Men on the Move'- A qualitative investigation into the broader impacts of a 12-week community based physical activity programme.

Waterford Institute *of* Technology

INSTITIÚID TEICNEOLAÍOCHTA PHORT LÁIRGE

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A Thesis submitted in Fulfilment of the Requirements for Degree of Masters (Research)

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Statement of originality

I declare that this thesis is entirely my own work other than the counsel of my supervisors Dr. Paula Carroll and Dr. Michael Harrison of the Health Sports and Exercise Science Department in the Waterford Institute of Technology, Dr. Noel Richardson of the National Men's Health Centre, Department of Science and Health, Institute of Technology Carlow and Professor Steve Robertson of Centre of Men's Health, Leeds Beckett University. This thesis has not been submitted for an award at this or any other institution.

Aisling Keohane

Acknowledgments

I would like to thank my supervisors Dr. Paula Carroll, Dr. Noel Richardson, Prof. Steve Robertson and Dr. Michael Harrison for their guidance, support and feedback on this project.

The rich and heart-warming stories in this study were thanks to the many men who participated in the interviews and focus group. Thank you for taking part in this study and for being so open and honest about your personal experiences of life and MOM.

Thanks also to the wider MOM research team Alex Donohoe and Liam Kelly for all their support and to all involved in the MOM Partnership Network especially the local sports partners who aided me with data collection and offered great insight into the work they do as well as giving food for thought throughout the project.

Finally, thank you to my wonderful family for your support and patience throughout my studies. I wouldn't be where or who I am today without you. A special thank you to Billy; you have opened my eyes to what truly matters and showed me the true meaning of life.

Abstract

Background

Supporting men to care for their health poses unique challenges for service providers. However, when the approach is right; men are willing to engage positively with their health. Men on the Move [MOM] is a 12-week community-based PA programme underpinned by current evidence of engaging men with their health. The purpose of this study was to gain deeper insights into men's lived experience of the programme and its broader impact on their health and lives.

Methods

32 Interviews and one focus group were conducted with MOM participants. A phenomenological approach using thematic analysis was used to analyse the data that emerged from the interviews and focus group. 10 transcriptions were independently coded resulting in a list of codes. Selective coding unified the codes into a related core category. These categories were later built into a framework. Three supervisors assisted with this. Additional transcripts (n=22) were analysed using the framework to ensure consistent analysis. Any new emerging codes/themes were accounted for and considered for addition to the framework.

Results

Preliminary findings reveal 4 emerging themes*; 1) Disconnection* describes how MOM acted as a catalyst for men to [re]connect with themselves, their families and with others; 2) *The context of MOM* with regards to [re]-connection looks at the overarching factors needed for men to overcome disconnection and achieve [re]connection. This theme is a key influence in themes 1, 3 and 4; 3)*The meaning of connection* explores what the term 'connection' meant

for participants; 4) *The impact of connection* highlights the impact MOM had on the men's overall health and wellbeing as well as the wider impact of MOM on family life.

Conclusion

Findings indicate that participation in MOM has a far-reaching impact beyond the physical benefits. MOM offers men opportunities for education, acts as a gateway to other local health and social services and it is a safe starting point for men of all backgrounds to (re)engage with their health. The findings provide valuable insights to the wider development of public health interventions for priority male population groups.

Main Message

A group physical activity programme provides a platform for men to re-engage with their health.

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CSO	Central Statistics Office
HLY	Healthy life years
EU	European Union
WHO	World Health Organisation
NMHP	National Men's Health Policy
PNAISH	Brazil's National Men's Health Policy
MHW	Men's Health Week
MHFI	Men's Health Forum Ireland
NGO	Non-Governmental Organisation
PA	Physical Activity
MOM	Men on the Move
LSP	Local Sports Partnership
FFIT	Football Fans in Training
MHF	Men's Health Forum

UK	United Kingdom
MDN	Men's Development Network
HSE	Health Service Executive
GP	General Practitioner
IT	Institute of Technology
SPHE	Social Personal and Health Education
NWCI	National Women's Council Ireland
GAA	Gaelic Athletic Association
SO	Significant Other

Chapter 1 Introduction

Men's Life Expectancy and Healthy Life Years

In Ireland, men account for higher death rates than women for most of the leading causes of death across all ages and currently, have a life expectancy of 81.5 years (Central Statistical Office [CSO], 2015). Life expectancy (LE) continues to rise for men in Ireland. This improvement is largely due to lower mortality and better survival conditions for chronic diseases such as cancers and heart disease in the aging population (Department of Health, 2014). However, despite this rise in LE, a gender gap in LE between men and women is still significant at 4.4 years.

As a result of people living longer, the healthy life years (HLY) measure was designed to monitor whether these extra years that people are living, are in fact spent in good health. The main indicator currently rests with the measure of a disability free life expectancy. On average, in 2015 HLY at birth was 66.6 for men in Ireland (Eurostat, 2017). Therefore, when considering men's LE [81.5years] and their HLY [66.6], men in Ireland are living up to 14.9 years with some degree of disability.

Gender disparities in Health

While men may be more vulnerable to certain diseases and illnesses than females (Kraemer, 2000), their susceptibility, due to genetic or hormonal factors, does not account for all of the differences in the observed health outcomes (Courtenay, 2003). Biological influences are only part of the complex of factors shaping the health of women and men, so it is more appropriate to probe beyond sex differences and understand the array of factors that contribute to the gaps in LE and to establish what sub groups of men are most at risk (Doyal, 2001). Differences can be seen in the way gender interacts with all social determinants of

health. Therefore, it is important to understand the differences in men and women's manifestation, epidemiology and pathophysiology of disease and service response.

Health outcomes for men can be influenced by a wide range of factors including biology (Kraemer, 2000), life style factors [smoking, drinking, levels of PA] (Pringle et al., 2014), social factors [living and working conditions, educational attainment] (Emmons, 2000, Payne, Swami and Stainstreet, 2008, Evans et al., 2011), environment [access to services, social capital within communities, cultural and physical environments] and gender (Oliffe et al., 2012, Connell, 2005, Courtenay, 2000). These factors are not mutually exclusive but collectively contribute to men's health outcomes observed. Furthermore, their influence can change over time and in different circumstances which compounds the challenge of addressing them from a public health perspective.

Despite the increased attention and knowledge on sex and gender, there remain hindrances in effectively applying gender specific healthcare for many of the common diseases (Regitz-Zagrosek, 2012; Johnson, Greaves and Repta, 2009). If health services are to meet the needs of men and women then all gender differences need to be taken into account for the planning and delivery of care.

Social gradient of health

Across Europe there is strong evidence of an east/west divide with regards to health status (White et al., 2011). Looking at Figure 1.1 below, it is clearly evident that the LE gap for men is more pronounced in the lower income countries [Lithuania (69.2yrs), Latvia (69.7yrs), Bulgaria (71.2yrs) and Romania (71.5)] when compared with the higher income countries [Iceland (81.2), Liechtenstein (80.9), Switzerland (80.8), and Norway (80.5)] Eurostat (2015).

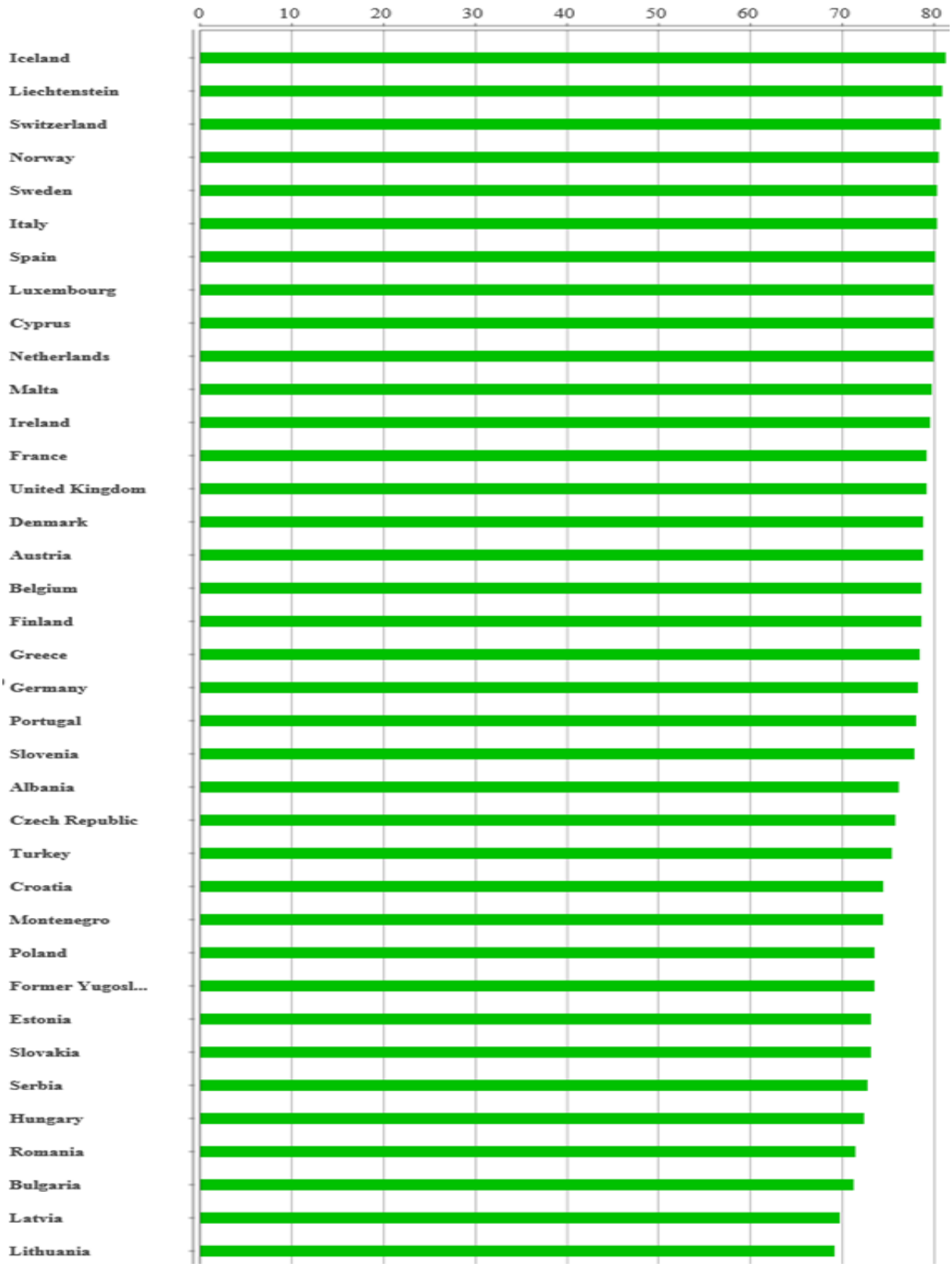

Figure 1.1. Life expectancy at birth for men in Europe EU, 37 (Eurostat, 2015)

In addition, while life expectancy for men differs from higher to lower income countries, so does the life expectancy of sub populations of men within these countries. These men have been termed the 'invisible population' (Treadwell and Ro, 2003). By focusing on a social gradient of health we know that the poorest men [deprivation index outlined in Table 1.] across all societies', in all low, middle and higher income countries, have the worst health outcomes.

Table 1.1 Deprivation defined in Ireland as an individual unable to afford 11 basic items outlined below (Department of Community, Equality and Gaeltacht Affairs, 2001)

1. Two pairs of strong shoes	6. To keep a home adequately warm
2. A warm waterproof coat	7. To buy presents for family and friends at least once a year
3. New clothes	8. To replace any worn furniture
4. A meal with meat, chicken or fish every second day.	9. A morning, afternoon or evening out in the last fortnight for entertainment
5. A roast joint or its equivalent once a week	10. To have family or friends for a drink or meal at least once a month
6. To keep a home adequately warm	11. Being left without heating at some stage in the last year through lack of money

In fact, in England and Wales, men aged 25-64 years in the higher socioeconomic groups are 3.4 times less likely to die than men in the lowest group (Office for National Statistics, 2013). Social and economic conditions [poor education and educational opportunity, underemployment and unemployment, poverty and income, social and racial discrimination and confrontations with the law] and their effect on people's lives determine

their susceptibility to illness and the actions they take to prevent illness or how they treat themselves when they become ill (World Health Organisation (WHO), 2013). Men's disadvantage in health outcomes is particularly evident in these circumstances. Evidence suggests that mortality rates for women are less affected by circumstances of lower socioeconomic status. Therefore, this would suggest that poorer men fare worse than poorer women (Cullen et al. 2016).

Following on from the points highlighted above, economic progress often translates into improvements in population health. However, in Ireland while the rapid social change of a 'modern Ireland' that resulted from the Celtic Tiger offers much to be celebrated [better wealth, overall population health etc.], economic disparities between the rich and poor increased resulting in a marginalisation of certain communities [poorest communities] (Reynolds, 2005). With regard to gender, marginalisation of certain communities is based on race, ethnicity or sexual orientation. Those particularly at risk include the unemployed, gay/bisexual, Traveller men (Lee and Owens, 2002; Evans et al., 2011; McGorrian et al., 2012). Therefore, to address health inequalities we must understand all the leading causes of death across all social groups (Law et al., 2007). Furthermore, in looking at the current (May 2020) situation regarding COVID-19, many men are losing jobs; which will mean the need to address inequalities in health is of great importance both nationally and globally.

Accessing health services

Gender differences [differences in how men and women communicate and act within society] in poor health consultation presentation rates are often most prevalent between the ages of 16 and 60 meaning that many chronic illness are not being detected. In Ireland, 9% of males and 50.1% of females aged 65 and over reported suffering from a chronic illness or health problem in 2016. This can be reflective of men's help seeking practices in Ireland

(Department of Health, 2018). It has also been found that gender differences in consultation presentation rates, noted in patients who are receiving medication for CVD or depression, are relatively small which suggests that men and women with similar conditions may have similar patterns of consulting. Therefore, health consultations and health service use do not always reflect typical gender stereotypes (Wang et al., 2013). Instead, it tells a story of the complexity that gender roles create in men and women's help seeking patterns within the context of health (McGraw, 2018). More recently the view that men's non engagement in healthcare is down to a disinterest with their health has been amended and instead focuses on more creative thinking on ways to access the men who are unreached by healthcare (Pringle et al., 2014). Instead, these men who remain unreached are seen as the result of the healthcare set up being unattractive and/or irrelevant to their value systems (European Commission, 2011).

Research has emerged in relation to 'what works' when engaging men with their health. Specifically Robertson et al., (2008), questions whether it is more effective to provide different services to men or the same services in a different way? While the answer is not clear as to what best serves men, we do know that gender is a key factor in men's late presentation to health services (Richardson, 2004).

Considering gender in an approach to men's health involves; a) providing services in different ways by providing education to service providers to adapt their service to men or b) implementing gender specific services allowing health professionals to look at how socialisation and gender conditioning can impact on how men value and manage their health within health services. Such an approach challenges service providers to be imaginative with health promotion targets and interventions. Strategies that have been found to be effective in engaging men include those that are; community based, exercise focused, focused on creating trust, safety, rapport and meaningful relationships and that are connected to positive

masculine identities (Oliffe et al., 2011; Lefkowich, Richardson and Robertson, 2015; Carroll, Kirwan and Lambe, 2014; Pringle et al., 2014).

Working towards better men's health

In Ireland, legislation is also known to be effective in affecting behaviour change. In a study by Fong et al., (2006) it was reported that the Irish legislation banning smoking (Public Health (Tobacco) Acts, 2002-2015) led to a dramatic decline in smoking in public areas such as bars, restaurants, workplaces and many Irish homes. However, as with many health policies, there is an absence of discussion regarding gender when developing and enacting legislation that needs to be considered to ensure its implementation and effectiveness. Through the analysis of the European Union [EU] report on the state of men's health, it was found that although countries developed health strategies and policies aimed at improving population health, they used a generalised approach which would seem to have disadvantages for both men and women (White et al., 2011).

The profile of men's health has been addressed on numerous occasions in recent years through policy work, men's health awareness weeks etc. both nationally and internationally creating great energy for action. As a result of this, Ireland became the first country in the world to publish a National Men's Health Policy (NMHP) 2008-2012 (Department of Health and Children, 2008). Within the Irish context, the development of a NMHP has placed a more explicit focus on men's health (Richardson, 2015). Much of the work to date has revolved around providing a vison and a framework that has enabled the area of men's health to develop. This has resulted in men's health being more visible and included as a priority discipline in the broad area of health.

Following a review of the NMHP a more focused Action Plan for men's health in Ireland was developed. The men's health action plan [Healthy Ireland-Men 2017-2021: HI-M

2017-2021] (HSE, 2017) sets out a new vision for men's health to 2021. A core element of HI-M includes a specific focus on dove-tailing other health policy areas. This process allows for the mainstreaming of men's health across a broad spectrum of policy areas. More specifically, under theme 2 the policy looks to address key lifestyle issues [PA diet, alcohol consumption and smoking] and to promote positive mental health and wellbeing by focusing on sub-populations of men most in need to put emphasis on reducing health inequalities between these sub-populations. The issue of reducing health inequalities can be seen across other policy areas with Theme 3 focusing on reducing health inequalities between different groups of men and empowering men by effectively engaging men with their health and a better use of services. MOM is a specific action that fits within these two themes.

In addition to the Irish Men's health policies, there is value in highlighting the international enthusiasm for policy, research and practice in the field of men's health. Brazil's national men's health policy (PNAISH) was published in 2009 and ran until 2011 focusing on improving men's use of primary care services. As an outcome, demand for services did increase, but the policy was seen to focus too much on men's responsibility for their health and not on the specifics of social determinants and a poor implementation strategy (Baker, 2015). Australia launched their first Male health policy shortly after titled; *'National male health policy; Building on the strengths of Australian males'* (Department of Health Australia, 2010). This policy provided practical suggestions to aid men in improving their health via six priority areas. It has been praised for its social determinants approach, recognising men's strengths and positive roles in society and focusing on specific groups of men. However, there has also been criticism of its modest scope, ambition and impact, poor governance and poor long term higher level support, lack of time frames for delivering ambitions, lack of training and no independent evaluation (Baker, 2015).

In 1994, the United States established an annual national men's health week (MHW) with an aim of providing opportunities to hold local men's health education events. This movement has broadened its aims to heighten awareness of preventable men's health problems across all ages, support men to live healthier lives, to encourage the early detection and treatment of health difficulties in males and to inspire inter and intra institutions to take action in providing better care facilities for men. MHW is now established within most European countries, the USA, Australia, New Zealand and Canada as well as many other places worldwide. In Ireland, there have been a recorded number of 15 national MHWs with themes ranging from men and obesity, wellbeing, work, PA and promoting access to services, turning words into action and creating culture change (MHFI, 2019). Since 2010, the Men's Health Forum in Ireland (MHFI) has documented the number of organisations that have contributed to the all island planning group of MHW. This number has risen from 15 in 2005 to over 60 in 2019.

Globally, there are many organisations focusing on the area of men's health; Australia's men's health forum, Canadian men's health foundation, Danish men's health society, European men's health forum, men's health forum England, MHFI, Sonke gender justice (South Africa) and the men's health alliance (USA). Global Action on Men's Health (GAMH) was launched at the start of the MHW 2014 to address inequalities across the world. There is merit for organisations to continue to focus their attention on men's health to maintain the momentum that has been gained to date and to continue progress in the area of men's health.

1.1 Focus of Thesis

The focus of T2 in the HI-M policy calls for interventions in places where men are likely to be involved or have an interest. While obesity is rising in both men and women, men

are less likely to engage in weight management programmes than women (Gough and Conner, 2006; Gough, 2007; Mallyon et al. 2010). However, PA as a setting for health promotion is increasingly being recognised as a medium to engage men (Gray et al., 2013). The use of PA is an area that promotes acceptable behaviours that are linked to socially constructed masculinities (Young, McTeer, and White, 1994; Connell, 2005). PA is a prophylactic to many of the chronic conditions affecting men (Buttar, Li, and Ravi, 2005). PA levels in men reduce with age, which is paralleled by an increase in overweight and obesity conditions (Richardson, 2004).

The HI-M (Department of Health, 2017) approach to policy implementation has been an explicit focus on gender-specific strategies related to community engagement, capacity building, partnership and sustainability. One exemplar of this approach is 'Men on the Move' (MOM); a community-based PA programme designed to engage inactive men.

1.2 Men on the Move

The Men on the Move [MOM] programme is a free 12-week community based 'beginners' PA programme for inactive adult men. MOM was first delivered by the Mayo Local Sports Partnership [LSP] and was adapted for delivery by the Donegal LSP. Considerable reflective practice from these programmes along with evidence from the literature; specifically a systematic review by Bottorff et al., (2015) and the Football Fans in Training [FFIT] programme (Hunt et al., 2014), formed the evidence base for the current MOM intervention design. In brief, MOM consists of a 1 hour structured group exercise twice a week, two facilitated experiential workshops [diet and mental well-being], a 24-page health information booklet, a pedometer for independent PA sessions, weekly phone contact, a customised wallet card to record measurements taken and a 5km celebration event at the end.

The core components of the structured group exercise are cardiovascular fitness and strength and conditioning training; however, in keeping with good practice, some flexibility was catered for between programmes to ensure that these core components were achieved in a way that best suited the participants' needs. Social cognitive theory (Bandura, 1986) underpins the MOM intervention: specifically components have been incorporated to develop self-efficacy [i.e. confidence to perform PA], to focus on outcome expectancies [i.e. positive outcomes weighed against any negative outcomes], to develop skills [e.g. goal setting and problem solving] and build social support. The programme is gender sensitised in relation to context [e.g. men only groups], content [e.g. information presented in a scientific manners, use of gadgets, competitive element] and style of delivery [e.g. participative and peer-supported, use of humour and banter]. A detailed outline of the MOM programme composition can be seen below in Table 1.2 (Carroll et al., 2018).

Description	Behaviour Change Strategy	Gender Sensitivity Strategy	Targeted Construct
Structured Group Exercise 60min twice a week			
Participants were invited to participate in their local community. Exercise sessions were led by a qualified PA co-ordinator and the programme was designed as an 'entrant programme' for those wishing to become physically active. Each session included approx. 40mins of cardiovascular fitness and 20mins of strength and conditioning. Men were encouraged to work at their own pace and to engage in independent sessions outside of the programme with their peers.	• Provide opportunities for PA • Increase social support for PA • Promote mastery learning through skill training • Improve knowledge and skill to perform PA • Promote positive outcomes for PA	• Training in gender competency for PA co-ordinator • All male groups • Participative programme • Peer-supported [encourage male banter] • Accessible time • Relating the information given to men's lives • Use of appropriate language [science of PA and weight management]	• Environment • Expectancies • Self-efficacy
Experiential Workshops 2*1 hour			
Two experiential workshops were delivered and were entitled; • 'Diet'. This was developed and delivered by a National Health Service dietician.	• Improve knowledge of a 'heathy diet' for health and well-being and capacity to do PA and manage weight • Improve knowledge of healthy alcohol	• Training in gender competency for workshop facilitators • Use of experiential methodologies whereby men are supported to	• Social support • Self-efficacy • Expectancies

• 'Well-being' with a focus on mental fitness and stress. Developed by the National Health Service and by a suicide resource officer and delivered by suicide resource officers, community mental health officer or ENGAGE trainers.	consumption and relation to capacity to do PA and manage weight • Improve knowledge of how to improve mental fitness and relationship of same with PA • Increase social support	access their own knowledge first and developed from there • Use of tangible examples for demonstrations	
Information Booklet Given to all participants in Week 1			
Provides information on PA, diet, stress management, a PA log book and useful numbers for referral	• Improve knowledge and skill to perform PA • Provide tracking mechanism for PA behaviour	• Imagery and Language of booklet • Log book provided tangible feedback that was both informative and appealed to their competitive nature to try to better their score.	• Expectancies • Self-efficacy
Pedometer Given to all participants in Week 1			
Pedometers given to all men to support them to do PA independently twice weekly. These 'gadgets' can be used to set weekly targets and also give	• Improve knowledge and skill to perform PA • Promote positive outcomes for PA	• Some men like gadgets and seeing how things work. They can motivate some men to engage in PA [goal setting and feedback on	• Expectancies • Self-efficacy

feedback to men as an educational component to the programme.		behaviour] • Competition re trying to better their score [self-monitoring]	
Phone Call/Text Message Weekly			
Men received a personalised contact weekly from the PA Co-ordinator or the LSP Co-ordinator. These contacts encouraged men to attend the sessions, praised their achievement to date and on occasion were a support for some men who wanted to talk.	• Provide feedback on PA behaviour • Reinforce problem solving for PA • Provide encouragement and help • Provide social support	• Human interaction can be important to support men to sustain engagement. • Social isolation is a reality for many men and the contact offered a connection for them to their community.	• Social support • Self-efficacy
Measurements and Wallet Card Start and beginning of programme			
Objectives measures [time to complete one mile, BMI, weigh t and waist circumference] were measured and results were given to the men in a personalised wallet card.	• Improve knowledge of health and wellbeing and impact of PA on measures • Promote positive outcomes for PA • Increase social support as measures taken collectively	• Training in taking measures for all service providers • Relating the results given to men's health, wellbeing and their lives • Use of appropriate language [science of PA and weight management]	• Expectancies • Social support

Celebration Event Once off			
A 5Km fun walk/run event in each county for participants and their families. The three MOM groups in each county come together for this event.	• Provide opportunities for PA • Increase social support for PA • Promote positive outcomes for PA	• Motivation of something to strive towards [goal setting and feedback on behaviour] • Competition between MOM groups • Self-monitoring	• Expectancies • Self-efficacy

All staff involved in MOM took part in 'ENGAGE' training, which aims to develop gender competency in the provision of health services for men (Osborne et al., 2016, Lefkowich et al., 2016). MOM, is a programme delivered free of charge to participants by community PA coordinators.

