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"THE ENVIRONMENT WAS LIKE THEY WERE IN THE PUB BUT WITH NO ALCOHOL" – A PROCESS EVALUATION OF ENGAGEMENT AND SUSTAINABILITY IN MEN ON THE MOVE AN IRISH COMMUNITY BASED PHYSICAL ACTIVITY INTERVENTION

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ABSTRACT

Men's health and life expectancy, particularly for those men from lower socioeconomic groups, remains an issue of concern in Ireland. This concern is reflected in the recent National Men's Health Action Plan where important priority has been placed on finding appropriate ways to garner sustained involvement in health promotion interventions for men. Physical activity (PA) has been shown to be a useful 'hook' to assist with such engagement. 'Men on the Move' (MOM) is a 12-week, community based, gender-sensitized, PA program established as a pragmatic controlled trial and aimed at improving the health and wellbeing of inactive men. The program was co-created with Local Sports Partnerships (LSP), delivered by experienced PA co-ordinators (PACs), and often supported by local community champions.

This paper reports on the process evaluation of the MOM program using data collected from focus groups with the LSPs and those involved in delivering MOM from all 8 counties that took part. It aims to describe how MOM program activities were delivered, how closely it was implemented as planned, and how well it reached the target population.

Findings highlight the importance of negotiated partnerships at and between national and local levels in terms of providing support, consistent guidance and appropriately branded materials to the LSPs. The underpinning inclusive ethos of MOM, embodied by the PACs, led to the creation of a fun, inclusive and comfortable atmosphere that helped sustain men's involvement. This was aided by the use of male-familiar settings through which to deliver the program. While PA focused, findings here suggest a much wider impact on mental wellbeing and social connection and that this was achieved in a very cost-effective way. Importantly, men's health training (ENGAGE) was a key factor in program design and implementation assisting in building capacity among service providers to work with men. Joined up service provision and drawing on existing, trusted, local community networks were vital to recruiting men into the program. Finally, the potential for MOM to signpost and offer an aftercare plan to community support for the men beyond the 12-week program was noted as important particularly where there is increased need of these among more marginalized groups of men.

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This process evaluation provides a good example of how health promotion interventions need to recognize and exploit the fact that health and wellbeing are integrally linked to the communities where people live out and experience their daily lives. Ensuring that MOM was embedded within existing community structures, and supported by community champions with the requisite skills and local knowledge, underpinned program success and sustainability.

Key Words: community, physical activity, men's health, process evaluation, engagement

The gap in life expectancy between men and women remains an issue of concern with global sex-differences in life expectancy being 5 years[1] and in Ireland 4.5 years.[2] While possible reasons for this difference in life expectancy vary, there is broad consensus that sex-differences in lifestyle factors such as smoking, drinking, and diet play an important role in men's higher rates of premature mortality and therefore lower life expectancy.[1,3] However, there is variation within men in terms of lifestyle practices and subsequent health outcomes. For example, in Ireland, rates of smoking are higher among men from lower socioeconomic groups[4] and whilst men from lower socioeconomic groups in Ireland drink less alcohol overall, they are more likely to binge drink and to experience higher levels of alcohol harm.[5] Importantly, these (and other) negative lifestyle factors have been shown to more frequently cluster together for those living in areas of deprivation.[6] Not surprisingly then, men who experience higher rates of socioeconomic deprivation have significantly higher mortality rates than those from affluent areas.[7]

Within an Irish context, this gap in health outcomes between rich and poor has increased in recent times, especially for men.[8] This has led to an increased public health spotlight on men's health, particularly on those sub-populations of men with the poorest health outcomes. Indeed, the publication of a National Men's Health Policy (NMHP) in 2008 marked the first attempt by any national government to target men as a specific population group when strategically planning health policy.[9,10] The recent follow-up document, the National Men's Health Action Plan,[2] is evidence of Ireland's ongoing recognition of the importance of, and commitment to, men's health. Underpinning the Irish government's approach to men's health policy implementation has been a focus on gender-specific strategies relating to community engagement, capacity building, partnership and sustainability.[11] Such strategies have been found to be particularly effective in engaging and sustaining engagement with those sub-populations of men often described as "hard to reach,"[12] in ways that generate positive lifestyle shifts and improved health outcomes.[13]

A key priority in men's health policy implementation in Ireland has been on finding a "hook" or a mechanism to attract hard to reach groups of men into health programs. In particular, the use of physical activity (PA) in interventions has been shown to be a useful 'hook' when engaging men in public health – a finding which is consistent with international evidence. For example, a program promoting PA through 16 Premier League football clubs in England showed positive results on a range of lifestyle indicators.[14] Similarly, the Football Fans in Training (FFIT) program in Scotland, a Randomized Controlled Trial of a sporting intervention for weight loss and lifestyle change in men, demonstrated positive results.[15] Such programs show that utilizing elements with which men are familiar and secure, especially around PA, can aid successful, sustained, engagement[16]. One example of this approach in Ireland is "Men on the Move" (MOM); a community-based PA program the detail of which is outlined in the following section.

