
6. Supporting the Innovation (incl Governance)	
6.1	**Executive leadership and oversight** Processes to involve and report to existing internal (and where applicable) external (partner) governing structures such as boards of directors, in the implementation effort.
6.2	**Operate an Expert Advisory Committee and Consumer Committee** Create and engage a formal group of expert and consumer stakeholders to provide guidance on implementation efforts and to elicit recommendations for improvements.
6.3	**Obtain formal commitments**
7. Training/education	
7.1	**Conduct educational (e-training) outreach** Host webinars for professional bodies and education institutions about the innovation with the intent of changing the user's practice; Conduct ongoing training as adaptations are made.
7.2	**Build a learning collaborative – communities of practice (network weaving)** Establish and support functionality of a community of users to foster a collaborative learning environment to improve uptake and evolution of the innovation, webinar program, educational meetings.
7.3	**Develop academic partnerships**
8. Engaging consumers	
8.1	**Advocacy campaign** Use mass media
8.2	**Create and increase demand** Attempt to influence the market for the innovation and to increase the maturity of the market for the innovation.
8.3	**Obtain user feedback** and evaluation to relay back to users and for marketing.
9. Change infrastructure	
9.1	**Create or mandate change** In credentialing and/or licensure standards and/or teaching standards (and learning outcomes). Includes conduct cyclical small tests of change.