



# MEN ON THE MOVE

**A Community Based Physical Activity  
Programme for Adult Men in Ireland.**

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**Evaluation Report: Executive Summary**

June 2019



Seirbhís Sláinte  
Níos Fearr  
á Forbairt

Building a  
Better Health  
Service

# Foreword



Delivering on Men's health with a broad variety of stakeholders is something that Health Promotion and Improvement have been doing very well for many years. Ireland was the first country in the world to have a National Men's Health Policy and more recently, the development of the Action Plan for Men's Health: Healthy Ireland-Men (2017-2021) has provided a vision and roadmap that will enable more effective implementation of mainstream programmes and services to have an emphasis on men.

Recognising the importance of effective programmes which engage men around their health, Health Promotion & Improvement invested in a national evaluation of Men on the Move in 2015. I am delighted to see the findings of this Report support a rationale for taking the next steps in expanding access to the programme nationally and determining its capacity to sustain the health benefits seen in the pilot phase.

The benefits of leading an active lifestyle are well documented and for the men that participated in the programme the positive outcomes in terms of physical fitness and body composition is really remarkable. What is even more encouraging is the impact participation in the programme has on other aspects of a man's health and life. It is evident from the report that Men on the Move provided participants with an opportunity to make connections which acted as a powerful catalyst for positive change in their lives. Men of course have been named as a priority group in our National Suicide Strategy Connecting for Life and this programme has been shown to support many marginalised men into more supportive social contact. It is critical we look to programmes that improve their levels of social engagement and self-efficacy.

It is significant that the recommendations recognise the importance of local communities and integration of local services to support future delivery. Through the Healthy Eating and Active Living Programme and our CHOs Healthy Ireland Implementation Plans there is a platform to support delivery of community based health promotion programmes such as Men on the Move.

I am delighted to see this Report highlighting that the level of engagement was so strong from key organisations such as the Local Sports Partnership Network, the Men's Development Network and the Irish Heart Foundation. Furthermore, the communities that supported and drove participation locally are to be congratulated on their pivotal role in enabling this research to happen. I extend my gratitude to all members of the Research Team and in particular Dr Paula Carroll, Principal Investigator, of Waterford Institute of Technology. Adopting evidence based strategies to promote physical activity that support men's health underpins the way in which we are striving to work, and integral to that is collaboration with our academic partners.

As pioneers of Men's Health policy, I am inspired to encourage everyone to think about the men in their lives- their fathers, sons, grandfathers, husbands and friends. Men on the Move provides an opportunity for all these men to grow and flourish, and I look forward to seeing programmes in more communities across the country.



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1. Aisling Keohane is the lead author of the findings from the qualitative interviews with participants.

2. Liam Kelly is the lead author of the findings from the quantitative measures.



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### **Conflicts of Interest:**

The authors have no competing interests.

# 1.0 Background

## **The case for focusing a spotlight on male health, and specifically male obesity, is a strong one.**

Men continue to die 4.5 years younger than women and are more likely to die of all the leading causes of death, at all ages.[1] With respect to male obesity, while only 16% of 25 - 34 year-old men are obese, this increases to 26% (age 35-44), 30% (age 45-54) and 39% (age 55-64) with age.[2] Of particular concern is that men tend to accumulate fat around their abdomen thereby increasing their prevalence of metabolic syndrome (24.6% v 17.8% among women), a condition that is directly related to mortality due to circulatory disease, many cancers and respiratory disease.[3] Since 1990, the prevalence of obesity among men in Ireland has increased from 7.8% to 25.8% (12.9% to 21.3% in women) and latest statistics show that only 31% of men in Ireland are of 'normal' weight.[2] This represents a significant public health risk with considerable associated social and economic costs that requires urgent attention. We know that physical inactivity is associated with overweight and obesity in men. However, we also know that many lifestyle risk factors (inactivity, smoking, poor diet and excess alcohol) are clustered with up to 60% of the population in the UK having one to two risk factors while approximately 30% have three to four of these risk factors.[4] Clustering is also more prevalent among lower socio-economic groups.[4] Wellness programmes that address multiple lifestyle risk factors are essential to initiate the 'unclustering' of unhealthy behaviours.

The publication of a National Men's Health Policy[5] in 2009 marked the first attempt by a national government anywhere in the world to target men as a specific population group for the strategic planning of health. The recent publication of a follow-up National Men's Health Action Plan[1] is evidence of Ireland's ongoing policy commitment to men's health. Underpinning its approach to policy implementation has been an explicit focus on gender-specific strategies related to community engagement, capacity building, partnership and sustainability; Men on the Move (MOM) has been named specifically as an exemplar of this approach.