The efficacy of the MOM program was investigated via a pragmatic controlled trial up to 52 weeks involving 8 counties (4 in the intervention group (IG); 4 in the comparison in waiting group [CG]) in Ireland. The health outcomes of MOM have been reported elsewhere.[17] This paper aims to describe how MOM program activities were delivered, how closely it was implemented as planned, and how well it reached the target population – in short, it outlines what were the

keys to MOM program success and the challenges encountered in delivering the program.

BACKGROUND

A framework for conceptualizing program sustainability was developed based upon Shediack-Rizkallah and Bone's[18] framework for sustainable community-based health promotion interventions.[25] In brief, a partnership network consisting of 13 organizations oversaw the design and implementation of the program. All decisions regarding program design were focused on what would work feasibly in practice and therefore the program was designed to require minimal funding by integrating services and using local facilities. A national MOM brand was created and locally adapted to reflect county colours.

The MOM program was originally conceived by one Local Sports Partnership (LSP) and was adapted for delivery by a second LSP. The evaluation findings from both programs, coupled with those from published literature of similar programs elsewhere[14,15,19,20] and considerable reflective practice by LSP practitioners, formed the evidence base for the MOM program. MOM is a free, 12-week community based "beginners" PA program for inactive adult men that aims to improve the overall health and wellbeing of participants. It has multiple components such as structured group exercise twice a week and 2 facilitated experiential workshops and, in keeping with good practice, some flexibility is catered for between programs to ensure that these core components are achieved in a way that best suits the participants' needs. Social cognitive theory underpins the MOM program, which is also gender sensitized in relation to context (e.g., men only groups), content (e.g., of "gadgets") and style of delivery (e.g., participative and peer-supported). All staff involved in MOM attended ENGAGE training; ENGAGE, Ireland's national men's health training, is a one-day comprehensive training that aims to develop gender competency in the provision of health services for men.[21,22] MOM was delivered by experienced PA co-ordinators (PACs) who were specifically recruited and counselled with respect to the nuances of the program and of working with male participants via the ENGAGE training.

Locally, the delivery of the MOM program was the responsibility of the LSP; each county in Ireland has an LSP whose remit is to increase the level of PA among the general population. Strategically, for the delivery of MOM, LSP co-ordinators partnered a variety of existing services in each community that could potentially host the MOM program e.g. men's sheds, sports clubs, community development projects and aid recruitment locally. Community champions were sought within host organizations; it was hoped that their "buy-in" would increase both recruitment and the probability of effectiveness and sustainability. The recruitment strategies used were diverse[23] and consistently used imagery of "real men" to whom the target group could relate and language that was gender sensitized and health literacy proofed. Men were invited to contact their local host organization (community champion) or LSP co-ordinator for further details of the program and all men who expressed an interest in becoming more active were invited to attend a formal registration evening one week before the commencement of the program. The LSP co-ordinator, community champion and, on average, 6 service providers, were present at the registration evenings to welcome the men who came. This was followed by an input from a local medical professional who spoke about the benefits of PA after which men were invited to have their baseline health assessments done. Tea and coffee were provided, and service providers sought out opportunities to speak to all men in person. Participants in the CG were invited to attend a series of health checks with a view to doing the program after 52 weeks.

The program team recognized that evaluating the process of engagement as well as tracking how sustaining engagement unfolded over time, were just as important as evaluating the desired health outcomes from the program. As Moore et al[24] suggest, process evaluations are important in examining the nature of what was implemented in practice, helping interpret context around intervention outcomes, and therefore informing future programs. In all, a recruitment target of 720 men was proposed for this study and 927 attended at registration. Of those in the IG (n=501), 68.3% attended at least 50% of the program, which was deemed indicative of weekly attendance. This

paper provides a process evaluation of MOM focusing on men's initial (registration) and sustained (during program delivery) engagement with the program.

METHOD

Ethical approval was obtained from Waterford Institute of Technology ethics committee [15/Dept-HSES/13]. This study has been registered with the 'International Standard Randomized-Controlled Trial Number' registry [ISRCTN55654777]. Full study protocol details are available.[25] This section therefore focuses specifically on methods and analysis relating to the process evaluation only. Written informed consent was provided by all study participants.

