FOOTBALL COOPERATIVE

Social Return on Investment (SROI), Evaluation Analysis
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SUMMARY

An SROI Evaluation Analysis of Football Cooperative, a community based 'pick-up' recreational football initiative for men in Ireland

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1.0 Acknowledgements

The research team would like the acknowledge the following for their contribution to this evaluation:

One of the FC Founders acted as a gatekeeper in both mapping stakeholder groups and supporting the research team to gain access to those groups throughout the SROI process. He was also instrumental in providing the research team with participation data which enabled the team to segment the participants while also assessing drop off since the end of the evaluation period.

Some 126 people, representing 4 stakeholder groups participated in this evaluation over a 12-month period. All are volunteers and/or working parents who gave up their personal time to contribute to this evaluation via interviews and/or ToC validation focus groups. In addition, the participants were extremely patient with the research team when collecting the objective data prior to their games.

The advisory board established to support the overall Football Cooperative project were a source of support to the research team throughout this evaluation; at advisory board meetings the research team presented progress to date which was rigorously discussed in terms of methods, interpretation and relevance to practice.

The research team are grateful to the funding body who continues to support the PhD student on this project, without whom this evaluation would not have been possible.

2.0 Executive Summary

In 2017, Football Cooperative (FC) was established and uses 'pick up' football to bring men together to play football and to improve their overall health and wellbeing. It allows men to partake in a competitive game of football, which is offered twice weekly in the evenings on an all-weather AstroTurf pitch. FC is run by volunteer coordinators who organise the games as well as participate in the games. The values that FC is driven are the cultivation of community, inclusivity, sportsmanship and life-long learning. The FC initiative is promoted via social media and 'word of mouth' and is continually open to new members of all ages and abilities. By the time of writing of this report, FC had grown to have 807 registered members across two sites in Ireland, and the vision is to scale up the FC model to bring 'pick up football' games to men in communities across Ireland and beyond to reduce isolation and to improve their overall health and well-being at a population level.

The purpose of this evaluation was to assess the feasibility for scale up of the FC initiative using a social return on investment (SROI) methodology. Various sections of the report below explain how the steps in the SROI approach were addressed including the research design, participant recruitment, data collection and analysis approaches.

A total of four stakeholders were initially identified; this included the participants, their family unit [significant others], the volunteer coordinators and the community partners who manage the facility where games are played. Outcomes for participants were measured via a pragmatic quasi-experimental one site repeated measures study over a 12-month period. A range of data was collected from all stakeholders using a combination of physical measures collected onsite, focus groups, surveys and interviews. Theories of change were developed for each stakeholder group which led to validated outcomes with each group and these outcomes included physical, mental and social benefits for the participants as well as increased injuries. The data was segmented to see if outcomes varied across different criteria and it was found that participation levels of the participants exerted an influence on the reported outcomes.

To value the respective outcomes of each stakeholder group, survey data gathered at 12 months [administered via the FC gatekeeper] was used for each stakeholder and various discounts [deadweight, displacement, attribution and drop off] were than applied before arriving at a final SROI calculation. Table 2.1 below details the various outcomes for each stakeholder group along with the

total input costs for each group leading to a final SROI for the FC initiative as €17.60 for every €1 invested.

Table 2.1: Components of the final SROI calculation

Stakeholder	Outcome	Total Benefit (current year cash flow)
Participants	Improved Physical Health	153,999
	Decline in Physical Health	- 22,523
	Improved Mental Health	116,019
	Decline in Mental Health	0
	Improved Social Health	82,221
	Decline in Social Health	-13,705
	Increased Injuries	- 100,042
Volunteer Coordinators	Improved self esteem	19,346
	Improved social connection	24,284
	Reduced stress	21,988
Community Partners	Satisfaction of having a Secure and Reliable Tenant	1,521
	Improved self esteem	2,288
Significant Others	Improved family dynamic/relationship	24,482
	Improved family physical health	53,433
	Improved mental health	32,636
Total Value of Benefits		**381,366**
Total Value of Inputs		**21,668**
Social Return on Investment		**17.60**

Following sensitivity and scenario analysis, the final SROI was found to range from €14.08 and €26.14 for every €1 invested and the report below adopts a prudent approach to valuation to avoid being seen to over-claim for benefits. The strong positive SROI calculation can be seen as a strong endorsement of the value-for-money offered by FC and the advisory board has thus adjudicated that the FC initiative is feasible for scale up, with plans underway to develop an implementation strategy for same.

3.0 Overview of the Report

This report will be presented in 12 Sections as follows:

Section 1: All contributors who supported the research team to gather information and to develop this report are gratefully acknowledged.

Section 2: An executive summary to this report is presented that details the purpose of the report, the methodologies used to determine, measure, value and discount the values identified. The final SROI calculation along with the sensitivity and scenario analysis is also presented.

Section 3: An overview of the report by section is presented.

Section 4: Drawing on literature, the background to the issues addressed by the FC initiative is presented and specifically the need to address men's health and the use of gender competent strategies to engage men in their health, such as football, is presented.

Section 5: An overview of the Football Cooperative initiative is presented along with details of how it operates, who it engages and its vision for the future.

Section 6: The social return on investment (SROI) approach adopted for this evaluation is presented along with examples of how the SROI principles have been integrated throughout the report.

Section 7: The SROI methodology used throughout this evaluation is presented and specifically with respect to a) determining outcomes, b) measuring outcomes, c) valuing outcomes and d) discounting outcomes.

Section 8: The final SROI calculation is presented along with sensitivity and scenario analysis.

Section 9: The limitations of the evaluation are presented.

Section 10: The conclusions drawn from the final SROI calculation and their implications for the FC initiative are presented.

Section 11: The appendices referred to throughout this report are presented.

Section 12: All supporting references underpinning statements made in this report are presented.

4.0 Background Literature

4.1 Men's health

The need to focus a spotlight on men's health has been well documented[1, 2]; men, and poorer men in particular, continue to experience an excess burden of ill-health, mortality and premature death[3]. This fundamental inequality in health has prompted the development of men's health policy in Ireland[4,5]; in fact, in 2008, Ireland became the first country in the world to publish a national men's health policy and remains only one of four countries to do so[6]. In 2018, the World Health Organisation (WHO) European Region published its first men's health strategy[7].

It is also well known that men's poorer health outcomes are not solely biologically determined, and that lifestyle behaviours[8,9], social factors[10] and gender[11,12] pay a significant role. For example, two lifestyle behaviours, smoking and hazardous drinking, were responsible for substantial proportions of the mortality gender gap in 30 European countries between 2003 and 2005[13]. Smoking-related deaths accounted for 40–60 % of this gender gap while alcohol-related mortality accounted for 20–30% of the gap in eastern Europe and 10–20 % elsewhere in Europe[14]. This variation within men in terms of lifestyle practices and subsequent health outcomes is also evident in Ireland; rates of smoking are higher among men from lower socioeconomic groups[15] and whilst men from lower socioeconomic groups in Ireland drink less alcohol overall, they are more likely to binge drink and to experience higher levels of alcohol harm[16]. Notably, negative lifestyle factors have been shown to more frequently cluster together for those living in areas of deprivation[17] and as a consequence, men who experience higher rates of socioeconomic deprivation have significantly higher mortality rates than those from affluent areas[18].

Men's underuse of health and social-related services also often compounds health risk; for example, they are less proactive than women at sourcing information and advice and are less likely to recognise the symptoms of possibly serious health problems[19]. As a result, male ill-health can go undiagnosed and untreated[20,21]. This is particularly true for men with low income and/or educational attainment, who are unemployed and/or socially isolated, who are often unreached by health service provision[22,23] and are less likely to be aware of their risk or to take action to mitigate against, a factor which also contributes to the higher mortality rates of these men when compared to their more affluent peers. However, gender is one of the most important social determinants of health associated with

influencing health related behaviour[24] and needs to be considered when addressing the health outcomes experienced by men in Ireland and elsewhere.

4.2 Gender and Men's Health

While the signficance of gender to men's health has been documented in the literature for a number of decades, it has only recently gained traction at policy level[25]. As far back as 1998, Courtenay[26] wrote,

> *"A man who does gender correctly would be relatively unconcerned about his health and well-being in general. He would see himself as stronger, both physically and emotionally, than most women. He would think of himself as independent, not needing to be nurtured by others. He would be unlikely to ask others for help. He would spend much time out in the world and away from home. The intense and active stimulation of his senses would be something he would come to depend on. He would face danger fearlessly, take risks frequently, and have little concern for his own safety"* (p21).

Since then, a growing body of literature indicates a significant role for 'masculine beliefs' in health and help seeking behaviours and health risk appraisal by men[27]. According to the European Institute for Gender Equality[28], men's health behaviours and outcomes are influenced by acceptable social norms for women and men, in a number of ways. First, societal gender norms discourage men from participating in health-promoting behaviour, usually seen as feminine; therefore, men are less inclined to use sunscreen[29], reduce their meat consumption[30] or choose meat free options[31] particularly in the company of other men[32]. Men are also less likely to seek help about their health[33], particularly for health issues such as physical disabilities[34], mental, emotional[35] and sexual concerns[36]. Evidence suggests that men struggle to acknowledge their symptoms or illness to others and even to themselves, and avoid seeking help because of stigma[37,38] and to conform with a socially prescribed male role of being strong[39,40]. Not surprisingly, men's use of services has been identified as a principal issue associated with improving health outcomes for men[41,42]. Second, social acceptance of certain risky health behaviours including unprotected sex, excessive use of harmful substances, extreme sports, violence, smoking and excessive alcohol consumption, is greater when such practices are carried out by men[43].

Furthermore, there has been an increasing focus on applying an intersectional lens to understand how gender intersects with other social determinants of health[44] to shape men's health behaviours and

practices. We know that men's health experiences are shaped within complex social systems [social identities, locations, and structures][45] that have a multiplicative effect on social (dis)advantage[46] and that masculinity and its intersection with aspects of male identity [culture or ethnicity] shape health behaviours[47,48]. Therefore a central focus of all men's health policy has been the provision of gendered approaches to health-related services for men that account for the complex factors that shape men's health experiences and behaviours [49,50].

4.3 Gender Competency in Men's Health Service Provision

There is a growing body of evidence of good practice of gender competent services for men that are tailored in terms of context, content and delivery. In Ireland, as a result of their successful evaluation, programmes such as Farmers Have Hearts (FHH)[51], Men on the Move (MOM)[52] and Sheds for Life (SFL)[53] have scaled up to regional or national level. The Scottish based programme, Football Fans in Training (FFIT)[54], has scaled up across Europe (EuroFIT)[55] and scaled out across a number of other sporting codes e.g. Aussie-FIT [Aussie rules football in Australia][56] and RUFIT-NZ [rugby in New Zealand][57]. Recognising the need to account for male gender norms, these programmes use opportunities for peer support and connecting masculine ideals [autonomy, control, resilience] with being healthy[58,59,60,61]. Community settings or sporting environments are frequently employed in such programmes as 'traditional' health programmes in health services settings are viewed as unappealing to men[62]. The mode of delivery frequently involves physical activity – specifically group-based exercise[63] or sports-based programmes for healthy or patient groups[64]. Other effective strategies that have been incorporated into effective programmes are the a) integration of behaviour change theory and the inclusion of family and friends[65], b) adoption of strengths-based approaches that revolve around creating safety, trust, rapport, and meaningful relationships with men[66], c) use of strong, positive messages that encourage men to engage with services without amplifying shame or blame[67], d) reflection of the wishes of men to maintain control and to engage with services on their own terms and in their 'own way'[68] and e) creation of opportunities to share men's stories to show common challenges, to foster peer-support and to create a community of mutual help[69,70,71]. In addition to improving physical health outcomes for men, gender competent services also create opportunities for social integration; using naturally occurring social relationships [between male peers] in community-based settings are most effective to address isolation and loneliness than providing social support via hired personnel[72].

It is therefore not surprising that in recent years, 'football sports setting' and 'playing football' in community and/or sports settings have been increasingly used as a medium to engage men in their health, and to very good effect.

4.4 Football as a Gendered Approach to Improve Men's Health

It has been well established that playing recreational football can be applied as an effective broad-spectrum non-pharmacological treatment of lifestyle diseases, such as hypertension and metabolic syndrome[73,74]. The multiple activity and movement patterns [e.g., high-speed runs, sprints, turns, jumps, tackles] and intensity profile [moderate and high] of recreational football provide exposure to a variety of areas of fitness [i.e., metabolic fitness, cardiovascular fitness and musculoskeletal fitness] which provoke adaptive changes in a number of physiological systems in the body[75]. Recreational football elicits positive effects on cardiorespiratory fitness, blood pressure, bone density, glycemic control, resting heart rate, postural control and fat mass [76, 77, 78, 79] and produces broad-spectrum physical fitness benefits which are all related to NCDs[80]. Recreational football has great potential for enhancing aerobic fitness, and for preventing and treating non-communicable diseases, and can also be effective in addressing lack of motivation, a key component in physical (in)activity[81]. In fact, the evidence is so compelling that playing recreational football has been now been established as an effective form of 'medicine'[82,83].