## 2.0 The Men on the Move Programme

Men on the Move (MOM), in essence, is a wellness programme with a primary focus on physical activity (PA). The purpose of the programme is to use PA as a 'hook' to engage men in their health with a view to improving their overall health and wellbeing. MOM was conceived in 2010 by Health Promotion and Improvement, in the Health Service Executive (HSE) along with the Mayo Local Sports Partnership (LSP) and, following evaluation,[6] it was adapted for delivery by the LSP in Donegal. In brief, the MOM programme is a free, twelve-week community-based 'beginners' PA programme for inactive adult men.

It consists of structured group exercise twice a week, two facilitated experiential workshops, a twenty-four-page health information booklet, a pedometer for independent PA sessions, weekly phone contact, a customised wallet card to record measures taken and a 5 km celebration event at the end. Social Cognitive Theory (SCT) is one of the leading behaviour change theories used to explain and predict PA in the general population and underpinned the MOM intervention.[7] The programme was gender-sensitised in relation to context, content and style of delivery[8] (see Table 1).

**Table 1:** An overview of intervention components, frequencies and some of the behaviour change and gender sensitivity strategies and targeted constructs adopted for the MOM programme.

Intervention Component	Gender Sensitive Strategy	Behaviour Change Strategy	Targeted Construct
Structured Group Exercise (60 mins twice weekly)	All male groups Venue and Timing	Social support Promote mastery	Environment Self-efficacy
Workshops (diet and mental wellbeing)	Experiential Tangible evidence	Knowledge Social support	Social support Expectancies Self-efficacy
Information Booklet	Imagery and language Log book	Tracking mechanism Promote mastery	Expectancies Self-efficacy
Measurements and Wallet Card	Knowledge Tangible evidence	Tracking mechanism Promote positive outcomes	Expectancies Self-efficacy
Pedometer	Gadgets Competition	Promote mastery Promote positive outcomes	Self-efficacy
Practitioner Contact	Language Knowledge	Social support	Social support Self-efficacy
Celebration Event	Motivation Competition	Promote positive outcomes	Expectancies

Evaluation findings from both Mayo[6] and Donegal[9] demonstrated the effectiveness of the programme and prompted a 'vision' that MOM could be delivered in all counties via the LSP network for the benefit of the male population. However, in order for any public health intervention to be delivered on a national scale it must be tested under 'real world' conditions[10-15] and be sustainable[16]. MOM was designed for and delivered in 'real world' practice and underpinned by the principles of sustainability. Locally, the delivery of the MOM programme was the responsibility of the LSPs; they oversaw the recruitment strategy, contracted local PA Coordinators and worked closely with them to oversee the day-to-day delivery of the programme. LSP Co-ordinators established a delivery system locally by partnering a variety of existing services in each community that could potentially host the MOM programme, for example, men's sheds, sports clubs and community development projects. 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.[17,18] MOM was delivered by experienced PA tutors who were specifically recruited and counselled with respect to the nuances of the programme and of working with male participants.

## 3.0 Research Design

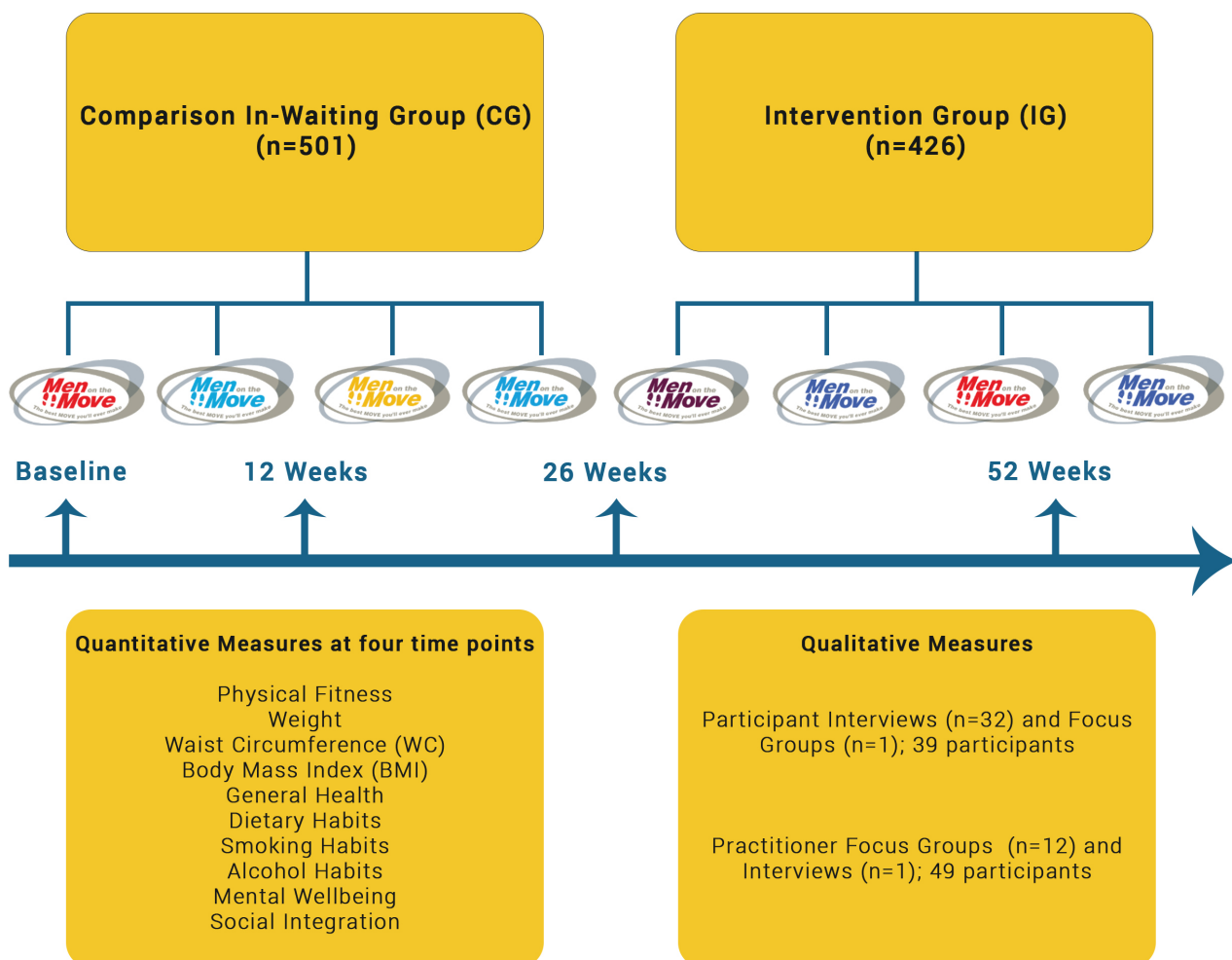
Both the research design and the protocols used to evaluate the impact of the MOM programme on biopsychosocial health up to fifty-two weeks were developed by the partnership network to ensure their feasibility in practice (see Figure 1). Ethical approval for the study was sought and obtained from the ethics committee at Waterford Institute of Technology [15/Dept-HSES/13]. This study has been registered with the International Standard Randomised Controlled Trial Number registry [ISRCTN55654777].