The amended framework for conceptualizing program sustainability[18] was also used to underpin the process evaluation of MOM. This framework is compatible with a process of abductive reasoning, having both deductive and inductive aspects, and was therefore also used to guide the evaluation. The process evaluation data was collected between weeks 6 and 9 of the program to investigate factors that contributed to men's engagement in the registration evening for the MOM program (IG) and the initial health check (CG) and their sustained engagement with the MOM program.

LSP co-ordinators and their team of community practitioners involved in all 8 counties (n = 49) were invited to participate in focus groups and all participated. There were twelve focus groups in total lasting from 11–96 minutes. One person was not available for the focus group but agreed to participate in an individual interview, which lasted 24 minutes. The topic guide for the focus group (and interview) was based on Shediac-Rizkallah and Bone's[18] framework and therefore explored: project design and implementation factors; factors within the organizational setting; and factors within the broader community environment. All focus groups were conducted by (PC, NR, AD, AK, LK). All data were recorded, transcribed verbatim and then anonymized at the earliest opportunity.

Analysis also followed a process in line with abductive reasoning. Deductive elements of analysis involved initial coding into the amended Shediac-Rizkallah and Bone[18] framework. This was completed independently by 3 team members (AD, PC, SR). Inductive elements were then applied by undertaking further analysis within each of the 3 areas of the framework. This aspect followed the process outlined by Braun and Clarke[26] and focused on both sematic (descriptive) and latent (interpretive) levels. This second level analysis was completed initially independently, then through integrative discussion, between 2 team members (PC & SR).

RESULTS AND DISCUSSION

Findings are presented and discussed in accordance with the 3 main sections of Shediac-Rizkallah and Bone's[18] framework.

Design and Implementation Factors

Project design and implementation factors relate broadly to the resources available to the project and consist of elements such as: negotiation processes, evidence of effective practice, the MOM model type, cost of delivery and training.

Negotiation was key to the development of MOM and its subsequent delivery. Negotiation processes centred on the creation of a national partnership network involving statutory, academic and community sectors in the development of the MOM model. The establishment of this partnership was crucial in providing a national structure that (a) created a network for the LSPs to connect for support, (b) ensured consistent direction/guidance to all local LSPs, and (c) provided links with partners beyond the LSP structure that also supported local delivery.

It is evident that the LSP partners found the national partnership network meetings beneficial for a number of reasons. Learning from one another, benefiting from practical support, engendering a shared sense of responsibility, and promoting improved motivation and a sense of togetherness were all cited as important:

> *'the group meetings with the other LSPs and all the stakeholders involved in the particular project worked very well.'*

> *'They [other LSP colleagues] would have rang me and said, 'oh this didn't really work now, try this now tonight and see'. And then I would have rang them and been like, 'how did you manage that now?' or 'what way did it go?' and everyone bought in together.'*

Whilst the peer support from the LSP generated shared pragmatic learning, the national lead for this support structure was also recognized as important. This national structure was seen as providing a coherent and consistent mandate for the program, laying out specific details for timelines, setting clear targets for the number of men to be recruited, and supporting with strategies and resources to help meet these targets. As part of the national partnership network, all LSPs were involved in designing all branded resources used to market the program. This level of input may have contributed to their confidence in them:

> *'The fact that it was led nationally for me was critical [. . .] we felt we had the proper direction, we felt that we had the proper tools and there was confidence in all the tools and resources which made it so much easier and that is important.'*

A UK study showed that advertising services as widely as possible, in simple but direct, informative and gender-sensitive ways, helped engagement with men from areas of multiple disadvantage[27] and this was similarly important here. Coles et al[27] also noted that many of the men they interviewed were angered by promotional material depicting masculine stereotypes. Others have also noted that this can not only be off-putting to men but may also reinforce negative aspects of men's social practices.[28,29] In developing and designing the MOM materials, much thought was given to this issue. The overwhelming view in the process evaluation data here was that the materials developed were well received and had positive influence on engagement without detrimental aspects being noted. This is important because, as Coles et al[27] point out, health promotion interventions can help change men's health and social practices. Indeed, other initiatives in Ireland have demonstrated the value, not only for the men but for the wider community, of challenging more unhelpful and stereotypical male gender norms in public health work with men.[13]

Negotiation was also important in the development of MOM program workshops. A member of the partnership team negotiated collaboratively with a senior mental health promotion officer and a senior dietician on the content and delivery methods ensuring gender sensitivity as well as ensuring consistent content across all 8 counties. Making the content relatable for the men and having practical and interactive aspects, were important factors in the design of the workshops. This helped create an informal atmosphere where the men were not afraid to speak out:

> *'It was a nutrition talk but there was no PowerPoint. It was done really nice, really informally and very interactive - lots of cartons and empty boxes and food labels - nobody was afraid to answer a question wrong. That was really important and is particularly important with men and any men that might be vulnerable.'*

As well as creating a network for the LSPs to connect for support and ensuring nationally consistent direction and guidance to the local LSPs, negotiation processes were also significant in developing the local partnerships that were crucial to the program. While partners were engaged at a national level, LSPs sometimes faced challenges when negotiating delivery locally with statutory bodies: that is, commitment at national level did not always translate into boots on the ground at local level. Issues around securing adequate personnel for out-of-hours program delivery and negotiating long-term commitment from program partners to ensure program sustainability were all named:

> *'One example in [community venue] I went into the public health centre to meet the public health centre manager and she did not want to know anything about the program . . .'*

> *'They saw it was a good opportunity, they liked the program, they were very interested, thought it would be very beneficial but just couldn't commit to the evening.'*

Sometimes then the vibrancy and momentum that was generated though national meetings of LSPs could be difficult to convert to required action with local partners. As noted by others,[13,30] there are sometimes undercurrents of disenchantment and apathy around public health work with men that can create early difficulties in engaging important local partners, especially those who are already over-worked and under-resourced. Nevertheless, as seen in the work by Lefkowich et al[13] and Robertson et al,[30] such relationships can be forged especially when "sold" in terms of shared values, organizational missions and resources, and the integration of MOM work such

as integrating workshop delivery and attendance at registration for health checks into the annual service plans of relevant service providers is one practical example of this.

In terms of effective practice, national factors were important in initiating engagement. Developing the national brand was important in attracting men to the program. It highlighted the national nature of the initiative, clearly presented the program as men only, used appropriate imagery to capture the target audience, and helped differentiate MOM from other more broad-spectrum programs:

> *'Yeah I would say they take notice of it when it says '*Men on the Move' *like. It is a catchy name and it's . . . I think they see straight away the way it is something specific for them like you know that's its . . . you know where if they see another poster for a generic name for an exercise program 8-week exercise program in a gym maybe they don't notice it as much you know.'*

As the program was targeted at inactive males in Ireland, and was designed to be a beginner or entry level program, there was strong commonality among those who attended – they were previously sedentary and shared a common purpose to become more physically active:

> *'It's nice having all men and not having that mixture because I get the feeling they're slightly more comfortable because they are all in the same boat.'*

> *'The way it was packaged is that men seem to . . . they will exercise with their peers right. So in other words if they know there is other guys their own sort of age and sort of weight, ability or whatever that they will attend an exercise session with.'*

This commonality led to a fun, inclusive and comfortable atmosphere being created that subsequently engendered trust among the group and was key to supporting sustained engagement in the program. There was a depth and intimacy to these interactions that generated strong bonds and the quality of these relationships was a significant factor in the men returning each week:

> *'Well the whole thing was the atmosphere was just so good and that was between the younger and older. They were all mixed together, they were all talking, they were all having a great real laugh maybe slagging or whatever . . .*

> *'And I think they trust each other as well you know they do trust each other which is I think a good thing.'*

Having created a trusted and safe setting for engagement, it became easier for the men to simply have fun and enjoy the camaraderie; they bonded in positive ways enjoying each other's company (see also[17] for more detail). As Robertson et al[16] point out, this element of shared fun and social interaction should not be underestimated either in its role in sustaining engagement in programs or in its health promoting potential for men. Even though the focus of MOM was on increasing levels of PA, its impact on other aspects of lifestyle and on mental wellbeing emerged from the focus groups with both LSPs and PACs as an equally important program outcome.

While PA was at the heart of the program, it was this underlying MOM ethos of inclusiveness and belonging that supported sustained engagement. The role of the PAC in fostering this positive atmosphere and sense of group identity was substantial:

> *'The choice of physical activity leader who leads the group every week or whatever is absolutely critical. Their disposition, their connection with those who attend, is paramount not only to the atmosphere that is created in the group, but it permeates through everything you know. As soon as men walk in the gate on the first night they are greeted, they feel warm, they feel welcome or whatever.'*

It was not only the PACs' qualifications that were important but the ability of the PACs to be empathic and have the interpersonal skills to engage the men:

> *'They have to know their stuff and that is the basic requirement they need to be trained and… but the likability factor is probably you know and approachability factor is very important in a leader…'*

The LSPs therefore gave careful consideration to their choice to the PAC at the outset.

> *'Each of the leaders were brilliantly chosen, they had a wonderful disposition and really connected with the men and as a result the men then connected with each other.'*

Crucially then, those local PACs who were directly involved were key to driving the program and developing the trusting, relaxed atmosphere and the inclusive feel within the groups that forms the basis for their success.