This study was part of the wider MOM project evaluation and consisted of three research areas that are depicted in Figure 1.2 below.

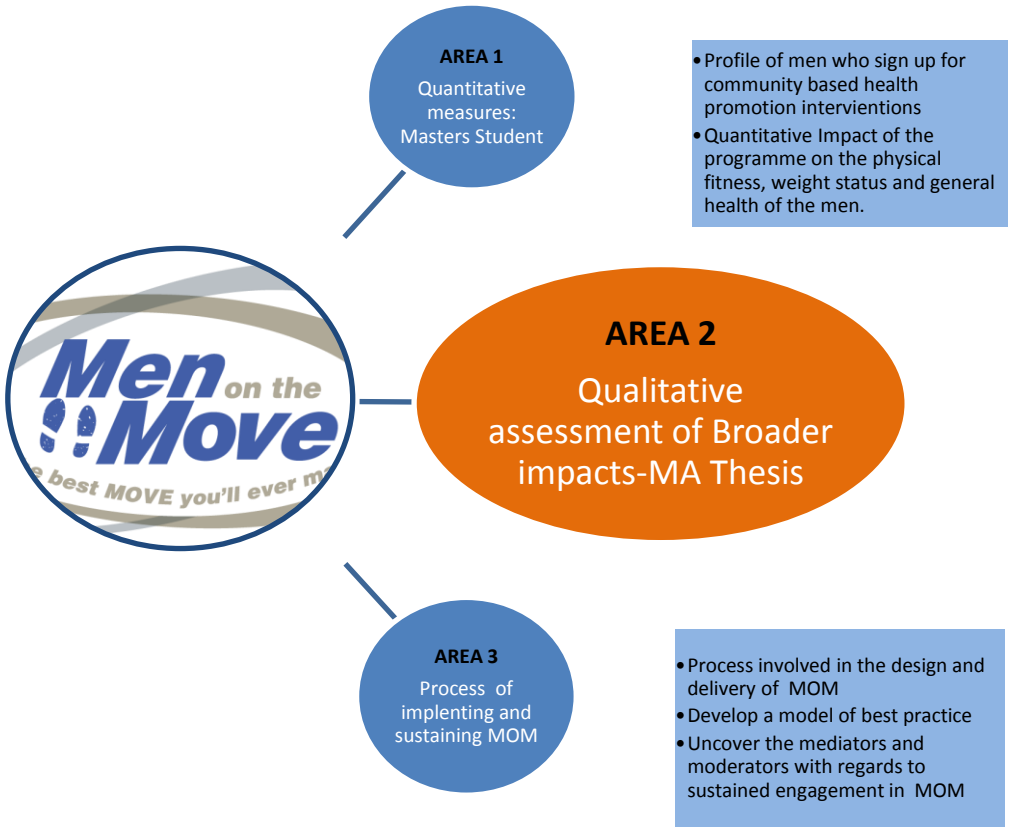

Figure 1.2: An overview of the MOM research project and its specific areas of focus.

MOM was delivered at 12 locations across 4 counties to a total of 501 men in the intervention group while a further 426 men in 4 other counties formed the comparison group in waiting. Specifically, the areas of research are the;

Area 1: The effect [biopsychosocial health measures] of the intervention was assessed up to 12 months post and compared with matched peers in 4 'comparison in waiting' counties.

Area 2: The broader impacts of MOM are the key area of interest for this study as highlighted in the diagram above. This qualitative study aims to investigate the lived experiences of participating on MOM.

Area 3: The process of delivering the programme was investigated and a model of best practice guidelines was developed.

The aim of this study was to:

Gain deeper insights into the lived experience of the MOM participants and explore the broader impact on their health and lives.

The objectives of this were to;

1. To gain an understanding of the experiences of those who participated on MOM.
2. To gain an understanding of the various ways the MOM PA programme can impact the lives of men
3. To gain an understanding of potential reasons why men might engage and sustain engagement with MOM.
4. Inform practice guidelines on the design and delivery of gender specific PA programmes with regard to influencing service provision for men.

1.3 Structure of the thesis

Chapter two comprises a literature review on five key areas that were deemed to be most pertinent to this study.

Chapter three outlines the methodology used for this study.

Chapter four provides a synthesis of the results from data analysis.

Chapter five consists of a discussion of the results from the study in the context of the study objectives and the key findings gathered from the literature review. The final sections in this chapter comprises a synthesis of the key findings, limitations and conclusions from this thesis and also incorporates recommendations for future studies and work in the area of community based men's PA groups.

Chapter 2 Literature Review

2.1 Introduction

The purpose of this chapter is to explore existing relevant literature which is pertinent to the key research aims in this study. Chapter two comprises three key sections; Section 2.2 provides an overview of men's health incorporating focuses on research, defining men's health, mortality and morbidity and the influence of gender on men's health outcomes. Section 2.3 looks at research focusing on engaging men with their health, national and international training that engages men with their health and examples of good practice in relation to men's health interventions. Finally, Section 2.4 examines the role of social connection more generally and especially in men's lives. In addition, it explores gendered relationships and the role of social networks, environments and structures on health.

2.2 'Men's health'

2.2.1 The Development of Men's Health as a Field of Research

It is somewhat ironic, that despite the traditional patriarchy and male dominance in cultures and societies where men primarily hold the position of power in the family (husband-father dominates wife and children; Heywood, 2017), and in organisations (Acker, 1990), where men are beneficiaries of higher income and social status, such advantage has not been reflected in the area of health (White et al., 2011).

In addition, despite the statistics on poorer male health, research on gender and health has focused almost exclusively on women; with much less research on men and the factors that influence their health (Barry and Yuill, 2012; Beery and Zucker, 2012). Paradoxically, for decades within the field of biomedical research, while men have been used as participants, women have often been overlooked based on concerns of hormonal cycles decreasing the

homogeneity of study populations and effects of experimental manipulations (Pardue and Wizemann, 2001). However, in more recent years a body of evidence on men's health and gender has begun to emerge (Barry and Yuill, 2012).

Three approaches have been identified by researchers in their attempts to understand men, masculinities and health (Lohan, 2007). The first focuses on the idealised version of what it means to be masculine. This approach dominates through popular portrayals of men in the media [e.g. men's health magazine], leading to the idealised notion of a masculine form with men's health having clear, but narrow, connotations with men's physical and sexual prowess and attractiveness to the opposite sex at the fore. This approach of an idealised masculinity has long been challenged as it fails to take into account the numerous types of men and masculinities within societies by only acknowledging one character of men which can also be linked to 'toxic practices' (Connell and Messerschmidt, 2005; Mackenbach, 2012; Goldberg, 1976). The second approach is broader in that it focuses on men's health and inequalities based on overall sex differences in health outcomes between males and females and also between different sub groups of men (Galadas, Cheater and Marshall, 2005). Finally, the third approach stems from critical studies on men which emerged from feminist theory and focuses on how men's lives are socially constructed and gendered by the culture in which they live. This is viewed from the perspective of 'men's health studies'. It encompasses both men's studies (adopts the perspective of men in crisis) and critical studies of men (how men are socially constructed and gendered by the culture in which they live) (Lohan, 2007).

While each approach offers an insight into men and their health, as a framework for research, no particular approach has been highlighted as being the most effective. Instead, integrated approaches; using all three intersecting ideas to gain a deeper insight into the area of men and their health may be of greatest benefit. In order to garner a more effective, nuanced and meaningful understanding of men's health with which to inform appropriate or

effective action, researchers need to look at the many other determinants of health that intersect with gender such as social class, employment, race, policy, culture and service provision (White et al., 2011).

In terms of a specific research focus, whilst there is much debate within the research in terms of what women's or men's health should focus on, recent research stresses the importance of not being drawn into a competing victims approach - men's health versus women's health. Deeper insights are needed to improve health outcomes and health services. By understanding gender relations, individuals working with men can be more informed in describing particular health issues and in developing gender-sensitive interventions that target the health issues identified. Therefore, the importance in avoiding the competing victims approach and focusing more on gender relations, allows for a deeper understanding into the connections between health and illness practices (Lohan, 2007; Broom, 2009; Oliffe et al., 2011).

2.2.2 Defining Men's Health

As a result of the focus of earlier research studies, earlier definitions of women's health tended to have a narrow biological focus on reproductive health; their function and capacity to produce and nurture children (Weissman, 1997; Connell, 2000). A by-product of the controlling focus on women's reproductive health was a focus on the male physical body and specifically the male sex organs (Connell, 2000,Thompson, 2001). As a result, many initial health approaches for men focused almost exclusively on the male body, physical vitality and risk of illness. For example, an earlier research article by Tiefer (1986) explored how sexual virility [the ability to fulfil the conjugal duty] created a feeling of sexual power seen as a requirement of the male role. Additionally, the term 'men's health' came to popular use in 1990 by focusing on terms such as 'baldness', impotence or prostate cancer (Sabo,

2000). Therefore, male impotence, testicular and prostate cancers were highlighted as matters of concern for men. However, such definitions disregarded personal experiences and accounts voiced by the men themselves (Watson, 2000). There has been much deliberation and debate about the focus and content of the definition across wide varieties of sectors from public health to men's health which are outlined below.

In 2008 Ireland's national men's health policy (NMHP) adopted a holistic definition encompassing the totality of the man not just his physicality;

> *"A healthy man is one who is empowered to experience optimum physical, mental and social wellbeing and who experiences health as a resource for everyday living"* (Department of Health and Children, 2008, p16).

This document goes on further to define a man's health issue as;

> *"An issue that can be seen to impact on men's quality of life and for which there is a need for gender-competent responses to enable men to achieve optimal health and well-being at both an individual and a population level."* (Department of Health and Children, 2008, p21).

This definition recognises that men's health status is not just a result of biological, physiological or genetic factors but influences also lie within wider social, cultural and environmental factors. The movement from biological to a broader definition of men's health is also evident in a definition by the Royal Australian College of General Practitioners (2006);

> *"Men's health in general practice is defined as the holistic management of health conditions and risks that are most common or specific to men in order to promote optimal physical, emotional and social health in the general practice setting".*

In Australia, there has been lack of consensus as to what constitutes men's health. In their national male health policy they use the label male health in preference to men's health. The reason behind this is that they recognise that males (men and boys) of all ages experience health implications and risks. In addition, they go on to outline how becoming a man depends on cultural norms around gender, roles and ageing (Department of Health Australia, 2010).

In the United Kingdom (UK), the Men's Health Forum's (MHF) first definition of men's health drew upon the WHO for inspiration for their definition of male health;

> *"Good male health is a state of physical, mental and social well-being that enables individual boys and men, and the male population as a whole, to meet the demands of everyday life and to realise their aspirations and biological potential."* (Men's Health Forum, UK, 2004).

They went on to further develop this definition by taking in to account Australia's term of a 'male health issue' to account for both boys and men and to underpin recommendations they make for future policy;

> *"A male health issue is one arising from physiological, psychological, social, cultural or environmental factors that have a specific impact on boys or men and/or where particular interventions are required for boys or men in order to achieve improvements in health and well-being at either the individual or the population level"* (Men's Health Forum, UK, 2004).

An international review in 2017 (Bardehle, Dinges and White, 2016) looked to redesign the definitions of men's health. A group of experts in the field of men's health identified 7 specific criteria (outlined below) and 15 relevant topics of which 8 were weighted (outlined below). None of the pre-existing definitions found in the literature review fulfilled these criteria;

7 Specific criteria

1) The WHO definition of "health" should be the basis for the definition of men's health,
2) The salutogenetic concept of Antonovsky must be emphasised,
3) Balance between risk and protection factors must be integrated,
4) Strengths and weaknesses of men must be considered,
5) Inclusion of joy of life and personal recognition,
6) Integration of social background and social support, and
7) Consideration of specific requirements for preventive measures and health care.

8 Weighted criteria

1) Mindfulness towards one's own health (7 points)
2) Healthy lifestyle (7 points)
3) Acceptance of one's own weaknesses (6 points)
4) Own health activities (5 points)
5) Sense and joy (5 points)
6) Health focus: salutogenesis (5 points)
7) Social class (belonging to a social class) (5 points)
8) Acceptance as I am as a man (4 points)

Therefore, the next step was for the experts to formulate a definition of men's health;

"Men's health includes those dimensions of health and disease, which are particularly relevant to men and boys. Health is a physical, psychological and social well-being that results from a balance of risk and protection factors that lie in individual, partnership-based and collective responsibility. Protection factors include a healthy and careful lifestyle, acceptance of one's own strengths, but also weaknesses as a man, sense of the experience and joy of life, social support and recognition. The risk and protection factors are unequally distributed, particularly among men, depending

on education, origin, income and occupation. Men's health problems require special preventive and care services throughout their life, which are still to be developed."

(Men's Health Expert Group. April 2013)

For this thesis, I have built upon these definitions to define a 'healthy man' as follows;

'A man who may or may not be in optimum emotional, physical, social or mental health and is personally aware of when there is a need to take a step to socially connect in a space that provides knowledge and opportunities that allows him to be himself and develop or rebuild emotionally, socially, physically, spiritually and/or mentally.'

This definition realises that many men may be experiencing optimum health; however this definition also acknowledges that a man can still be healthy if he has not reached optimum emotional, physical or psychological health. A man can experience some degree of ill-health and still function on a daily basis as a healthy man; his awareness of his health and of what he needs to do to rebuild, develop or manage his health is what allows him to be 'healthy' while experiencing ill-health. The rationale behind taking this approach to men's health lies with encounters I have personally experienced. I am aware that many of the men I crossed paths with either on a personal level or throughout my studies in men's health and nursing, had an issue with one or more of their 5 dimensions of health. However, I observed that these men were still able to live happy, healthy and/or functioning lives even though they had long term difficulties or illnesses. This was achieved by acknowledging and then tending to these areas that needed consideration. As the research question for this thesis addresses the broader impacts of health, this definition allows us to address many different types of male participants. Some, who were carrying illness or personal difficulties, but yet connected in some way with themselves and took the step to engage with MOM either to rebuild or

personally develop, as well as those who were carrying illness and difficulties but were not in a position to take action and address what they were experiencing.

This section has explored a wide variety of definitions on men's health, male health or a man's health issue. However, one continuum can be seen throughout; each definition has moved beyond the previous narrow interpretation of men's health and now encompasses a wide reach of what researchers, policy makers and service providers view as 'health' and the factors that underpin optimum health.

2.2.3 Sex, gender and men's health

The distinction between gender and sex

While sex refers to the biological differences between men and women and how one's anatomy leads to being identified as male or female, gender looks at the complex relations between social, cultural and psychological practices of being a man or a woman or what culture prescribes as being masculine or feminine (Barry and Yuill, 2012; Crawford, 2011). Gender is a socio-cultural factor that is hugely influential on health practices and outcomes (Evans et al., 2011). The terms masculine and feminine tend to look beyond categorical sex differences to ways in which men and women differ among themselves in matters of gender (Kimmel and Aronson, 2011). Carrigan, Connell and Lee (1985) highlight how masculinity is not a trait but a form of collective male practices. The notion of 'traditional' or hegemonic masculinity often revolves around specific male attributes such as independence, aggression, ambition, competitiveness, forcefulness and dominance (Connell, 1987; Connell and Messerschmidt, 2005; Mansfield, Addis and Courtenay 2005). However, individuals differ in how strongly they hold such beliefs in their actions and attitudes.

Gender role beliefs are both descriptive and prescriptive in that they indicate how men and women should act (Wood and Eagly, 2009). Traditionally gendered roles have been assigned to individuals as defined by their sex. These gendered roles are socially constructed from stereotypes and norms associated with what it means to be a man or a women (Addis and Mahalik, 2003). Examples of gendered roles include women as homemakers and men as breadwinners (Oliffe et al., 2011). Much of the pre-feminist work treated gender roles as complementary and necessary.

Changing gender roles

Connell (2002) states that gender is a fluid and dynamic structure, therefore, there is no one masculine form but multiple masculinities based on different cultures and periods of history that construct different masculinities (Connell, 1995). Kimmel and Messner (2007) go on to explain how men are not born, they are made, and aspects of gendered identity are shaped through interaction with culture and the environments in which men live, work, play and pray. Masculinity therefore is not fixed or rooted in the body but instead is shaped through the interplay of bodies, social practices and social situations and settings, which can have particular implications for men's health (Connell and Messerschmidt, 2005).

Although research into masculinities allows for a more nuanced look at the different perspectives and experiences between men and women but also sub populations of men, such practices also have to be looked at within our social and economic contexts (Bates, Hankivsky and Springer, 2009). Therefore, masculinities are highly dynamic as cultures and societies are forever changing [expectations change thus in response genders also evolve]. Such changes are often brought about by critical transition points in life or through policy and legislation.

Furthermore, gender roles can be influenced or changed by life transition points such as fatherhood, retirement, age and illness (O'Brien, Hunt and Hart, 2009). Scholars have found that generational differences in gender attitudes and practices, in addition to structural changes in society can challenge masculinities (Connell and Wood, 2005). Generally when this occurs, a new hegemonic masculinity emerges. This new hegemonic masculinity then becomes more powerful due to its ability to adapt and resist change (Connell, 2005). These changes can be identified as gender-role re-evaluation which is the process whereby men and women assess maintain and redefine their thoughts, feelings, and behaviours around masculine, feminine and intersexual roles (O'Neill, 2013). For many years, changing social patterns and norms have had an influence on traditional roles. With men's roles changing, so do their masculinities.

One area of masculinities which hasn't received much consideration is the idea of caring masculinities. These are masculine identities that reject the more dominant masculine identities [hegemonic] and focus on values such as positive emotion, relationality etc. Elliot (2016) believes that these caring masculinities are a result of men engaging and involving themselves in gender equality. Patterns of the male providers and female nurturer are gradually wearing away leaving fathers in contemporary Ireland with increased responsibility of being more 'hands-on' (McKeown et al., 1998). At least 20,747 men in Ireland consider themselves stay at home dads. This figure is a 15% increase on the last intercensal period. However, men still only represent 6.8% of all Irish homemakers (CSO, 2016). Wall and Arnold (2007) note how the role of fatherhood is a secondary occupation for most men that arises as a result of losing their primary role as financial provider for their family. However, there has been a steady increase of women taking up employment outside of the home (CSO, 2012) resulting in mothers contributing to a greater share of the household income (Raley, Bianchi and Wang, 2012).

Therefore, during a recession, where men may have suffered reduced working hours or unemployment, fathers were more likely to participate in both home production and child care which maybe reason for the resultant increase in stay at home fathers in-between the censuses stated above. Therefore, the role of a stay at home father was socially constructed and forced. The majority of stay home fathers report staying at home because they either cannot find work or cannot work due to illness/disability (Chelsey, 2011). However, the proportion of men stating that they are at home to take care of their family is increasing, suggesting that while factors like job loss or illness may still be critical in the decision to stay home, men may also choose to do so. With this increasing acceptability for men to stay at home, masculinities are also adapting. Egalitarian masculinity incorporates both men's employment and responsibility for children (Shows and Gerstel, 2009). In a study by Chelsey (2011) men felt that by being more involved in parenting they were more nurturing, better communicators and could identify better ways to deal with challenging situations. In addition to men staying at home, there has been a shift in what normally would have constituted a women's career. Men and women are now taking up gender atypical careers (Hakim, 2000).

In an article by Apeso-Varano, Barker, and Hinton (2015) the authors outlined men's accounts of how being a grandfather or an older man was seen as less macho and more caring. It was thought that these men, most of whom suffered from depression, successfully reformulated their masculine self to better negotiate less suffering and a better way of living. As such, for these men, an outcome of being more caring translated into self-care. This highlights the idea of a spectrum of masculinities, where one end represents the highly traditional masculine characteristics [macho] and the other represents more caring masculinities. In other words, they are an inverse of one another.

To compensate for the many emerging masculinities, researchers argue for new approaches to thinking and theorising about masculinities, and proposed the notion of

'inclusive masculinities' (Anderson, 2009) to account for the growing acceptance of behaviours that were once stigmatised under hegemonic masculinity; for example, more emphasis on male grooming, appearance and the presentation of one's self (Sturrock and Pioch, 1998). Inclusive masculinity theory adds to Connell's (2005) hegemonic masculinity theory in a society where areas like homosexuality are more accepted. Hybrid Masculinities on the other hand refer to how men are selective in what they incorporate from performances and identities associated with marginalised and subordinated masculinities and femininities (Demetriou and Demetrakis, 2001; Messner, 2007; Messerschmidt, 2010).

However, 'inclusive' masculinities may not be experienced equally across all sections of society particularly in lower socioeconomic communities or certain ethnic groups of men that align to the more traditional hegemonic masculinities as first described by Connell (Anderson and McCormack, 2018).

Connell (1998) argues that since different groups of men are differently placed in gender relations, multiple masculinities are likely to be produced. Therefore, this contributes to the diversity of expectations men place on themselves with regards to the management of their health as well as the diversity of health related behaviours that may or may not be helpful to address health problems experienced. This further highlights the importance of looking beyond sex differences and instead focusing on the disparities within different sub groups of men and in examining the 'relations' between different types of masculinities (Williams and Collins, 1995).

Gender and Men's health

The health-related beliefs and behaviours and other social practices that men and women engage in are their way of showcasing masculinities and femininities. As such, masculinity as a dynamic construct is therefore influenced by gender (Courtenay, 2000).

Male roles such as independence, being tough and strong may negatively affect men's experiences and behaviour's toward illness or may also act as a barrier to men appropriately accessing and using health services (Connell, 2000; Lee and Owens, 2002; Seymour-Smith, Wetherell and Phoenix, 2002; MacDonald et al. 2004). Courtenay, (2003) goes on to state how poor health-seeking behaviour results in poor health care use among men, which limits their access to information and restricts opportunities for health promotion interaction and primary care use.

The complexity of factors influencing men's health and health keeping behaviours heightens when one considers critical transition points [for young men; moving away, relationships breakups (Grace, Richardson and Carroll 2016), for adult men; retirement, unemployment, relationships changes (Department of Health and Aging, 2010)] in men's lives that typically coincide with men feeling more personally responsible for their own health (Richardson, 2010).

Research highlights the potentially damaging effects of the gender stereotypes that society reinforces. These stereotypes generally lead to boys feeling reluctant to look for help for health issues and misrepresent that girls will always wilfully seek help (Mac Lean, Sweeting and Hunt, 2010). However, Williams (2003) states that the main reasons for an increasing interest in men's health is that men do care about their health but find it difficult to express such fears or distress due to compounding factors like social constraints. It is important to challenge the notion that men are disinterested in their health. Increasing evidence suggests that men will and do engage with their health when the intervention is appropriately gender-sensitised (Robertson et al., 2013).

Current research suggests that research into gender and health should include intimate, social and family relationships in order to unveil the influence generational and

specific life course transitions might have on one's health and illness (Oliffe et al., 2011). Over the course of a lifetime, men experience gender role transitions resulting in a moulding of their masculinities and femininities (O'Neil and Egan, 1992). O'Brien, Hunt and Hart (2009) suggest that men typically re-evaluate their health practices following illness, fatherhood and aging. There are often exceptions to men's reluctance to seek help for fear of threatening their masculine identity. These come under the 'hierarchy of threats' to ones masculinity where men choose to look after their health to preserve rather than threaten their masculine identity.

In a study by O'Brien, Hunt and Hart (2005) two scenarios were found where participants spoke of these 'hierarchy of threats'. Firstly, it was found that in occupations [fire fighters] which provide men with highly masculine identities that consulting for trivial problems or to prevent illness was an important behaviour to maintain health and thus continue to work. Secondly, regarding participants' sexual performance, those who had issues would rather risk their masculine status by consulting about their sexual health problem rather than not be able to have sex which was seen as a greater threat. Furthermore, following illness, men usually reflect on masculinities and health. Men who have experienced life threatening illness meant that preservation of their future health took centre stage over re-evaluating their masculinity. In addition, these men were sometimes critical of other men's general reluctance to seek help. In O'Brien, Hunt and Hart (2005) examples were given of how these men acted to self-care in order to preserve their masculinity i.e. not working and not being able to perform sexually were greater threats to their masculinity than being seen going to the doctor. It is argued here that these men re-evaluated their masculinity in light of their life threatening illness and regarded seeking help as preserving their masculinity because it preserved their life. This re-evaluation of their masculine alliance resulted in men being more responsible [and therefore manly] for their health. Oliffe (2005) also highlighted

the fluidity of masculinities as well as the relationship between sex and gender and its impact on a man's masculine identity. In his study he explored the effect of impotence on a man's masculinity, sexuality and intimate relationships.