The research design used to evaluate the impact of the MOM programme was a pragmatic controlled trial.[19] In total eight LSPs were included in the study; four in the intervention group and four in the 'comparison in-waiting group' that acted as a control. Each LSP was set a target of recruiting 104 men across three community settings in their county. An experimental mixed-methods approach was used to ascertain the following:

- The impact of the programme on the biopsychosocial health of the participants up to fifty-two weeks.
- The process of designing and implementing a community based PA intervention for inactive men.

MOM programmes were delivered in twelve communities across four counties from September to December 2015, culminating in a celebratory 5 km event in each county. Participants were evaluated at baseline and twelve weeks and followed up at twenty-six weeks and fifty-two weeks.



**Figure 1:** An overview of the study design and data collection for the MOM evaluation

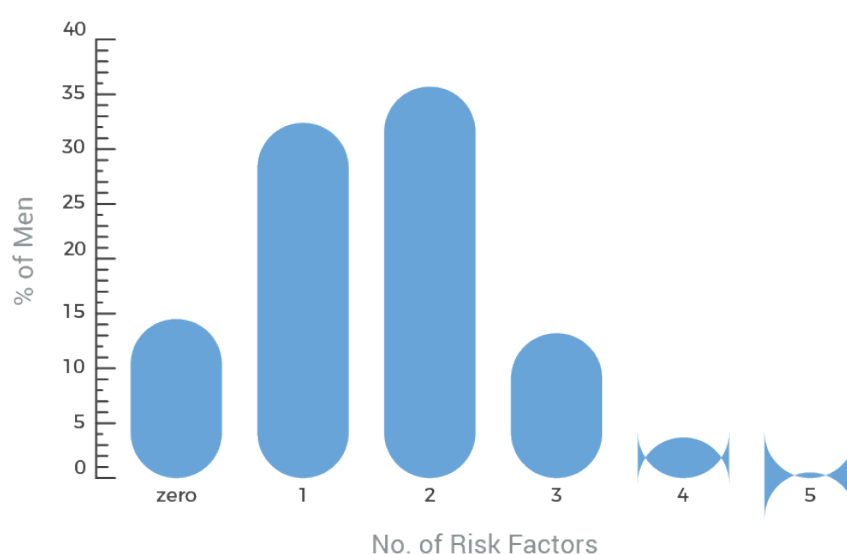
## 4.0 Research Findings

In excess of 900 men participated in the research project. The profile of participants was that of a middle-aged (82% aged between 40–70), predominantly white (98%), married/cohabiting (78%), population, with almost half (48%) having completed third-level education.