As well as the PACs helping create the relaxed environment, the physical setting itself was significant. Using familiar venues to host the program, such as local clubs or community centres, meant that fear of a clinical or gym type setting was removed:

'The environment was like they were in the pub but with no alcohol.'

'It was the right environment that was created by a combination of factors they just felt really comfortable. Like it wasn't the clinical setting, the hospital setting, there was no one going around in a white coat or a stethoscope it was just like a bit of fun, a bit of craic.'

As the LSPs and PACs highlighted, and as anticipated in MOM program design, the settings used undoubtedly had positive impact on men's willingness to engage. Of the 30 venues used, 21 were sports venues, one a men's shed and 8 community centres.[23] As noted earlier, other interventions[15,16] have shown how utilizing PA or sport can help create a safe setting for engagement in health promotion work with men and this certainly was the case here – though, of course, no data was collected from men who chose not to engage so only limited inferences should be drawn from this. As we highlight elsewhere,[23] certain groups of marginalized men were under-represented through the current MOM approach and this would require consideration in any future roll-out of the program.

Whilst the qualifications and experience of PACs added to the perceived integrity and credibility of the MOM program, having that "X-factor" in terms of being able to connect with the men was equally if not more important:

'And a suitable leader maybe be someone you know that, OK, they have qualifications but they also have a significant personality and, you know, social skills yeah you know to interact.'

These qualities, and the atmosphere and values demonstrated by the PACs, were recognized as important in sustaining the groups:

'He made it very clear there were no groups, no cliques, it's not like that. So then it becomes more appealing to people from the outside coming in and people continue to join. It just works because of the, I suppose, the way he handles it and the way he managed the group initially. He would have them up, and has them in for tea and he is very inclusive.'

The role of the free health checks in effectively engaging men in the program was also apparent. The time (evening), local venue setting, and having a full suite of tests (such as blood pressure and cholesterol) suited many of the men, and was especially attractive to those who might not otherwise get to see a GP:

'A huge part about getting them there was having the blood pressure, having the cholesterol, the whole package. That is where the interest was . . .'

'And the fact it was in the evening time, that they could pop along and you know get the health checks done free of charge, was also another bonus.'

The focus of the MOM model was primarily preventative, aiming to improve PA and to prevent future ill-health. However, all key stakeholders were aware of the wider preventative remit and how the program focused on more than just PA. The LSPs, whose normal remit is solely on increasing PA levels, elaborated on how wellbeing and social integration were also core objectives of the program. They were explicit in highlighting the impact a simple group PA program could have on mental wellbeing and social connection often extending beyond the MOM sessions:

'Some of the social aspects have just been absolutely massive for their mental health maybe more so than their physical health . . .'

'They now have a new network, a new group, a new social group that meet on a Sunday morning when we weren't even there and go for a walk on the railway track.'

The purposeful linking of PA and social aspects created a low pressure, fun, environment which appealed to the men, sustained engagement, and ultimately generated the effective program outcomes.[17]

The MOM model was designed to require minimal funding by integrating services and using local facilities and this seems to have been achieved. The LSPs were aware of previous funding difficulties for men's health work and the program design sought to find ways to minimize or alleviate these challenges. Keeping equipment costs low and drawing on specifically designed MOM materials and existing services both helped with this:

'They don't have to go and buy a load of new gear you know, they just have to go and do it. It is possible and it is not massively expensive.'

'I think the model that is set there is financially viable for us like if we can utilise the booklets and the theory sessions supported by the HSE and we just need to pay for a tutor.'

However, there was also awareness and concern over how the work might be funded beyond program completion. Most envisaged a situation where groups became self-sustaining through a combination of direct payment by the men attending, voluntary engagement in roles by the men, and fundraising:

'So the models that have been used . . . some of the men have been actually paying the co-ordinators themselves and some of them have agreements with their local community centres around using the facility and then raising funds for it and that sustains the project for them as well.'

Overall, there was consensus that the return on investment for the available resource was significant:

'It's been run on a very shoe-string budget you know, there's not a whole lot of investment in it, and I think that is what pleased us as well – that we could achieve so much from so little.'

The ENGAGE training provided for all front-line staff was a key factor in program design and subsequent implementation. At its most basic, this training helped in *'dispelling some myths and thinking this is how we can kind of recruit gentlemen.'* Beyond this, the staff learnt how to be sensitive, to make the men feel welcome and valued, and some also learnt new practical skills around measurement and data collection:

'It was my first time with the men. It's great because I've learned more, I've learned the likes of measuring and stuff like that [. . .] So I felt as if I've learned a lot through that. I learned like, as well as that, with speaking to other men, learning how they are feeling and stuff like you know.'