Fatherhood is often beneficial to a man's health (Bartlett, 2004). Throughout fatherhood men generally feel encouragement to increase their connections with family, participate in service-orientated activities and put in more hours of paid labour. However, this is usually at the expense of time they would have previously spent socialising (Knoester and Eggebeen, 2006). Men who adhere to the masculine trait to protect and be strong for others are brought to the forefront through family connections. Similar to the findings stated above, the father role enables men to avoid health risks while positioning help seeking as a wise, rational action in re-establishing self-control. This is seen to revolve around men's desire to be good partners and fathers adding a certain amount of self-pressure to avoid inflicting pain on their family through risky behaviours (Oliffe et al., 2012). The health effects of fatherhood are often mediated by number of children, role of competency and lifestyle (Bartlett, 2004).

The relationships between masculinities and men's behaviours appear to be more complex in that in addition to health risks some aspects of masculinities were found to be associated with health promoting behaviours. Therefore, the recent research has looked beyond the disadvantages or the potentially damaging effects of gender stereotypes and is considering the use of traditional masculine stereotypes [traditionally masculine settings [sports grounds], casual and trusting approach etc.] in an attempt to engage men with their health (Levant and Wimer, 2014).

Incorporating Gender roles into policy and legislation

Current evidence to focus on fatherhood is at the forefront of many governmental agendas and policies such as The Brazilian National Policy of Integral Health Attention to

Men (Chakora et al., 2015) and the NMHP (Department of Health and Children, 2008). The review of the NMHP (Baker, 2015), found that the implementation of father inclusive frameworks across government departments in terms of policies and practices, was limited with the exceptions of the improvement in paternity leave. Nordic countries [Sweden, Norway, Iceland, Denmark and Finland] were among the first in developing paid paternity leave. When the Nordic countries revised their family legislation in the 1920s–1930s, there was an emphasis on how men and women should be equal with respects to their children and family life. As such, paid paternity leave was first introduced in Sweden in 1974, Norway in 1978, Iceland in 1981, Denmark in 1984 and Finland in 1985 (Haas and Rostgaard, 2011; Valdimarsdóttir, 2006). However, despite the joint entitlements to parental leave, mothers continued to use a greater share of the parental leave with fathers taking little advantage of it (Leira, 2006). Because of this, in the early 1990s new developments looked to allocate part of the paid parental leave to fathers to ensure that more men took parental leave. Norway was the first country to enact this father's quota in 1993, followed by Sweden in 1995, Denmark in 1998 (abolished in 2002) and Iceland in 2000. While Finland decided in 2003 to provide fathers with an additional 12 days leave if they used 12 days of the initial parental leave. In 2010, Finland extended the number of bonus days to 24 days. Although, initially these bonus days could only be used at the end of the paid parental leave and depended on the mother's consent but this was changed in 2013 to give men an individual, non- transferable right – a father's quota (Salmi and Lammi-Taskula, 2013)

Today, all the Nordic countries have extended the total leave period. Denmark increased its leave from 30 to 50 weeks. In Iceland the number of weeks was increased ensuring each parent a 13-week quota and an additional 13 weeks which the parents could divide between themselves. In Norway, the total period and the father's quota has gradually been increased and in 2013, 14 weeks were reserved as a quota for each parent but has been

reduced to 10 weeks from 1 July 2014 (Brandth and Kvande, 2015). In Sweden parental leave is 69 weeks. Parents are each entitled to 240 days but they are free to transfer their rights to the other parent except for an eight week father's and mother's quota. The last change in length was in 2002 when the leave was extended by 4 weeks. In 2008, a special equality bonus was enacted for parents choosing to use the leave equally (Duvander and Lammi-Taskula, 2011). Thus, all of the countries have extended the total period available. All countries have extended the father's quota except Denmark where it was abolished and have increased the number of weeks specifically for fathers.

However, emphasis on a father's quota is different among the Nordic countries. While Norway, Sweden and Iceland have developed towards equal quotas for both parents, Finland has only recently changed the entitlements of fathers to a quota. Denmark is the only Nordic country that does not provide fathers with a quota.

Ireland too is progressing paternity. The paternity leave and benefit Act 2016 provides two weeks paid leave to fathers. Ireland is now on a par with the UK, Australia and Denmark but behind Spain at fifteen days, twenty days [ten of which are compulsory] in Portugal and three months in Iceland. However, as stated above, many countries have evolved their paternity leave with progress from paid paternity leave to extended bonus days to extended weeks, therefore; this may highlight the possible implications for male roles in Ireland going forward and the great evolvement of gender equality.

Intersectionality of gender and social determinants of health

As mentioned previously, health outcomes for men are not a result of a single influencing factor but rather reflect a complex interaction of environmental, social and cultural factors. When we take an intersectional approach to gender it suggests that socially defined and socially meaningful characteristics are inextricably linked and therefore cannot

be fully appreciated as independent factors and cannot be fully appreciated as factors that operate (Cole, 2009; Warner and Brown, 2011).

Therefore, when examining health outcomes, research should not focus explicitly on biological factors. The many other factors that impact on men's health include lower educational achievement, unemployment, poor living conditions, income inequalities, and lower economic demography within communities. Furthermore, the literature states that we cannot understand issues such as aging, sexuality class, race or ethnicity without continually looking to gender, since gender relations are a major component of our social structure (Evans et al., 2011). This is mirrored within the study of intersectionality which "moves beyond single or typically favoured categories of analysis (e.g. sex, gender, race and class) to consider simultaneous interactions between different aspects of social identity as well as the impact of systems and processes of oppression and domination" (Hankivsky, Cormier and Merich, 2009; Collins, 1990; Crenshaw, 1989; Hooks, 1990). White et al., 2011) states that we can achieve and create more efficient targeting resources by focusing on a more detailed look at how sex links with the intersectional factors (such as age, ethnicity, disabilities and sexuality) and the wider social determinants of health.

2.3 Engaging men with their health

Gender & Help seeking

As discussed above, hegemonic masculinities can have an effect on both protective and risk behaviours contributing to a man's health outcome and can be affected by a broad range of factors (Oliffe et al., 2012; Schofield et al., 2000; McKay et al., 1996). Earlier attempts to explain such health disparities between men and women, focused on men and women's engagement with health services, with women generally engaging more regularly with current health services thus adopting the 'sick role' more easily (Maclean, Sweeting and

Hunt, 2010; Robertson et al., 2008). Maternal and child health have been and still are unavoidably large components of women's health care (Weissman, 1997). As a result, women's role in childbearing may have typically exposed women to the healthcare system making them more familiar with procedures and language used when discussing or presenting a health issue. However, a change in gender roles [e.g. more fathers adopting child care roles] as discussed above may have an impact on men's health keeping behaviours as a result of gaining new empathetic abilities, better self-confidence (Plantin, 2007), developing less negative health behaviours (Umberson, Crosnoe and Reczek, 2010) and participation in pre and post-natal courses (Madsen, Link and Munck, 2002). Despite an increase in involvement, numbers are still low regarding fathers participation in their child's health care and visits to health care centres in comparison to mothers. However, when services communicate directly with fathers, and encourage participation for the sake of their child, fathers do become actively engaged with their child's health care (Fletcher and Dip, 2008). This further highlights the need to actively involve men to engage in their health.

Given the impact of gender on male health, engaging men in their health can be challenging for service providers and men's social networks. Section 2.3 will explore current evidence of the engagement process. Specifically, looking at the need to build capacity among service providers, how building capacity for service providers aims to support and add to the knowledge of practitioners to enable them to engage men with their health through more attractive services and settings and better communication and marketing of services. Marketing health to men; what it is and why does it need to be tailored to men. Osborne et al., (2016) study focuses on 'The Hook' which looks at highlighting appealing factors of a programme to entice men to engage with their health. Evidence on interventions that used specific hooks will be explored as well as identifying the commonality between them. All this evidence on interventions engaging men will provide examples of good practice of public

health interventions and how current evidence can be integrated in an intervention to engage men with their health.

As mentioned in section 2.2, research has recently begun to highlight the deficit in gender sensitive service provision. Therefore, men have often been seen as 'the problem' by service providers or that they are 'hard to reach' (Clark, 2011; European Commission, 2011; White et al. 2011; Withall, Jago and Fox, 2011). Furthermore, it has been highlighted how the skill of the health service providers can sometimes be to the detriment of men's engagement. In the past, there was a paucity of literature exploring the views of health service providers, however, more recently such literature has begun to emerge.

2.3.1 Training & support for men's health practitioners

Recommendations from the NMHP & HI-M to capacity building in men's health

In a study by Grace, Richardson, and Carroll (2016) there was evidence of how service providers felt torn between the desire to support young men and despair in not knowing how. The despair was highlighted by what they perceived as a lack of expertise in an area that was already seen as providing a scarcity of services. This literature details how health service providers feel ill-equipped to deal with men's health issues appropriately. Furthermore, this study looked at the factors that support or inhibit young men to engage with services. The findings indicated that in many cases young men are unwilling to engage with services and highlighted the need for more strengths based and gender sensitive services and programs that account for the broader contexts of young men's lives. The study identified a need to work with service providers and support them in exploring more specifically, the world of young men and the context of their lives by providing an explicit focus on opportunities that exist for engagement and the process in doing so [the 'whys' and 'how's']

In 2008, the NMHP (2008-2013) called for more specific training and supports for those at the frontline of primary care services that engage or strive to engage with men (Department of health and children, 2008). As a result, the emphasis in the area of men's health is now focusing on better approaches to support practitioners to effectively engage men in their health and ultimately to enable them to adapt current services to be male friendly or implement new gender specific interventions.

Throughout Ireland, two training programmes [ENGAGE and the Men's Development Network (MDN), 7 questions] have been specifically focusing on gender and men's health (Baker, 2015).

ENGAGE training programme

ENGAGE, Irelands national men's health training (Richardson et al., 2013; Fowler et al., 2015) is a programme set up to meet the recommendations of the NMHP (2008-2013) to develop training courses on men's health to those working in health and social services (Department of Health and Children, 2008). MDN men's health programme is also meeting the recommendation of the NMHP by delivering key health and wellbeing themes with and on behalf of men as well as community development and training. This is still on the agenda for HI-M 2017-2021 (Department of Health 2017) under theme 3 which calls to; build capacity with those who work with men and boys to adopt a gender competent and men-friendly approach to engaging men and boys at both an individual and an organisation level (Department of Health 2017, P13).

ENGAGE has 6 units with the development of 7 and 8 underway. Units 1-5 are delivered as a 1 day course aiming to give individuals a better understanding of; the broad determinants of men's health, guides to health consultations, best practice guidelines in working with and engaging men, the barriers to health and how to set up and support group

work with men [included in the full days training only]. Following the findings mentioned above from (Grace, Richardson and Carroll 2016) a new unit [unit 6] was added to the ENGAGE training titled 'connecting with young men' (Fowler et al., 2015). This training unit specifically focused on the engagement of building relationships with young men to directly meet the gap identified in the study. It is evident from the evaluation of this additional unit, that the training has been positively received whilst also demonstrating its importance of supporting providers to engage more effectively with young men (Grace, Richardson, and Carroll, 2016). Unit 7 focuses on middle aged men and suicide and finally, unit 8 is under development and will focus on farmer's health. Findings from the first evaluation of the ENGAGE unit 1-5 training found significant improvements in participants self-reported level of knowledge, level of skill and capacity to identity men's health needs and to engage men with their health (Osborne et al., 2016). The findings suggest that as a programme it succeeded in improving service provider's capacity to engage and work with men and their health up to five months post training while also integrating their learnings into their work place. Consequently, improving the service provider's ability to engage with men may result in increased use of services by men thus improving their overall health outcomes (Osborne et al., 2016). Regarding international training on men's health, a review carried out by Baker (2015) found no equivalent training programme to ENGAGE in any other country.

The MDN

The MDN has played a significant part in the delivery of many men's health workshops to General practitioners (GP's), public health nurses, social workers and in schools, colleges, prisons and to health NGO's. Through their annual 'National men's health training' and 'development summer schools', the MDN has trained over 300 men's group leaders and members over the 5 years the NMHP was running. More specifically, the Health Service Executive (HSE) funded the MDN to develop a training manual for a programme on

Traveller men's Development. In addition, MDN has been working with Travellers' agencies [Pavee Point and The Roma Centre] to develop a training programme where by Traveller men engage their peers in health. MDN has delivered men's health workshops to GP's, public health nurses, social workers and in schools, colleges, prisons and to health Non-Governmental Organisations (NGO's) in an attempt to educate them more on how to effectively work with men.

Research and other activities

In addition to progress in training, research into men's health specifically has been on going. The National Centre for Men's Health at Institute of Technology (IT) Carlow has set up a specialist research centre on men's health. In Waterford IT, there has been research into men's health issues as well as a Health Promotion BA (Hons) which offers a final year elective module on gender and health. Waterford IT also offers training on gender and health to trainers of teachers and other workers who deliver Social Personal and health education (SPHE) and work with young men. The National women's council Ireland (NWCI) is currently seeking to integrate men and gender into training programmes for nurses and midwives. In relation to content on academic curriculum, with the exceptions of the above, there are currently few modules on gender and men's health integrated into the courses of health professionals.

Furthermore, other institutions have been at the fore for producing resources for the better engagement of men with their health. In 2012, the HSE and the NWCI published *Equal but Different: A framework for integrating gender equality in Health Service Executive Policy, Planning and Service Delivery.* This was followed in 2014 by three complementary resources. The first two, *Gender Matters: A User Friendly guide to Gender Mainstreaming* and *Gender Matters: Training Handbook on Gender Mainstreaming in Health* was followed

by *Gender Matters: Toolkit for implementing gender mainstreaming in the health sector.* These publications provide excellent resources for furthering training in the area of men's health and have already been used in training programmes for nurses, midwives and in the future GPs throughout Ireland. In addition to the training programmes listed above, four partners [IT Carlow, Waterford IT, MDN, HSE (health promotion department)] and support from MHFI collaborated to launch a comprehensive training day focusing on men's health [ENGAGE] in 2012.

2.3.2 Effectively engaging men with programmes & services

By applying gender specific programmes and services to men, service providers can increase the participation of men. Research suggests a number of best practice guidelines when engaging men with health programmes and services all of which will be detailed below.

The appropriate approach

Effective communication is essential when engaging with human beings on any topic. In order to communicate effectively with men i.e. exchange information via speech, written text or another such medium, it's important to understand how men communicate. There is a body of emerging literature that explores language and masculinity and asks whether there is a masculine language and whether men use language to express their masculinity. This is pertinent when communicating with men in order to engage them in their health and will be presented here.

One of the most successful areas within these studies is on how individuals use language to express gender, with almost every characteristic of language linking to gender from small sounds to widely characterised discourse strategies (Kiesling, 2007). Numerous recent studies have found that generally, men prefer a male approach that comprises an

informal based conversation with tones of humour, boisterousness and a harsh or derogatory language to relay stories, fears and anxieties (Keohane and Richardson, 2017; Grace, Richardson, and Carroll, 2016; Knight et al., 2012). Additionally, when engaging with men within a primary care setting, Smith et al., (2008) found that men valued the adoption of a 'frank approach', the demonstration of competence, humour, empathy and a prompt solution. If a health professional uses medical jargon when consulting with a man, this emanates a power struggle with the man, therefore, breaking down the likelihood for engaging further with the service.

Health literacy is concerned with the knowledge and competences of persons so that they can meet with the demands of health in a modern age (Kickbusch and Maag, 2008). Understanding predictors of health literacy is crucial given that this is a well-known predictor of poorer health outcomes. It is also important for researchers and health promoters to adapt information materials, services and design health information programmes (Frisch et al., 2011; Berkman et al., 2011). Poor literacy can have implications on accessing services (Coulter and Ellins, 2007; Pignone et al., 2005). Adherence to masculine norms, such as self-reliance, has been thought to predict lower health literacy. The resulting lack of engagement with health-care services and the shame that accompanies illness and distress may also be related to poorer confidence in a man's ability to effectively communicate with health-care providers which are linked to certain aspects of health literacy. Therefore, it can be argued that some masculine norms (self-reliance) may be incompatible with health literacy (Milner et al. 2019).

The many factors listed above highlight the importance of considering health literacy with regards to how we portray health promoting messages to men.

'The Hook'

There is a paucity of studies that specifically address the question of how best to promote services to different groups of men. It is important to market health more specifically to men. It has been demonstrated that because of men's reluctance to seek help [as discussed in section 2.2] marketing services in an appropriate manner which is congruent with traditional male gender roles may help with men's reluctance to seek help (Robertson and Fitzgerald, 1992).

The appeal of a programme or intervention to men, can be described as 'the hook' and can often be seen as a set of measures that are closely associated with a man's interests, and thus are used to get men more involved in their own health (Department of Health and Children, 2008). Numerous health promotion interventions have been built on presumptions about how hegemonic masculinity shapes health behaviours (Robertson, 2007). For instance, initiatives have framed men's health in terms of mechanical objects, such as cars, requiring tuning (e.g., Banks, 2002; Cuthbertson and Callaghan, 2003; Doyal, 2001), or offering work-friendly hours (e.g., Watson, 2000) etc.

Fathers are often more willing to engage with a programme that is linked to or supports their role as a father [putting their child(ren) over themselves]. The Fathers wellbeing project [Salford Dadz (Robertson et al., 2018)] is a project that aims to find new ways to improve the wellbeing of local men, specifically fathers and thus improve the wellbeing of their children. This programme itself was a hook as it specifically focused on engaging fathers (and their children); as well as having a very positive impact on the men's partners and the wider community (Hanna et al., 2016).

Furthermore, men often seek and accept help after or during experiences of crisis such as relationship break ups etc. Therefore programmes targeting such men should emphasise how getting involved in the programme will enable them to learn from the situations of other men (King, Sweeney and Fletcher, 2005). A movement which supports some men through

crisis experiences is the Men's Sheds movement. Throughout Ireland, Men's sheds has become a prominent feature within many communities (Lefkowitz and Richardson, 2016). Men's Sheds started as an Australian initiative that looked to work with rather than change men's traditional masculine traits by reinforcing the value of camaraderie, group activities and productivity and a sense of achievement (Oliffe and Philips 2008). In a study carried out by Wilson, Cordier and Wilson-Whatley (2013) they found that while the men came from a wide range of occupations they all shared the commonality in a long working life and were now retired. The lack of occupation was described as a vacuum or void in their lives. Many had a desire to give back to communities especially now they had spare time and Men's Sheds provided them with the opportunity to do that. In looking at the successful men's shed movement, their success is based on engaging men in practical, social activities as men's reason for engagement with services and starting friendships are typically built around 'doing' (Golding et al., 2007). An Irish study investigating men's experiences of Men's Sheds and the relationship between their involvement and their wellbeing found that participating in the sheds contributed positives to men's overall wellbeing (Lefkowitz and Richardson, 2016)

Furthermore, we know men are more reliant on exercise than nutrition to maintain a healthy weight (Roberston et al., 2013). Therefore, programmes associated with sport or PA has proven to effectively engage men. While sport is associated with winning, medals, performance, and can be competitive at numerous levels etc. PA looks at the daily activities an individual can do to keep body and mind well. These two distinct areas have been combined in recent years for the purposes of effectively engaging men with their health. While a sports club primarily exists to promote sport, there are often many opportunities missed to promote health (Kokko, Kannas and Villberg, 2006). However, in more recent years men's willingness to do PA has been at the forefront for health promoters. Programmes

that use PA as 'hook' include but are not limited to; a) The GAA [Gaelic Athletic Association] is the largest sporting organisation in the country, holding up to one million members hence presenting an ideal setting for health promotion. Stemming from the wide reach of the GAA is the GAA healthy clubs project which was developed to support more structured health promotion activity in the GAA club setting. The Healthy Clubs Project aims to provide training and guidance to help clubs deliver improved health promotion and to incorporate health in the day to day workings and overall philosophy of the club (Lane et al., 2017), b) The Football Fans in Training [FFIT] programme which aims to help overweight men who are predominantly football supporters, to lose weight by increasing activity levels and improving their eating habits. This study looked to recruit men through different strategies such as website advertising, for city-based clubs and leaflets to men on the season ticket holder database in smaller clubs. However, others heard from third party sources or read it in the local and national newspapers and c) Premier league health club which is a 3 year programme of men's health promotion. It is delivered through sixteen English Premier League clubs. All three will be discussed in greater detail below (Hunt et al., 2014).

The Setting

Many programmes focus on men's familiarity with the setting and ease and comfort associated with that. Furthermore, men typically prefer community based setting or sports clubs to health care settings to improve their health (Carroll, Kirwan and Lambe, 2014; Hunt et al., 2014). One commonality that exists among the initiatives mentioned above, is the location used to base the interventions. Be it in a safe, community based setting [men's sheds, Salford dadz] or a familiar sports ground [FFIT, Premier league health, GAA healthy clubs], all men were offered a setting outside of the usually health service and instead were provided with a familiar location. The literature supports this by stating how the setting of a health

intervention has a considerable effect on its ability to engage the target group (Witty and White, 2011).

As such, improvements have been made on this front to increase more community based or sports based health initiatives to better engage men. Many programmes look to provide outreach services in locations frequented by men (e.g., Lloyd, 2002), and targeted men at their place of work (e.g., Holland, Bradley, and Khoury, 2005).

Findings from the second evaluation of the 'Salford Dadz' programme acknowledged how the men involved describe how it provided them with a safe setting and environment in which they can be socially involved with other men. This resulted in opportunities for personal sharing and for recognising that many of their own issues are common among other men. (Hanna et al., 2016).

Sport settings have been effective in engaging male fans with PA programmes. FFIT draws on professional football clubs, this programme was able to target men who are usually deemed 'hard to reach' or those at a higher risk of ill health. The programme consists of an initial intensive 'weight loss' phase [12 weekly, 90 minute sessions delivered free of charge to participants at football stadia by club community coaches] and ongoing 'light touch' weight maintenance support to 12 months. Educational classes included a dietary component. FFIT incorporates 2 PA components; 1) pedometer based walking programme and 2) in-stadia PA sessions. Retention throughout the programme was good. At the 12 week mark, participants lost significantly more weight than their comparison group, maintaining this up to 12 months. In addition many reported sustained change in self-reported PA and diet. In the premier league, most of these health interventions were delivered in /by the clubs. Men attended match day events and/or weekly classes involving PA and health education. The programme was generally targeted at men 18-35 who had never used their GP or health

service for support and information. The effects of the programme were assessed and indicated that they were successful in engaging men with unhealthy lifestyles, and multiple risk factors as wells as a third of men who had never attended a GP or health service. Improvements were made in lifestyle behaviours. In addition to health improvements men viewed this programme as acceptable which meant priority groups such as men from black and ethnic minorities made up one third of the overall group (Pringle et al., 2014).

The settings outlined above typically provide health practitioners with large groups of men who have unhealthy lifestyles but do not engage with primary health care services (Mc Coy, 2013; Mason and Holt, 2012). Additionally, when engaging with men in these settings Smith et al., (2008) found that men valued the adoption of a 'frank approach', the demonstration of competence, humour, empathy and a prompt solution thus adding to the atmosphere. It is well documented that strategies that have been found to be effective in engaging men focus on creating safety, trust, building rapport and meaningful relationships with other men and personal and to foster peer-support (Oliffe et al.,2011; Lefkowich et al., 2015; Grace et al., 2016). Therefore, coordinators or facilitators in these programmes and services have a vital role to play in monitoring the dynamics among the participants. Coaches in FFIT were encouraged to create a motivational atmosphere. Participants spoke of how they enjoyed the positive environment in which they could share experiences and laugh alongside the 'serious' business of behaviour change (Wyke et al. 2015). In addition, away from the context of PA groups, many shedders in a study by McGeechan et al. (2017) praised the coordinators who were always there to support them and talk to them about anything. One particular group in this study felt the coordinator was responsible for turning their lives around.

In summary, section 2.3 has detailed the factors that improve engagement that should be considered by practitioners when trying to engage men By improving practitioners knowledge for gender specific interventions, they are better informed on a) men's specific

way of communicating health b) how health should be marketed to men, c) the importance of using hooks and d) using evidence from existing interventions that have successfully engaged men.

2.4 Being connected and men's health

2.4.1 Social connections and influences

In the literature there is little evidence of a specific definition of social connection. However, assumptions can be made that within a social context, connections can be made through an association or relationship with family, friends, and work colleagues [social support] or through the use of services, participation in or through association with activities [social networks]. Human beings depend on the ability to create mutually beneficial relationships with others to feel connected, to trust and love and to feel the same in return (Baumeister and Leary, 1995; Brewer, 2004). In particular, the need to belong has been well established as a fundamental human need and therefore has a great influence on an individual's health (Baumeister and Leary, 1995). Consequently, many studies have highlighted the negative health impacts that are posed on an individual in the absence of social connection [social disconnection] (House, 2001; Brummet et al., 2001; Pressman et al., 2005; Steptoe et al., 2013; Wu et al., 2013). Studies that have investigated the effects of social relationships on mortality consistently show that individuals who lack or have low levels of social relationships have more than doubled the risk of death compared to those with higher levels of involvement (House, Landis and Umberson, 1988, Berkman and Syme, 1979; Holt-Lunstad, Smith and Layton, 2010; Cacioppo and Cacioppo, 2014; Holt-Lunstad et al., 2015; Holt-Lunstad, 2017). Holt-Lunstad, Smith and Layton (2010) highlights how the negative impacts of social disconnection are comparable, and in many cases, exceeds that of other risk factors such as smoking up to 15 cigarettes per day, obesity, physical inactivity and

air pollution. While Karp (2017) states that depression is an illness of isolation and a disease of disconnection. Many other studies have also highlighted the negative health impacts that are imposed on an individual in the absence of social connection [social disconnection] (House, 2001; Brummet et al., 2001; Pressman et al., 2005; Steptoe et al., 2013; Wu et al., 2013, Cacioppo and Cacioppo 2018)

Regular, in the moment connections, increase feelings of belonging and inclusion therefore, during times of need many individuals rely on connections for support (Langley, 2012). In addition, they are an integral part of human well-being as well as having a large part in the maintenance of health (Holt-Lunstad, Smith and Layton, 2010). Murthy (2020) states how connection with self is needed before we can truly connect with others. If we can be in a good place with ourselves, we can do better in our lives generally. This relationship is cyclical whereby connecting with others can also help us to further connect with ourselves. He goes on to highlight how to connect with ourselves when we need to 1. Understand our worth 2. Understand your value which gives you the power to be yourself in different settings and not try to be someone else because you feel you are not enough and 3. To be grounded and to be able to come from a place of peace. As a result, when we approach other people coming from a place of peace and knowing our true worth; we approach people with a willingness to listen and are able to be ourselves instead of trying to get something they want us to be.