**Table 2:** Physical measures for all men who presented at baseline

	Weight (kg)	BMI (kg/m <sup>2</sup> )	Waist Circumference (cm)	Time to do 1 mile (m:dm)
IG	94.12±16.04 (501)	30.83±4.67 (501)	107.71±12.44 (495)	13.86±3.13 (435)
CG	91.01±15.87 (426)	30.10±15.21 (426)	102.12±13.08 (423)	12.57±3.88 (362)

Key: SD = Standard Deviation; No = number; kg = kilogram; IG = Intervention Group; CG = Comparison in-waiting Group; BMI = Body Mass Index; m<sup>2</sup> = metre squared; cm = centimetre; m:dm = minutes:deciminutes.



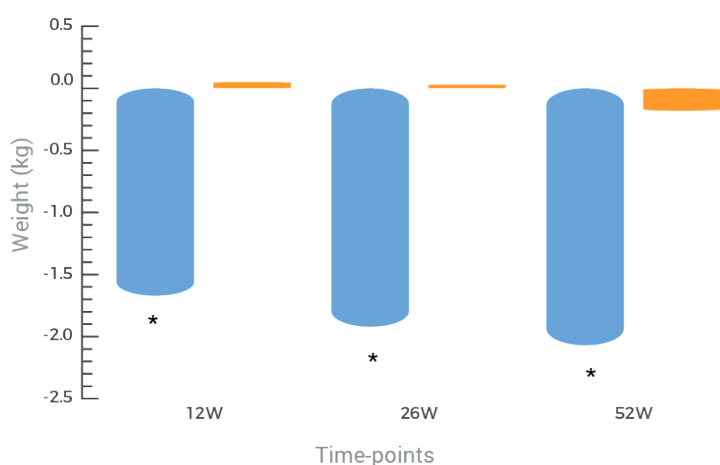
**Figure 2:** Prevalence of cardiovascular risk factors at baseline for both the IG and CG

Baseline health indicators show that the programme was attended by predominantly overweight/obese men. Nearly 90% (89.3%) had a body mass index > 25 and over half (55%) had a waist circumference > 102 cm (40 inches). The majority (84%) were not engaging in PA on five or more days of the week. Over half of the men (53%) had ≥2 cardiovascular disease risk factors. Almost half (47%) of the men had taken prescription medications in the previous twelve weeks, including 9% for blood pressure and 8% for elevated cholesterol. Some 14% reported their mental wellbeing as below average.

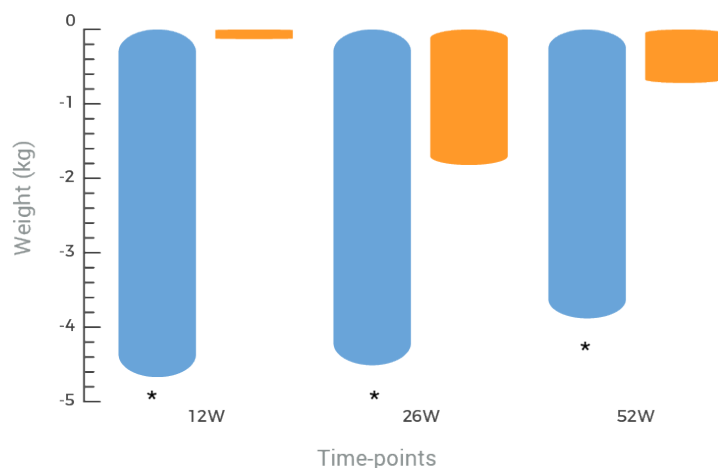
The MOM intervention targeted a 5% reduction in body weight, a 5cm reduction in WC and a 1 MET increase in aerobic fitness. A 1 MET increase in aerobic fitness represents a 15% reduction in cardiovascular (CVD) risk.[20] A 1 cm reduction in waist circumference represents a 2% reduction in CVD risk.[21]

After twelve weeks, 74% of the intervention group achieved the 1 MET increase in aerobic fitness, 13.5% achieved the 5% reduction in bodyweight and 48% achieved the 5cm reduction in waist circumference. At fifty-two weeks, 52%, 22% and 42% of the men in the intervention group were achieving the aerobic fitness, body weight and waist circumference targets respectively.

The mean changes ( $\pm$ SD) in body weight in the intervention group at twelve weeks, twenty-six weeks and fifty-two weeks were  $-1.7\pm2.8$  kg,  $-1.9\pm3.3$  kg and  $-2.1\pm4.1$  kg respectively. The mean changes ( $\pm$ SD) in waist circumference in the intervention group at twelve weeks, twenty-six weeks and fifty-two weeks were  $-4.7\pm4.4$  cm,  $-4.5\pm5.3$  cm and  $-3.9\pm5.2$  cm respectively.