Physical activity (PA) interventions based on football have been utilised in a variety of settings and with a variety of cohorts, for example to improve well-being and reduce social isolation for younger people with severe mental illness[84] and as a health education programme for children[85]. These programmes have demonstrated positive benefits across a variety of health outcomes for these population. Football settings, as well as PA interventions based on football, have also been used to host weight loss[86,87] and health-related programmes[88] and have repeatedly demonstrated that men do engage and experience the social, mental and physical health benefits of doing so.

In particular, football has been viewed as an important medium to engage men who are seen as reluctant or unwilling to access traditional health services[89] due to men's familiarity with football settings, the game itself and the approach adopted i.e. working with rather than against masculine ideals[90,91]. Playing football allows men to express feelings that are usually frowned upon e.g., sentimentality, fear, pain, hurt, doubt, and the need to be nurtured[92]. Robertson (2007)[93] suggested that men 'do' emotion through action [like engaging in football], and that this emotional connection

that many men have with football appears to enable men to feel safer engaging with football-based health initiatives. The emphasis on participation, supportiveness, and relationships in football initiatives may provide a useful model for health promotion work[94].

With an estimated 4 billion supporters worldwide, football is the dominant global game. Football has distinct local constructions, and thus has various functions and meanings in different contexts[95]. The international replicability of football-based health interventions has already begun to be explored via FFIT as stated above, however, to date, no such model exists in an Irish context to scale. Football Cooperative is one such initiative that shows promise and is the subject of this project [see Section 5.0].

5.0 Football Cooperative – An Overview

Football Cooperative (FC) is a social enterprise (SE) that is unique to Ireland and was established in 2017 and uses 'pick-up-football' as 'a hook' to bring men together to enjoy 'the beautiful game' with a focus on improving participants' overall health. FC games are currently available in two locations in Ireland and are organised by a core team of volunteers. This team oversees the governance responsibilities for managing the venues [bookings, insurance, health and safety], drives the strategic direction of the SE [advancement of delivery model, stakeholder engagement], communicates with all FC members, organising social activities around games [e.g. meet ups to watch Association Football, summer BBQs, end of year outing] and ensures that the values of FC are upheld. Specifically, these values centre around fair play, respect, integrity, inclusivity and community. These are enacted by ensuring that games are a) accessible i.e. community-based amenities are used for games; b) flexible regarding attendance [played 2-3 nights/week], c) affordable to ensure inclusion of all and d) offered to all levels of fitness and football capacity [see https://www. facebook.com/footballcooperative].

'Pick-up-football' refers to a flexible form of engaging football which has notable differences from Association Football in terms of pitch size, game format and how rules are officiated. FC games [60-90 mins depending on pitch availability] are played on a rectangular pitch that has floodlit capability and an astroturf surface to ensure year-round activity. Game format is dependent on the available participants of an individual game night and can be limited to a minimum and maximum capacity [5 to 10 a-side]; team composition has been determined as a crucial factor to ensuring both the game and social experience is maximised.

Game Coordinators [multiple at the site] manage a multitude of tasks within a dedicated game cycle. This encompasses event logistics from venue management, game creation, picking teams, ensuring equipment is on site for activities to proceed and supporting game delivery. Using a 'bespoke game portal' [developed in house], they publish a game notification out to the registered participant pool in advance of the game night. Through this notification, participants are asked to express an interest to play up to a determined deadline. To do this, participants must access the game portal to 'confirm their place' through the payment of a nominal fee[1]. Once the cut-off point has been reached, the Game Coordinator leading out the game night will determine the preferential game format(s) based on the available participants. Subsequently, they will set about tactfully composing the teams for the

[1] Players pay €5 per game, however, the fee is reduced or waived for those who may struggle to pay and this is at the organisers discretion.

game [based on data points gathered at the participant registration stage - playing position, football experience, self-determination of fitness and football capacity] with the objective to find a cumulative balance while also ensuring the make-up of teams is unique from one game to the next.

The Game Coordinator that is leading out the game night is often a participant in the games themselves and through this are also responsible for ensuring that the FC values are followed by all participants. Games are not refereed and therefore, via leadership from Game Coordinators, the onus is on all participants to manage the situations on the pitch to achieve a fluid, enjoyable and competitive game. After games, the Game Coordinator submits a game report for review by the FC core team; optional details include game outcome, game incidents i.e. participant behaviour or injury as well as pitch or location problems i.e. lights, parking. Notably, FC games are volunteer led and a sophisticated infrastructure [bespoke game portal] has been developed to ensure self-sufficiency using minimal resources. The FC initiative is promoted via social media and 'word of mouth' and is continually open to new members of all adult ages (over 18) and abilities.

In 2021, following a 5-month lapse in games due to the Covid-19 pandemic restrictions, a study was conducted at one site [based in an affluent area] which at that time had 123 registered members[96]. The purpose of the study was to investigate at the reach and cardiovascular disease (CVD) risk profile of participants at that site. Some 71 registered members participated in the study; the mean age of the players was 39.3 ± 7.0 years and the majority had some/completed 3rd level education [87.3%], were married/cohabiting [84.6%] and living with partner/children/parents/friends [94.3%]. Mean body mass index (BMI) was 27.2 ± 3.5 Kg/m^2, with 60% classed as overweight and a further 13.9% as obese. A large majority [83.1%] had three or more CVD risk factors. Most participants [81.7%] failed meet recommended guidelines for fruit and vegetable consumption, while habitual weekly alcohol consumption was also prevalent [71.9%]. Some 68.9% failed to meet the recommended PA levels[97], and 66.1% met the threshold for an at-risk waist circumference of ≥94cm[98]. Almost half [49.3%] were considered at risk by reporting their sleep quality as fair or poor[99]. Notably, very poor or poor aerobic fitness was the next most common risk factor [31.7%][100] Finally, smoking was also a modifiable risk factor for a minority [11.3%][101]. In short, this data suggests that despite being from an affluent area, being relatively young and well educated, a large number of FC members are at risk of CVD. Notably, despite their health risk, 90.1% of participants described their general health as good, very good or excellent and this lack of awareness of health risk among men has been well established in men's health research.

Games resumed at both sites on May 17th, 2021 following the lifting of the Covid-19 restrictions in Ireland. Not surprisingly, FC membership increased and at the time of writing, the FC initiative have a total of 807 registered members across both sites. In 2022, the FC initiative hosted 188 game nights across both sites translating into 349 games and 15,420 minutes of football played by a total of 6,382 participants.

The vision of the SE is to scale up the FC initiative to bring 'pick up football' games to men in communities across Ireland and beyond to reduce isolation and to improve their overall health and well-being.

5.1 Scope of the Project

The project aimed to evaluate the FC initiative at one site using a social return on investment (SROI) framework to assess feasibility for scale up. The rationale for choosing only one site was that it was the initial site ongoing since 2017 and it was very well established. These FC members had experienced playing for a number of years before the lapse in play due to Covid-19 restrictions and a) had considerable experience [positive and negative] of participating and b) were ready to resume the group immediately post lifting the restrictions. The second site only started in late 2019, shortly before the initial Covid-19 restrictions in the Republic of Ireland [March 2020]; these members had only played intermittently throughout 2020 and were not a well established group. Therefore, the research team decided to focus on the established site rather than trying to evaluate a site that was still in the formation stage.

Specifically, the objectives of the study were to:

1. Establish an SROI Framework: Develop logic model with stakeholders to show the relationship between inputs, outputs and outcomes to allow for the identification of indicators to measure outcomes.
2. Deliver the FC initiative and assess up to 12 months post baseline; assess all inputs, outputs and outcomes for each stakeholder group.
3. Define the SROI of the FC initiative and adjudicate on the feasibility of replicating it across multiple sites.

5.2 Governance and Funding

In June 2021, an Advisory Board (AB) consisting of 12 organisations representing football and sporting organisations [FC, Football Association of Ireland (FAI), Union of European Football Associations (UEFA), Sport Ireland (SI), Fingal Local Sports Partnership], national health charities [Irish Heart Foundation and Irish Cancer Society], the Irish national health service, the Department of Health, a philanthropic organisation [Rethink Ireland], Volunteer Ireland and a team of academics [n=5] was established to inform the strategic direction of the FC project.

This project is the subject of a PhD at the South East Technological University, Ireland that has been funded by the South East Research Development Fund [WD SERD_2020_54_WSCH, €90,000]. One author of this report [SD] is the PhD student.

5.3 Ethics, Consent and Data Management

Ethical approval for the project was sought and obtained from the ethics committees at the South East Technological University [SETU] [WIT2021REC006]. This project has been registered with the 'International Standard Randomised Controlled Trial Number' registry [ISRCTN17438373].

Details of the project were clearly explained to participants both verbally and in written format prior to data collection. Written informed consent was provided by all project participants.

Data was collected for this project during the COVID-19 pandemic and therefore, all qualitative data [with the exception of the one focus group] was collected via Zoom as per SETU's protocol. In brief, only the audio recording was saved on a desktop before being stored on a password protected OneDrive to be transcribed. When saved to OneDrive, the audio-recording was deleted from the desktop. Transcription was completed within 7 days and audio files deleted from OneDrive. Confidentiality and anonymity of participants was ensured through the project's compliance with SETU's protection policy. Namely, all identifiable information such as consent forms were stored securely on OneDrive separately from the transcribed research and questionnaires and only accessible by named researchers. All data sets were kept on] OneDrive and only members of the research team had access to specific data sets.

Research data was fully anonymised; participants in qualitative research were assigned a unique code and all identifying information were de-identified in any reporting of data; the only identifiers collected for quantitative data were participants date of birth and mother's maiden name so that they could be tracked over time and linked with their participation data.

6.0 Social Return on Investment Approach

The purpose of this project was to evaluate this community-based football social initiative for men under 'real world' conditions to assess feasibility for scale up. While the community setting boasts many benefits in terms of implementing interventions, these settings are highly variable and unpredictable[102]. Therefore, the challenges of implementing and sustaining interventions within these complex settings require a shift from focusing on tightly controlled efficacy trials to evaluation in the real world context from the outset[103]. If feasible, plans will be put in place to upscale FC games to improve reach (population and geographical access) and equitable access to the games and the games benefits[104]. Specifically, the purpose of this report is to detail the protocols used and outcomes obtained in the evaluation of the FC initiative using a SROI framework with a view to assessing feasibility for scale up.

Therefore, the seven step SROI methodological approach was adopted and informed the research design. Furthermore, the implementation of this methodological approach requires adherence to the principles of SROI which are integrated throughout the research process [see Figure 6.1 below].

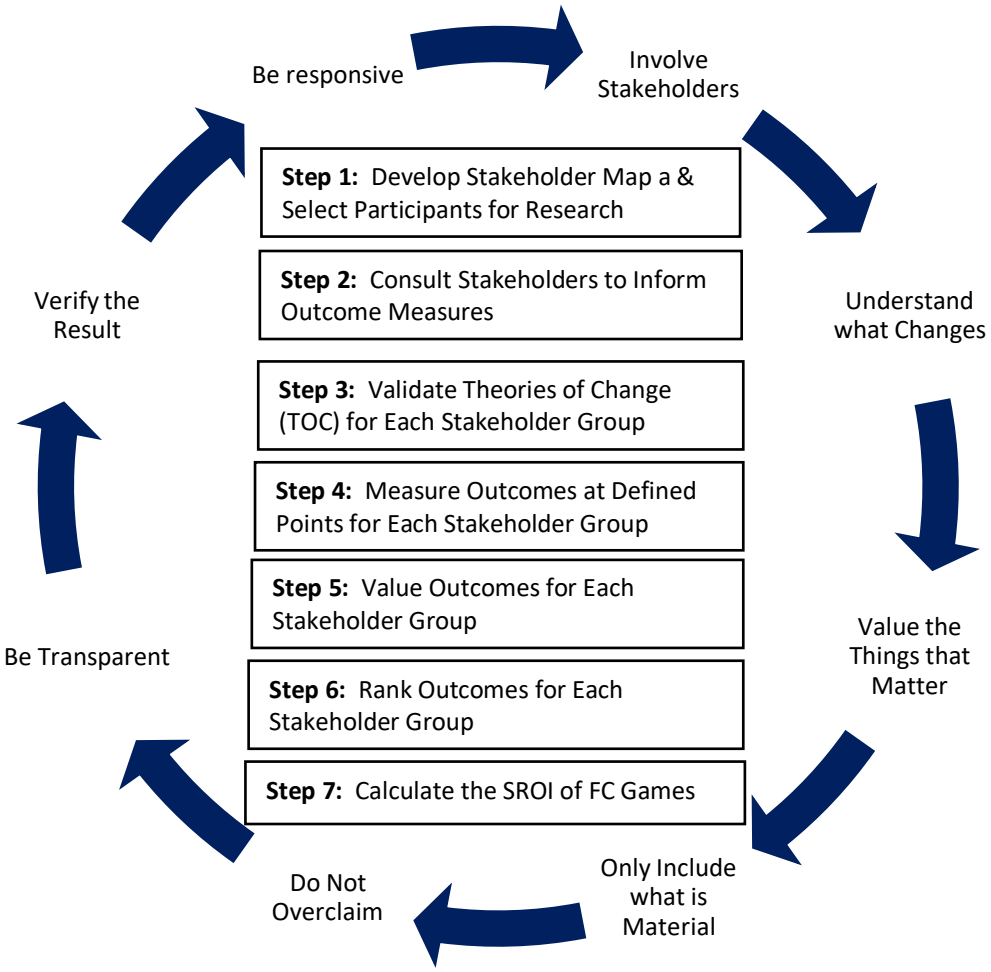


Figure 6.1: An overview of the seven step SROI methodological approach underpinned by the principles of SROI (Adapted from Social Value UK, 2015[105] and produced for Carroll et al., 2023[106])

Table 6.1 below details how the social value principles have been applied throughout the methodology adopted for this evaluation.