2.4.2 Social supports and networks that matter

Social support has broadly been defined within the research as gaining resources from another individual (Cohen and Syme, 1985). Social support can be divided into two components; emotional support and instrumental support (Seeman and Berkman, 1988). Emotional support addresses if individuals have someone they can rely on in difficult

situations where instrumental support is measured by more tangible services that an individual can rely on and which others [emotional support] can direct them to. While the term social support [emotional and instrumental] refers to support at an individual level, social networks refer to the collective structure of social relationships that surround an individual, shedding light on how well an individual is integrating with others. It is believed that social networks operate at a behavioural level through provisions for social support, social influence on engagement and attachment and access to resources and material goods (Berkman and Glass, 2000).

The measure of social integration and connection relies on a) the number of relationships an individual has and b) the level of support offered within these relationships. However, studies focusing on social networks have tended to focus on determining network size and rarely focus on the actual interactions within these networks (Hill and Dunbar, 2003). Therefore, to be socially integrated an individual must participate in a wide range of social relationships such as participation in social activities and personal relationships and feel a sense of communality and identification within these social roles (Holt-Lunstad, Smith and Layton, 2010).

Within social networks, individuals form attachments and connections with others which provide access to resources and services and offer coping strategies that support positive health (McNeill et al., 2006). Social networks are known to affect health through a variety of ways including (*a*) the provision of social support (both perceived and actual), (*b*) social influence (e.g., norms, social control), (*c*) social engagement, (*d*) person to-person contacts (e.g., pathogen exposure, secondhand cigarette smoke), and (*e*) access to resources (e.g., money, jobs, information) (Berkman and Glass 2000). A social network of caring and respectful relationships has been found to reduce at risk behaviours such as substance abuse, bullying and violence (Bernand, 2004).

According to McNeill, Kreuter, and Subramanian (2006) an individual's social environment is made up of five components 1) Social support and networks, 2) Socioeconomic status and income inequality, 3) Racial Discrimination, 4) Social Cohesion and Social Capital and 5) Neighbourhoods. However, overall, there is no exact definition of what constitutes a 'social environment', the social environment can sometimes be seen as a place where an individual resides and which influence behaviour by shaping norms, enforcing patterns of social control, providing or not providing environmental opportunities to engage in particular behaviours, reducing or producing stress and placing constraints on individual choice hence poorer people are worse off (Institute of Medicine, 2003). The social environment can be much bigger with regards to the social context of policy, legislation, social institutions etc. This was particularly evident when legislation prohibited smoking in enclosed public places, thus altering the social environment in which people gather (Hargreaves et al. 2010).

Figure 2.1 outlines these many influencing factors from the social environment on social connection and social disconnection. In addition, this section will explore the relevance of social connection on men's lives and the contribution it makes in their lives. There will be a particular focus on social connection by exploring the importance of having relationships [social support and networks] on health as well as the negative impact their absence can equally have.

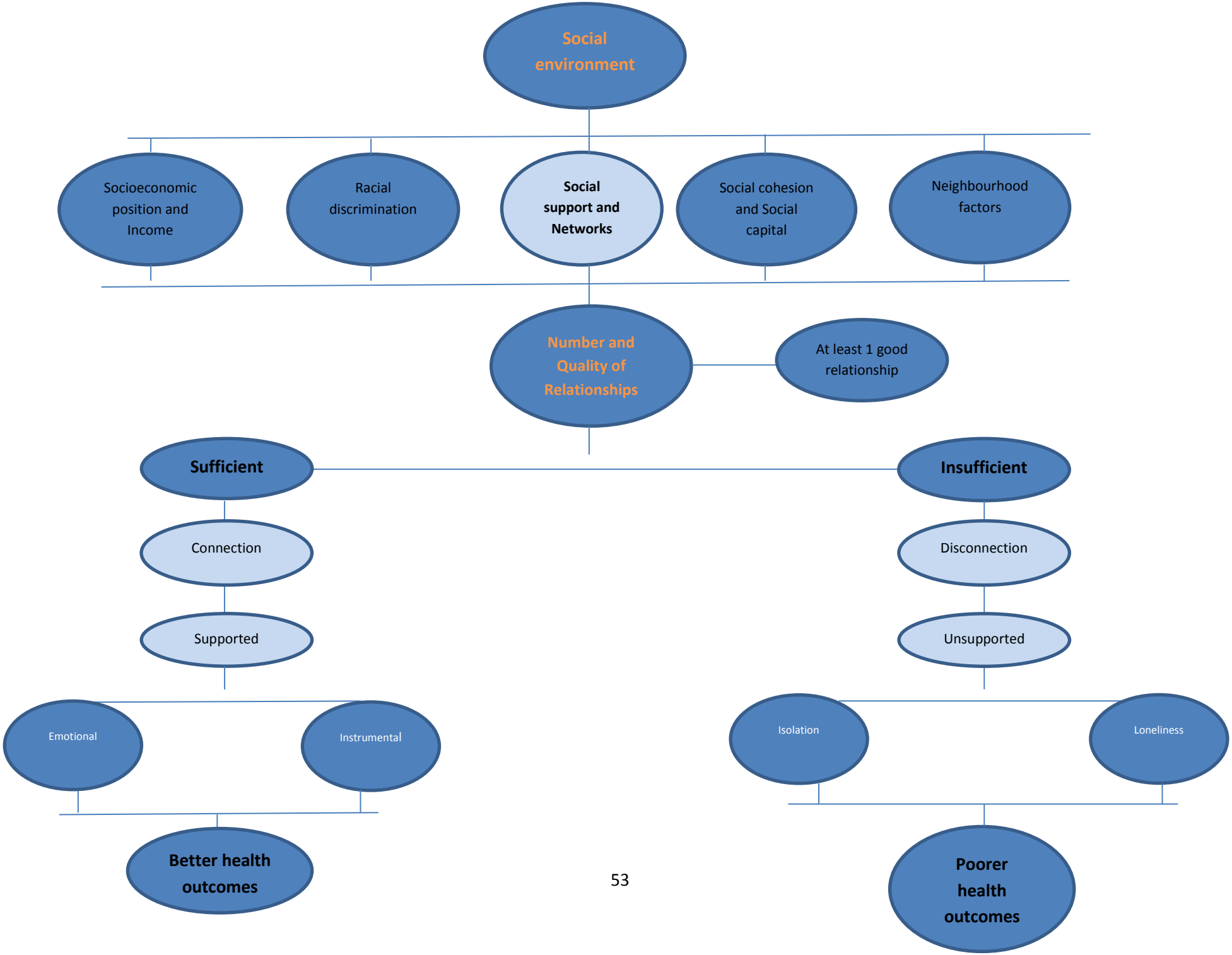
Social environment
Socioeconomic position and Income
Racial discrimination
Social support and Networks
Social cohesion and Social capital
Neighbourhood factors
Number and Quality of Relationships
At least 1 good relationship
Sufficient
Insufficient
Connection
Disconnection
Supported
Unsupported
Emotional
Instrumental
Isolation
Loneliness
Better health outcomes
Poorer health outcomes

Figure 2.1: The influencing factors from the social environment on social connection and social disconnection.

Studies show that social relationships can have short and long term effects [positive and negative] on an individual's health. Friendship can be defined as a personal or voluntary relationship that exists within a social context (Butera, 2008). Friendships are usually characterised by companionship, intimacy, support, self-validation, reliable alliance and emotional security (Mendelson and Aboud, 1999). However, while we may feel that we make our own choices when it comes to friends, social and cultural contexts can influence friendship choice and also the opportunities for making friendships (Way and Greene 2006).

2.4.3 Social disconnection, Isolation and loneliness and consequences for health

When individuals lose connection or are not experiencing sufficient support within existing relationships, they may experience social disconnectedness or social isolation. Social isolation is described as the absence or lack of contact and integration with other people while loneliness is more focused on the feeling of being without that contact (Wenger and Burholt, 2004). However, there are many different measures of isolation and loneliness.

Baarsen et al., (2001) view social loneliness as the absence of integration and companionship and emotional loneliness as the absence of an attachment figure. Whereas according to de Jong-Gierveld and Hagestad (2006), isolation is the opposite of integration and loneliness is the opposite of embeddedness. Furthermore, social disconnectedness can be characterised by a lack of contact with others and is signified by situational factors such as a small social network, infrequent social interaction and lack of participation in social activities and groups. Perceived isolation on the other hand can be characterised by the subjective experience of a deficit in one's social resources [companionship and support]. These subjective experiences can be feelings of loneliness and not belonging which indicate a

perceived inadequacy of the intimacy or companionship of one's interpersonal relationships compared to the relationships one would like to have (Van Baarsen et al., 2001).

For many, life experiences such as unemployment, retirement, bereavement and for some, parenthood may also lead to social isolation. Social isolation has long been linked to numerous health risks including suicide, obesity and alcohol consumption, as well as suffering from higher rates of morbidity, mortality, depression and infection (House, 2001; Brummet et al., 2001; Pressman et al., 2005; Steptoe et al., 2013; Wu et al., 2013). In a study by Grace, Richardson, and Carroll (2016) withdrawal, loss and isolation were used by young men to describe their disconnection and were seen as both a cause and consequence of their mental health sufferings. This has links with the Interpersonal Theory of Suicidal Behaviour (Joiner, 2005) which also makes reference to how individuals perceived sense of social isolation along with feeling burdensome can lend to an increase risk of suicide (Joiner et al., 2009). This theory (Joiner, 2005) reports how our need to belong to caring and supportive relationships is so significant that when it is disrupted, it contributes to a desire for suicide. Yet compared to some of the leading health risk behaviours [smoking, obesity] little is known about how and why social isolation affects our health (Cacioppo and Hawkley, 2003).

Cornwell and Waite (2009) combined multiple indicators of social isolation into scales assessing social disconnectedness (e.g., small social network, infrequent participation in social activities) and perceived isolation (e.g., loneliness, perceived lack of social support) to examine the extent to which social disconnectedness and perceived isolation have distinct associations with physical and mental health among older adults. Their results indicated that social disconnectedness and perceived isolation are in fact independently associated with lower levels of self-rated physical health.

2.4.4 Men connecting with one another.

Understanding the gendering of friendships is important as it enables greater understandings of how relationships are interpreted (MacAnGhaill et al., 2012). Trends in masculinities show how either 'too much' masculinity, such as an inability to express feelings or self-sufficiency, or 'not enough' masculinity may result in rejection from significant others or peers (MacAnGhaill and Haywood, 2012).

According to Mac George Feng, and Burleson (2011) communication is an essential medium through which support for challenging events is experienced. In addition to the research into gendered language, recent research in supportive communication is also looking at detecting and explaining gender differences in message reception. There is a popular belief that men are less willing or able to communicate upsets than their female counterparts (Virtanen, Isotalus, and Keaton 2014). In a study by Cleary (2012) conventional constructions of masculinity were seen to influence decisions made not to disclose psychological issues to family, girlfriends or partners. Participants did not speak to their fathers out of fear of a possible rejection or unresponsiveness and girlfriends and mothers were not confided in, in an attempt to protect them. Furthermore, it is also believed that when men are met by upset, many men offer practical solutions instead of comfort to those who are hurting (Virtanen, Isotalus, and Keaton 2014). Keohane and Richardson (2017) found that for many of the male participants in their study, giving help was not necessarily contingent on having high levels of emotional literacy with many acknowledging that as men they do offer help and care but in their own way such as having a cup of tea, or just sitting down with them and talking or having 'banter'. Therefore, having time to reflect over situations can be seen as more influential to a behaviour change or supportive during times of crisis than seeking professional help.

This idea of offering more ‘mocking’, ‘banter’ led help was also evident in a study of English secondary school students. Naylor, Cowie, and del Rey (2001) found that adolescent boys were more likely than adolescent girls to mock those in emotional distress arising out of possible macho or ‘laddish’ values and to avoid seeking help for their own emotional problems. It has also been proposed that whilst women more generally share feelings with friends and provide avenues for support, men prefer more activity based and less emotive friendships (Walker, 1994; Fox et al., 1985). Social constructionist theories of masculinity (Seidler, 1992; Connell, 1995) describe how men more generally tend to focus on independence and self-sufficiency within their friendship and support circles. However, within recent literature, there is also a sense that men need to belong and be part of a community of other men (Shaw, Gullifer and Shaw 2014; Lefkowitz et al., 2015).

In a study by Butera (2008) the term ‘mateship’ which has its origins in Australia was explored. The views of 3 generations of men were used to explore how men’s same sex friendships have evolved. They found that although men’s friendships are expanding, they have not yet reached the status of ‘pure’ friendships but could be described as a neo-mateship which encompasses a more flexible, emotionally expressive and individualistic type of mateship.

It was seen by Emslie, Hunt and Lyons (2013) that men regard drinking alongside other men an ‘act of friendship’ and deemed drinking with peers an appropriate means of communication under hegemonic masculinity. However, in addition to a true masculine behaviour of drinking alcohol, men spoke of emotions, mental health and other behaviours that generally would not be acceptable in masculine norms but where overlooked given the highly masculine setting.

Park, Cho and Moon (2010) equally focused their study on gender specific support and found that gender specific social support was essential with regards to suicide prevention.

Men offer support by providing perspective, suggestion and reassurance. In general men prefer to offer "cold comfort" through indirect support which they feel leads to self-realisation, thus resulting in more permanent and positive change (Virtanen, Isotalus, and Keaton 2014). Keohane and Richardson (2017) found that simply knowing that friends could be relied upon for support was of comfort to many of the participants in their study. Participants valued openness and disclosure within their relationships. Therefore, whilst men typically acknowledge that their wives and families provide great support, there is evidence that men also get support and comfort from being part of men's communities.

Social relationships are not fixed entities but instead, like masculinities, are fluid, dynamic and can be influenced and changed over time (Dindia and Canary, 1993). A focus group study by Levy (2005) indicated that men's need for friendship may change and that circumstances, particularly those relating to loss, may also change the nature of friendships. This is seen in male friendships that differ depending on age. Younger men typically prefer intimacy and openness whereas older men seek friendships that have commitment, loyalty, reliability and dependability (Butera, 2008).

2.4.5 Generating environments where men can support one another

Sharp et al. (2018) conducted a study focusing on a PA group for older men. They found that participants enjoyed being with a group of men that had common interests, values, and struggles as it provided a connection that subsequently led to a sense of camaraderie to develop within the group thus making them feel accountable toward the group. Participants described this camaraderie by stating how they did not view the programme as a chore, but rather a time equivalent to a social outing with friends. The literature highlights the effects of a practical setting like a PA group on connection by stating how it can facilitate social

relationships through social connectedness arising from building friendly and trusted relationships between people during activities (Lubans et al., 2016).

Outside the context of a PA group, Lefkowitz and Richardson (2016) highlight how facilitating banter will result in a more relaxed atmosphere. Men in their study spoke of how the relaxed atmosphere in the shed would allow casual and comfortable interactions with each other, jokes and stories being told and enjoying light-hearted interactions all of which contributed to the sense of camaraderie between the men. This highlights the importance of environment in developing social bonds. There is an established body of literature that supports a connection between social experiences, the social environment, and physical activity (Bauman et al., 2012; McNeill, Kreuter, and Subramanian, 2006).

In summary, social connection and gendered relationships are important components for men's lives. We have seen in section 2.3 how connection can support engagement with services by allowing men to feel at ease in their locations along with feeling supported by other men. Thus, social connection can have a massive impact on a man's behaviour change abilities. More specifically the 5 areas that matter when engaging men in their health refer to developing the right approach with regards to communication, 'the hook' being gender specific and linking into men's true interests and concerns, the setting which should be easily accessible, male friendly and garner a welcoming and safe atmosphere. Finally, by generating social connection in programmes and interventions will sustain engagement and positively impact the man. Men do engage when the approach is right and notably this evidence was used in the development of MOM where by the programme was welcoming, safe [men only, private setting], supportive [Specifically trained PA coordinator guiding group] and incorporated the use of humour and banter.

Chapter 3 Research Method

3.1 Introduction

The purpose of this chapter is to discuss how this research was carried out, why it was carried out in this way and what difficulties were encountered. This chapter starts by looking at the research design (Section 3.2); 3.2.1 population, 3.2.2 data collection procedure, 3.2.3 data collection instruments, 3.2.4 data storage and 3.2.5 data analysis. Section 3.3 focuses on reflexivity which encompasses; 3.3.1 being part of MOM project, 3.3.2 empathy and 3.3.3 being a female facilitator. Finally, the ethical considerations for this research are presented in Section 3.4 with 3.4.1 focusing on the trustworthiness of the data. Ethical approval for the study was sought and obtained from the ethics committees at Waterford Institute of Technology [15/Dept-HSES/13].

3.2 Research Design

This was a qualitative study which looked to explore how the men experienced participating in MOM. A qualitative design instead of a quantitative design was best suited to capture the broader impacts of the project as it is easier to explore views, experiences and motivations from individual perspectives (Gill et al., 2008). Interviews are especially appropriate when little is known about the topic in question, where detailed insights are required from individuals or when the topic in question is of a sensitive nature invariably leaving participants to feel uncertain about talking openly in a group environment (Vogt, Gardner, and Haeffele, 2012.). Interviewers can build trust with their participants through careful management of appearance, charm, a gentle and client centred manner which then allows the interviewer to create a personal encounter where the participants will unveil their deeper experiences and thoughts (Doucet and Mauthner, 2008). There are three types of interviews that are commonly used in the field of health research: (1) Structured; (2) semi-

structured; and (3) narrative interview. Semi-structured interviews were chosen for this study. Semi-structured interviews are suitable when the research study outlines a specific focus, but the questions are flexible in order to account for the participants' responses which will direct the flow of the interview (Stuckey, 2013). Therefore, for this particular study, I was able to get a more in-depth, detailed and honest representation of the impact of the programme on participants. By choosing interviews, I was able to speak to men on an individual basis creating a safe and confidential space.

3.2.1 Population

A total of 32 men participated in this study across the 4 intervention counties as per Table 3.1 below.

Table 3.1: The number of participants via interview and focus group across five counties

County	**Interviews with Men**	**Focus groups**
Waterford	15	
Donegal	3	1
Galway	7	
Mayo	7	
Total number of participants (n=39)	32	7

Sampling

The selection process for participants was the subject of considerable discussion and debate amongst the research team. A number of options were proposed as detailed below but the sampling procedure chosen to recruit participants for this study was option 3.

Option 1: Random selection

There was consideration given to gathering a diverse group of men to represent the men who attended at baseline. A representative sample of participants was to be selected based upon the sociodemographic data collected at baseline. However, on considering this, it was felt that because I was looking at the lived experiences of individual men who attended the programme I needed to think more qualitatively.

Option 2: Attenders

As the aim of this study was to investigate the impact of the programme; I thought that basing the sample on attendance was of significant importance. It was felt that those with a high attendance rate would have a greater lived experience, a more in-depth knowledge of the programme and potentially a greater personal impact to share at interview.

Discussions around 'what defines attendance?' subsequently followed. Although while MOM consisted of two nights per week, I felt that some men might have only been practicably able to attend one of these nights, but then attended that night consistently over the course of the 12 weeks i.e. attended weekly. Therefore, I felt that the cut off percentage for attendance was ≥50%. In looking at this I found that 340 of the 489 men who signed up had attended ≥50% of the MOM programme thus, offering a large sample of men to choose for interview. With this large group of attenders, there was merit in suggesting taking a representation sample from the 340 men, but while this gave information re attendance it said little about participation and involvement.

Option 3: Programme participators as identified by practitioners

Finally, I considered that the LSPs and the PA Co-ordinators should be asked to select men as they were most familiar with them. The LSPs and PA coordinators were asked to think of men whom they felt 'got the most out of the programme' through their participation and involvement and who would be suitable for interview. By keeping this question open for

interpretation, I was accounting for any personal biases by allowing each individual to interpret the statement in their own way.

As a result of this recruitment strategy, purposive sampling was used initially to recruit 'those who got the most out of the programme' and there after snowball sampling was adopted. A purposive sample is a non-probability sample that is selected based on characteristics of a population and the objective of the study. Purposive sampling can be very useful in situations when you need to reach a targeted sample quickly (Patton, 2014; Bernard, 2017). Whereas snowball sampling, also known as referral sampling, is widely used in qualitative research due to its ability to recruit hidden populations (Snijders, 1992; Faugier and Sergeant, 1997; Baltar and Brunet, 2012). However, as snowball sampling relies wholly on selection of the initial seed which in this study was the men themselves, purposive sampling needed to be used to get the men who would then recruit other men for the study (Magnani et al., 2005).

For this study, contact was made with the LSP Co-ordinators who then made contact with the PA Co-ordinators who had been working with the men over the 12-week period, or in some cases, where sustainability was good, still working with the men.

3.2.2 *Data Collection Procedure*

I contacted the men that were identified as potential participants and asked them to provide a convenient time and location for the interview to be conducted. Generally, interviews took place in the evening at local centres or GAA clubs [many local towns in Ireland have a GAA club which usually has an associated club house for social gatherings and meetings] with facilities to make a cup of tea or coffee.

In Waterford, interviews were conducted 10 weeks after the programme ended whereas in Galway and Donegal interviews and the focus group were conducted 14 weeks after the

programme ended (at 26-week quantitative data collection night) while in Mayo data was collected 28 weeks after the programme ended to allow for data analysis and for the Summer break for participants.

As many of these men were involved in all aspects of the research (quantitative measurements and questionnaires, qualitative interviews), it was important to be aware of how these men felt about the research and not lead them to feel 'used' or 'burdened' as a result of their participation in the study. To ensure that these men didn't feel 'used' I explained the relevance of their contributions and what impact it would make to other men in the future. Additionally, I clearly described what was involved, asked how they felt about that and finally gained consent [Appendix A]

I acknowledged that it was a challenge for some men to give the time to be interviewed. This was observed through men's body language, positioning and simply by men stating that they didn't really have time to be participating. However, many of these men made time out of their busy schedules to attend the interview. This could be seen as men's want to contribute or give back to the research that had provided them with a positive and sometimes, life changing experience.

I explained the length and format of the interview to each man at the beginning and sought permission from participants in advance for the interview to be audio taped.

3.2.3 *Data Collection Instruments*

Initially, I developed a topic guide to elicit participants' experiences and perspectives on MOM. The initial interview structure was based on previous approaches that investigated the experiences of individuals who participated on community based PA programmes (Carnegie Research Institute, 2007). The initial topic guide started with multiple potential questions to follow such as;

- ‘What was it like for you to have MOM available to you back in September?’
- ‘What has your life been like since you signed up?’[For full topic guide see Appendix B].

This topic guide was used for 3 initial interviews; however, what occurred to me throughout the interviews was reliance on these questions and not on the natural flow of the conversation. This resulted in a shorter interview time and shorter statements from the men. While this topic guide hindered data collection somewhat [the topics of conversation weren’t explored to a deep level], the topics that emerged were still of some relevance to the research question. Therefore, these interviews were recorded as being used under the initial topic guide but still incorporated into the analysis process. In response to the initial topic guide, I developed a more open and effective topic guide [see Appendix C for full guide] during the data collection process which included less detailed questions and more bullet points such as;

- Getting involved or
- Impact

In following the bullet points, I was able to use my own open-ended, clear and sensitive questions which resulted in a better flow of discussion. Subsequently, this led to the exploration and unveiling of the lived experiences that the men who participated in the MOM programme encountered. Reflections and clarifications of statements were useful to reiterate a point or gain a deeper insight into what the participants were saying to avoid misinterpretation. I felt that adding humour to the conversations or more relaxed statements generally set a good tone in the interviews. This was then used as the main guide to follow during the remaining interviews. Whenever additional data emerged, this was added as a bullet point to the topic guide and explored further. The aim of achieving a good interview was to establish a relaxed and flowing conversational style, and to encourage participants to

speak as much as possible therefore allowing me to be less involved. At all times, I strived to ensure that any personal biases did not influence the process in anyway.