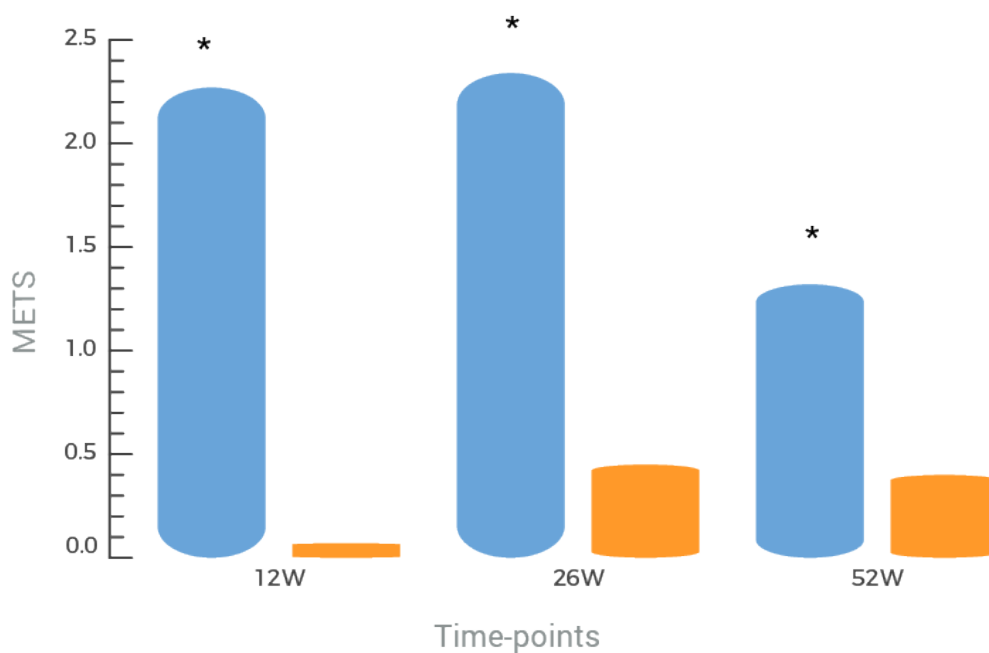


**Figure 3:** Body weight change scores (kg) of the intervention group (IG) and comparison group (CG) between baseline and twelve weeks, twenty-six weeks and fifty-two weeks. \* Change in IG different to change in CG at this time-point,  $P<0.05$



**Figure 4:** Waist Circumference change scores (cm) of the intervention group (IG) and comparison group (CG) between baseline and twelve weeks, twenty-six weeks and fifty-two weeks. \* Change in IG different to change in CG at this time-point,  $P<0.05$

The mean changes ( $\pm$ SD) in aerobic fitness in the intervention group based on time to complete one mile at twelve weeks, twenty-six weeks and fifty-two weeks were  $2.3\pm1.8$  metabolic equivalents (METS),  $2.4\pm1.9$  METS and  $1.3\pm1.9$  METS respectively.



**Figure 5:** METS change scores (m:dm) of the intervention group (IG) and comparison group (CG) between baseline and twelve weeks, twenty-six weeks and fifty-two weeks.\* Change in IG different to change in CG at this time-point,  $P < 0.05$

The mean changes in the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) mental wellbeing score was +1.9, +2.6 and +1.0 at twelve weeks, twenty-six weeks and fifty-two weeks respectively. An increase of 3 in this scale represents a meaningful change. The percentages achieving this change in the intervention group were 46%, 50% and 44% at twelve weeks, twenty-six weeks and fifty-two weeks respectively. No significant changes between group change scores from baseline across all time-points were found for social integration. Both groups achieved a mean score of 3 across all time-points, which corresponds with a moderately integrated classification.

It is evident from the findings that MOM succeeded in reaching its target population of inactive men with a high risk of CVD; 84.0% did not meet the national PA guidelines which is considerably higher than that reported for the adult male population in Ireland (66%)[22] and over half of the men (53%) had  $\geq 2$  CVD risk factors. Some 54% were in the 'high risk category' according to WC measures. MOM also succeeded in sustaining men's engagement on the programme with 70% of the IG attending over 50% of the programme. Findings show a significant reduction in weight, BMI and WC coupled with a significant improvement in aerobic fitness up to fifty-two weeks for the IG with a resultant reduction in CVD risk of 7.8% (WC reduction) - 19.8% (MET increase).

While little change was found in mental wellbeing and social integration via quantitative methods, it is evident from the qualitative interviews with the participants that MOM provided participants with an opportunity to make connections that acted as a powerful catalyst for change in their lives (see Figure 6).