Table 6.1: Application of the SROI principles to this evaluation

Principle	Application
1. Involve Stakeholders	Stakeholders are those individuals, groups or organisations who are impacted (positively and/or negatively) as a result of the activity. This principle underpins the importance of identifying all stakeholders and involving them in consultation so that the 'value' defined is determined by 'those affected by or who affect the activity'[107, p96]. In this analysis, stakeholders were involved in every stage to ensure they informed a) the outcomes to be measured, b) the verification of those outcomes, c) the value of those outcomes [see Sections 7.1-7.3] and d) the discounting of those outcomes [see Section 8]. Stakeholders were also involved in determining and valuing inputs [see Section 7.4].

2. Understand what Changes	Stakeholders will experience change [intended/unintended, and or positive/negative] as a result of activities. This principle requires evidence of what changes and the need for the process of how that evidence was generated to be clearly stated. A theory of change (ToC) was developed and verified with each stakeholder group after a period of consultation [see Sections 7.1.3.1-7.1.3.4] and stakeholders were consulted in the measures to be used as an indication of outcomes identified. The evidence provided by stakeholders was reviewed in conjunction with objective measures, where possible, to define thresholds of meaningful change [see Sections 7.2.1.5-7.2.1.7].
3. Value the Things that matter	Market values for many of the outcomes experienced by stakeholders do not exist and therefore, values for these outcomes needed to be generated. This principle states that 'financial proxies should be used in order to recognise the value of these outcomes'[108, p97]. In this analysis, financial proxies were identified through consultation with stakeholders; each stakeholder group defined the value of each outcome for that group [see Section 7.3]
4. Only Include what is Material	This principle requires that boundaries are established "….of what information and evidence must be included in an account of value to give a true and fair picture, and one that is based on the evidence from stakeholders so decisions taken focus on the changes that matter."[109, p2.] In this analysis, materiality was adjudicated for each outcome identified by stakeholders; and only those outcomes that were important enough to consider when making decisions about allocating resources were included. See Section 7.1.3.3 where materiality was not found for a stakeholder outcome.
5. Do Not Overclaim	This principle ensures that practitioners only claim the impact the is due to the activity and that they 'take account of what would have happened anyway'[110, p97] if the activity did not happen. A conservative approach was adopted in this analysis particularly with respect to assigning value [see Section 7.3], attributing value based upon relative impact [see Section 7.3] and discounting factors [see Section 8.0].
6. Be Transparent	Assumptions and limitations are to be expected and this principle requires full disclosure of any such assumptions and limitations as they arise. These may relate to stakeholders, outcomes, outcome measures, thresholds for meaningful change and methodological considerations. Furthermore,

	details of how results are communicated to stakeholders to effect change in the activity must be explained and documented. The logic of assumptions made and decisions taken are explained throughout the report. Section 9.0 is dedicated to the limitations of the report and modelling of different assumptions is detailed in the sensitivity analysis [see Section 8.6]. Stakeholder engagement is also detailed in Tables 7.1 & 7.2 and Sections 7.1.2, 7.1.3, 7.2, 7.3 and Section 8. Reporting of results to the participant stakeholder group is detailed in section 7.2 and how they will continue to be informed of and consulted on the results is detailed in Section 10.0.
7. Verify the Result	An SROI analysis invariably involves subjectivity and therefore 'Appropriate independent assurance is required to help stakeholders assess whether or not the decisions made by those responsible for the analysis were reasonable'[111, p98]. In this analysis, practitioner's consistently involved stakeholders to verify outcomes, theories of change and the valuation of and discounting outcomes measured [see Sections 7.1-7.3 and Section 8]. Literature was also consulted to support decisions taken throughout this report. In addition, we sought independent advice from an SROI accredited practitioner in Quality Matters to discuss assumptions, decisions made and the SROI process applied in this analysis.
8. Be Responsive	This principle requires that information gathered and conclusions drawn from this analysis are communicated to the stakeholders who contributed to the report and all those who are materially affected by the activity. Plans of how the organisers intend to use the findings to optimise the impact of the activity on outcomes should also be reported to stakeholders. Information gathered on participants and changes observed in outcome measures were reported to participants on an ongoing basis during data collection [see Sections 7.1.3.1 – 7.1.3.4 & 7.2]. Furthermore, plans to communicate this report to all stakeholders are detailed in Section 10.

7.0 Overall SROI Methodology

In the following sections, each of the seven steps in the SROI methodological approach [see Figure 6.1 above] will be presented separately as a) determining outcomes [Steps 1-3; see Section 7.1], b) measuring outcomes [Step 4; see Section 7.2] and c) valuing outcomes [Steps 5 & 6; see Section 7.3]. The methodology used to determine and value inputs [See Figure 7.2 below] will be detailed in Section 7.4 while that used to calculate the SROI of FC games [Step 7] will be presented in the following Section [see Section 8.0].

Where appropriate, the research design, participant recruitment, data collection and analysis approaches will be detailed within each section. Notably, this methodology was initiated in the weeks prior to lifting COVID-19 restrictions in the Republic of Ireland as it was imperative that Steps 1 and 2 for FC members were completed prior to the resumption of games. Games were postponed from Dec 5th 2020 and resumed on May 17th 2021. Therefore, given the absence of five months of games, the resumption of play was viewed as a baseline for data collection from players. Consequently, the research team operated under a very tight timeframe to determine the outcomes to be measured in Step 4 for FC members which began for players when they returned to play.

All data collection instrumentation and processes for data collection were reviewed with a view to optimising acceptability to FC participants. The timeframe for the seven-step data collection and management process is detailed in Figure 7.1 below.

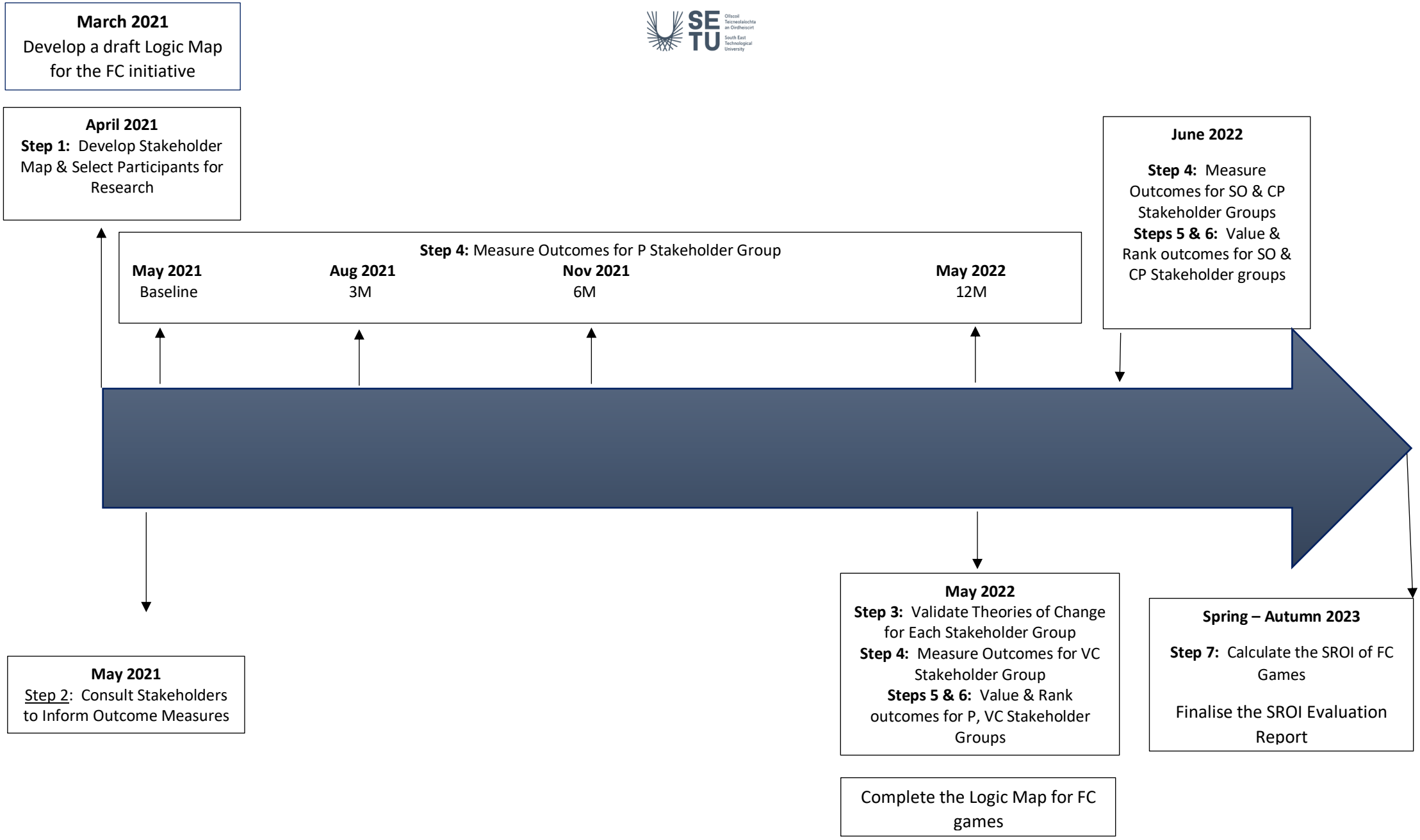


Figure 7.1: An overview of the timeframe for the seven-step data collection and management process for the project

Prior to commencing the seven step SROI methodology and following consultation with the FC Founder, a draft logic model for the FC initiative was developed [see Figure 7.2 below]. Specifically, this consultation, conducted over several informal interviews and emails with the FC Founder and including the review of FC material [grant applications and mission statements], explored how the FC initiative situated itself in terms of the need it aimed to address, the assets it used to address that need and the stakeholders involved in the initiative. Consideration was also given to understanding the mission, vision and values of the FC initiative as detailed in Section 5.0 above as well as the resources required to deliver the initiative along with other collaborators, local dynamics and competitors to the initiative. The 'intended outcomes' of the initiative were also discussed but not included in the logic model below as the research team preferred to use the SROI evaluation to define the short and medium term 'actual outcomes' for each stakeholder group. Long term outcomes i.e. beyond 12 months were beyond the scope of this evaluation.

As can be seen from Figure 7.2 below, the activities of the FC initiative included hiring of the venue, the provision of insurance and the purchasing of equipment [footballs, bibs, pumps and medical kit] so that the games could be organised and played. Committee meetings were held, members and volunteers were recruited and inducted into the values and ethos of the games as well as the practicalities of registering for and organising games. The committee also produced a newsletter to keep players up to date with FC activities and throughout the evaluation period the committee organised one[2] social event which doubled up as a fundraiser for a local charity.

In order to ensure these activities happened, investment in the form of labour, money and technological resources were required. Further detail on determining these inputs for each stakeholder group will be detailed in Section 7.4.

At this stage, stakeholders were identified as regular attenders, irregular attenders, dependants of players, significant others, volunteer coordinators, community partners and a local charity. See Section 7.1.1 below for details on the stakeholder mapping process.

The research team also recognised that the evaluation process would be subjected to external factors and assumptions that would limit the findings. Therefore, assumptions were rationalised in consultation with stakeholders, an independent accredited SROI evaluator, evidence in the literature

[2] Two other events were cancelled due to Covid-19 restrictions and a spike in cases.

and lengthy research team discussions. The logic for all assumptions is detailed throughout this report and limitations are detailed in Section 9.0 below.