After requesting individual interviews with several men in one location, they showed up together and asked to participate in a focus group (see Table 3.1 above). The same topic guide was used for this focus group however, as the facilitator; I took note of any initial observations. These observations included; did men talk about other men in the focus group? Would more personal anecdotes of their lives still have emerged in the focus group when compared to the interview setting? Was the energy that was portrayed in this focus group a small snippet of what it would have been like on the programme? As a result of using these observations in conjunction with the transcription of the focus group, I could reflect on these questions. I found that men interacted with each other in almost mocking tones or with an air of 'tough love' which is well documented within the literature (Park, Cho and Moon 2010; Virtanen, Isotalus, and Keaton 2014; Keohane and Richardson, 2017). However, a result of this style of communication [and possibly the more male friendly location of a sports clubhouse], men seemed more at ease with each other which led to each man speaking openly which also mirrors current literature (Emslie, Hunt and Lyons 2013). Additionally, each man listened attentively to the others and in some cases encouraged men to tell a story about an achievement they had made during the time in MOM. The data from this focus group was not used in conjunction with individual interviews. However, I felt the context of the men wanting to be interviewed together was an interesting finding which is supported by the findings of the study (See chapter 4).

By listening over the interviews and the focus group and becoming familiar with my data, emerging areas would become apparent that I could then test in subsequent interviews. This was done by adding the emerging focuses to the topic guide that would then be explored in the following interviews until it became grounded within the data [i.e. continuously

repeated by interviewees]. These were then explored further or dropped if it wasn't a point of agreement. Data collection continued until data saturation had been reached and agreed by the research team.

Each interview lasted between 20-50 minutes and the focus group lasted 50 minutes. After the interview, the tape was switched off and I asked the men to self-reflect on how they felt after the interview. I made each participant aware of supports however, only two men needed referrals to PA co-ordinators and LSP's [both incidences were regarding issues with the programme structure]. I thanked the men for their time and contribution. I regularly debriefed with LSP co-ordinators to check that none of the men had concerns or felt discomfort after the interviews; I also met regularly with my supervisors to review progress and to discuss any issues that may have been raised in my field notes and personal journaling. This informed ongoing data collection.

3.2.4 Data storage

All of the qualitative data was collected using an electronic Dictaphone and transcribed verbatim as soon as possible after collection. Audio files were destroyed and the word file with the original transcription that identified participants was password protected and accessible only by the research and her supervisors. All data was stored on a password protected cloud data storage area. Data will be retained for a minimum of five years from date of publication.

3.2.5 Data analysis

The analytical method adopted was thematic analysis as per Braun and Clarke (2012) (see Table 3.2 below). This approach involves a six phase process. Unlike other approaches, this is not tied by a specific theoretical framework but instead provides a method to guide

researchers which allows this approach to be highly flexible to a wide range of qualitative methodologies and research questions (Clarke and Braun, 2014).

Table 3.2: Outline of Braun and Clarke's phases of thematic analysis

Phase	**Description of Process**
1. Familiarising yourself with your data:	Transcribing data, reading and re-reading the data, noting down initial ideas
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking in the themes work in relation to the coded extracts (Level 1) and the entire data set (level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
6. Producing the report.	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back to the analysis to the research question and literature, producing a scholarly report of the analysis.

Following transcriptions of all interviews (n=32), phase 2 of the thematic analysis [Table 3.2] was conducted. Predetermined codes were not assigned. Only 10 of the 32 transcriptions

were initially independently coded. Three researchers were involved in the process of developing the code book [Appendix D]. Each researcher independently coded the transcripts and there after discussed the codes with each other to agree on the code book. Sentences and statements were assigned a code that captured what the participant was saying. Any field notes that were collected were added to support codes. This resulted in the development of a list of codes and emerging key concepts. Codes were further developed using constant comparative analysis, which assisted me in guarding against bias by challenging concepts with fresh data. This analysis involved the comparison of code lists, negotiating different interpretations and refining codes to agree a cumulative or 'master' code list. At a later stage of analysis, selective coding followed. This process unified all codes around a core category [phase 3. Table 3.2]. These codes had similar meanings and were refined to form sub themes or categories. Over the course of this analysis these categories were built into a framework [phase 4. Table 3.2]. Following this method, all additional transcripts (n=29) were analysed using the framework to ensure consistent analysis of further transcripts. Any new codes/theme that emerged was accounted for and considered for addition to the framework [phases 5 and 6. Table 3.2]. The data that has emerged from these interviews are presented next in Chapter 4.

3.3 Reflexivity

As the primary researcher I was mindful of the complex challenges inherent in studying health and individual participants' background. In studying an area that deals potentially with deep emotions and personal accounts of a distress, it was important to have measures in place to protect myself. I set myself boundaries of what I could deal with on a professional level and when it was important to ask for outside interventions. Debriefing with my supervisor after each group with regards to acknowledging any difficulties I encountered or issues of concern, was also an important outlet. While self-awareness and mindfulness were important

considerations for me as a researcher, it was equally important that my own personal reactions or responses did not bias the research process. I endeavoured to steer away from possible prejudices, judgements that I might have felt, by facilitating findings to emerge from the data as opposed to my own personal opinions and experiences shaping the data.

3.3.1 Being part of the MOM project

As this study was part of a larger scale project; background data needed to be collected based on the project timeline before the qualitative data could be collected. Furthermore, there were many stakeholders involved in this project; particularly the LSP's who were working on the ground. As a result, the LSP's were key figures to liaise with in this study particularly regarding the recruitment of participants.

3.3.2 Empathy

The concept of empathy within the qualitative field is widely regarded as an ethical solution (Prior, 2018; Heggestad et al., 2018). However, empathy is an unsteady term where the meaning may not always be clearly outlined. There is the assumption that empathy between researcher and participant will result in richer, deeper data. In applying empathy to the data collection phase of this study, it in fact assisted me to break down any barriers that would have suppressed data emerging, namely me being a young female. Applying empathy to situations that men found themselves in, helped me to facilitate men with a trusting space and create a balance between myself and the participant by trying to see things from the participants' perspective (Kvale and Brinkmann, 2009). In addition, Watson (2009) believes that as researchers we should put our empathetic responses through investigation. Therefore, throughout data collection, it was important for me to reflect on my responses of empathy and consider the impact they might have had on the interview process.

3.3.3 Being a female facilitator

Prior to interviews I considered how being a young female researcher would influence the flow of conversations with men. Manderson et al. (2006) state how the social dynamics of the interview, sex, age and background shape interview interactions and produce knowledge. Therefore, research stresses the importance of considering gender and its significance in qualitative methods regarding female interviewers and male participants (Pini, 2005; Schwalbe and Wolkomir, 2003). Furthermore, it is also generally considered that when the interviewer is closer to the age of the interviewee might result in a better rapport, as their background, interests, and use of language may be similar (Manderson et al. 2006; Grenier, 2007). As a result, this study developed strategies to support comfortable interactions between participant and interviewer. This was achieved through casual introductions, establishing a set of boundaries, the use of refreshments if needed, a neutral setting and a relaxed and casual approach.

Throughout the interviews, on some occasions, men mentioned uncertainties about how the relationship would go. However, what started with very abrupt and short statements soon began to progress and an atmosphere of trust and understanding was established. Following this, data began to emerge through longer and deeper statements and therefore, resulted in a long and productive interview. By acknowledging these as potential barriers prior to interviews, in addition to creating an adequate amount of trust, openness and empathy, I was able to minimise the impact it had on data being collected.

3.4 Ethical Considerations

Ethical approval for the study was sought and obtained from the ethics committees at WIT [15/Dept-HSES/13]. This study has been registered with the ‘International Standard Randomised Controlled Trial Number' registry [ISRCTN55654777]. Ethical consideration

was given to a) risks to persons (see section 3.5.1) and b) the trustworthiness of the data (see section 3.5.2).

a) Informed consent was sought and given at the beginning of the MOM programme. However, men were still made aware of this and again asked for their verbal consent prior to the interviews.
b) Participants were free to refrain from answering any questions or to withdraw from the study at any stage without consequence and were informed of this at the beginning of interviews.
c) Participation was on a voluntary basis.
d) Men were reassured about confidentiality and how personal or identifiable information was used anonymously in the preparation of reports. Pseudonyms were used for direct quotations.
e) Hard copies of all interview data were stored in a locked filling cabinet. All soft copies of data were removed from portable devices and stored on a cloud based password protected file. The primary investigator was the only researcher to have access to all copies of data. However, in the case of unforeseen circumstances, the project co-ordinator/supervisor would only then gain access.
f) A respectful and sensitive approach was adopted so that participants felt at ease.
g) In an attempt to safe guard the participant, referral pathways were established contingent on any distressful or sensitive topics emerging from the interviews. These referral pathways were as follows; a) PA and LSP Co-ordinators for matters regarding the programme and PA, and b) Local primary care services for concern regarding a health issue. In addition, contact details of support services were made available to all men who attended the MOM programme via the MOM Health Information Booklet [see Appendix E]. Given the structure of the programme i.e. locally based within

services or sports clubs, there was always a point of contact who could direct men to more local services if and when required. The researcher's contact details were also made available to participants and they were encouraged to make contact if they felt the need to do so. Any issue of concern was reported to the supervisory team.

h) Continuous training and supervision was given to the interviewer in attempt to provide support through this process.

i) A non-judgemental approach was used thus creating an open and trusting space for each man.

3.4.1 Trustworthiness of the data

a) Credibility:

The topic guide was first tested and amended. Three researchers contributed to the code book thus accounting for any bias. Any factors that may have influenced the data were foreseen and appropriate measures were put in place.

b) Transferability: Can the researchers' findings be applied to another context?

It is not the researcher's task to provide an index of transferability. However, the data provided in this study explores the findings in depth to provide rich descriptions which other researchers can use in different settings and contexts.

c) Dependability & Confirmability:

The researcher engaged with her supervisors to present and debate her rationale for interpretations. 3 researchers were involved in this process. She also looked to her peers in the postgraduate area to review data analysis.

Chapter 4 Results

This Chapter explores in detail how men journeyed from disconnection to connection within the context of MOM and subsequently experienced many impacts to their health and overall life. Disconnection is defined in the context of this study as experiencing an isolation from others or a previous occupation which results in a lack of control, purpose and feelings of shame. Disconnection emerged as an important backdrop and starting point for the majority of participants initial engagement with the programme. For many men, participation in MOM prompted connections with self, others and their surroundings whereby connection at one level supported a deeper connection at another. The men in this study spoke of connection in many ways, and from their contributions the following definition of connection emerged which will be used for the purpose of this study;

> *Experiencing a sense of belonging to a group of men with whom they identified, an energy between the men as a result of feeling understood, valued and accepted, getting involved by both giving and taking from the group and feeling a sense of purpose to do more for their health.*

This journey will be outlined through 4 themes and their accompanying subthemes as per Figure 4.1 below; Theme 1 focuses on *disconnection* which explores how men felt prior to MOM as a consequence of many critical life circumstances Theme 2 addresses *the context of MOM with regards to [re]-connection* and looks at the overarching factors needed for men to overcome disconnection and achieve [re]connection. This theme is a key influence in themes 1,3 and 4. Theme 3 seeks to explore *the meaning of connection* which focuses on what connection meant for the participants and how it helped them overcome personal challenges and finally, Theme 4 focuses on *the impacts of connection* by exploring the many impacts

men experienced as a result of feeling more connected with themselves and others. Themes 1-4 will be summarised in section 4.5.

Figure 4.1 outlines the links between themes. While disconnection was the starting point for many men, the context of MOM is an overarching theme in that its influence was the original source to many of the other themes occurring.

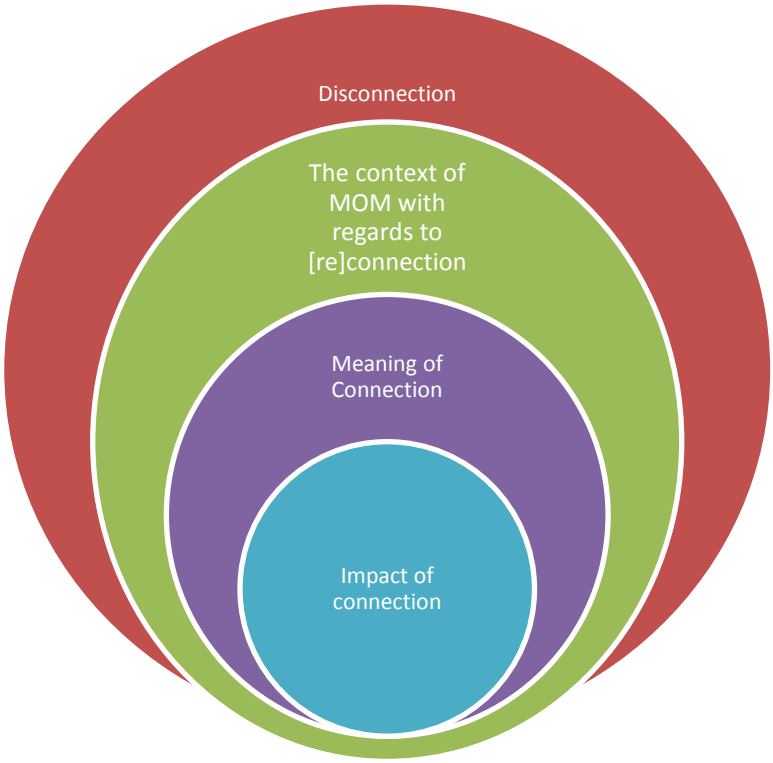

Figure 4.1: Journeying from disconnection to connection within the context of MOM.

Ultimately, feeling connected positively impacted men's heath (social, physical, mental, emotional and spiritual) and lives.

4.1 "When you're retired you're not meeting the same amount of people"- Disconnection

Many men spoke of experiencing disconnection with themselves and from others prior to MOM typically resulting from critical life changes (CLC) such as illness,

unemployment or retirement. For some, simply ageing or being overweight and/or unfit underpinned their disconnection. Irrespective of what prompted disconnection for these men, it manifested in feelings of shame and loneliness in their lives. For the majority of men, this void alongside other personal factors [having children, experiencing illness personally or through a relative] jumpstarted them into taking the step to bring about a change to their circumstance.

Shame was experienced in a variety of contexts; particularly when men compared themselves with others. Some men experienced shame in social or public settings due to being overweight or physically unfit;

> *E128: '...when you go on holidays and everyone else is slim and then you have a big belly and out on the beach…I was at weddings and you stand out awful heavy and you know you don't feel great in yourself. My girlfriend would never say anything about it but I knew myself she probably knew I was heavy but she'd never say it*.'

Feelings of shame led some men to do PA in private which itself, may have contributed to their disconnection and isolation;

> *J69: '...at the beginning I was going to the beach most days…because it's quiet, you can do it* (PA) *there…I used to be self-conscious with regards to people saying "look at that clown"...'*

For some men shame arose from a sense of failure in not living up to either self-imposed expectations of themselves or perceived external expectations from others. This prompted many to withdraw from others and from society;

> *E128: '... I used to just walk the dogs but you'd feel ashamed walking out on the road when you're unemployed… F: 'What would make you feel ashamed?' E128: 'Well the*

neighbours would think, "why isn't he doing something around the house instead of running or walking out the road?"…'

Shame following retirement and unemployment, left men bereft. Some men spoke of how they confined themselves inside for fear of being seen to have nothing to do. However, a consequence of this meant they were '*bored* [and were] *doing nothing'* resulting in loneliness:

H25: '…I was bored doing nothing, I had nothing, I had no money, no job, no nothing…'

B123: '…from a personal point of view, my wife passed away 3 and a half years ago so I found that walking part could clean my head you know; my way to relax would be to go for a walk. F: and since your wife passed away was the social aspect of things like Men on the Move important to you? Ohhh critical 'cause I'm a people's person you know I love mixing with people…'

Some of the men who spoke of having '*plenty of time'* as a result of retirement, may not necessarily have been feeling isolated or lonely but may have been lacking something else in their lives. MOM instead acted as a forum for these men in which they could fill their free time with the added bonus of getting fit and meeting new people;

J69: 'I'm retired so, I have plenty of time on my hands but the way I see this is its (MOM) *encouraging, it's encouraging me to continue and keep fit. Keeping fit as in walking on a daily basis…'*

For some men, reaching a certain threshold of distress may have been the tipping point that motivated them to make the final push to do something about what they were experiencing. While these men alluded to not always knowing what was wrong with them, many still had

the inclination that something needed to be done. Some men made reference to the fact that it was them alone that had to make the decision to attend the programme and make the commitment to attend for 24 sessions over a 12 week period even though some weren't 'quite sure what MOM was about':

> *E126: 'I saw the advertisement of Men on the Move so I said to my wife "I think I'll go to that" so she said "well I actually saw that but I said nothing because I thought you wouldn't go". You see I was going through a bit of eh em* (Pause), *not feeling great, if you know what I mean? I had gone very much into myself…'*
>
> *J34: '…I saw the notice for Men on the Move. I wasn't quite sure what it was but I came down and I said to myself; "I just need a little push to get going or to get out".'*

Many of these men who had encountered life changing experiences which resulted in isolation, loneliness and shame, made the decision to participate on MOM. In taking part, many men were able to shift from feeling unsure about who they were to gradually use MOM as a starting point to reconnect with themselves, others and their local surroundings.

4.2 *"…from the very beginning we kinda bought into it* (MOM) *really, really well…"*- The context of MOM with regards to [re] connection.

The context of MOM contributed to both men's decision to participate on MOM as well as sustain their engagement. As a result of their sustained engagement, men had the opportunity to [re]connect. The context of MOM will be explored below under the following headings; initial engagement, the impact of the PA Coordinator and the appropriate setting.

4.2.1 Programme 'hooks'

On a whole, these findings make reference to what men needed in a certain part of their lives to make and sustain a change to their disconnection and/or health. These aspects of

MOM will be explored with regards to what enticed men to join MOM and what encouraged them to stay. Furthermore, some men spoke about the previous difficulties they faced with regards to signing up or engaging with something suitable for their needs.

Appropriate setting

Some men spoke of how they previously joined gyms which didn't work out for them and/or didn't meet their needs, so therefore, didn't attend again. These men felt that the setting of the gym and the lack of interaction with other gym members was not something that suited their interests in relation to exercise as a recreational activity. Furthermore, some men associated gym settings with being unfriendly and daunting as a result of being associated with the male ego [weightlifting], fitter individuals and not being able to strike up a conversation with others as easily. MOM was their alternative which offered them something different. These men felt much more at home in the outdoor setting in comparison to what they regarded as the '*snobby*' environment of the gym. The outdoor setting also contributed to a sense of safety and comfort which might not have been possible under the glare of a gym setting;

> *H113: '...a lot of men would go to the gym for a little ego busting weights. I tried that but it's boring and if I went to the gym classes, they're taken up by women and you didn't get to know anybody in them. Whereas Men on the Move is different. Every time you go down you're just interacting with people.'*

> *E114: '...the outdoor element was good. Like a gym setting where you would have used equipment would not appeal to my age group anyway or the group that were at Men on the Move. The scenery changing was great and the surroundings. I would not be as happy in a gym anyway.'*

H25: '…well in the gym you're there on your own again and there's no motivation really you know what I mean, there's kind of…I call em 'snobby people' in the gym. I always find that they do not want to talk to ya. I'd be trying to talk away to people.'

In the past, many of the older participants struggled to find a PA group suitable for their age. In addition many other men felt there was little on offer for men only. These men felt that MOM filled that gap and provided them with a PA group they felt comfortable in;

E126: '…there never seemed to be anything on for people of my age group and unless you were into the GAA it was difficult to do anything else…'

Many MOM programmes, especially those in the rural communities, were either based in natural areas [lakes, sea, woods etc.] or in parks or training grounds away from the busyness of the local town centres. Men spoke of the views they had from the MOM training grounds, '*looking down on the water*' or being surrounded by '*the trees and the mountains*', which many found peaceful and encouraged them to do more;

J69: '…we were away up in the air (training grounds)*, we were up high and when you looked down, you were looking down on the water and I thought this is some setting and it gave ya this wee push to keep going ya know?'*

J34: '…the forest, it's lovely down there([in the village)*; absolutely gorgeous and peaceful. You can't beat the trees and the mountains and the golf course beside us and so the bit of nature is lovely. F: Do you appreciate that a bit more now you can go out and walk? J34: Definitely. That's by accident that* (awareness) *happened it's not that we didn't appreciate nature but because we're in the facility of that* (nature) *a lot more often, we enjoy it. And it is a lot more peaceful and we've noticed that a lot of men are meeting a lot more people outside of the group.'*

As men shared these experiences of nature together, such as '*looking at the stars'*, men were connecting spiritually with themselves but also connecting with the other men through these joint experiences. This, in addition to the support of other men in the group, meant that they were more relaxed to challenge themselves, push the boundaries and do things '*that men would not normally do*';

> *E109: '…it was a new experience for a lot of men to be out walking at night. I mean it was lovely up there and a lovely moon and you'd be looking at the stars with the lads and things like that, that men would not normally do and to be out walking with a group and maybe sometimes it could be dead silent you would think there was 1000 people there because there was so much laughing and chatting…'*

Men-only programme

One man spoke of how the context of the male only PA group meant it was acceptable for him to open up to other men about his diabetes because he felt that it was a relevant and acceptable topic to bring up in the context of the programme. He spoke about this in contrast to his membership of the 'men's shed group' where the setting and activities [wood work etc.] were seen as less conductive to raising health topics;

> *H25: 'Well it's* (MOM conversations) *good 'cause I do not talk about…who do I talk to about diabetes? No one, the wife? She's not diabetic so the conversation doesn't come up that much. So when you're talking to men at the programme, I'd be asking them "what's your sugar levels?" or "What do you do to bring 'em down?" or "if you're going for a walk, what kind of food would you have?" stuff like that. So you kind of learn a bit of 'what works' for me…I would not talk like that, even in the men's shed like kinda would not talk about that like it doesn't come up. 'Cause when you're exercising you're talking about like protein and what you eat and all that but*

in the men's shed you would not, you'd be talking about probably making a bucket or a doll's house or something. You'd be making stuff like so it's a different conversation.'

As many of the men were only starting back into exercise and PA, the importance of light hearted competition made it easier for them to engage in MOM. This created a less formal environment which subsequently allowed men to relax into the group. The majority of men spoke of the fun and craic [Irish term used to describe enjoyment or entertainment] they had as a motivating factor which enticed them to come back each week;

H129: '... you know we have our own bit of pushing and shoving but there's nothing too much…ah it's competitive yeah, competitive streak kinda comes out that you've probably lost ahm when you were younger you know but it's it comes out again…'

E114: '...there was a great crowd of lads here and good camaraderie and banter and that and when the night would be over you'd look forward to the next night.'

Free programme

MOM as a programme was initially free to all participants, however, after the 12 weeks, many groups decided to continue each week for a small fee to cover any costs [venue, facilitator etc.]. Many men spoke of how having the initial programme free of charge was a great incentive for them to join and sample what MOM was about. Some of these men who were still working or made reference to having money said that being free was a hook regardless of their financial status because it gave them the opportunity to test it out. However, for the other men, being offered a free programme was a hook for the simple reason that they could not afford to attend paid sessions. This was highlighted further on in

the interviews when they spoke of not being able to sustain engagement once the sessions became 'pay as you go';

> *H113: '...the fact that it's free or not is neither here nor there the money's not a problem for me. Ahm. Initially when I looked at it and I saw, 'twelve weeks free' I thought OK, I'll try it out and if I do not like it I can walk away no big deal. But I stayed and did it for the twelve weeks and enjoyed it.'*

> *H25: '...when the Men on the Move was free, it was great…like now* (when it was 'pay as you go)]*, I just haven't got the money…it mightn't be much but I would not have 40 euro you know what I mean so...it do not sound much to some people but it's a lot for me…'*

4.2.2 The approach of the PA Coordinator

All men made reference to their PA coordinators and the impact they had on their participation in MOM. The PA Coordinator played a central role in creating an environment of care and respect. PA coordinators helped the men feel at ease in a variety of ways that were meaningful to all men; they showed an interest and dedication to them, they used their first names and took pride in their achievements. All of this underpinned men's experience of feeling acknowledged and cared for;

> *E132: 'The last day she* (the instructor) *had tea and sandwiches and she made them all herself like. She had a party planned and we all said we would bring something. But she said, "No, I'll look after it'. She was very interested and dedicated to us like.'*

> *B54: 'There was one thing that stuck out in my mind that was how the Instructor was so proud of the whole thing* (MOM celebration day)*…He kept going "They all came in under an hour"…he was really thrilled to bits with it.'*

Some men made particular reference to the importance of being called by their name. These men felt it was an approach that made them feel respected and like an equal;

> *E11: 'The PA coordinator is great. He knew everybody by their first names… if you can call someone by their first name it means a lot to them. When you call someone by their first name you acknowledge you know them.'*

Participants' age and experience of and capacity to do PA varied considerably within groups. For those who had previously been inactive [majority], coming to the MOM group could be a daunting experience and it was important for them not to be judged or for the group to be competitive. Therefore, the emphasis the PA Coordinator placed on going at one's own pace and '*not overdoing it'* reinforced this value of participation over competition and was important to the men. It is evident that participation, in whatever way a man was able, took primacy in MOM groups;

> *H7: 'I never played football or hurling or anything like that but that doesn't matter. On a Thursday night we play walking football in here and it's absolutely great. You'd be drowned* (reference to sweat as a result of the effort)*.'*

> *E109: 'Up here some men could jog, some could run but it made not one bit of a difference. We were altogether at the end and we were altogether during it. No one judged each other. There was no competing against each other…'*

> *E11: 'After the first night I said, "I won't last". But as the PA coordinator told us "Don't overdo it". Just do it how we thought we were able and do it slowly.'*

Many men also spoke of their reliance on the instructor's presence for guidance. This guidance was seen to be of particular importance as they believed when they were doing exercise alone they were more than likely doing it wrong. This in turn, would have added to the burden of shame of not being able to do PA 'right';

> *E109: 'She was very kind and motherly like and great encouragement you see I suppose grown men are only boys in some sense* (laughs) *so we needed some guidance. She was ideal for that group of people…'*

> *H129: '…and the instructor is nice…he doesn't push you, he knows how far you can do and he tries to encourage you along…you can chat away to him too and ask him different things…'*

> *E109: '…our leader obviously she cared for us. She was giving us her time…it's the nicest kind of counselling you could get…'*

PA coordinators integrated local amenities and community constructions e.g. play grounds or car parks into the MOM training programme. As a result, men described how they were able to gain new knowledge of how exercise can be achieved without expense or in the ease/safety of their own surroundings;

> *H129: '…I kinda learnt that compared to the gym, you can get just as much exercise even out there in the yard or kinda walking around or if you know the different things to do, there's no need to spend hundreds a year on going to a gym when you can get just as much exercise without buying a whole load of equipment, a couple of bottles filled with water...'*

> *J39: '…you would have identified local places where walking is relatively safe… I really liked the nights we did in a car park. It was just showing us how you can*

actually fit so much exercise in a small space, using just a car park. Over and back and round and around.'