**Figure 6:** The power of connection as a catalyst for change and improving the quality of a man's life

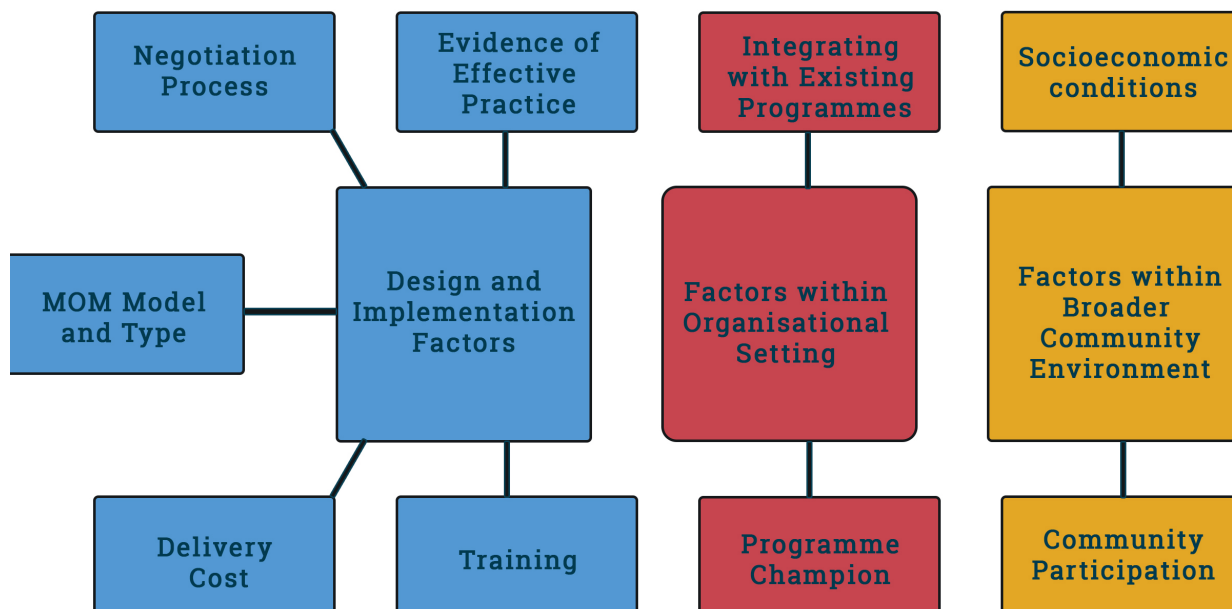
Many men who participated in MOM had experienced challenging life events that manifested in the data as isolation and loneliness, a lack of confidence to make changes for themselves and an internal struggle to adjust to changes in their lives. They felt disconnected from others and their communities and some were aware of a disconnect from themselves. MOM supported them to begin the journey to (re) connect with themselves; a journey that began via the creation of a safe and non-judgemental environment in which they could connect with their surroundings and other men with whom they could relate and finally, with themselves.

*B104: '... from a loneliness aspect it'd [MOM] break that [loneliness] up a bit you know? Meeting more people and meeting them twice a week and you're talking about various subjects ... just being in contact with people.'*

With this self-connection came a sense of belonging, an awareness of their self-worth and how they felt, clarity in how to readjust to life challenges, and a greater self-confidence. Men who initially were not confident in their ability or capacity to do PA, went on to recalibrate and surpass their PA expectations.

*H25: '... only through Men on the Move I wouldn't have been doing it [PA] only for it 'cause it [MOM] got me going, I got an interest in it [PA] I got stuck into it and I got going again and only for it now I'd definitely be sitting at home doing nothing.'*

Furthermore, it is evident that the process of connecting experienced by the men was cyclical rather than linear in nature; initial connections prompted learning and behaviour change, which supported men to grow in confidence, which in turn enabled men to connect with others and themselves on a deeper level.



**Figure 7:** An overview of the factors that underpinned the success of MOM

Negotiation via a partnership network involving the statutory, academic and community sectors was key to the development of the MOM model and its subsequent delivery. The establishment of this partnership was crucial in providing a national structure that a) created a network whereby the LSPs could 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. The atmosphere created was central to initiating and sustaining engagement of men on the programme and was reliant on branding, the group approach, the physical activity co-ordinator (PAC), the venue and the free health check.

***'The environment was like they were in the pub but with no alcohol'. (78)***

Specifically, the PAC was identified as key:

***'the physical activity coordinator is important, it is not your normal somebody with a whistle and a tracksuit it is somebody that can empathize with the men around what their needs are because the issues that were coming back were health related, some of them physical, some of them mental health'. (12)***

The focus of MOM was primarily preventative. All key stakeholders were aware of the wider preventative remit and how wellbeing and social integration were core values of the programme and were explicit in highlighting the impact a simple group physical activity programme could have on mental wellbeing and social connection:

***'I suppose the ethos is different you know as I said from the start it's a social model with physical activity attached onto it'. (12)***

The purposeful linking of physical activity and social aspects created a low pressure, fun environment which appealed to the men, sustained engagement and ultimately generated the effective programme outcomes. The MOM model was designed to require minimal funding by integrating services and using local facilities and the fact that ENGAGE training was provided for all front-line staff was also identified a key factor in programme 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. The integration of services for programme delivery and identifying champions within LSPs who subsequently identified PACs, were also key to the successful gains seen above.

Finally, linking into existing community groups was an effective use of existing networks, promoted social engagement and was less threatening for many men who engaged. Because the MOM programme hit needs clearly present in the communities, these communities were often eager and open to working alongside and helping the local LSP 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 programme'.***

While the socioeconomic context brought obvious and diverse challenges, the MOM team recognised the value of community participation, especially in poorer areas for engaging men. However, further support is required in this area to sustain men's engagement.