Being approachable, having the right interpersonal skills and an empathic understanding of the men's motivation and needs were crucial to sustained engagement. In mapping what helps in mental health promotion work with men, Robertson et al[30] show the range of characteristics said to be important for facilitators, including those highlighted by the data here. However, these characteristics are not always naturally acquired and training around gender-sensitive work with men has been recognized as an imperative part of program success.[21,22,30,31,32] It is no surprise then that the ENGAGE training required for the LSPs, PACs and other service providers involved was so well received and implemented by them throughout the MOM program. The ENGAGE training was effective in building capacity among service providers to work with men[22] and its consistent delivery has been previously recognized and praised in the evaluation of Ireland's NMHP.[33] Such training optimizes the sustainability of men's health work and gain in Ireland through the MOM program; it may be that building capacity for doing men's health work via MOM may support service providers to integrate that understanding and knowledge into other areas of their work and/or to advocate to men's health work in their field.

A number of design and implementation factors in the MOM program were clearly important in contributing to it becoming a coherent and effective program. However, these factors sit alongside other factors operating in the organizational and community environment to ensure maximum program sustainability and it is to these that we now turn.

Factors within the Organizational Setting

Two factors seemed significant when thinking about the organizational setting; integration with existing services and program champions or leaders.

The delivery of the workshops was integrated into business plans of HSE staff representing joined up service provision. As noted in the previous section, establishing these partnerships was a large part of making MOM effective and required understanding and appreciating one another's roles and seeing the added value that expertise could bring:

'The expertise of the HSE [health services] and links in with those GPs and other kind of groups and clubs is a huge positive. If you are doing this program, everyone has their own areas of expertise so just utilise that. If we did it on our own it wouldn't have worked as well.'

In addition, the MOM program was co-ordinated by LSPs. These are service providers that already had considerable links and networks in their localities (for example with community centres, family resource

centres etc.) deemed crucial in taking MOM forward and achieving its goals:

'If you were to go at this in the dark you would probably come up a bit short. I suppose in X in particular we would have good working relationships with a lot of partner organizations that we would use an awful lot for these types of programs.'

These existing relationships were drawn upon to successfully facilitate opportunities for recruitment, especially where there was a sense that this would be well received:

'We worked with particular community groups to recruit the men rather than targeting the men individually.''

With our own contacts and with our own groups we are working with already and just from kind of knowing people we decided to target 3 specific areas in X to recruit the men from.'

These existing local connections were not just about third sector and voluntary groups but also included local statutory providers who engaged with MOM and this was particularly appreciated by the men attending adding gravitas to the program:

'The GPs and the medical, the clinical, people locally were very good in supporting it. The local GP came the first night and spoke.''

There has been great support, you know, a nutritionist there, doctors, everybody. And most people take that as a positive, you know, when they are getting loads of feedback on their health and stuff like that.'

Crucially, the LSPs were best positioned to identify the right groups and services within their communities for whom the MOM program could provide opportunities to meet their own organizational objectives. There was a strong feeling then that integration into existing programs and services, along with the significant role that community champions play, were crucial parts of establishing and sustaining success within the MOM program. In this scenario, a synergistic relationship was established that provided mutual benefit to all concerned and particularly to the men engaging with the program. Furthermore, while only 8 LSPs were involved in the current study, their national structure across all 26 counties in Ireland offers an opportunity for national delivery of the MOM program. Notably, the review of Ireland's NMHP[33] found that progress in developing appropriate structures for men's health, at both national and local level, to support the implementation of the policy was underdeveloped. It is evident from this process evaluation, that the MOM structural framework lead by the LSP network and the model that integrates service delivery locally may provide a good example for how such structures might be developed when implementing the next phase of the policy; the *National Men's Health Action Plan*.[2]

Factors in the Broader Community

Having established the importance of both program design and implementation factors, and factors within the organizational setting, the MOM program was delivered within a wider community environment and context that also influenced the work. Two factors were important here: socioeconomic considerations and community participation.

A range of socioeconomic and environmental factors – such as economic disadvantage and social isolation – emerged as important factors for consideration in justifying the need for the MOM program:

'Living in a rural area as well obviously quite a lot of marginalized disadvantaged people you know men living on their own you know that really don't come out apart from maybe they might come into the town maybe once a week maybe to get their social welfare or whatever it is you know or you might see them in the pub . . . So I felt it was worth testing the project here.'