As a result of MOM using local facilities, men began to discover new places or amenities as a result of the instructors alternating settings or the routes taken each week;

H43: 'When you're walking you're enquiring looking around seeing what's there. I've been to a, b, c so you would be walking around towns you haven't been to in years and it keeps you going.'

Men used the context of MOM to break down barriers that prevented them from engaging with PA. In addition, men highlighted the many programme details which initially attracted them to MOM. While most of the conversations revolved around their engagement with MOM, naturally conversations of past difficulties in first finding a suitable programme and then signing up to it began to emerge.

In summary, many factors of the MOM programme mattered to the men to help them engage and sustain engagement. These many factors included; how the PA coordinator managed the group; the non-judgemental atmosphere, going at your own pace etc. Having the programme free, set in appropriate easily accessible locations and age and gender appropriate. As a result of their sustained engagement with the programme and ongoing interaction with the other men and the environment in a safe social space, opportunities for connection happened with themselves, others and their natural environment.

4.3 "*…just being in this group…talking to the men in a casual way like the banter and slagging…looking out for others"*-The meaning of connection

4.3.1 Caring for others

Participants' spoke of how they felt cared for or how they would care for others in the group. They also spoke of having a group of people to call 'friends' and being accepted and understood;

> *E109: 'You have to care for someone if you're walking with them and chatting with them…out walking with a group of people who are similar and people who care for you'.*

A majority of the men spoke of a sense of camaraderie in their MOM group and it was evident that the men cared for one another. They spoke of rarely missing a night of MOM out of respect for the group, except when it was unavoidable; they acknowledged a group member's absence when he missed a session; they stayed to support those slower than themselves so as not to 'leave him too far behind'; and they were kind to one another;

> *H6: 'Ahh you kind of felt as if you had let the guys down a bit you know* (if he missed a session) *even though I missed one or two sessions because I was actually overseas but I came back and ahh I renewed the rivalry, as they say, the following week so got back into again straight away…'*

> *E126: 'Now a mate of mine was fairly heavy and I didn't want to leave him too far behind* (laughs). *We were both moving so it didn't make much of a difference.'*

After breaking his foot, one of the participants was struck by the kindness of another participant who took the time to bless his foot;

B54: 'One of our African gentlemen came in one night… and I had the boot off… and he got down on his knees and he blessed my foot, 'cause he's a lay preacher...I thought it was very nice of him.'

4.3.2 Friendship

Banter was a recurring feature of MOM sessions, which many felt made the hour pass quickly and the PA more achievable. Banter is a term commonly used when referring to a playful exchange of good humoured teasing remarks. However, men acknowledged that engaging in banter was only possible 'at a certain level of friendship' because outside this level, banter could be taken up as rude or insulting. This finding is indicative of the level of connection established between group participants. Having a place to enjoy banter among men was particularly meaningful for those men who may have been experiencing loneliness and isolation prior to MOM;

B54: '…you know this Irish tradition that people slag (mock) *each other. It's meant in the nicest possible way but you can only do that at a certain level of friendship, otherwise it's misunderstood…men carried this banter through to the actual going out running at night.'*

Numerous and 'great' friendships were created in MOM groups and the level of connection within these allowed men to 'open up'; and feel included;

H80: '…just being in this group and talking to the men in a casual way like the banter and slagging it just helped a massive amount. You can just open up and chat about it.'

F: 'Would you see those friendships outside of men on the move? H6: Oh god you would yeah, you would and people that you'd meet on the street now you'd know them at least or you'd meet people that you didn't know before.'

The importance of doing PA with others was aptly outlined by a man who spoke of how he missed the group when he started in a local cycling club and doing PA alone;

> *H25: '…I'd go out every Sunday with the* (local) *cycling club, there's a group there that's grand when we're cycling but I go out 2 evenings a week now running and it's kind of getting a little bit boring now 'cause I'm on me own again…when people aren't with you, you kinda get bored, I do anyway…'*

4.3.3 Being accepted and acknowledged

For those who identified as 'non-locals' [n=9], having a sense of belonging to their MOM group, over time, evolved to connecting with and being accepted by their community. Prior to getting involved in MOM, men who were non-locals spoke of the difficulties they faced with regards to integrating within their communities. MOM was a vehicle for breaking down boundaries for 'outsiders' to integrate or 'connect' with their community. These non-local men found they could easily integrate on the commonality of MOM instead of trying to draw on geography or community as a reason to connect with other men;

> *J69: 'So wee things like that, getting your photo taken and put in the local paper…if it goes in the local paper you feel as if you're now part of the community. I mean there's a saying in* (County) *which I heard… "you're a blow in" F: So what is it like for you to feel part of that community? J69: It means a lot to me.'*

> *H25: 'I don't know see I'm only new to the town and I went to the men's shed like and I made a lot of friends there but I couldn't get no one to kinda go walking all the time with me…'*

> *B100: '…I'm not from around here either so I didn't know the group. Most of the guys knew each other and I'd chat to different people there I was chatting to people*

outside but I wouldn't really know them you know...I wouldn't know who I was talking to properly.'

4.3.4 'Identification'

Many men spoke about how a commonality with other men opened up opportunities to establish friendships and to feel normal or accepted as a result of normalising what they were going through. The majority of men identified with one another as individuals on many levels e.g. their appearance, their level of fitness, life experience and collectively they identified as a MOM group. Blending in and not standing out supported men to normalise their experiences [job loss, bereavement, retirement, illness] and accept themselves as being 'OK' while helping them to overcome prior feelings of shame associated with being slower or heavier;

E126: 'I looked around and all the blokes there were in my age group which made me feel comfortable…you know everyone sort of looked the same (laughs)*… so I thought "well you're not going to stand out here"…'*

H7: ' People my own age, I mean if you go into some place with young fellas there who will run rings around me but here that's not happening here. The lads are my own age and there is nobody making fun of anybody if they are slower you can be last walking around the circle and there would be someone with you. So that's very important.'

However, it is important to note one man's statement of feeling left out of a group he belonged to. When other members of the group were progressing, he felt he couldn't keep up and left as he did not want to be a liability. He felt other men did the same when they joined

the group but did not fit into a category. This highlights how important it was for the PA coordinator to monitor the inclusiveness of the group;

> B123: *'There were 5 or 6 categories of ahm abilities. There were guys who are extremely fit, or the very, very fast walkers. I just could not keep up with them. I would have been the trotters* (laughs)*] and ahm a category ought to have been in place maybe for the slow walkers, people who had little ailments maybe back, hip, knee problems or some other medical difficulty. I could see a couple men tried it* (MOM) *one or two nights and then kind of petered out ahh just like I petered out there at Christmas time. The reason being that there was nobody in my category, at least if they were they had become very rapid walkers. So I just found it impossible to keep up and ehh I didn't want to be a liability to the group…'*

Men felt understood because they were surrounded by other men who joined the programme feeling similar fears or anxieties. This common understanding made men feel safe and accepted and ultimately meant that conversation was easier to initiate. Most men spoke about opening up and discussing what might previously have been regarded as taboo topics and, as a result, gained support from others in the group;

> *E109: 'I think a lot of us realised we all have the same concerns and that's why we felt comfortable…we would touch on different topics and when people would be comfortable they would chat away it was nice…we were discussing every topic under the sun and topics that some lads would never have discussed.'*

Collectively, many men identified as 'MOM men' and participated as a group in many community events. The strength of this identity was made apparent when men organized t-shirts to show they were part of a group;

E114: '…We helped out in a recent cycle event and helped doing stewarding. We had our t-shirts on (laughs). *It gave us a bit of identity. So yeh, we would have some sort of affiliation to MOM if you like…It would be important to have a kind of identification that you were going to something or you have something to aim for rather than fellas just meeting for no reason…'*

There is also anecdotal evidence from a group leader of how, on the sudden death of a group member, men from his group presented his wife with a MOM t-shirt at his funeral, which highlights the meaning of the group identity to the participants.

4.3.5'Purpose'

Purpose in terms of connection was spoken about with regards to adding structure to or establishing a routine to the day or week. Furthermore, feeling useful, and setting new goals or aspirations also allowed men to gain a sense of purpose thus establishing an identity and giving them a sense of belonging.

Routine, structure

MOM provided many men, particularly retired and unemployed men, or those who found themselves in a routine of staying indoors after work, with a purpose and an opportunity to get involved in something. For some participants, simply being 'in contact with people' was enough to 'liven' them up. Getting out regularly, gave these men a purpose or meaning to their lives and a sense of belonging to the group and their community;

H129: 'I'm retired the last 3 years so it's kind of a nice hour and a bit like with a couple of the lads and have a bit of banter and a bit of fun and a bit of exercise...I needed something to liven' me up.'

B75: 'And what happened before the 'Men on the Move' came into action is that from work, I'd go to bed, sleep all day or be working or get a call for work. I'd sit on the couch, watch TV and do nothing…'

4.3.6 Feeling useful

Some men spoke of feeling useful in the group and they identified different roles they adopted such as the 'joker', the 'agony aunt' or the 'water boy'. One participant spoke of how he redefined his role within the group after sustaining an injury. This man continued to participate in MOM by redefining his membership to something purposeful that didn't require PA;

B54: (After sustaining an injury) *'I was here every night and I made the tea and coffee and I cleaned up and washed up and all that sort of thing. So I became a kind of water boy for the duration and I didn't have a problem with that, you know. On the final night that we broke up here I did a whole menu for them with prawns and salmon and the whole thing…'*

It's evident that the connection to and camaraderie within the group instilled a sense of duty in participants to show up and keep the group going.

H6: '…one of the big things was the camaraderie that we had among the group…you kind of felt as if you had let the guys down a bit you know if you missed one or two sessions…'

Men spoke of the need for something to be the catalyst or 'kick in the ass' to get them involved in something;

H78: 'It was fantastic. It was really fantastic because it was the ignition, the start which I needed. And in plain English the kick in the ass which I needed…it was the ignition, the starting point which I needed to say "Come on, do something"…'

For many men, giving back to others led to them feeling included or valued. These men helped out in their communities volunteering to clear paths, steward events or to participate in community led activities;

J34: '…there was a lot of physical work getting the actual path for walking ready but we really loved it, lovely place and the people the local people are also enjoying it every Saturday morning and we're getting a great buzz out of it.'

The meaning of connection to the participants provided them with a group of men with whom they could be themselves and create friendships. The relationships they built in the groups led to feelings of care and acceptance. The connections that men felt were the catalysts for change that men needed to make changes to their health behaviours.

4.4 "You feel healthier and happier in life because you're losing weight…everything during the day is easier when you're fitter" -The Impact of Connection

Engaging in PA from a social perspective increased self-efficacy and agency in men to live a better life. Through participating in MOM, men were supported to overcome feelings of shame and to value themselves, which in turn prompted change for the better in their lives.

4.4.1 Overcoming shame and recalibrating goals & priorities [or redefining boundaries]

Participating in MOM presented the men with numerous opportunities to overcome feelings of shame that they had previously felt. In particular, the sense of normality that came with finding common ground to share anxieties and vulnerabilities, coupled with the sense of achievement that the men experienced with the passing weeks of the programme, were both

instrumental in building self-confidence and dismantling that shame. Simply leaving the house to participate in MOM was an achievement for many men. For others, achieving in PA beyond their expectations of themselves reduced their self-consciousness about being active in public, built self-confidence and self-efficacy and motivated them to achieve further;

> *E128: '…even going on holidays with a big belly I was ashamed but now I'm looking forward to it. Even my clothes size has gone down, everything which is no harm. I'm just delighted it's* (MOM) *there. Like its great, an absolutely great programme.'*
>
> *J69: 'I could be down the beach just now and exercising it would not bother me now if there was people about because who's bothered? People aren't bothered. But I would not have done it before so now I'm not as self-conscious…'*

A sense of pride replaced shame for many and was a resultant impact of being more active and achieving more physically;

> *E132: 'It is yeah and proud of yourself for losing weight like for at no big cost like because not spending thousands on gym memberships and that.'*
>
> *J69: 'She said "No, you've lost weight, I can see it in you" so it's a nice feeling when people recognise that you have lost something isn't it?'*

For many, it took time for them to accept that they had succeeded in losing weight. For some men, lighter and leaner bodies became the embodiment of better overall health and feeling more content with and confident within oneself. This was particularly significant for the men who had spoken about the void that had once engulfed their lives. The change in their physicality mirrored the momentous step they had taken toward reconnection;

> *J69: '…a couple of days ago this lad said "Christ man you've lost some weight" I said "no I haven't, I haven't lost a lot of weight, I'm wearing smaller clothes"… I*

think just to lose that little amount I have probably just dropped a size in clothes and that's what people noticed.'

New goals and achievements

The majority of men wanted to sustain their achievements post MOM. After reflecting on their health in the past, men began to take ownership of their health in an attempt to prevent future health complications. Many men felt that by recalibrating their goals and priorities they would be able to continue toward success and achievement;

H63: 'Oh definitely my health is a lot more important now. See the trouble is when you're 40, 50, you think there's always time to lose it. But time could be running out. (laughs) *When you get to 60 you have to start. And in saying that I did a guard of honour Sunday for a man, so it just puts it* (life) *into perspective…'*

Through a continued progression, many men relayed how they began to set goals, and in achieving them, they were able to progress onto new targets, in turn increasing their self-efficacy to 'do' PA. In seeing themselves progress in weight loss, participation in community runs or taking on a 10km, motivated them to keep going as they felt that they now knew that they could achieve things;

E109: 'I did a marathon that was 10km. I ran every bit of it, well not ran but jogged a good jog. Now for me, that was like winning the Olympics.'

E128: 'Once you get going and see you lose weight you really work at it then because you know you can achieve things…'

E126:'…as the time progressed you started saying well I have done 5 laps this week I might try for 6 next week…'

Initially, for the majority of men, age was a major contributing factor with regards to why they decided to start on the programme. Many men described being at an age where they felt their bodies to be in physical decline. These men spoke of how they wanted to do something to defy or cheat the ageing process. Throughout the programme men began to surprise themselves in what they could achieve as well as surprising younger members of the community. As a result, these men challenged their own ageist views that had previously prevented them from competing in PA set ups;

> *H80: 'Yes* (laughs) *like as we were leaving the AstroTurf the other night there were lads coming in for rugby and I said 'Right come on we'll take you on'. We have a bit of banter there with the young lads. So I do not think age would come into it now really.'*

> *H6: '...watching these young lads watching us play indoor soccer and you know...and we proved to them that we can do it…even though it was at a much, much slower pace you know we still played...'*

> *H25: '....I suppose I joined* (MOM) *for my health 'cause I'm a diabetic so I needed to lose weight which I have lost weight…and I've arthritis and since the programme. I'm able to jog 4 miles now and I'm able to cycle every Sunday…'*

4.4.2 Improvements in health behaviours and associated benefits

Improvements in health behaviours-diet, alcohol, exercise, relaxation

As a result of the considerable achievements in weight loss, emotional and mental health, improvements in fitness and overall health, many men were very reluctant to fall back into poor health behaviour practices. Many men spoke of applying practical skills obtained

from the wellbeing and nutrition workshops or taking on board useful tips from other men. Such skills and knowledge helped men change and to make healthier choices;

> *E11: '...I now throw an apple or two and a drop of water in the car so it's made easy for me and it will be far better.'*
>
> *E114: '...having met the dietician you would have more of an interest in what you were eating and you would appreciate a good diet whereas before you would not be too pushed.'*
>
> *E11: '...there's no point going doing exercises when you eat 4/5 mars bars and a couple of bags of taytos on the way home in the car.'*

Many men spoke of a better relationship or respect with food. Many men mentioned how as a result of them talking about the information they received at dietary workshops, their family members took this on board too, reducing the intake of sugary foods or increasing foods such as fish or vegetables;

> *E114: '...you would appreciate it more and you would have a better appetite and feel more for food you know…'*

Weighing up the cost of drinking alcohol against what they got from MOM was something a lot of men did. As a result for a majority of men, they spoke of a reduction in their need to go out drinking as they all got something more fulfilling from MOM;

> *E114: '...when you spread it* (cost of programme*) out over 13/14 weeks its only small really. It's a pint a week I suppose* (laughs*)…'*

The majority of men had stories to tell about how MOM impacted on the general improvement of their way of life. Many of those men who were working mentioned a heighted concentration or focus towards their work as well as improvements in their work/life

balance. They felt they had become more efficient in what they were doing or how they would deal with problems in work or in their personal lives. For the majority of these men, they felt that any problems they had in work were dealt with in MOM instead of bringing them home which would have been something that impacted on their family relationships in the past;

> *B78: 'What it means to me is that I'm fitter, I'm more relaxed. OK as I said I work with people with special needs and it is quite tough I have some guys who are quite rough but now, I'm far more relaxed. I'm better able to just cope with the situation but also the situation with three youngsters at home it makes all the difference just being more relaxed and at the end of the day still having energy to play with them.'*

Prior to MOM, men felt they didn't have time for PA. However, as a result of their participation, many men now incorporate their own structures into their daily lives and found a time [lunch breaks, weekends etc.] where they could fit in their daily exercise. Taking time enabled them to switch off and to do more of what excited them in terms of PA;

> *J74: 'Now before this* (MOM) *you thought you would not have time to do it like, you have that time now to get out…I've got a wife and kids too but I have that time to slot in the week…'*

One man spoke of how he would always fit in his steps even when on holidays;

> *H43: '…I walk a minimum of five times a week for an hour each time so I kind of hold myself to that and tick it off my diary you know I would be methodical like that…or even if I was going on holidays now for a trip. I like to go on city breaks and walk around I would wear the step counter.'*

In addition, some of these men felt that having to be at MOM at a set time was the push they needed to finish work on time.

> *B21: '...before I could go to work at half 8 in the morning and could be half 9 or 10 o clock at night before I'd come home. Now MOM actually makes me finish work on time…as the wife said "you know you can finish for this but you can't come home to me"* (laughs)…*'*

The associated benefits of being part of a PA group

Becoming more active and learning to take time out for themselves resulted in other changes and benefits to the majority of men's lives. Such changes included, but were not limited to, the following; improved fitness and overall health, having more energy, being better able to relax, snore less, walk to the shop, play with their children, *'tie [his] shoe laces in the morning without being out of puff'* , garden without back pain and paying greater attention to detail at work. These improvements were used to bench mark how they had improved their lives;

> *B75: '...before Men on the Move I lived in the back* (of the estate) *here and I used to walk to* (supermarket) *and before I reached* (Supermarket) *I would have to sit down in the field because of my back aching. Now I can run it.* (laughs).*'*

For some men, improving chronic conditions meant a lot as they now felt free of the condition that had many implications on their lives prior to MOM. Many of men felt that previous health complaints disappeared as a result of doing more PA which resulted in feeling fitter and stronger. One man referred to himself as *'a crock that's been improved'.* These men made reference to how they reduced medications. One man spoke of his doctor's comment of how he often '*puts people up in medication doses but never puts people back'*

with another man being so amazed by the improvements to his diabetes; he brought his insulin and blood sugars record book as proof of his achievements;

> *H25: '...isn't that proof* (holds up insulin booklet])… *I brought it in because you could say that I was telling porky pies…my diabetes has gone right back down* (reduction in insulin intake) *and everything is gone because of all this…that's changed my life now being honest with you…'*
>
> *E128: 'You feel healthier and happier in life because you're losing weight, and you're healthy and fitter. And everything during the day is easier when you're fitter…'*

As a consequence of being more relaxed, some men described feeling a stronger connection with nature as a result of being able to take a step back and notice their surroundings. Men spoke of how they were taken aback by the lakes, stars, the smell of flowers all of which surrounded the various MOM training settings or were found in nearby parks that men used outside of MOM hours;

> *E109: '...you notice the smells of the flowers and the little birds, I love nature, tramping along its heaven!... your mind is clear and you're better able for work and better able for leisure and for everything you know…'*

As a result of men's improvements in their own lives, men spoke of how this influenced others to consider joining MOM. In addition, other men mentioned the increase of MOM conversations in the community as a result of seeing the local men's participation and associated improvements;

> *E128: '....lads who are going to come on board who would have weight on and feel embarrassed going but looking forward to it now especially when they have seen how everyone else lost weight…'.*

J69: 'But I have heard other people you know I can quote 6 guys who I would see over a weekend, and this is always a conversation 'Men on the Move' that's a conversation you know.'

A result of the initial MOM participants' achievements and increased conversations on MOM in the community led to a 'gateway' for other men to try out MOM. As stated above, in addition to other men wanting to sign up, female family members were also interested in a 'Women on the Move' group being set up[1]. Some men spoke of their influence and how their wives were asking when a 'Women on the Move' was starting up or that they were going out for more walks at the weekends as a couple;

B111: 'As a matter of interest my wife was asking if you were going to run one [MOM] for ladies? It was just of interest to her…'

4.4.3 Improvements to Family life

Taking up PA for the majority of men also promoted ripple effects to their families' health behaviours such as dietary changes;

B75: '…when you are exercising you change your diet, like I am I have a sweet tooth…I used to have (named fast food outlet*) every Sunday for my family, since we started MOM they never had a* (named fast food outlet) *so I cook for them.'*

H111: '…real eye opener was the sugar in the soft drinks. Consciously I made a change of those drinks at home. The family are sort of coming off the back of my experience. That is something the kids are not having soft drinks anymore which has come from my experience. So what I learn I bring home. When I come home from a

[1] Women on the Move groups have been established in… locations at present.

session they always ask how you get on and we always talk about it. I'm trying to get them more involved.'

For many, MOM had a transformative effect in terms of re-energising participants and infusing increased vitality and connection with loved ones. Many of these advances were mentioned by men in relation to an improved 'role in fatherhood' or becoming a 'proper father'. Men felt it was imperative to be able to demonstrate to their children the importance of keeping healthy. This was seen when some men would practice their stretching or core exercises at home often resulting in other family members joining in:

H78: 'I'm better to just cope with three youngsters at home… just being more relaxed and at the end of the day it's still having more energy even to get some paper work done…'

E132: 'I've a young family so I wanted to be around when they're a bit older to be able to play football with them, run and play with them and not be out of breath…I always give my best to the kids, they're first and my wife…you just have more energy for doing more and you would not be bunched after it…I never let the kids know I was tired, ah no 'cause it's a bad example like. No you just get on with it, when you crash you crash at night but you just have more energy for them.'

One man spoke of how each year he would miss climbing a local mountain with his family as he was out of shape but was now looking forward to accomplishing it the following year. This man not only achieved things for himself but also his family as a result of being able to plan and participate in family activities;

H111: 'One of the other things we always did as a family was climb [a local mountain] and last year I could not make it because I wasn't fit enough to do it. So I

have planned to go back and do it this year and just prove a point on a personal level that I can do it and for my family too…'

Men felt they became better father figures for their children, showcasing the importance of being healthy. In addition, family members gained new skills and knowledge regarding exercise and nutrition. Improvements in all-round health led to an upgraded way of life in work, in accomplishing many of the activities of daily life and in realising the importance of a work/life balance. Finally, MOM led to many changes in health behaviours which were used so as not to waste the efforts they had put in to date. Such changes included reducing a reliance on medications, gaining new skills regarding making the right food choices and how to fit exercise into their routines.

In summary, this chapter explored 4 themes. *Disconnection* explored how men felt prior to MOM as a consequence of many critical life circumstances they experienced and how this impacted on their ability to do PA. *The context of MOM with regards to [re]-connection* explored the many factors that men needed in order to overcome disconnection and achieve [re]connection. *The meaning of connection* focused on what connection meant for the participants such as feeling cared for, having friends that you can identify with and having a purpose all of which helped them overcome personal challenges. Finally, *the impacts of connection* explored how connection acted as a catalyst for them being able to enjoy many aspects in their life to the full.

Chapter 5 Discussion

5.1 Introduction

It is important to acknowledge that the change men experienced was the result of feeling more connected. Subsequently, men felt more connected as a result of the effects of the change they experienced. Therefore, there is a constant cycle between seeing a change and feeling more connected. This meant that while connection led to a change in men's behaviours or way of life, this change also led to a greater connection. This cycle is presented in the Figure 5 which was developed in response to the results from this study.