## 5.0 Recommendations

These recommendations have been informed by translational formative evaluation that was conducted with stakeholders involved in the delivery of MOM in preparation for this report.

### **R1 Scale-up MOM Nationally for the Benefit of all Men in Ireland**

As a result of the findings from this study, a MOM Co-ordinator has been appointed within the Health Service Executive, with a remit to oversee the national scale-up of MOM. In light of this appointment, R2-R10 from this study are now presented with a view to informing the national scale-up.

### **R2 Conduct a Translational Formative Evaluation**

The translation and up-scaling of the evidence presented in this report into population wide implementation cannot happen effectively without additional formative research. Specifically, translational formative evaluation is the key first step when up-scaling any public health intervention from 'efficacy testing' and 'replication' to national 'dissemination'. [23] Translational formative evaluation should include:

1. A review of available evidence of MOM and current best practice elsewhere,
2. Qualitative research with the MOM participants and stakeholders involved in the delivery system to refine the model to be delivered nationally, and
3. Situational and environmental analysis of the LSP system to understand the delivery capacity and to develop realistic logic models for each LSP at county level.

The findings of this translational formative evaluation should inform a longitudinal business plan for the national scale-up.

### R3 Ensure the Ethos of the Programme is Maintained

While acknowledging the need for translational formative evaluation to inform the final MOM model for delivery, it is imperative that the ethos of the MOM programme is maintained via translation. The ethos is underpinned by specific conditions that ultimately a) appealed to men thereby sustaining their engagement over the lifetime of the programme, and b) created a social environment that was conducive to establishing connections between men that were a catalyst for change in their lives. These conditions are:

- 1. Simplicity:** The simplicity of MOM is at the core of its success. The programme does not require sophisticated facilities or equipment. The men only need a pair of runners and freely accessible spaces within their communities that can be used to run the programme.
- 2. Level:** MOM is a PA programme designed for 'beginners' and targets inactive men. Men are encouraged to participate at their own pace and different PA abilities are catered for within the one group.
- 3. Focus:** While PA is the 'hook' that engages men onto the programme, its social nature is key to building self-efficacy in PA and sustaining men's engagement on the programme. There is no agenda towards a specific PA target.
- 4. Men only:** The programme is delivered to male only groups. Adult men of all ages are welcome.
- 5. Cost:** The 'initial' twelve-week programme is free to all men.
- 6. Structure:** The 'initial' programme offered is twelve weeks in duration, delivered on two evenings per week for sixty minutes. Workshops on diet and mental wellbeing are integrated into the twelve-week structure around weeks six (diet) and eight (mental wellbeing).



- 7. Flexibility:** While each session consists of approximately forty minutes of cardiovascular exercises and twenty minutes of strength and conditioning exercises, programme content must be flexible to meet the needs and preferences of each group. Flexibility with respect to the timing of programmes, both in terms of time of day and time of year, is also essential.
- 8. Educational Component:** Health literacy and knowledge can be poor among many men. Opportunities to educate men on 'how' to a) engage in PA appropriately, b) become PA in their communities and c) improve their overall health and wellbeing should be integrated into each session. The health information booklet can be used in this regard, as it contains the key take-home messages that can be used for reflection and to prompt change in other areas of their life.
- 9. Measurements:** Taking simple, objective measurements at the beginning and the end of the programme can both motivate men to engage and inform men about their health.
- 10. Exit Workshop:** An exit workshop should be hosted at the end of the programme to support groups to stay connected. This may prompt the continuation of MOM in another format and/or can be used as a vehicle for social prescribing whereby men may transition to community support, for example Sheds for Life.

It is evident, however, that any one local community can only accommodate one MOM programme. Therefore, once an initial twelve-week programme is complete (as per above), MOM programmes evolve to meet the needs of the group. In many instances, groups meet weekly and are self-funded. When a new entrant joins one of these existing MOM programmes, the first twelve-weeks should be offered free of charge. Consideration needs to be given by the scale-up team as to how to evaluate the experiences of these men who may not have a similar experience to the men who get the 'initial' twelve-week programme. Also, consideration needs to be given as to how to incorporate further workshops into the delivery of ongoing programmes.