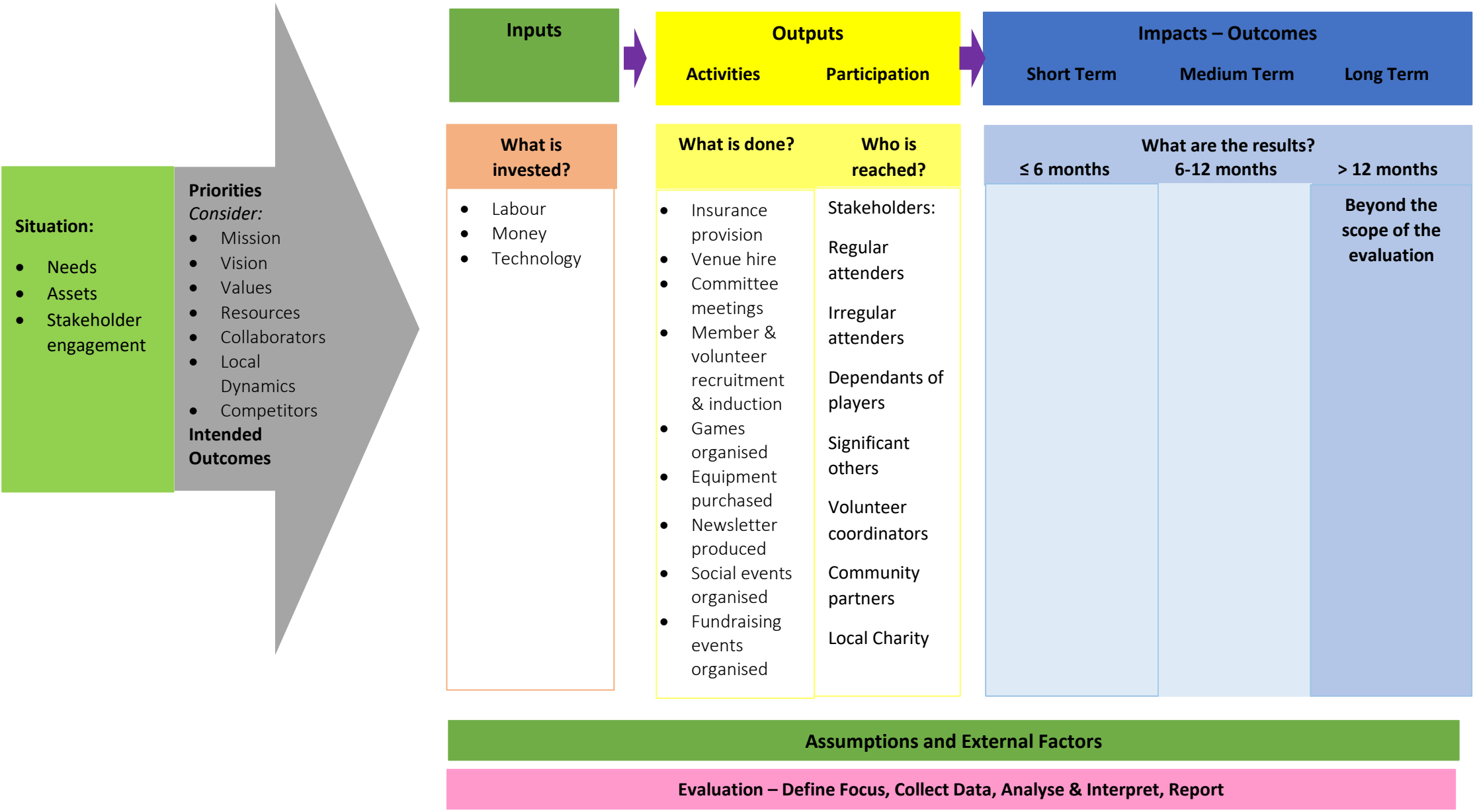


Figure 7.2: The draft Logic Model for the FC initiative to be completed via the data from the SROI evaluation.

7.1 Determining Outcomes

7.1.1 Develop Stakeholder Map and Select Participants for Research

A stakeholder was defined as any group that may potentially have experienced positive or negative outcomes [intended or unintended] from the FC initiative. As stated above, following consultation with the Founder of the FC initiative, seven stakeholder groups were identified [see Figure 7.2 above]. The inclusion of each stakeholder group was justified by considering the consultation with the FC founder, reviewing evidenced based literature and discussion on the materiality of the outcomes for each stakeholder group [see Table 7.1 below].

Table 7.1: Rationale for the inclusion and exclusion of stakeholders in the SROI evaluation

Stakeholder Group	Rationale	Decision
Regular attenders	There is a considerable body of evidence that those who engage in football or PA regularly or irregularly directly benefit from such engagement [see Sections 4.3 & 4.4 above]. Both of these groups were directly involved in the FC games and at least, it is probable that they gained some physical benefit from doing so.	Included
Irregular attenders		Included
Volunteer coordinators	It has been well documented that there are multiple benefits to be gained by altruistically giving of your time via volunteering[112]. As volunteers directly involved in organising the FC initiative, it is probable that they experienced material benefit from doing so.	Included
Community partners	Those community partners who liaised with the FC initiative, did so on a voluntary basis so, as per the volunteer coordinators, it is probable that they experienced material benefit from doing so. In Ireland community clubs [not for profit organisations] leasing their facilities for the purpose of sport or PA are entitled to do so and income received is exempt from VAT[113]. Therefore, this money can be freely used by the organisation for their benefit.	Included
Dependants of players	Given the age profile of players, this stakeholder group were probably predominantly minors. Therefore, the research team believed that it would be extremely challenging to get ethical approval to include this stakeholder group in light of the ongoing Covid-19 pandemic throughout this evaluation. Furthermore, the fact that the players and significant other stakeholder groups were in a position to provide secondary accounts of the experiences of their dependants, it was agreed to not consult with this stakeholder group as part of this evaluation.	Excluded
Significant others	Evidence from another community-based PA programme for men in Ireland identified benefits for the significant others of those men who engaged in the programme[114]. Therefore, it is probable that the SOs experienced material benefit from their partners' participation in the FC initiative.	Included

Local charity	This stakeholder group only received a once off donation and so this outcome is not material and can be accounted for in the FC outputs.	Excluded

Therefore, five stakeholder groups were identified; a) regular attenders [RA], b) irregular attenders [IRR], c) volunteer coordinators [VC], d) community partners [CP] and e) significant others [SO] for inclusion in this evaluation.

RAs and IRRs: As of May 2021, prior to the resumption of games, FC had a database of 123 members at the evaluation site who were eligible to participate in this SROI evaluation. In recognition of the fact that outcomes experienced may be related to the level of participation[115] FC members were divided into two distinct groups for consultation. RAs were identified as those members who played FC games weekly for six to twelve months prior to imposition of the Covid-19 restrictions [n=61; medium & high full participation levels – see Table 7.7, Section 7.2.1.4 below] and IRRs were all other registered members [n=62]. Following the resumption of games, new participants joined the FC initiative and were eligible to be included from Step 4 of the evaluation i.e. outcomes could be measured from these participants. It was agreed that men were eligible for inclusion in the evaluation if they a) were aged at least 18 years, b) were a registered member of the FC initiative, c) completed the physical activity readiness questionnaire (PAR-Q) [see Appendix 1] d) could read and write in English and e) provided written consent. Answering 'yes' to any item on the PAR-Q did not warrant inevitable exclusion from the evaluation. In practical terms, these men attended the FC initiative to participate and would play whether they were part of the evaluation or not. Therefore, as per the Men on the Move trial[116], men were advised to discuss any issues arising from PAR-Qs with their own GP.

VCs: This stakeholder group were defined as those who engaged in a voluntary role within FC i.e. Match Coordinators [n=6]. This role incorporated administrative, logistical and functional demands such as the registration and induction of new players, organising games, dealing with issues arising on/off the field, managing payments, creating social events, rating participants and fostering and safeguarding the FC values and ethos. All VC's identified were FC members and had been involved since its inception in 2017. Members of the VC stakeholder group were eligible for inclusion if they a) were at least 18 years old, b) could read and write in English and c) provided written consent.

CPs: The CP stakeholder group were volunteers of a local sports club from whom the FC initiative hired the Astroturf pitch for games [n=2]. Those in this stakeholder group acted in the capacity of facility managers. They personally enabled FC member's access to the pitch and managed the payment for

its rental. Volunteers were eligible for inclusion if they a) were at least 18 years old, b) could read and write in English and c) provided written consent.

SOs: SOs [spouses, partners or close family members] were typically individuals who would have been well placed to observe (i) changes in the men attributable to their participation in FC games and/or (ii) experienced an impact on themselves/their families through their acquaintance with a FC participant [n=123]. SOs were eligible for inclusion if they a) were at least 18 years old, b) could read and write in English and c) provided written consent.

7.1.2 Consult Stakeholders to Inform Outcome Measures

The full population in each stakeholder group was invited to participate in the consultation process. Table 7.2 below details the recruitment of stakeholders.

Table 7.2: Recruitment of stakeholders in terms of population, those who expressed an interest in participating, those who participated and the representation at consultation

Stakeholder Group	Expressed Interest (n)	Participated (n)	Representation (%)
Regular Attenders (n=61)	35	10	16
Irregular Attenders (n=62)	20	4	6
Volunteer Coordinators (n=6)	6	3	50
Community Partners (n=2)	2	2	100
Significant Others (n=123)	2	2	2
Total	**65**	**21**	

With the exception of SOs, all stakeholder groups were contacted by the FC gatekeeper (a VC) and invited to participate in this study. An invitation seeking an expression of interest (EOI) to take part in the consultation for the SROI evaluation was sent all stakeholder groups from the FC gatekeeper via email initially and thereafter via WhatsApp on two occasions. Those interested contacted a member of the research team directly. SOs were recruited via snowball sampling via their partners and those interested contacted a member of the research team directly.

RAs & IRRs: Some 55 FC members [RA=35; IRR=20] expressed an interest to participate in the project. A total of 17 interviews were scheduled [RA, n=13; IRR, n=4] and from the 4th to the 12th of May 2021, 14 interviews were conducted[3] with RAs [n=10; 23-50 mins] and IRRs [n=4; 29-48 mins]. Not

[3] One RA cancelled their interview while two other RAs failed to show.

unsurprisingly, it was more challenging to engage IRRs in the consultation process after a 5-month lapse in games.

VCs: All VCs expressed an interest in participating in the consultation and a focus group was held with 3 members of this stakeholder group on May 11th 2021 [n=64 mins].

CPs: Both CPs expressed an interest in participating in the consultation and a focus group was held with 3 members of this stakeholder group on May 25th 2021 [n=25 mins].

SOs: Only two FC members [RAs] successfully recruited their partner to participate in the consultation process for this project. Interviews were conducted with SOs [21-23 mins] on the 17th and 18th of May 2021.

Interviews and focus groups sought to ascertain motivation to get and stay involved in the FC initiatives [RAs, IRRs, VCs] and the impact of participation on them personally, their family [RAs, IRRs, VCs, SOs] and their organisation [CPs]. Data collection was conducted on the Zoom platform and transcribed verbatim [see interview topic guides; Appendices 2-5]. Transcripts were analysed deductively using predefined codes namely, a) the environmental factors that influenced their experience [inputs and activities], b) participant characteristics [outputs], c) the impact of the programme on them and d) the outcomes they experienced as a result of this experience. A Theory of Change [ToC], which is a comprehensive description and illustration that not only defines outcomes that are expected to happen in a particular context but also describes how and why those outcomes are expected[117], was drafted for each stakeholder group. Each draft ToC was then discussed with the wider research team and refined following review of the data and examples in literature. It was evident from this consultation that the draft ToC for the RA and IRR stakeholder groups were the same which would indicate that the outcomes experienced by the same was not dependent upon the frequency of play.

7.1.3 Validate Theories of Change for Each Stakeholder Group

The final ToC for each stakeholder group was validated via a workshop style focus group. Several attempts were made to complete this step; from December 16th 2021 data collection with all stakeholders was scheduled monthly but they were continually thwarted for a variety of reasons including a spike in COVID 19 cases and the unavailability of stakeholders due to logistical reasons and/or COVID 19. Naturally, it was imperative that ToCs were validated prior to the final data collection at 12M so the research team persevered and this was achieved [see Figure 7.1 above].

The full population in each stakeholder group was invited to participate. As per Step 2, with the exception of SOs, all stakeholder groups were contacted by the FC gatekeeper. Unlike Step 2, the FC gatekeeper arranged the final focus groups given the challenges of previous experiences stated above. Table 7.3 details all those who participated in this stage of the evaluation as well as the sample size for each stakeholder group and the representation of each stakeholder group across both Steps 2 and 3.

Table 7.3: Recruitment of stakeholders in terms of population, those who participated and the representation of each stakeholder group [consultation and validation of ToC steps combined]

Stakeholder Group	Participated (n)	Representation (%)
Regular Attenders (n=61)	7	29
Irregular Attenders (n=62)	10	15
Volunteer Coordinators (n=6)	3	50
Community Partners (n=2)	2	100
Significant Others (n=123)	4	5
Total	**26**	

With the exception of the CP focus group, all validation focus groups were held on the Zoom platform. During the focus groups, the draft ToC for each stakeholder group was shown to that stakeholder group and following discussion edits were suggested. All data were recorded as per the ethical protocols for the research. During focus groups, details of the project and findings to date were fed back to stakeholder groups [RAs, IRRs, VCs] as per the SROI principle regarding responsiveness [No.8].

Post data collection, members of the research team independently, deductively analysed the focus groups via review of the recordings to draft a final ToC. All ToCs were discussed at a team meeting to achieve consensus on the final draft. The final draft for each stakeholder group was then sent to the participant stakeholders of each focus group for validation. No additional edits were made by participants so the stakeholder ToCs were adopted [see Figures 7.3-7.6 below]. Notably, the final ToC for the RA and IRR stakeholder groups were identical so the research team made the decision to merge them into one 'Participant' stakeholder group [see Figure 7.3 below]. Notably, the presentation of the ToCs was discussed with an independent accredited SROI evaluator to ensure they clearly represented the data.