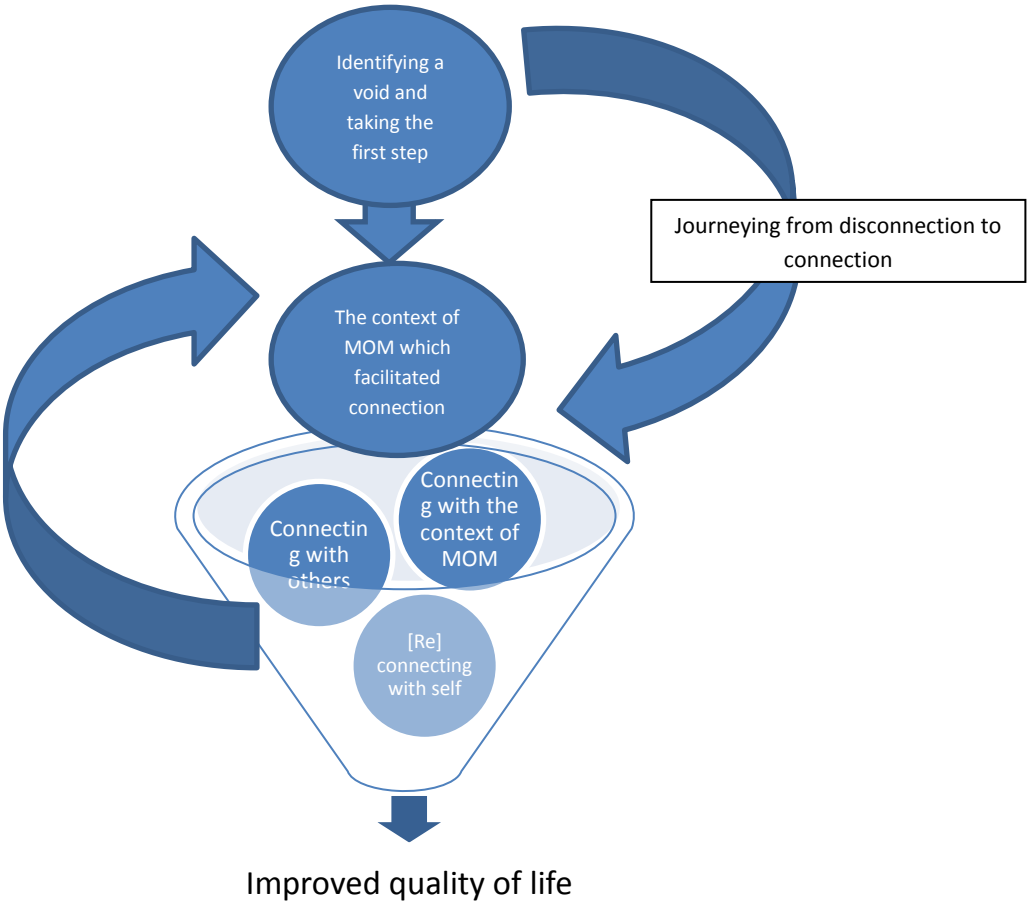

Figure 5.1: An overview of the context needed to [re]connect and how different stages of connection can merge and lead to the final outcome of behaviour changes subsequently leading to an improved quality of life.

The aim of this study was to gain deeper insights into the lived experience of the MOM participants and explore the broader impact on their health and lives. This chapter will summarize the four themes that emerged from the study in the context of the wider literature under the following headings; 1. Human connection; the corner stone of overall health & wellbeing and 2. Facilitating connection in men's PA programmes.

5.2 Human connection; the corner stone of overall health & wellbeing

Disconnection

For the majority of participants in this study, disconnection emerged as an important backdrop and starting point for their initial engagement with the programme. Disconnection for the men in this study referred to an isolation from others or a network resulting in a lack of control, purpose and feelings of shame. Within the literature, human disconnection has been described as the disconnection from and devaluing of the sensory experiences of our physical selves which ultimately causes us to lack compassion for and be abusive to ourselves, others and to our natural surroundings (Rinzler, 1984). The literature mirrors this and states when individuals lose connection or are not experiencing sufficient support within existing relationships, they may experience social disconnectedness or social isolation which can be characterised by a lack of contact with others (de Jong-Gierveld and Hagestad, 2006; Wenger and Burholt, 2004; Van Baarsen et al., 2001). Many factors underpinned participants' disconnection such as job loss, experiencing illness, bereavement or just not feeling comfortable within themselves as a result of ageing or being overweight and/or unfit. O'Donnell and Richardson, (2018) reflect this by saying how isolation and social disconnection for men can be product of a number of changes or critical events in their life such as unemployment, bereavement, relationship breakdown or a decline in rural communities.

Where disconnection or social isolation is described as the absence or lack of contact and integration with other people, the term loneliness is more focused on the feeling of being without that contact (Wenger and Burholt, 2004). In the context of participants in this study, irrespective of what prompted their disconnection, it manifested in feelings of shame and loneliness in their lives which prevented them from participating more fully in life. Many other studies also highlight the many other ways disconnection can manifest such as a failed belongingness (Joiner, 2005), loss of personal control (De Leo, 2002), loss of integration (Durkheim, 1979), loss of identity or purpose (Turner et al., 1994; Walsh and Walsh, 2011) and a critical and unkind treatment of self (Terry and Leary, 2011) fuelled by shame which can underpin a wide range of mental health issues (Brown, 2006).

Many of the men in this study still had families, were working or had a partner but still spoke of feeling disconnected. Murthy (2020) believes that there are 3 dimensions of loneliness and can be described by the type of relationships we are missing which are 1. Intimate or emotional loneliness which is the longing for an intimate partner or close confident whom you share a close mutual bond of affection and trust, 2. Relational or social loneliness which is the yearning for quality friendships and social companionship and support and finally, 3. Collective loneliness which is when one is missing a network or community of people who share your sense of purpose and interest. Therefore, while the participants in this study appeared to be connected in other ways [with family, jobs etc.], perhaps they were missing a different sort of connection in their lives [i.e. social or collective].

The majority of men in this study never referred specially to being ‘lonely’ or feeling ‘shame’. Instead they spoke of their disconnection with regards to having a lot of time to fill as a result of not having the same routine or busy schedule that work or family life once offered. Others spoke of the embarrassment or worry they felt when they would go out to do PA in public. Whereas others spoke of how they were looking for an outlet to enjoy the

company of other men. This is also evident in Murthys' (2020) research which highlights how we judge and blame ourselves for who we are when we are lonely i.e. "I am lonely because I am broken". He believes this is why individuals do not seek help for loneliness as there is still a stigma attached to it.

For the most part, many men in this study were shown to be quite stoic in how they spoke of their loneliness, which is linked to the traditional masculine attributes such as; (1) stoicism or inexpressiveness (a man must not express his emotional distress) and (2) autonomy or independence (a man must solve his problems alone, without the help of others) (Jansz, 2000; Maclean, Sweeting and Hunt, 2010). However, many men did not uphold these stereotypical male ideals and behaviours with regards to attending registration and subsequently committing to MOM. This highlights how integrating traditional masculine stereotypes positively into MOM, allowed men to engage with the programme by making it acceptable for them to engage with a programme as it didn't clash with their gender beliefs. As a result of this gendered approach, MOM did not require men to be emotionally expressive but to just participate which itself supported men. This approach is outlined in more detail below.

Connection

Men in this study spoke of connection in many ways such as being able to open up and talk casually with other men or caring for one another such as blessing a man's foot. Others spoke of connection as feeling like you belong to a community because your photo was in the local paper and feel normal because everyone has similar concerns and looked similar to you. All of which made men feel normal which meant that the shame they initially felt began to dissipate. All of this is replicated literature. Human connection can encompass many different forms making it difficult to pinpoint a definition that captures the wide variety

of connections individuals can make. However, many studies make reference to the many aspects that make up connection which are pertinent to this study such as belonging, identification, feeling seen, heard and valued, awareness of self and the natural world and self-compassion (May, 2013; Allen and Leary, 2010; Brown, 2006; Mayer and Frantz, 2004; Karcher and Lee, 2002; Baumeister and Leary, 1995).

As a collective men in this study spoke of connection as looking out for the group by making sure nobody was on their own or not let men down by not missing a session or being part of the groups' identity by wearing MOM t-shirts. Therefore, as connections increased in men themselves, so did the connections in the group. Connection provides individuals with a social network of caring and respectful relationships which have been found to reduce at risk behaviours such as substance abuse, bullying and violence (Bernand, 2004).

Regular, in the moment connections increase feelings of belonging and inclusion therefore, during times of need many individuals rely on connections for support (Holt-Lunstad, Smith and Layton, 2010; Langley, 2012). Men in this study found it difficult to initially communicate how they were feeling. However, after being offered appropriate spaces, with likeminded and being in a practical situation, men were supported by other men through the casual sharing of regular conversations which built up over time to the more intimate conversations of topics that would usually not have been discussed. The literature highlights the effects of a practical setting like a PA group on connection by stating how it can facilitate social relationships through social connectedness arising from building friendly and trusted relationships between people during activities (Lubans et al., 2016). Furthermore, evidence to support the role of PA's contribution to overall wellbeing is greatly established in the literature (Grunseit, A., Richards, J. and Merom, D., 2018; Dinas, Koutedakis, and Flouris, 2011; Edwards et al., 2005). The impacts of PA on wellbeing are said to be attributed to enhanced feelings of control, improved self-concept, self-esteem and self-efficacy and

more positive social interactions (Scully et al., 1998). Therefore, in addition to the camaraderie, support etc. that the men experienced in this study, the act of doing PA and becoming more active may have further supported and/or deepened the men's connection.

The conversations that emerged in this study were likened to the more intimate conversations of 'pillow talk' which could only have happened with a certain level of connection. More specifically, men spoke freely about health matters [diabetes, physical concerns etc.] to one another that were acceptable in the context of a male only PA group. In other words, there was a different norm or practice created for these men when they were participating in MOM. Findings from the second evaluation of the 'Salford Dadz' programme (Robertson et al., 2018) acknowledged something similar. Men on the Salford Dadz programme described how it provided them with a safe setting and environment in which could socially interact with other men resulting in opportunities for personal sharing and for recognising that many of their own issues are common to other men.

Feeling a sense of belonging with the group allowed many of the men within MOM to flourish on both a personal and social level. This is in line with the social cognitive theory whereby our findings indicate that the better the support from the social environment [participants and instructors] and from the physical environment [surroundings, settings], the more likely the men played an active role in the group which resulted in a deepened self-awareness.

One's fundamental need to belong, and to connect with others has a great influence on one's health (Keohane and Richardson, 2017; Brown, 2007, 2010; Joiner, 2005; Baumeister and Leary, 1995). Men in this study spoke of how they gained weight as a result of their disconnection with others mentioning being on a number of medications for depression or blood pressure or some men spoke of feeling unfit. The effects of disconnection and isolation on health that participants in this study experienced are mirrored in the literature. Studies that

have investigated the effects of social relationships on mortality consistently show that individuals who lack or have low levels of social relationships have more than doubled the risk of premature death compared to those with higher levels of involvement in social relationships (House, Landis and Umberson, 1988, Berkman and Syme, 1979; Holt-Lunstad, Smith and Layton, 2010; Cacioppo and Cacioppo, 2014; Holt-Lunstad et al., 2015). All of which make connection an essential human need.

Holt-Lunstad, Smith and Layton (2010) highlight how the negative impact of social disconnection are comparable, and in many cases, exceed that of other risk factors such as smoking up to 15 cigarettes per day, obesity, physical inactivity and air pollution. Karp (2017) also acknowledges isolation and disconnection as a major health impact by stating depression is an illness of isolation and a disease of disconnection. Many other studies have also highlighted the negative health impacts that are posed on an individual in the absence of social connection [social disconnection] (House, 2001; Brummet et al., 2001; Pressman et al., 2005; Steptoe et al., 2013; Wu et al., 2013, Cacioppo and Cacioppo 2018).

The need for connection is especially evident during present times of Covid-19 and perhaps, in later years, the potential impacts of social distancing will demonstrate more than ever the importance of human connection and its impact on health.

Connecting with self and others

Many of the participants in this study who had gone through trying circumstances were able to begin to reconnect or form deeper connections with themselves as a result of their participation in MOM and what it offered them. Such findings have also been explored in Brown's (2006; 2007; 2010) studies. Her 'Shame Resilience Theory' (2006) is based on building resilience to shame by connecting with our deepest self and growing meaningful relationships with others. When we are experiencing shame, shame resilience involves moving away from shame (fear, blame and disconnection) towards empathy (connection,

compassion and courage [self-worth]). The need to address shame before we can empathise with ourselves is also recognised by Murthy (2020). He also acknowledges that connection with self is needed before we can truly connect with others. This is a cyclical relationship whereby connecting with others can also help us to further connect with ourselves. This was one of the major findings in this study which acknowledges the change men undertook as a result of feeling more connected was the result of a constant cycle between connection with self, others and the environment. This meant that while connection led to a change in the men's' behaviours or way of life, this change also led to a greater connection with self and others. Therefore, connection was the catalyst for change and the result of many impacts to participants' lives.

Participants' sense of self-worth and self-efficacy seemed to be enhanced by MOM as a programme, through the connections they felt; feeling cared for, valued etc. and self-efficacy was nurtured via education on healthy eating, PA and the practical support available from connection with others all of which will be explored below. Therefore, as a result of the context of MOM [trusting and comfortable space with likeminded men, with sufficient time to develop relationships with others whilst being treated with respect] many men developed compassion and concern for others as detailed above [blessing a man's foot, making sure nobody was left alone]. In turn, this care and compassion that the men were shown helped to nurture them and reconnect with themselves and others. This eventually led to the development of self-worth and self-efficacy. Literature more generally states how as human beings we strive for care and compassion therefore interventions that effectively increase how individuals feel compassion and concern for others lead to a more deeply rooted sense of connection (Baumeister and Leary, 1995; Brewer, 2004; Hutcherson, Seppala and Gross, 2008). Evidence from this study highlights the importance of a sense of belonging in the

participants' lives and how participation supported men to connect with themselves and others.

When MOM participants connected with others who shared a similar identity; similar age, weight, who experienced similar life events etc. they felt supported and were provided with a sense of normality with regards to what they were experiencing and feeling. Addis and Mahalik (2003) state how men who see that their issues or experiences are shared by other men are more likely to seek support. Therefore, while a lot of the men in this study entered into MOM in a vulnerable state, and were perhaps initially reluctant to show such vulnerabilities they soon began to feel comfortable in the group as a result of seeing other men who were also coming from difficult places; thus leading to a more effective group dynamic for participants. In addition, Forsyth (2009) explains how when the ties linking members in a group are strong, the group is more sustainable and the influence on its members is more extensive. This was also found in an all-male PA group in a study conducted by Sharp et al. (2018). They found that participants enjoyed being with a group of men that had common interests, values, and struggles as it provided a connection that subsequently led to a sense of camaraderie to develop within the group thus making them feel accountable toward the group. Participants described this camaraderie by stating how they did not view the programme as a chore, but rather a time equivalent to a social outing with friends.

As a result of men feeling 'normal' about their experience as well as MOM being set in a place where men felt at ease, a lot of the male participants began to find a new found confidence and connection within themselves which meant that men found it easier to integrate, take on roles and for those from different communities or nationalities, become locally integrated. The literature mirrors such findings and states that to be socially integrated an individual must participate in a wide range of social relationships such as participation in

social activities and personal relationships within these activities and feel a sense of communality and identification with individuals within these roles (Holt-Lunstad, Smith and Layton, 2010).

The power of connection

Change in health behaviours being able to achieve things they would not have before

Connections influence on health was the result of many different connections coming together as outlined above; social [friendships and normalization, breaking loneliness], personal [developing self-worth and learning about their potential] and environmental [being able to acknowledge beauty elsewhere]. In attempting to further engage men with their health, sociological theory and research highlight the importance of social relationships in affecting health behaviours (Umberson and Karas, 2010). Therefore, if men feel more socially connected, generally, they are more likely to engage with their health.

Connecting with others led to a development of self-worth whereas the programme aided self-agency and self-efficacy re doing PA all of which led to changes in health behaviours. In support of this, the literature states the importance of self-worth in shaping long and short term goals (Crocker and Knight, 2005) and self-efficacy is the individual's perceived ability to act on such goals and the ability to make choices. Participating in a PA group helps to remove personal barriers to social interaction, provides individuals with perceived emotional support and generates a sense of self-esteem. The result of an increase in self-esteem and social support work together to affect behaviour change leads to further action (Bandura, 1989; Baumeister and Leary, 1995; Bandura and Locke, 2003; Masi et al., 2011; Maddux, and Kleiman, 2012).

Lubans et al., (2016) states how PA helps to improve individual's quality of sleep, quality of life and improvements to self-regulation skills. All participants in this study made reference to improvements they made either physically [losing weight, reducing medication], emotionally [feeling better in themselves, more energy and happier], psychologically [better able to focus at work] or socially [feeling supported, greater enjoyment and confidence at home]. All these improvements are in contrast to what men struggled with prior to MOM such as a fear of doing PA in public, not being able to go on family outings as a result of being too unfit or not leaving the house as a result of the crippling effects of depression. A similar 12 week programme for men with prostate cancer yielded similar findings. Men in that study noted a reduction in fatigue, an increase in fitness and they spoke of being provided with confidence and skills to adopt new behaviours and increase PA levels, as well as noticing an increased functional ability when carrying out ADL's (Culos-Reed et al., 2007). The Football Fans in Training programme also found that their participants weighed, on average on average, 5.6 kg less 12 months after baseline, compared with 0.6 kg in the control group. In addition, participants noted significant improvements in their blood pressure, PA ability, diet, alcohol consumption and mental well-being (Hunt et al. 2016).

As a result of the participation in MOM, men had accumulated experience of looking after themselves as well as gaining skills to help them sustain these changes [education on diet, guided through exercises etc.], men gained self-efficacy, which, in turn, enabled them to sustain their new found health promoting behaviours. Nutbeam (2019) highlights this in his work by stating how education on health, helps individuals to develop transferable decision making skills which can help them make informed behaviour changes. As such health education can be viewed as the cornerstone for modern day health promotion. MOM participants, having a new found self-efficacy and being able to set new goals and new targets due to their new connection meant a continued purpose. Murthy (2020) recognizes that being

and doing are two parts of who we are where the doing is guided by the being. If we can be in a good place with ourselves, we can do better in our lives generally.

In this current study, men, particularly fathers were concerned about their health and how it would affect their lives and the lives of their dependents in the future. These concerns were highlighted to them while playing with their children. Such findings are also addressed within recent literature. This literature details how fatherhood can result in men revaluating their health practices and feeling greater responsibility for their own health (Richardson, 2010; O'Brien et al., 2009). MOM participants spoke of the increased energy they had following PA, thus allowing them to spend more time playing with their kids. In addition, Murthy (2020) acknowledges that when we are more connected with ourselves, we have more to give to others.

Furthermore, men spoke of how their family impacted positively from MOM by adapting their diet. The rippling effects of interventions to non-participants have long been established as a valuable public health benefit. Research in the past highlights that behaviour changes may be adopted by individuals who are close to the intervention participant. This is due to the fact that they can observe changes more closely and then replicate them (Glasgow, Lichtenstein and Marcus, 2003). Understanding the potential benefits of the rippling effects of a health promoting intervention is relatively underexplored. If the impact of interventions beyond the initial participants can be assessed, then we may find ways of capitalizing on the benefits of such rippling effects. Especially in present times with limited resources, this area of research could be an essential asset (de Heer et al., 2011).

The current findings reveal the power of connection between men as a key catalyst for change within a community based PA programme.

5.3 Facilitating connection in men's PA programmes

The ethos of MOM

The approach of MOM was underpinned by social cognitive theory (Bandura, 1986). Specifically, components were incorporated into the intervention to develop self-efficacy [i.e. confidence to perform PA], to focus on outcome expectancies [i.e. positive outcomes weighed against any negative outcomes], to develop skills [e.g. goal setting and problem solving] and build social support (Anderson, Burton and Anderson, 2012). The PA coordinator was the medium in which all of these components were delivered and managed.

Within the literature, social cognitive theory is commonly used to examine and explain the links between the physical environment and individual behaviours (Stahl et al., 2001). Social cognitive theory (Bandura, 1986) acknowledges the dynamic interaction between people, their behaviour and their environments and how people learn from individual experiences, the actions of others, and their interaction with their environment. In other words, the social cognitive theory believes that an individual's health behaviour can change as a result of a range of components such as self-efficacy; behaviour capability, expectancies, self-control, observation and reinforcements. Many of these were achieved in MOM. The broad range of health and social benefits for the majority of the MOM participants was the resultant impact of the multidimensional approach of MOM. The programme was gender sensitised in relation to context [e.g. men only groups], content [e.g. information presented in a scientific manners, use of gadgets, competitive element] and style of delivery [e.g. participative and peer-supported, use of humour and banter]. This is evident in the way men spoke of the many factors of the programme that facilitated change in their lives.

Lefkowitz and Richardson (2016) highlight how facilitating banter will result in a more relaxed atmosphere. Men in their study spoke of how the relaxed atmosphere in the

shed would allow casual and comfortable interactions with each other, jokes and stories being told and enjoying light-hearted interactions all of which contributed to the sense of camaraderie between the men.

Care & Supportive approach

The PA coordinator adopted a caring and nurturing role to develop self-efficacy and keep men engaging in the programme. This approach of the PA coordinator was mentioned throughout the interviews by all men. In contrast to the traditional male characteristics of being stoic [not expressing emotional distress] (Jansz, 2000), PA coordinators didn't adopt a personal trainer style approach that would focus on outcomes and goals. Instead, MOM PA coordinators chose a more kind and considerate approach toward the men and the group. All of the MOM participants related to their PA coordinators and made many references to this. These included; how they demonstrated pride in their accomplishments, feeling cared for as a result of the PA coordinator making food or taking time to talk to them, and being acknowledged by their first names.

For many men, this was something that they felt they were lacking or hadn't been shown for a considerable amount of time. This was specifically referred to by the men who had found themselves disconnected as a result of the critical life changes they had experienced. The role of this caring relationship between the men and their instructor helped men feel valued, thus enhancing their connection with others and particularly themselves. The creation of a positive motivational atmosphere is known to be important for behaviour change in PA.

Such findings are also evident in the Football Fans in Training where coaches were encouraged to create a motivational atmosphere. Participants spoke of how they enjoyed the positive environment in which they could share experiences and laugh alongside the 'serious' business of behaviour change (Wyke et al., 2015). In addition, away from the context of PA

groups, many shedders in a study by McGeechan et al., (2017) praised the coordinators who felt were always there to support them and talk to them about anything. One particular group in this study felt the coordinator was responsible for turning their lives around. MOM participants took time to report the caring gestures shown to them because they mattered, they felt cared for, valued and this enhanced the connection they felt with others and themselves.

Creating a motivating and positive atmosphere.

It is well documented that strategies that focus on creating safety, trust, building rapport and meaningful relationships with other men and personal and to foster peer-support have been effective in engaging men (Oliffe et al.,2011; Lefkowich et al., 2015; Grace et al., 2016). The many ways of engaging men with their health have been outlined in the sections above. These have contributed greatly to improvements in men's overall health and their engagement with services. Going forward, these advances regarding men's health, health practices, and masculinities need to be mobilized towards interventions and more practical applications and evaluation. Such interventions should focus on specific male critical life time milestones as well as focusing on community sub groups (Evans et al., 2011). Reinforcements that came from the PA coordinators encouraged men to continue to participate. Therefore, men were not just acknowledged on their performance in the group but congratulated each night for showing up and taking part. As a result the PA coordinator was able to keep the focus on the process of being in MOM and not the outcome of doing PA. Furthermore, mutual support was really important in the group so that men could see their peers achieving and thus motivating them to identify with their own achievements. Focusing on the social side to PA for older men, Sims-Gould et al. (2018) found that the social connections offered encouragement to engage in regular PA and made PA more enjoyable.

Participants described how other participants' efforts of doing PA was encouraging, as it initiated the feeling of wanting to progress themselves.

The PA coordinator also had the capacity to manage the group dynamic so that it was nurtured as a positive space for the men to learn and grow in. Chapman et al., (2016) found that when vulnerable individuals are participating in PA groups, they prefer activities that are close to home, facilitated outdoors mainly, have professional instruction and with people of the same ability. Chapman et al., (2016) said that the PA instructor was the most commonly endorsed support as they were guided and supported through exercises.

The importance of designing programmes to address both individual motivations as well as fostering group atmosphere is particularly important for older age PA groups. Liechty et al., (2019) found that the participants in their study sustained engagement as a result of the positive social interactions that were facilitated in the group. Specifically, participants appreciated the space provided to make new friends, it's welcoming and non-competitive atmosphere, and how it provided them with a sense of belonging. Participants in a study conducted by Sharp et al. (2018) pointed to the role facilitators played in creating a comfortable space for open conversation and camaraderie in the group. Qualities that participants particularly liked in the facilitator were being credible, relatable, and likable.

Many men in this study mentioned the non-judgmental atmosphere and how they felt like an equal coming in regardless of their background or present situation and the majority referred to the importance of putting in the effort, being there to make up numbers out of respect for others.

In addition, it was important for men that the programme was gender sensitised in relation to context [e.g. men only groups], so they would not feel judged. Bottorff et al. (2015) suggest that using a gender-sensitised approach in the development of interventions for men, by taking account of their interests and preferences, may improve engagement,

retention, and outcomes of that intervention. The Sharp et al., (2018) study supports this as the participants in their study indicated high levels of acceptability toward their programmes gendered components and materials, which appeared to help reduce common barriers to men's engagement with health interventions.