## **R4 Build Capacity within the Delivery System**

The delivery system is made up of staff from a variety of sectors namely the LSP network, the HSE, the local community (partners and host organisation) and the private sector (PA tutors). In order to address the capacity building needs of each group the following actions should be taken:

1. Develop a two-day training and supporting training pack that builds competence and confidence among staff to deliver MOM. Specifically, this training should include input on gender and men's health and engaging men in their health, detail the MOM programme and the process of establishing and delivering a MOM programme as well as imparting the skills for pragmatic evaluation.
2. Establish mentoring systems whereby:
  - Staff from LSPs with experience of delivering MOM programmes can support less experienced LSPs to do so. A structure for this support should be developed in partnership with staff from the experienced LSPs.
  - Novice PA tutors can shadow experienced PA tutors and be guided on how to manage a MOM programme while promoting a positive group dynamic.
3. Strengthen the delivery network via annual MOM meetings in which LSP staff and community partners can learn from and support one another to deliver MOM.
4. Develop a PA tutor pack that details a range of sessions suitable for the MOM programme that tutors can draw upon.
5. Develop a series of thirty-minute health-related workshops (diet, mental wellbeing etc.) and material, such as video resources with processing questions in conjunction with HSE staff (Dietitians, Mental Health Officers etc.) and upskill LSP staff and/or PA tutors to deliver them. This may address the issue of availability of HSE staff to deliver workshops in the evening.

## **R5 Engage Local Champions**

Anchoring MOM programmes in local communities underpins their long-term sustainability. Community partners and host organisations will differ between communities. Engaging local champions who are committed and passionate about the programme and who want to take ownership of it (with LSP support) is of paramount importance. In fact, investment in a local community may be dependent upon the presence of a committed local champion. The role of the LSP may differ depending upon the capacity and commitment of local champions. Ideally, local champions will drive recruitment and provide a venue leaving LSPs the responsibility of making connections with community partners, recruiting and managing the PA tutor, attending the programme periodically and overseeing the evaluation. LSPs may have to support participant recruitment where local champions struggle to do so.

## **R6 Recruit Appropriate PA Tutors**

Engaging the right PA tutor is essential to the success of the MOM programme. While tutors can be supported via training, mentoring and the tutor pack (see R4) it is evident that effective MOM PA tutors:

1. Have good group facilitation skills and can create a positive group dynamic.
2. Have a wide variety of experience and can integrate games and fun activities into sessions while also supporting men to progress their PA.
3. Are adaptable and are capable of working with whatever ability and environment they meet at a given session.
4. Are knowledgeable of PA and health and can signpost participants to relevant services and supports.
5. Are community orientated and participation focused.
6. Are empathetic and demonstrate care and respect for the participants.

## **R7 Ensure the Integration of Local Services**

The integration of services is essential to the recruitment and delivery of MOM. Locally, service providers (such as the GP, pharmacist, etc.) should be made aware of the programme and be encouraged to refer clients. The HSE also has a key role in supporting the delivery of MOM:

1. MOM should be identified as a referral pathway for service users in the 'Make Every Contact Count' training currently being rolled out to all HSE staff.
2. It would be preferable for HSE staff to deliver workshops on the programme given their expertise and knowledge of referral pathways within the HSE. Integrating these workshops into their business plan may also reduce the cost of delivering MOM should PA tutors be called upon to do so. However, consistent HSE support should be given between counties to ensure the quality assurance of the programme. The scale-up team needs to consider the best mechanism for workshop delivery that can be given consistently across counties.

## R8 Develop a Systematic Recruitment Strategy for MOM

Engaging inactive men who don't typically interact with local services can be challenging for LSPs and service providers. While building capacity (R4), recruiting local champions (R5) and integrating local services (R7) will all play a role in recruiting participants onto programmes the following actions should be taken:

1. Ensure that the MOM brand, that is localised according to county/LSP colours, is developed across the delivery system and available for all marketing and promotional materials.
2. Update all educational and promotional materials to ensure that they are current and relevant to participants. Specifically, a promotional video highlighting personal stories of participants could be developed and circulated nationally to aid recruitment.



## **R9 Resource MOM Programmes Appropriately**

A variety of resources are required to support the establishment and continuance of MOM programmes:

1. Establishing a new MOM programme is considerably resource intensive on the part of LSPs who have to build relationships with community partners, source local champions, recruit and support tutors and, in some instances, support/drive recruitment. The costs associated with delivering the programmes in this study were estimated to be €3,100.
2. Supporting MOM programmes beyond the initial twelve-weeks requires resources to cover the costs of new entrants and to support participants for whom funding would be an issue.
3. Establishing and supporting MOM groups in areas of designated disadvantage poses particular challenges for LSPs and local champions and further resources are required to ensure that men from these areas can avail of the benefits of the programme.
4. Developing an equipment bank of PA materials as well as physical assessment equipment will ensure that programmes meet the needs of participants and evaluation can be conducted consistently across counties.

## **R10 Monitor and Evaluate the Scale-Up of MOM**

Up-scaling MOM ought to improve reach and equitable access to MOM and its benefits.[24] Given the investment in the national scale-up it is essential that its implementation is monitored and evaluated to ensure that there is a continuous quality improvement process that underpins and justifies public funding. Specifically, a centralised surveillance system needs to be established to oversee the:

1. Monitoring of implementation to assess programme fidelity, quality assurance, population and geographical reach, and
2. Evaluation of implementation to assess effectiveness. It is reasonable to assume that height, weight, waist circumference and time to complete one mile can be collected as part of the programme along with qualitative testimonials.

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