7.1.3.1 Regular and Irregular Participant Validated Theory of Change

A focus group was held RAs [n=7; 60 mins] and a focus group was held with IRRs [n=10; 60 mins] on May 5th, 2022. The participants were given an opportunity to discuss a) what it is about the environment created by the FC initiative that appeals, b) what do participants have in common, c) what impact their participation in the FC initiative has had on them and d) outcomes experienced from those impacts, both positive and negative [see Appendix 6]. However, as per above, it did emerge at these focus groups that similar outcomes were experienced by both types of player but that the extent to which each category of player experienced these outcomes varied [note that this is discussed further in Section 7.2.1.5-7.2.2.7]. Therefore, the ToC in Figure 7.3 below is that which was used for all FC members and for the remainder of this report, the term 'Participant' will be used to describe the stakeholder group that represents all FC members.

As can be seen from Figure 7.3 below, FC members were male and were diverse with respect to age and backgrounds. They predominantly lived near the FC site and were motivated to play to engage in recreational activities, and particularly competitive football, in the evenings and to connect with others. They enjoyed the FC environment because games were not weather dependent, well organised competitive [but not aggressive], reliable, flexible and affordable.

They experienced a number of personal impacts from playing which translated into meaningful outcomes. FC members reported experiencing a better work/life balance and improved self-esteem which in turn improved their overall mental health/well being. FC members also reported positive behaviour modifications such as dietary improvements and engaging in other forms of exercise and this overall increase in physical activity helped them stay 'in shape'. These changes resulted in an improvement in their overall physical health. Through playing football, FC members' social networks increased and friendships were formed and as a result of these social interactions, an improvement in their overall social health was reported. However, FC members also experienced some injuries and their sleep was somewhat affected on game nights which resulted in an adverse outcome for some [increased number of injuries].

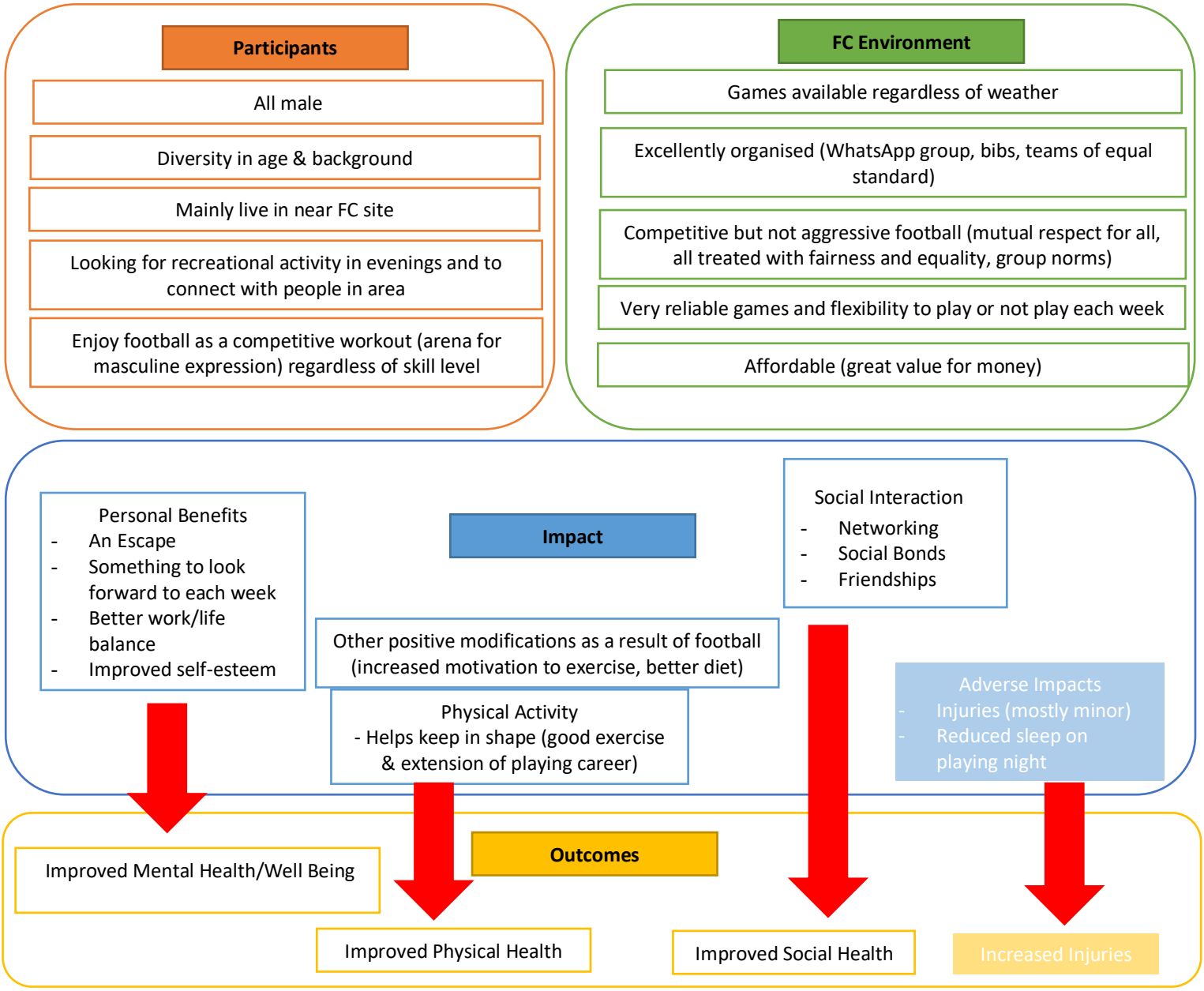


Figure 7.3: The validated ToC for the Participant stakeholder group

The materiality of each outcome was determined on the basis of whether FC members a) identified the outcome as a result of the impact of participation when validating the TOC [Stage 3 – see Figure 6.1 above], b) valued the outcome when asked at the 12M survey [Stage 5 - see Figure 6.1 above] and c) defined the importance of the outcome as relevant at the 12M survey [Stage 6 - see Figure 6.1 above]. As a result of this three-step process, all outcomes identified in Figure 7.3 above for the Participant stakeholder group were deemed material.

At baseline, FC members were asked what motivated them to participate in FC games. As can be seen from Table 7.4 below, of those who answered the question [n=72], the majority were motivated to participate due to their 'love of competitive football' and were not seeking health related benefits. Some 42.3% of FC members were motivated to 'improve fitness/keep fit' while very few participated for mental or social benefits.

Table 7.4: FC members motivation to participate in FC games and baseline

Initial Motivation to Play	**%(N)**
Love of competitive football	47.9 (34)
To improve fitness/keep fit	42.3 (30)
To release stress	5.6 (4)
To integrate into my community	4.2 (3)

While it was expected that many participants would experience a combination of physical, mental and social benefits as a result of participation in FC, it was also viewed that these were independent outcomes i.e. it would be possible for participants to experience a physical benefit without a mental or social benefit and vice versa. To support this view, data gathered from 3M and 12M surveys with participants is shown in Table 7.5 below.

Table 7.5: Self-Reported benefits by participants at 3M and 12M

		@ 3M			@12M	
		Mental Benefit			**Mental Benefit**	
		Yes	**No**		**Yes**	**No**
Physical Benefit	**Yes**	20	27	**Yes**	40	5
	No	13	6	**No**	2	0
		Social Benefit			**Social Benefit**	
		Yes	**No**		**Yes**	**No**
Physical Benefit	**Yes**	15	32	**Yes**	33	12
	No	32	12	**No**	1	1
		Social Benefit			**Social Benefit**	
		Yes	**No**		**Yes**	**No**
Mental Benefit	**Yes**	9	24	**Yes**	32	10
	No	13	20	**No**	2	3

Table 7.5 above shows that in the eyes of the participants, it is possible to experience some but not all of the three benefits (physical, mental, social) – for example, at 3M, 27 of the 47 participants (58%) who experienced a physical benefit did not experience a mental benefit. Furthermore, 32 of the 47 participants (68%) who experienced a physical benefit did not experience a social benefit, and 24 of the 33 participants (73%) who reported a mental benefit did not report a social benefit. While more

participants reported at 12M that they experienced a number of these benefits simultaneously e.g. 40 of the 45 participants who reported a physical benefit also reported a mental benefit, it is still evident that a number of participants experienced one of the benefits without experiencing other benefits. It may well be that more benefits were experienced simply due to longer participation duration. In short, while it is difficult to rule out the possibility that the act of experiencing one of these benefits has some impact on the chances of experiencing other benefits, this 3M and 12M data supports the view that the three benefits are largely independent of each other i.e. it is possible to experience one benefit without the other. For this reason, the research team decided that the various outcomes are independent and were therefore treated as such in the subsequent analysis.

7.1.3.2 Volunteer Coordinator Validated Theory of Change

A focus group was held with the same three members of the VC stakeholder group [n=3: 65 mins] on March 29th, 2022. Stakeholders were given the opportunity to discuss a) what drew them to get involved in organising the FC initiative and define what they have in common, b) how they work together i.e. the environment they have created and what makes it effective and what might need improving, c) what impact their role as volunteer has had on them and d) outcomes gained as a result of being a VC [see Appendix 7]. The validated ToC is detailed in Figure 7.4 below; it is evident that VCs share common values and traits in that they want to contribute to their communities [notably they live near the FC site] and are 'fair minded', natural leaders. Significantly they have previous experience of playing recreational football and hence know what does/does not work well in terms of providing a positive experience. They have time to both play and organise the FC games and consequently are quite knowledgeable about the FC initiative from both sides [player & coordinator]. The majority of their role before and after games is conducted via their bespoke 'games portal' and notably, VCs also have competency in the use of such technology which makes this possible [one VC developed this in-house].

Their role is varied. Prior to games they induct new players and introduce them to the ethos, values and practical aspects of the initiative, they pick teams to make sure that everyone has a competitive, enjoyable game in a relaxed atmosphere and they coordinate the collection of participant game fees. When opportunities arise, they foster leadership in other players who in time may elevate to coordinators and/or team captains who uphold the values of the games in the absence of a referee.

After games they do a short game report and deal with any on/off field issues that may arise. As a group, they work as a team in terms of sharing roles across game nights and they have autonomy.
It is evident that volunteering in this capacity significantly impacts VCs. They were emphatic in stating that their experience is 'almost always positive' and that they get great enjoyment from being involved in something positive and providing a service that they know men need. Their experience as a VC also provides them with an opportunity to 'escape' their day, gives them a distraction and can improve their day, especially if work is challenging all of which in turn reduced stress in their lives. Through their leadership role they enjoy being able to influence the culture and future development of the games. They also experience validation and empowerment through their leadership of the games in terms of recognition and positive feedback they receive from peers which translates into an improvement in their self worth/self esteem. Despite having to deal with issues of disgruntled participants at times they also feel connected to both the group of participants but also to the group of VCs as a result of which they have experienced an improvement in their social connection.

Despite acknowledging that at, at times, there are adverse impacts to being a VC of the FC initiative e.g. the time it takes [1-2 hours/week] and the competing responsibilities with family, this group of stakeholders were clear that they do not translate into any negative outcomes for them in their lives i.e. they are not material is per the SROI principle [No.4].