Some men spoke of how they had rarely seen a male only PA class or group advertised. One man specifically said he would not have come to the group if it was mixed because he felt it was inappropriate and that the banter would not have flown as well.

The need for an all-male group is also spoken of by participants in a review of Men Sheds in Ireland. Participants were generally split about the all-male environment. Those who favoured an all-male environment was the result of feeling more comfortable or included which was mirrored by participants in this study. However, those who had previous bad experiences in stereotypical 'macho' male environments were generally more hesitant about the all-male space of the men shed (Lefkowitz and Richardson, 2016).

Facilitating the development of self-worth and efficacy through guidance and education

Many men were unsure of how to do PA right and felt ashamed about doing it wrong or at their age etc. Therefore, guidance and education was an integral aspect of MOM to aid the development of self-worth and efficacy. Self-efficacy and behaviour capability were managed by the PA coordinator because he/she didn't just show men PA exercises, they guided them and educated them so that they could transcend the PA outside of the MOM circle. This in turn helped to build self-agency to do PA and then their confidence in their ability. As a result of this, men were enabled to overcome shame [expectancies] and begin to believe in themselves and their ability. Participants in a study evaluating men's sheds in Ireland spoke of how by having the opportunity, support and space to engage in new activities had a profound impact on participants' sense of self (Lefkowich et al., 2015).

Men also spoke of how other men in the group encouraged them. By observing how other men performed or surpassed what they and others expected from them, encouraged them to continue [observing]. With this new found belief and appreciation for the results warranted [reinforcements] from hard work, men practiced self-control and made changes to help continue their achievements.

As a result of the impact education had on men in this study and what is documented in the literature about the impacts of education on health, it is critical that education should be an integral part of all men's health initiatives.

Chapter 6 Conclusion

Overall, the findings in this study point to the impact of connection as a catalyst for change in an all-male PA group. Consequently, it is vitally important to facilitate connection in PA groups. It is evident from the findings of this study that the participants of MOM had an overall positive experience. In brief, these experiences were the result of experiencing connection with other men [friendships, care, and identification] or with the group as a whole [belonging, purpose, routine and structure]. The impact of such connections dissipated the shame they originally felt and allowed them to feel normal and accepted thus enabling them to make changes to their health behaviours.

The context of MOM was vitally important to facilitating connection. In particular, the caring and respectful approach of the PA coordinator was mentioned throughout interviews. The importance of a good PA coordinator is also well documented in the literature and therefore should be considered when facilitating connection in a PA group.

The findings in this study establishes a basis for effective practice guidelines on the design and delivery of gender specific PA programmes with regards to influencing service provision for men. It is clear from the findings of this study and the wider literature that facilitating connection in a PA programme can lead to many impactful changes on the participants lives. This study has provided strong evidence in support of more gender specific community based PA groups that consider facilitating 'connection' in a 3 way process; with their surroundings, with others and with themselves.

There is an established body of literature that supports a connection between social experiences, the social environment, and physical activity (Bauman et al., 2012; McNeill, Kreuter, and Subramanian, 2006). However, where the literature is limited is on studies that focus specifically on the impacts and lived experiences of male only PA programmes within

the Irish context. Therefore, the literature presented for discussion was based on more generalized findings and not specifically men. However, this underpins the significance of this study's findings in filling a gap in the existing literature. In addition to evaluating the impact of MOM on the participants, the findings from this study have the potential to make an important contribution towards informing gender-specific community based PA programmes generally. While the impact of connection on health is evident in the literature, there is a gap in the literature with regards to how the development/nurturing of such connections are facilitated in an all-male group.

6.1 Recommendations for practice

1. **Continue to empower men to take increased control over their health by adopting more gender specific approaches**

   It was refreshing to see in this study the power of adopting a gender specific approach on men taking action for their health. It is important to take note of the specific aspects of this approach that the participants highlighted to ensure that other men can continue to take control of their health.

2. **Effectively train PA coordinators on the specific ways to engage men**

   The PA coordinators approach was highlighted by all the participants. Therefore, it is vitally important that this approach be replicated where appropriate to achieve the benefits of connection with regards to the groups' success.

3. **Incorporate the 3 areas of connection [self, others, environment] into all PA community based groups for men**

   As highlighted in this study, connection is a powerful catalyst towards facilitating change. It is important, therefore, that future programmes consider how they might facilitate not just on one area of connection but all 3. It has been shown in this study

and other studies that all areas of connection are required to feel whole and as one. Furthermore, the change that men undertook as a result of feeling more connected was the result of a constant cycle of interaction between the two [change and feeling more connected]. Consequently, ways to nurture this cycle should be considered so that connection can continue to affect a change in behaviour but also the change in behaviour can be sustained to further connection.

4. **Focus on the rippling effects of connection; from participant to their social circle**

Participants made reference to the rippling effects of their success out to their families and social circles. Research has been carried out as part of the wider MOM projects on the impact of MOM on the participants' significant others. The wider impact of any health promotion intervention is widely sought after. Therefore, future studies should focus on this aspect to gain a deeper insight into what programme qualities effect this change.

6.2 Limitations

The findings are a good representation of those who got most out of the programme.
Therefore, they tell us little about the experiences of those who dropped out and perhaps did not have a positive experience.
Furthermore, in terms of diversity the participants cannot be said to be representative of all sectors of Irish society. The study may have benefited from a more diverse representation of socio-demographic groups.
It is worth noting that participants were selected based on 'those who got the most out of MOM as a programme. Please see methodology page 66. This may reflect the positive nature of the findings outlined in this chapter.

Although the study looked to explore the broader impacts of MOM on the participants, it would have been beneficial to explore those participants who did not get much from the study in order to adapt and engage such participants in other ways. However, recruiting such participants to facilitate this study would have been challenging both ethically and practically.

The generalizability of this study may be limited to PA groups for older men within the Irish context. This is especially due to how the programme is managed in each county under the LSP's. Furthermore, given the significance of the impact of the instructor to the participant's experience, it would be recommended to follow the recruitment and training criteria used in this study.

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APPENDICES

APPENDIX A: Consent form for interview participation

Consent Form for Intervention Group

This has to be completed at the FIRST TIME POINT of data collection with each participant.

Participant Name: _____ [PLEASE PRINT]

Contact Details: Mobile _____ [PLEASE PRINT]

Email _____ [PLEASE PRINT]

To be Completed by Research Team:

Code Assigned: County Code; B;26P;52P

Participant Code: _____

IF AN ADMINISTRATOR IS PRESENT – Protocol for Administrator:

1. Read the instructions below to the participant prior to administering the questionnaire. In particular insure that the participant gives their consent to participating in this phase of the study.
2. When necessary, use block capitals when documenting evidence, otherwise clearly mark the answer given.
3. Ensure that the participant can see the questions at all times and that he can clearly see how you are responding on his behalf.

Informed Consent:

1. We would appreciate it if you could take the time to participate in this study as part of the Men on the Move programme. Participating in this study involves having your height, weight, waist circumference and time to complete one mile recorded as well as completing a questionnaire at the beginning of the programme, at the end of the programme and again next February and next August. You will also be invited to participate in a focus group with other men who participated in the Men on the Move programme or a one-to-one interview.

2. All information will be held in the strictest of confidence. All data will be stored securely and only the primary researchers will have access to the data. THE INFORMATION

COLLECTED HERE WILL BE SEALED IN ENVELOPES THIS EVENING AND SENT VIA REGISTERED MAIL TO RESEARCHERS AT WIT. NO SERVICE PROVIDER HERE THIS EVENING WILL GO THROUGH THE INFORMATION IN DETAIL; THEY WILL SIMPLY CHECK THAT ALL OF THE INFORMATION IS RECORDED. The findings from this study may be disseminated via a variety of media; however, at no point will personal details be included in any report or paper published. Data will be stored for 5 years post publishing and will be destroyed thereafter (in accordance with WITs Data Protection Policy).

3. While there are no physical risks from participating in this project, you will be asked some personal questions. However, as stated above, all data will be documented with the utmost respect and sensitivity and will be held in the strictest of confidence and stored anonymously.

4. You are free to refrain from answering any question you choose to and/or to withdraw from this study at any time without consequence.

5. If you consent to participate in this research study please tick the box □

APPENDIX B: Initial topic guide

Interviews with men

To elicit men's experience of participating in MOM to uncover the potential 'broader' impacts of a physical activity programme.

- What did it mean [what was it life for you] to you to have MOM come into your life back in September?
- Were you ready to make a lifestyle change or did you have some help?

  -who encouraged you to attend?
- How did you feel in the weeks/days approaching the programme?

  -What did you expect?

  -What feelings were present i.e. excitement, anxieties?
- Do you feel a sense of belonging to the 'MOM' programme in comparison to others you many have participated? **Or** In comparison to other programmes you have participated on, what sort of similarities or differences did you notice? **OR** Did you try any other PA programmes before? What do you think was different about this?

  -What was this from? **Or** What do you think caused this sense of belonging?

  -What did 'MOM' mean for you personally, if anything?

  -So from what you are saying, MOM for you was more of a personal thing or more of an opportunity to be sociable.
- Was there ever an evening that you didn't attend? Was there any particular reason? Could you tell me the reasoning behind this?
- What was the driving factor that kept you coming back?
- What were the aspects of the programme that meant the most to you?
- Has the programme had any effect on you? If so what changes have happened?

- Has your life changed / would you say your life has changed in anyway having taken part on the programme?
- If you were to describe men on the move to another person what would you say to them? Or if you were to describe men on the move using 3 key words to a friend what would these words be?
- How have things been for you since the 12 week programme ended back in December?

APPENDIX C: Updated topic guide

Start from the beginning.

- GETTING INVOLVED/days approaching/thoughts seeing the poster
- MOTIVATION/attendance/what was it like if you missed a session
- Think of a particular session. Why?
- IMPACT-big changes to the more subtle ones.
- PART OF THE PROGRAMME-Phase in-between the first programme and the next

APPENDIX D: Code book

Themes	**Sub themes**	**Codes**
Engagement & Sustainability		
Initial engagement	Fate [relation to starting but also throughout no rain etc.]	Right place, right time, trigger needed, just happened [as a pose to going to look]. No rain throughout 12 weeks. Most men had an initial thought of wanting to do something before becoming aware of Mom. Air of destiny Higher force involved Right time, no rain, info to start just fell into their lap.
Note: why men signed up and what was it that kept them there.	Personal	Wanted to combat isolation, get more active and fight off the effects of age. Sedentary lifestyle. Reason to leave the house. Ill health and illness- need to get fitter to prevent. Family illness has knock on effects to personal health outlook. Being a good example for family. Failing to play with young relatives or children. Being a 'good dad'

	Difficulty in signing up	Light bulb moment for change-comparing yourself to others Men and weight embarrassment Admitting you need to change hardest step. Having low mood, depression hard to motivate yourself Steps of acceptance of an issue Boring to work alone-Difficulty in finding exercise partner outside of the group .
	Favour	Signposted For somebody else Make up numbers Doing it with a friend Doing it for others[friend, family and later on MoM participants] not letting them down
	Marketed	Advertisement Email Poster FREE prog. Hook regardless of money status
	Programme	Need for an external set up to motivate September good month to start-new beginnings Meeting on common ground

SUSTAINABILITY FACTORS	Light hearted competition	Fun and craic as motivating factor that helped them come back each week Male ego takes over
	Competing at your own level	At own level with others-when the others disappeared feeling of alone or not fit enough made it less enjoyable [g123] Importance of breaking down unhealthy competition so that everyone can go at their own pace and not feel threatened or left out Being in a group makes it more acceptable to be seen out exercising
	Respect	Called by name Felt like equal. Respect for others, putting in the effort. Being there to make up numbers. Being honest and open about the programme-no hidden agendas. Group having knock on effect-all in or nothing. When a majority drop off the group falls apart.
	Leadership/instructor	Mentoring, personal approach, Safeguards for men. Kind & motherly instructor-men need guidance

		signing in encourages men Reliance on instructor presence for guidance. Found doing exercise alone led to doing it wrong
	Men only	Men only Regimented. Knowing the times. Format of group- doing things in pairs helps socially Application of common sense to life Length- reach a certain stage before you open up therefore length of programme important.
	Variation	Different needs met. The need for further stimulation than just exercise-craic, fun chat adds to the experience. Right balance for men of a certain age Variety of activities each week.
	Inclusion	Everyone could play a part-ref to man breaking leg became administrator and tea maker. Everyone on same wave length nobody

		isolated Group motivation- same goal, see others lose weight or go faster helps. Everyone at a similar level starting off- nobody feels 'inadequate'
	Three pronged approach	PA, Social, MH all catered for.
	Influence of community facilities	Not highly technical even just the presence of street lights to do work at night.
	Attendance	Men only missed sessions for genuine reasons. Word of mouth bringing new participants in Those who showed up; specific individuals who need motivation and need to prove something to themselves [MO109]. Following drop off rate-waiting for it to level out and get balance right
Personal	Sense of ownership	'buy in' Men feel responsible for its success and also for its down fall if they don't show up
	Cost	Having to pay for some men was too much.

		Thankful for opportunity
	First impression of first night dependent on whether they would come back	
	Giving back to others	
Transitions	Surpassing expectation	Something needed to reignite interest- confidence that they can actually do it. More confidence to keep going and try new things. People noticing achievements adds to feeling of success Personal acknowledgement of ability Progression in self-efficacy to do it alone. And to chat more open up
Note: Joining the group led to men surpassing personal, cultural and social expectations.	Transcending ageist views	Less self-conscious reaching a certain age.
	Transcending gender stereotypes **M**	Group walking more generally associated with women Feel that although men and women diff perspectives or communication can be beneficial when combined. Combining forces. Men initially still uphold masculine traits but once the

		waters are tested became more open and trusting. More able to break stereotypes by doing it in the group-DL34 Irish dancing
	The Unknown	Entering the unknown [achievement 1] conquering the unknown [achievement 2] Realising others are like you Having to reach a certain point of the programme before you will open up Feeling ashamed walking out on the road people would think what are you up to-now doesn't care.
	Transcending community boundaries	Becoming a local Motivation to form park run group [DL34].
	Raising the bar	Recalibrating expectations Confidence in self-I can do this. Training in secret. Going from not wanting to run alone as worried what people will think of me-5km. Its ok to run once you have the exp and reach a certain level. The need to have a

		platform to grow in confidence, skills & supports. Providing an opportunity for men. Men get motivation from setting goals and reaching them or seeing themselves lose weight. Breaking barriers to go on and achieve more. [TESTING WATERS] Excitement of starting new challenges; marathons, 5km
	Friendship transitions	Acquaintances to friendships Catalyst for forming friendships-provides opportunity.
	Transcending level of knowledge	Realisation of importance of health-change in views on smoking, diet etc.
	Then & now	Physical progress-looking back on what they could do in youth whereas some look back and feel can do more than in youth due to illness[missed out] Being able to do the 'normal things' walk to shop, play with children, plan trips. Realisation that more can be done Exercise in youth but lull in later years.
Connection Connection socially,	Filling a void	Retirement, Bereavement,

intellectually personal environmentally and physically.		Unemployment, Illness. Adding meaning to what you do with your time. Feel cared for/sense of belonging. Treating men with depression normally but filling void by offering support through talking and exercise
Note: Men feeling at one with themselves, environment & Others.	Involvement	Being part of something, feeling helpful. Everyone offering something through diff roles [joker, agony aunt G129] Being missed in the group. Noticing absences. Feeling included. Some felt left out when their level group dropped off or moved on. Helping out in community-Wearing t-shirts, stewarding, clearing paths. Better connection and involvement with children. More patience.
	Acknowledging the Surroundings	Appreciating and noticing the environment, setting.

		Much more appreciative than the gym. Some men felt more at home liking the gym to a snobby setting. Knowledge of local training grounds. Using a car park or other things as a means to train Appreciation and acknowledgment with surroundings. Mainly outdoor sessions. Connecting with environment-discovering new places, noticing and appreciating things.
	Shared Identity	Sense of loss with dropouts and injury. Feeling belonging to the group camaraderie in it together. Offering a purpose to men with no job realising that it isn't just you without a job. Common goal [lose weight get fit] helped with connection Getting the MoM identity. Meeting on common ground easier to integrate-not just GAA, soccer, culture.

		Time to be a man, as a man, with other men. Men have a unique method of interacting.
	Forum for sharing	Balance of feeling connected with others as well as the setting allowed for men to effortlessly open up and tell their story. Each week men can build up conversations i.e. how is your knee after last week A lot of men bringing personal 'luggage' with them Reaching a certain stage before you open up therefore, length of programme important. Giving men opportunity/platform to grown in confidence, skills and support. Space to let down barriers.
	Feeling content/ Connection with oneself	Improved appearance, awareness of appearance, and pride in one's appearance. Being relaxed in surroundings lead to more chatting.
		Time to switch off from the world and just be at one with self

		Men know how they are feeling however most may not know what they are feeling room for education on this. MO126 Way to unwind. Chance to refocus mind.
	Connection with others	Different social groups [work, childhood friends] meaning different levels of connection Just be connected doesn't have to lead to friendships Blow in different stages of connection Building relationships good for others and for oneself. Each add to each others experience.
Ripple effects	Gateway to other services or influencing peers to sign up	More public exercise facilities are needed. Access influences PA. Not good to only have pools attached to gyms. Those too embarrassed to sign up previously saw the effects on others and plan to sign up next year. Identifying a gap in the area of male PA groups especially for older men.

	Family Life **M**	Feeling like a 'proper' Father, being the dad they want to be and more energy for it. Family tragedies linking to health [heart attach etc] motivates men more to change. More patience with children-better father role. Family learning about diet from his experience-making changes for the whole family. Wives curious about programme for themselves.
	Extra training & Involvement	Learning the importance of exercise Motivation and determination to do more-extra training. Learning how to do warm up and down exercises transcended outside group to own personal routine. Excitement of being able to start something new/different-marathons, 5km
	Catalyst for forming friendships	The need to have something to form deeper connections

		Want to carry on conversations following finish of programme each night
	PA led to social integrations and improvements in MH Connection	PA 1 Social 2 MH 3 Profile of MoM in the community-feeling important Realisation that you still care about appearance regardless of age. Isolation more prevalent as a result of legislation [drink driving] MoM offered an alternative reason to leave house.
	Effects of programme on ADL making life tasks easier	Change in daily activities: Gardening walking to the shop for groceries. More attention and detail at work. Even going up and down the stairs at home Problems with joints that medicine didn't help, regular exercise has helped to strengthen and worked well. New knowledge insightful and helpful-applicable info
	Way of life	Way of life instead of passing phase or block programme. Looking forward to things as able to do

		more. Mo128 Reduction in pharmaceutical assistance. Discovering ways to fit in exercise that suits personally [using landmarks]
	Change in diet	Not wanting to waste effects of exercise by eating poorly. Not wanting to take a step backwards. Skills of making small changes to make it easy to make the right choice. Realisation of health-changing views on smoking, diet etc. Developing a better relationship with food. Weighing up cost of alcohol against programme to show what you get out Not wanting to waste positive effects of exercise by eating unhealthily
OTHER	Community integration	X
	Public recognition of achievements Heightens successes	X
	Community-Taking & Giving	X
	Cultural integration	
	Cultural learnings	
	Kenyan group didn't work. Mix of cultures more	X

	relaxed less pressures.	
	Caution not to sound misogynistic by saying that men only is better than mixed.	X
	Feeling that men are being de-masculated in society today. Not wanting to promote machoness but awareness that men need time to be men.	Transcending gender stereotypes
	Using other men to weigh up odds of succeeding i.e. those more overweight, older etc.	
	Aware of health influences-diet nutrition- in a peripheral way.	
	Motivational drops throughout the year [i.e. Christmas]	
	Conversations based on natural flow- whatever arises.	
	Learning to trust and awareness of different characters	Connection/friendship transition
	First impressions of men in group living up to them	
	Those left behind seen as the 'lesser' or 'trash'	
	Involvement in sport previously led to different motivation	
	Importance of being aware of the benefits of your losses	
	Using other men's successes to influence personal	i.e. if mike can do it so can i

	progress	
	Men to men chats similar to pillow talk-chilled out	
	Applying weight loss in practical means-means more	i.e. going down in clothes size
	Harsh male communication-tough love	
	Women offer a different insight of different conversation	
	Gap in the market for male PA groups	
	Men embarrassed about weight.	
	Providing variation to the gym	
	Cost of programme against other outlets [pub etc]	
	Practicality of knowledge supplied important	
	Men want more to the point Mental health talk-more practical	
	Give men credit for what they know and their experiences-men know how they are feeling but only some may know what they are feeling	
	Practical steps to get out of crisis	
	The need to have proof [insulin booklet, measurement card] so you would believe their progress. Element of attached to it.	
	Practical measurements	

	important guideline for men re their progress- belt knotches, buying smaller clothes size.	
	MoM as a topic of conversation makes it easier to talk or have a reason to talk to other men from the prog when they see them outside of it	
	No judgement	
	Need to justify achievements [e.g. I came in the 100 but there were 300 running it]	

APPENDIX E: MOM health information booklet

Each county had their own cover in the counties colours. E.G. Waterford=blue and white. However all the information and contact details inside were generic.

The Men on the Move Partnership Network is represented by the:

- Cork Sports Partnership
- Donegal Sports Partnership
- Dublin City Sports Network
- Galway Sports Partnership
- Health Promotion and Improvement, Health and Well Being Division, HSE [National and West]
- Institute of Technology Carlow
- Irish Heart Foundation
- Kilkenny Recreation and Sports Partnership
- Limerick Sports Partnership
- Mayo Sports Partnership
- Men's Development Network
- Primary Care Services, HSE West
- Waterford Institute of Technology
- Waterford Sports Partnership

Supported by:

Get Ireland Active · Irish Heart Foundation · Healthy Ireland · Feidhmeannacht na Seirbhíse Sláinte Health Service Executive · Waterford Institute of Technology · Carlow · Irish Cancer Society

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Designed by Modern Printers 056 7721730

Men on the Move — The best MOVE you'll ever make

Waterford Sports Partnership — An Irish Sports Council Initiative

INFORMATION BOOKLET

The Purpose of this Booklet:

This booklet has been developed as a guide to support you to do the Men on the Move physical activity programme. You may also find it a useful source of health information.

Safety First!
Check with your GP before attempting any of the exercises featured in this booklet if you:

- Have a health problem, or
- Are worried about any aspect of your health, or
- Are not used to physical activity.

All exercises featured in this booklet are done entirely at your own risk.

Your Local Sports Partnership:

Waterford Sports Partnership
Civic Offices, Dungarvan, Co. Waterford
and Regional Sports Centre, Cork Road, Waterford

(058) 21194
(051) 849855
info@waterfordsportspartnership.ie
www.facebook.com/WaterfordSportsPartnership
www.waterfordsportspartnership.ie

Acknowledgements:

This booklet is based upon the Mayo, Men on the Move booklet that was designed in association with the Erris Men on the Move Group. We would like to acknowledge the work of Michelle Healy [leader] and Padraig Brogan [Belmullet, Men on the Move Group]. This booklet also draws from literature produced by the Carlow Men's Health Project[1], the Irish Heart Foundation[2], the Irish Cancer Society[3] and the Food Safety Authority of Ireland[4]. This booklet was prepared by Dr Paula Carroll, Centre for Health Behaviour Research, Waterford IT with support from the Men on the Move partners.

1. Carroll P. (2013). Men's Health Matters: A practical Guide to Healthcare for Men. Waterford: Centre for Health Behaviour Research, Waterford Institute of Technology.
2. A Man's Guide to Heart Health. Dublin: Irish Heart Foundation. Available at: http://www.irishheart.ie/iopen24/heart-health-leaflets-1-14_239.html
3. Manual for Men. Destination Health. Dublin: Irish Cancer Society. Available at: http://bit.ly/healthofmen
4. Healthy Eating and Active Living from Adults, teenagers and children over 5 years. A Food Guide for Health Professionals and Catering Services'. Dublin Food Safety Authority of Ireland. Available at: http://www.drugsandalcohol.ie/17715/

Need Someone to Talk To

Want to Get Healthy and Need Support:		
Irish Heart Foundation	01 6685001	www.irishheart.ie
Safefood	021 2304100 01 4480600 1850 404 567	www.safefood.eu
Irish Sports Council	01 8608800	www.irishsportscouncil.ie
Mental Well-being:		
Samaritans	116 123	www.samaritans.org
Mental Well-being		www.yourmentalhealth.ie
Mental Health Ireland	01 2841166	www.mentalhealthireland.ie
Aware	1890 303302	www.aware.ie
GROW in Ireland	1890 474 474	www.grow.ie
Drugs / Alcohol / Smoking:		
HSE Drug and Alcohol Helpline	1800 459459	www.drugs.ie
Alcoholics Anonymous		www.alcoholicsanonymous.ie
The National Smokers' Quitline	FREEPHONE 1800 201 203	www.quit.ie
HSE Infoline	1850 241850	www.yourdrinking.ie
Suicide and Bereavement:		
Console	1800 247247	www.console.ie
Abuse and Domestic Violence:		
Aoibhneas	01 8670701	www.aoibhneas.ie
Other Numbers:		
Men's Development Network	051 844260/1	www.mens-network.net