LSP co-ordinators were adept at recognizing that there were differences in the socioeconomic circumstances within the areas they covered and that these generated different needs among the men and different challenges for them as service providers:

'In my particular area I have a huge mixture of nationalities so it is different to the parish system that the other 2 groups are in. We have thirty-five different nationalities, maybe forty now, living in the X area and it is a big rental area, 65% of properties are rented in that area. So that is a challenge certainly . . . Looking at the 3 different groups there is a massive difference between the 2 rural groups – if you want to call them that – and X. The economic and social backgrounds of the people in the city group is way more diverse . . . an awful lot of different nationalities, different income levels, different you know . . .'

The social context was often one with high alcohol consumption and where men ceased PA after a certain age:

'Alcohol is a huge issue with that particular group you know so you will find some of the men have very low self-esteem and a lot of the time they engage with alcohol because the fact they can get a bit of a boost out of it and it is just part and parcel of their lifestyle.'

'A lot of men there I knew one or 2 of them and I knew they had done nothing since they finished hurling [indigenous sport] at twenty-two or twenty-three and they are showing up suddenly at forty-eight or fifty and they have done nothing in the meantime.'

For some lower socioeconomic groups, the sense of safety and trust they associated with MOM led them to feel comfortable enough to use the program as a vehicle for seeking support on other matters. Notwithstanding the additional workload and responsibilities that this might confer on PACs and/or LSPs, this highlights both the need for increased support services for more marginalized groups of men, and the potential of MOM in offering an aftercare plan and/or signposting men to community supports. In this way, MOM helped promote confidence in the men to address wider community factors that impact their health and wellbeing:

'Two of the men have come in and asked for information or help with welfare rights stuff. You know ask for letters to be written or help with maybe there would be literacy issues for some of the guys. So I mean they have actually come and asked and you know that is another mark of there is a sense of safety or confidence or something so…'

Despite the obvious and diverse challenges that presented in working with poorer and more marginalized groups of men – challenges that were recognized by the MOM team – there was also recognition of the assets present within the various communities and what advantages good community participation could bring. Linking into existing community groups was seen as an effective use of existing networks, promoted social engagement and avoided the suspicion often associated with professionals from outside the community:

'We did try use community groups so it is the people that were in the community groups were responsible for the men.'

As envisaged during program development, community champions were vital in ensuring program success. Identifying who might make good community champions was therefore very important and the LSPs played a significant role in recognizing the qualities required of local community groups and champions:

'X had fantastic contacts in terms of picking leaders in the various towns. X is a well-known GAA [national sports organization] person here in X city, the county and probably nationally as well in terms of refereeing in GAA. He would have fantastic contacts and his choice of leaders in each of the 3 towns was critical to securing men onto the program. He was fantastic.'

Because of their established networks and relationships, community champions were also an important part of reaching recruitment targets:

'We knew that it would be a good partnership here with X and the healthcare initiative because she has great relations with all the communities. So if anybody could get the 30 men that we needed we knew we would kind of get it here.'

Some of these community champions were not necessarily directly involved with the program but, because of their gravitas within their communities, they could be influential in recruitment just by being affiliated with the program:

'Those people [local doctor, local priest] amazingly sort of have a lot of influence in communities especially in rural communities. So their saying something about maybe going along would be of help, even their recommendation would get people out.'

Underpinning the important role of community champions was the added efficiency and cost-effectiveness that their involvement brought, often where resources were scarce:

'If it is a case we have to go back into a community and up skill people and re-train them as leaders again then we do that and that is low cost because they then in turn are basically soldiers on the ground they are the people who are driving it on. People like X you know they are flying the flag for us and we are not paying them you know what I mean.'

Using a variety of existing, trusted networks in engaging men (also mentioned in earlier sections), and using "word of mouth," have both been shown to be important in health promotion work with men.[13,16,30]

As Kierans et al[34] point out, the structural embedding of neglect, abuse, resentment, and cultural misunderstanding within communities experiencing multiple disadvantage can help explain why initial approaches and engagement with men needs to come via already trusted individuals and community groups. That MOM managed to engage so many men from areas of multiple disadvantage[23] attests to the work done by the LSPs, PACs and community champions in embedding the work within functioning community partnerships. As mentioned earlier, it also offers scope to signpost and connect these marginalized men into community groups and supports.

Because the MOM program met needs clearly present in the communities, these communities were often eager and open to working alongside and helping the local co-ordinators:

> *'There was a real need and communities were coming to us as well you know. Once we went with the idea they were chomping at the bit like … there was a real demand for the program.'*

Differences were noted though with some communities being less eager or ready to engage than others, with urban locations being seen as possibly having less community cohesion:

> *'As I said in some areas it worked well other areas maybe it is a little bit weak alright and probably in urban areas it can be difficult you know to get a partner like say to a community partner.'*

There was a two-way, reciprocal relationship in terms of community participation within the MOM model. There was recognition of the importance of embedding the program within a community assets model and also a desire to ensure that men (re)integrated into existing community initiatives, particularly as the program came towards completion. Again, this demonstrates how MOM was not conceptualized as a "stand-alone" program but was intended to be fully embedded within the communities and acted as a gateway to accessing other community services or supports among a cohort of men who might not otherwise have engaged with such services.