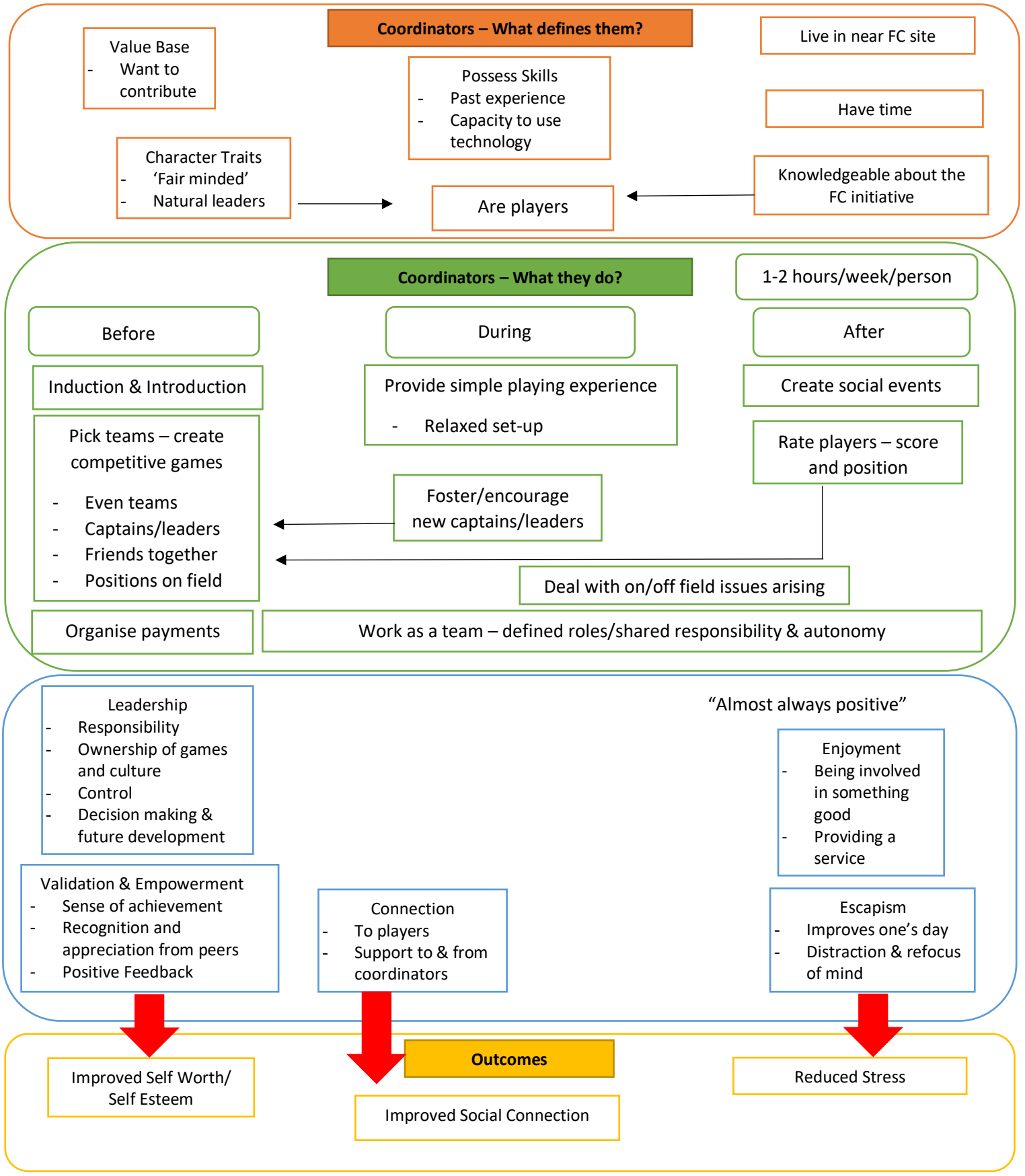


Figure 7.4: The validated ToC for the Volunteer Coordinator stakeholder group

Materiality of each outcome was determined on the basis of whether FC members a) identified the outcome as a result of the impact of participation when validating the TOC [Stage 3 – see Figure 6.1 above], b) valued the outcome when asked at the 12M survey [Stage 5 - see Figure 6.1 above] and c) defined the importance of the outcome as relevant at the 12M survey [Stage 6 - see Figure 6.1 above]. As a result of this three-step process, all outcomes identified in Figure 7.4 above for the VC stakeholder group were deemed material.

The research team also considered the independence of the various outcomes for the VCs and after reviewing the focus group data which led to this TOC, it was felt that it was possible for the coordinators to experience one of these outcomes without experiencing the others. The analysis shown later in this report and the Value Map does show that all of this small group of volunteers attained these three benefits; however, this did not mean to the research team that these outcomes depended on each other – this conclusion is similar to that for the participants where it was found that many participants were able to experience one benefit without attaining other benefits.

7.1.3.3 Community Partner Validated Theory of Change

A focus group was held with the CP stakeholder group [n=2: 45 mins] in-person. Stakeholders were given the opportunity to discuss a) the duties they perform for the FC initiative as volunteers for their organisation, b) the impact the relationship between the FC initiative and their organisation has had on their organisation and c) the impact this relationship has had on them personally [i.e. their role as volunteer with their organisation to liaise with the FC initiative; see Appendix 8]. The validated ToC for the CP stakeholder group is detailed in Figure 7.5 below.

The CPs were resident near the FC site, were volunteers in their local club as they wanted to give something to their community and had time to do so. Their role involved managing the pitch schedule and payment of same as well as liaising with any tenants, such as FC, who leased the pitch from the club. Their involvement as volunteers impacted them personally [positively and negatively] and there were also impacts for their club [positive only]. For the CPs themselves, their involvement enabled them to be part of building a community spirit through FC activities and they were appreciative of the asset their club pitch was to the community. As a result, they experienced an improved self-worth/ self-esteem. They were also appreciative of their relationship with FC who represented a secure and reliable tenant who are also available over the summer months [they would be difficult to replace]

which translated into a positive outcome for CPs; satisfaction of having a secure and reliable tenant However, at times, they found it difficult to get others to replace them when they were away and the need for them to be there to allow access to the pitch did infringe on their personal recreational time. Initially [at Stage 3 – see Figure 6.1 above], this stakeholder group identified this impact as an adverse outcome [a reduction in personal time].

The club itself was impacted through an increased revenue stream via the pitch rental from the FC initiative and the easy relationship with FC that ensured monies were paid on time and all year round [see Appendix 11 for income received during evaluation period].

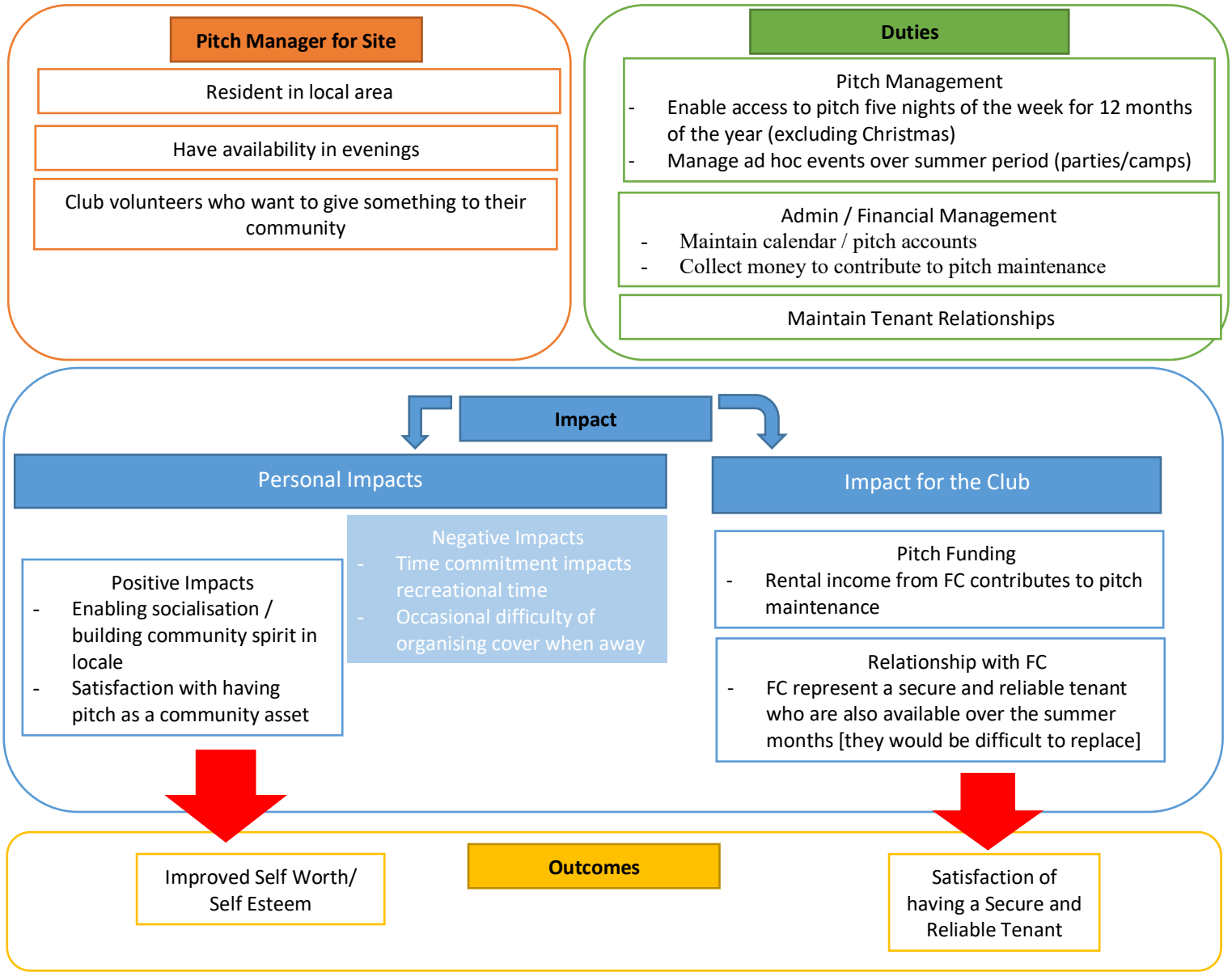


Figure 7.5: The validated ToC for the Community Partner stakeholder group

Materiality of each outcome was determined on the basis of whether FC members a) identified the outcome as a result of the impact of participation when validating the TOC [Stage 3 – see Figure 6.1 above], b) valued the outcome when asked at the 12M survey [Stage 5 - see Figure 6.1 above] and c) defined the importance of the outcome as relevant at the 12M survey [Stage 6 - see Figure 6.1 above]. However, following the valuation of outcomes by this stakeholder group [see Section 7.4 below] the adverse outcome identified was deemed 'immaterial' [SROI Principle No.4] as stakeholders valued this outcome at €0. The ToC was amended to reflect this as per Figure 7.5 above. As a result of this three-step process, all outcomes identified in Figure 7.5 above for the CP stakeholder group were deemed material.

Notably, outcomes were deemed independent on the basis that their self-worth/self-esteem was influenced by their role and that of their club while the second outcome was as a result of their specific relationship with one client [the FC initiative].

7.1.3.4 Significant Other Validated Theory of Change

A focus group was held with the SO stakeholder group [n=4: 45 mins] via Zoom. Stakeholders were given the opportunity to discuss a) what it is about the environment created by the FC initiative that appeals to them, b) what impact their SOs participation in the FC initiative has had on them, their family and/or community and c) the outcomes gained for them, their family and/or community as well as adverse outcomes [see Appendix 9].

The SOs lived near the FC site and both them and their families experienced significant impacts from their partners participation in the FC initiative that translated into meaningful outcomes. In fact, this stakeholder group were adamant that they did not want the FC initiative to end.

According to the SOs, communication between them and their partner increased and there was a better routine in the home in evenings as their partners were more involved with the household chores e.g. feeding, bathing and getting children to bed before heading out to play football. In fact, their partners spent a greater amount of time with the family and also with them via the FC social evenings [which they could also attend] which positively impacted their social connection. The combination of these impacts resulted in an improvement in their partner and family dynamic/relationship.

SOs also acknowledged that they took great pleasure in the happiness their partner got from playing and had a better peace of mind regarding their partners health. Notably, they also reported a happier home environment for the whole family which, when coupled with other impacts, translated into an improvement in their mental health/well being/happiness.

Through engaging in healthier behaviours SOs also reported that their partners were positive role models for them and their children and they also found that they had more time to do their own health enhancing activities as the men had a greater appreciation for such time. As a result of these impacts, SOs experienced an improvement in their family's physical health.

When probed, the SOs reported that an adverse impact is that participation in FC games was time consuming, but with the VCs, they were adamant that this did not translate into an adverse outcome i.e. they are not material is per the SROI principle [No.4].

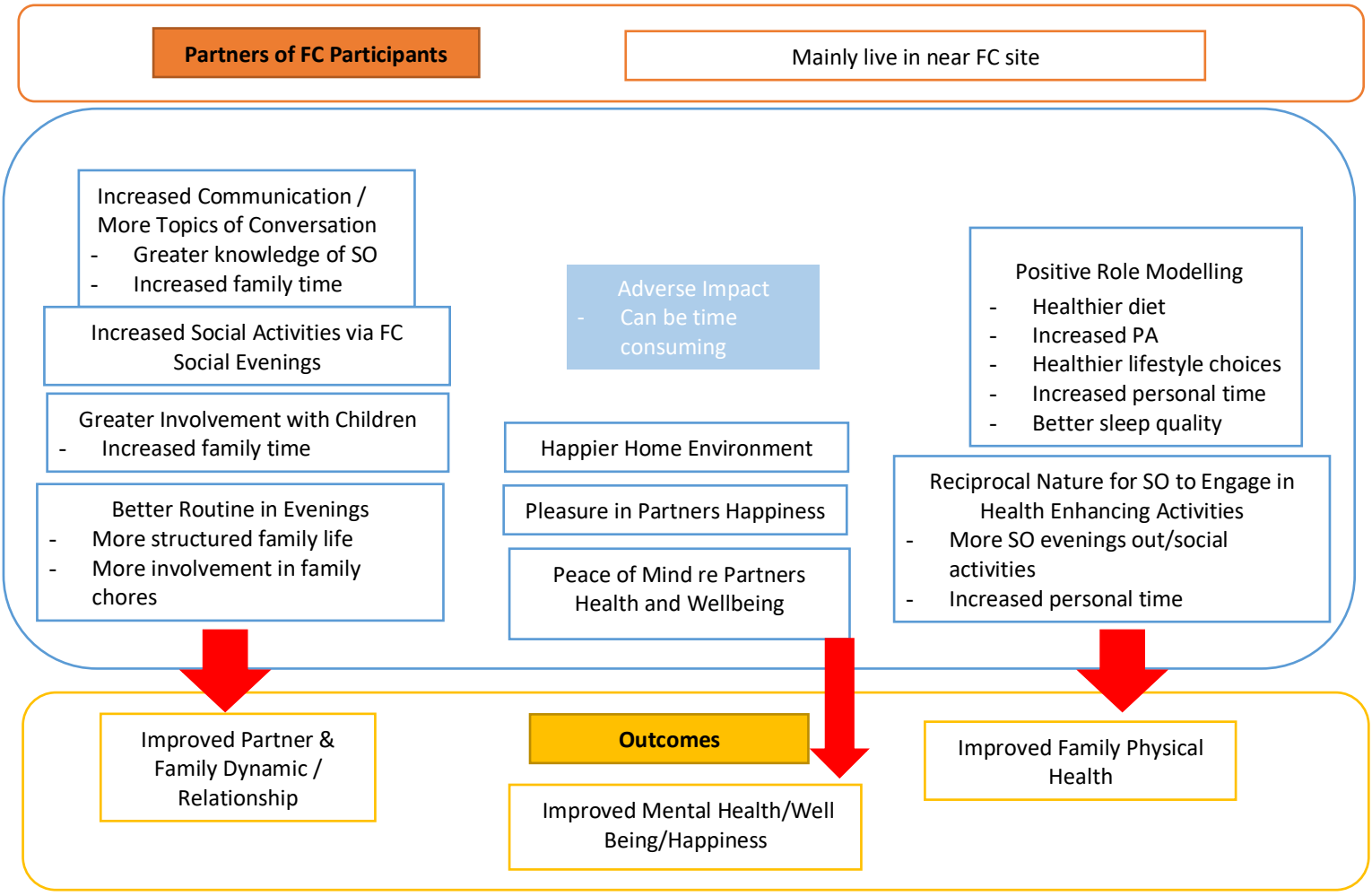


Figure 7.6: The validated ToC for the Significant Other stakeholder group

Consistent with other stakeholder groups, materiality of each outcome was determined on the basis of whether FC members a) identified the outcome as a result of the impact of participation when validating the TOC [Stage 3 – see Figure 6.1 above], b) valued the outcome when asked at the 12M survey [Stage 5 - see Figure 6.1 above] and c) defined the importance of the outcome as relevant at the 12M survey [Stage 6 - see Figure 6.1 above]. As a result of this three-step process,, all outcomes identified in Figure 7.6 above for the SO stakeholder group were deemed material.