> *'If it was computer classes, whatever it was, or even* learning *a new language, anything different that they wanted to try that they would feel comfortable going to the community and that they would have something there to support them to further develop themselves, that it's not just Men on the Move that there is something else for them.'*

In this sense, linking the program with community champions, and integrating other services, supported men to engage with local amenities that they were previously unaware of or struggled to use. This provides 'added value' for these men, empowering them to utilise community resources well beyond the 12-week MOM program.

Understanding the socioeconomic circumstances in which the MOM work took place, and ensuring the program linked to existing community-based activities and initiatives, helped ensure that the program was seen as authentic by those being engaged, sustained their engagement through the program, and provided a springboard for continued personal development after the 12 weeks were completed. Previous community-based interventions with men have shown the importance of authenticity often achieved through local cultural experience and knowledge.[31] Previous process evaluations have also suggested that short course interventions are often not sufficient in leading to longer term lifestyle change.[16] The capacity of MOM then to embed itself in local community settings and activities provides opportunities for the men to continue their personal development in ways that are sensitive to local sociocultural contexts and that can generate longer term sustained health changes.

Whilst we have presented the 3 elements for promoting program sustainability (project design/implementation, organizational factors and broader community factors) as separate here, these obviously operate together in facilitating (or constraining) program success and sustainability. Accounting for these elements from program conception and development through to implementation has been the cornerstone of the MOM model that has generated such positive outcomes.[17]

CONCLUSION

This paper has outlined data relating to the processes of initial and ongoing engagement of men in the MOM program specifically considering the underlying factors that contributed to success at registration

(927 men attending overreaching the target of 720) and the sustained engagement over the program such as weekly attendance of almost 70% of the IG. This process evaluation has a limitation previously highlighted in the baseline characteristics paper[23]; namely that MOM encountered difficulties in reaching more marginalized groups, such as migrants, ethnic minority groups, or Travellers. In addition, no data was collected on the sexual orientation of the men engaged so it is not currently known how effective MOM is in reaching men who may identify as gay or bisexual.

It is evident from the findings here, that design and implementation, organizational and community factors working in tandem were key to engaging men at registration and sustaining their engagement in the MOM program. It is clear also that one of the main drivers of MOM's success has been the multi-layered approach, involvement and integration from national level to very local level. This has been key in demonstrating buy-in across these levels and in also having national consistency (of content, approach and tone etc.) but with the necessary flexibility to make it relevant at local levels. The recent and important Shanghai declaration on promoting health (published by the World Health Organization,[35] rightly states that "Health is created in the settings of everyday life – in the neighbourhoods and communities where people live, love, work, shop and play" (pg.8). In trying to optimize aspects of initial and sustained engagement, MOM was designed in a way that links the advantages of a national program with the need for delivery and implementation to be grounded at the local level within these settings of everyday life. This paper demonstrates the various ways that this design has been followed through and successfully implemented within the MOM program.

The implementation of the MOM program was also underpinned by the capacity of staff on the ground; PACs, community champions and other local partner services were carefully chosen and each brought specific skills and attributes to the program which were complimented by their training in the ENGAGE program. The gain is not only for the men themselves but also in the increased understanding and experience of working with men gained by all those trained creating a pool of skills and knowledge for future work in the area of men's health.

Anchoring the program within the LSP network ensured it would benefit from the vast local networks within each LSP while also enabling it to translate nationally beyond the 8 counties in this study. Therefore, LSPs were well positioned to establish local structures to ensure the program was embedded within a community organization and supported by community champions with the requisite skills and local knowledge to underpin its sustainability. While the integration of local services proved challenging at times, continued efforts should be made to overcome these challenges to ensure that men are exposed to these service providers with potential gain for the men beyond the MOM program. Despite these challenges, MOM clearly functioned as a gateway or conduit for men to access a range of community services and supports and therefore has significant potential in terms of continuity of care and support for these men beyond MOM completion.

While the success of the MOM program has been recognized in Ireland's recent National Men's Health Action Plan[2] and plans are underway to ensure its delivery nationally, it is imperative that the wider dissemination of the MOM program builds upon the strengths of the implementation model described here.

CONFLICTS OF INTEREST

The authors have no conflicts of interest.

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