The independence of the various outcomes for the SOs was also considered and the research team again felt that the various outcomes for this stakeholder were largely independent of each other. This conclusion was arrived at after reviewing the focus group information where it was clear that some SOs achieved more of one outcome and less of other outcomes – in many respects, this was similar to the conclusion presented earlier for the participants where it was found that many participants were able to experience one benefit without attaining other benefits.

Having consulted with all stakeholders to determine the outcomes for evaluation, the logic model for the FC initiative was completed as is presented in Figure 7.7 below.

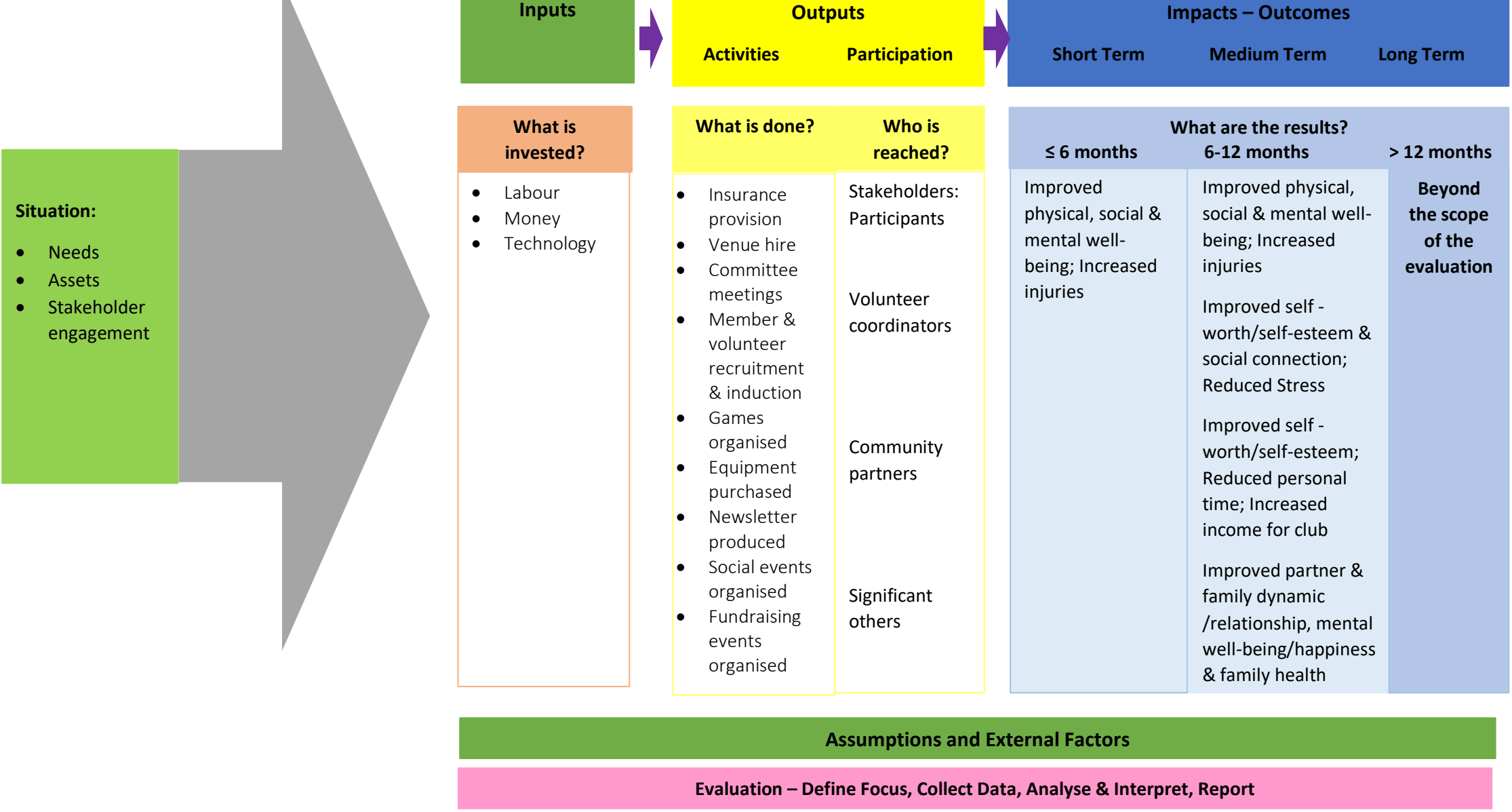


Figure 7.7: The Logic Model for the FC initiative completed via the data from the SROI evaluation

7.2 Measuring Outcomes

Having arrived at outcomes for each stakeholder group, the next step in the SROI analysis was to seek to measures these respective outcomes. For this task, every effort was made to capture the views of the various stakeholders and to gather as much data as possible to get a rigorous assessment of the amount of change in each of the various outcomes. At this time, the research team also considered the level of involvement each stakeholder group had in the FC initiative along with a likely timeframe in which change could reasonably be expected to occur. The chosen research designs to capture the various outcomes for each stakeholder group is shown below.

7.2.1 Measuring Outcomes for Participants

7.2.1.1 Research Design

A pragmatic quasi-experimental one site repeated measures study without a control was adopted to measure the participant outcomes to be determined. This design was chosen as it was neither logistically feasible nor ethical to conduct a comparison control trial; participants had already been restricted from play for 5 months so therefore we could not ethically ask men to delay returning to play further given the importance of participation on mental health issues arising from COVID 19 restrictions[118]. Furthermore, it was impossible to locate an alternative 'group in waiting' given the ongoing COVID situation throughout this evaluation and therefore, men acted as their own control post a 5-month lag in games. Randomisation was also not an option given the population size and subsequently the probable sample size[119]. We recognise the limitation of non-randomisation and the absence of a control but assert that the decisions taken regarding the study design are a natural occurrence in action-based research in real world settings and under the constraints of public health restrictions during the COVID 19 pandemic.

7.2.1.2 Sample Size Estimates and Participant Numbers

Two outcome measures were used to calculate the sample size [based on $p<0.05$ and 90% power to detect differences in a repeated measures design] required for the evaluation; it was found that a small sample size [~15 participants] would be needed to detect a 1 level [320 m] increase in Yo Yo Intermittent Recovery Test (YYIR Level 1) performance and a 5 cm reduction in waist circumference. These calculations were based on data available in Grgic et al., (2019)[120] and Schmidtz et al., (2018)[121] but also from the Men on the Move dataset[122]. The decision was taken to attempt to recruit all 123

active participants at the site into the evaluation for the following reasons: 1. In adhering to SROI principles, the primary outcome measure(s) cannot be identified in advance and the sample size must be sufficiently large to ensure that each of the outcomes can be evaluated should they be prioritised by stakeholders; 2. Previous experience of the research group with the Men on the Move evaluation[123] indicates that when participants are tested on 4 occasions over a 12 month period that a full dataset may only be achieved in 25% of the study cohort; 3. A larger sample size allows for the primary outcome measures to be evaluated separately in subsets of participants and the research team believed that it was likely that segmenting the sample for participation levels would be relevant for the evaluation.

7.2.1.3 Outcome Measures and Data Collection

A number of variables were captured at baseline (B), 3 months (3M), 6 months (6M) and 12M to assess a) the participant demographics, b) factors about the FC initiative, and c) the participants health as per the outcomes identified. Self-reported variables were recorded via self-administered questionnaires across all time points [see Table 7.6 below & Appendix 10 for an example of the survey at B].

Table 7.6: An overview of the variables collected from FC participants at each timepoint throughout the study

Variable	Baseline	3M	6M	12M
Demographics				
Age	√	√	√	√
Ethnicity	√			
Nationality	√			
Education	√			
Has there been any change in your relationship status in the last 3 months		√	√	
Relationship Status	√	√	√	
Living Arrangement – Who & Number	√	√	√	
Has there been any change to your employment status in the last three months?		√	√	
Employment Status	√	√	√	
Has there been any change to how you are managing financially in the last three months?		√	√	
Financial Strain	√	√	√	
Football Cooperative				
Heard About It	√			
Primary Motive for Playing	√			
Travel Time	√			
Self-Rated Ability to Play	√	√	√	√
What benefits, if any, have you gained over the last three months as a result of your participation in the FC initiative?		√	√	
What benefits, if any, have you gained over the last 12 months as a result of your participation in the FC initiative? (Physical, Mental, Social, Other or Non)				√
What adverse outcomes, if any, have you experienced over the last three months as a result of your participation in the FC initiative?		√	√	
What adverse outcomes, if any, have you experienced over the last 12 months as a result of your participation in the FC initiative? (Mild injury, Moderate injury, Major injury, other, none)				√
In the last three months have you become involved in another indoor or outdoor physical activity, (a gym for example) that may contribute to the benefits and/or adverse outcomes you have described already?		√	√	√
About Your Health				
Quality of Life - SF-12	√	√	√	√
Physical Activity Frequency	√			
Vigorous Physical Activity Frequency		√	√	√
Fruit & Vegetable Consumption	√	√	√	√
Smoking Status	√	√	√	√
Alcohol Consumption	√	√	√	√

Variable	Baseline	3M	6M	12M
Over the past three months have you modified your lifestyle behaviours (e.g. fruit & veg intake, smoking, alcohol consumption, physical activity) with a view to improving your health?		√	√	
Over the past 6 months have you modified your lifestyle behaviours (e.g. fruit & veg intake, smoking, alcohol consumption, physical activity) with a view to improving your health?				√
What lifestyle behaviour(s) have you modified (tick all that apply)?		√	√	√
Has your participation in the FC initiative influenced your decision to modify your lifestyle behaviour(s)?		√	√	√
Sleep Quality	√	√	√	√
Self Esteem	√	√	√	√
Loneliness	√	√	√	√

The FC gatekeeper mediated the administration of questionnaires via their IT system when men signed up for games. Participants were directed to a link to the survey on the Qualtrics online survey platform. A number of measures were recorded at B, including participant demographics (date of birth, ethnic origin, educational attainment, relationship status, housing and employment status and financial strain), how participants had heard about FC games, their motivation to play, travel time to perceived play and ability to play. As the study progressed, participants were asked about the benefits and adverse outcomes they experienced as a result of playing and whether they were engaged in other forms of PA that could account for the benefits and adverse outcomes recorded. At all-time points, self-reported health outcomes were measured that included quality of life [SF-12], sleep quality[124], self-esteem [Rosenburg Self-Esteem [RSE] Scale][125], loneliness [UCLA Loneliness Scale][126] and lifestyle behaviours including PA, fruit and vegetables consumption, smoking and alcohol consumption.

Three objective outcome measures were assessed at all time points and were aerobic fitness, body mass index (BMI) and waist circumference (WC). Weight [kg] was measured using a Seca 813 electronic weighting scales [light clothing, no shoes and with empty pockets] and height [cm] was measured using a portable Seca 213 stadiometer [without shoes]. BMI [kg/m2] was measured using weight and height measurements. WC was measured using a standard tape measure in accordance with standard protocols. Aerobic fitness was assessed via the YYIR Level 1 in accordance with standard protocols[127]. All equipment was calibrated prior to commencing fieldwork and all data collection complied with COVID regulations. The same personnel conducted anthropometric and fitness measures across all time points to safeguard against inter-tester errors.

To maximise retention at 3M, 6M and 12M, men were contacted by the FC Gatekeeper via their WhatsApp group and email database in the days before data collection; the link to the survey was attached and in addition, they were reminded to attend the games for physical measures. At 3M, 6M and 12M, participants were informed of their data up to that point to both adhere to the principle of responsiveness [No.8] and to act as a non-monetary incentive to show up for data collection. In addition, a subsidised[4] ticket for a corporate box was arranged for a Republic of Ireland football game which was offered to all participants as a thank you for supporting the research and to incentivise participation at 12M.

7.2.1.4 Profile of Stakeholders and Identification of Subgroups

An important part of SROI analysis is to consider if there are subgroups within the population which may experience different outcomes or different levels of the same outcomes and therefore in advance of the measurement of outcomes, a range of demographic and participation data was considered. For the main stakeholder group in this study (participants), a profile of this group from the various measures outlined in Table 7.6 is shown below in Table 7.7.

Table 7.7: Participant Profile Data

Age (years)	**% (N)**
20-30	11.3 (8)
31-40	42.3 (30)
41-50	40.8 (29)
51-60	5.6 (4)
Overall	
Ethnicity	**% (N)**
White (Irish or any other white background)	95.8 (68)
Any other background	4.2 (3)
Nationality	**% (N)**
Irish	77.5 (55)
Other European nationality	12.7 (9)
African nationality	4.2 (3)
Others	5.6 (4)
Highest Educational Attainment	**% (N)**
Some/completed 2nd level	12.7 (9)
Some/completed 3rd level	87.3 (62)
Relationship Status	**% (N)**
Married/Cohabiting	84.6 (60)
Single	7.0 (5)
Relationship not cohabiting	5.6 (4)

[4] This was €110 for the ticket as opposed to its original price of €160

Table 7.7 above shows that from the 71 survey replies received from the participant population, the majority were of a white background (96%), Irish (77.5%), had completed third-level education (62%) and were married or cohabiting (84.6%). A mixture of participants from various backgrounds and nationalities were included in the discussions that led to the ToCs being developed in Table 7.3 – and a review of this data showed no noticeable variation or difference in the stated outcomes [physical, mental, social and adverse] across different backgrounds or nationalities although the small sample of people who were not white or Irish is acknowledged as a limitation in making this assessment. Neither were noticeable variation or difference in the stated outcomes [physical, mental, social and adverse] observed between participants with different education levels or living arrangements. Therefore, subgroups, based upon these variables, were disregarded.

In the subsequent analysis of the various participant outcomes [see Sections 7.2.1.6-7.2.1.9], two main subgroups have been identified:

1. **Age** – as per Table 7.7, there is a good variation in ages across the participants and for simplicity, the subsequent analysis will assess whether outcomes varied for those less than 40 years compared to those above 40 years.
2. **Participation and Completion Level** - data was obtained from the FC gatekeeper on participation levels from May 17th 2021 to the May 18th 2022 for the 123 participants, and this is summarised in the histogram below [see Figure 7.8].

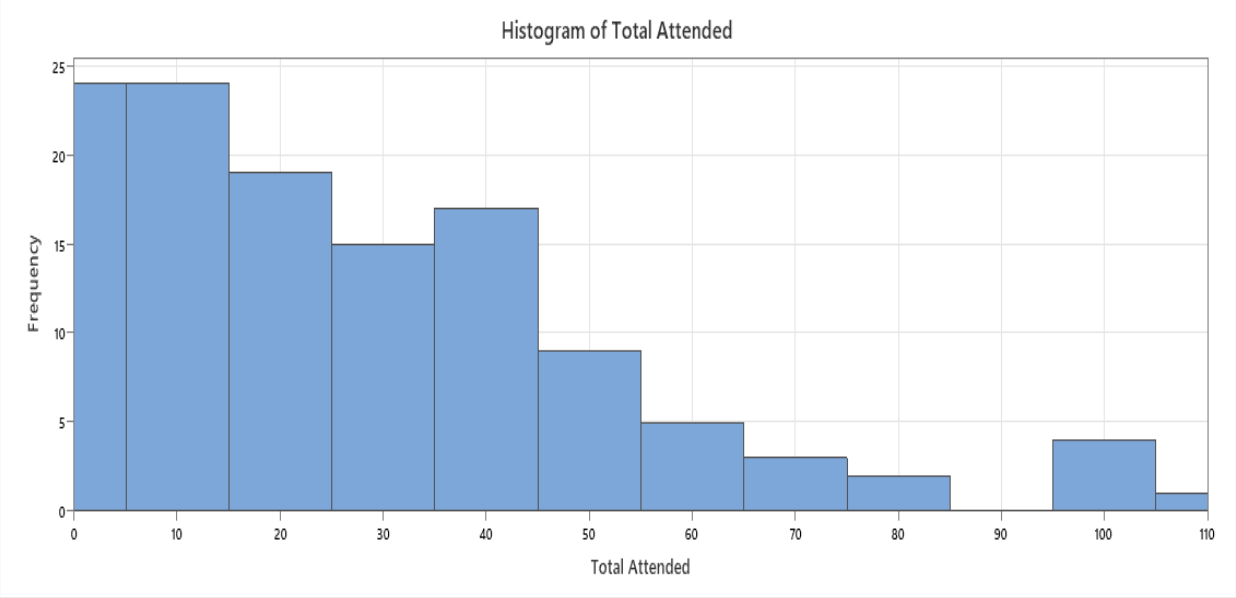


Figure 7.8: An overview of the participation level across the evaluation period

This shows the distribution of attendance at the sessions over the 12-month period (an average of two game nights were played per week); it was evident in this histogram that there were various levels of participation in this cohort and the research team decided to collapse the variation in participation into three broad categories as per Table 7.8 below.

Table 7.8: An overview of the defined participation categories and the representation of players in each category

Participation Category	Description	Number of Participants
Low	Participation less than once a fortnight (allowing for holidays/illness/other commitments = Less than 22 appearances)	58 (47%)
Medium	Participation once a fortnight (26 - 48 appearances) less four break weeks for holidays/illness/other commitments = 22-28 appearances)	47 (38%)
High	Participation once a week (52 or more appearances) less four break weeks for holidays/illness/other commitments = 48 or more appearances)	18 (15%)
Total		**123 (100%)**

While participation was considered likely to affect the achievement of outcomes, completion level was also considered to be equally important and a further analysis of the participation data showed that some participants had played for the full time period (12M) while others had played for lesser periods (3M, 6M and 9M). This led to a breakdown of the 123 participants across participation and completion levels as per Table 7.9 below.

Table 7.9: An overview of participation and completion level of the participants

	3M	6M	9M	12M	Total
Low	17	19	8	14	58
Med	0	1	3	43	47
High	0	0	0	18	18
Total	**17**	**20**	**11**	**75**	**123**

Table 7.9 shows that all of the high participation players played for the full 12M, a high proportion (43 of the 47) of the medium participation players played for 12M whereas only 14 of the 58 low participation players played for 12M. This led to a final collapsing of the data from Table 7.9 into six participation and completion categories [see Table 7.10 below]. These categories will be revisited as each of the respective outcomes for the participants are discussed in the subsequent sections.

Table 7.10: The number of FC members in each participation category defined according to participation and completion level

Participation Level & Completion Level	Number in Population
Low Full	14
Medium Full	43
High Full	18
Low 3M	17
Low 6M +9M	27
Medium 6M+9M	4
Total	**123**

Conclusions on Subgroups for Participants

Having considered the role of possible subgroups by age and participation & completion level, an analysis was conducted on how the various outcomes differed across different subgroups. This revealed that while many of the outcomes varied across participation and completion level, no major differences were observed across age levels. By way of illustrating this, Table 7.11 below shows how objective outcomes and participation levels varied across two age categories.

Table 7.11: Impact of Age on objective measure and Participation levels

	Age Category	
	Less than 40 years	**40 years and over**
Objective Measures		
Average VO2Max at Baseline	39.9	39.8
Average VO2 Max at 12M	40.7	40.9
Average BMI at Baseline	26.7	27.7
Average BMI at 12M	25.6	27.6
Participation Level		
Low	31	27
Medium	27	20
High	7	11

Table 7.11 above shows that there are no clear trends of age impacting on the attainment of the various outcomes for participants; in terms of VO2 Max [a measure of cardiovascular fitness], the average values are similar at baseline and at 12M for younger and older males with both seeing a small increase over this period. This trend is broadly repeated for BMI [a measure of relative body weight] with small improvements for both age groups over the period of the study. In terms of participation levels, there is also no clear evidence that older participants play more or less regularly than younger

participants - older males are shown to be more likely to have higher participation levels compared to younger males but this difference is not statistically significant.

Based on this analysis of subgroups and considering how the achievement of the various outcomes varied across different subgroups, a decision was taken to segment by participation and completion levels and not by age – this segmentation is shown in the following analysis of the various outcomes for participants.

7.2.1.5 Physical Health Benefits for Participants

Consideration was given to the range of data obtained from the participants as to which of this data would be used as indicators of the physical benefit that participants had described in the ToC consultations. This led to three measures being selected and the following thresholds – as shown in the extract below from the Value Map [see Figure 7.9 below].

Improved physical health	Weight via standardised measures repeated by same tester, TO BE INCLUDED PARTICIPANTS MUST ACHIEVE AT A 5% WEIGHT LOSS OR Physical fitness via the Yo Yo Intermittent Recovery Test Level 1, TO BE INCLUDED PARTICIPANTS MUST ACHIEVE AT LEAST A 10% GAIN **OR** Waist circumference via standardised measures repeated by same tester**,** TO BE INCLUDED PARTICIPANTS MUST ACHIEVE AT LEAST THE AVERAGE WAIST LOSS OF 3CM **AND** Physical health via SELF REPORTED SURVEY AT 12M (MUST HAVE REPORTED A PHYSICAL BENEFIT)

Figure 7.9: Value Map extract; Physical health benefit for participant stakeholder group

The choice of thresholds for these three measures was guided by relevant literature. According to the British Nutrition Foundation significant health benefits and reduction of risk of developing obesity-related diseases like type 2 diabetes and heart disease can be achieved by losing and keeping off even a small amount of weight (such as 3% of bodyweight if you are obese or about 5% for most people)[128]. Therefore, **the threshold for weight loss in this evaluation was set at 5%** as they were not an obese population. With respect to WC, a study of Japanese men concluded that a metabolic syndrome is significantly reduced with a 3cm reduction in WC[129] while others have reported a 2% reduction in CVD risk with every 1cm reduction in WC[130]. Given the impact of even a small reduction of WC on CVD risk and overall health, Mulligan et al.[131] recommend that interventions focusing on preventing increase in central adiposity rather than lowering weight would be more effective for health. Therefore, while the participants in this evaluation were not an obese group **the threshold for WC in this evaluation was set at 3cm.** The threshold for aerobic fitness, as measured by the YYIR test, was set after

consultation with Prof. Peter Krustrup, a founder member of the Football is Medicine movement[132]. Prof. Krustrup is the world's most widely published academic on the health benefits of recreational football; the research team consulted with him after he presented to the advisory board [meeting Dec 9th, 2022] and he stated that **a 10% improvement in the YYIR result as measured by meters travelled** would be an indicator of an improvement in aerobic fitness and physical health.

With data being gathered from participants at baseline, 3M, 6M and 12M intervals, this allowed for the number of participants achieving the chosen thresholds to be assessed. This is summarised in the Table 7.12 below.

Table 7.12: An overview of the number and percentage who achieved the defined thresholds for physical benefit at 3M, 6M and 12M as well as the participation level of those achieving the defined thresholds for physical benefit

	3M [n; %]	**6M [n; %]**	**12M [n; %]**	**Participation Level 3M**	**Participation Level 6M**	**Participation Level 12M**
≥5% Weight Reduction	2/31; 6%	1/25; 4%	5/35; 14%	H,L	H	H,H,,M,M,L
≥3cm WC Reduction	5/32; 16%	10/25; 40%	17/35; 49%	H,H,H,H,L	H,M,M,M,H H,M,H,H,,H	H,H,H,M,M H,M,H,M,H H,M,H,H,M LM
≥10% Rise in Aerobic Fitness	3/24; 13%	1/22; 5%	4/27; 15%	H,H,L	L	H,M,L,H
Self Reported Physical benefit	47/66; 71%	29/44; 66%	45/47; 96%			
Overall Benefit			18/36; 50%			H,H,H,H,H H,H,H,H,H M,M,M,M,M M,L,L

For the **weight loss data**, it can be seen that 2 participants out of 31 with available data achieved a 5% loss within 3 months [i.e. 6% of those assessed], while the percentages achieving this threshold at 6M and 12M was 4% and 14% respectively. This suggests that the chances of achieving this threshold increases if participants engage in the initiative for 12M than part thereof. Table 7.12 also shows the participation rate [high/medium/low] of those who achieved the weight threshold and for example, for the five achieving a 5% loss within 12 months, two had high participation, two had medium participation and one had low participation levels. Overall, this evidence would not provide a convincing case that participation levels are very linked to achievement of the weight loss threshold although sample size numbers are small here.

For the **WC data**, the percentages shown [16%, 40%, 49%] suggest that it needs participants to be present for 12M to attain this waist 3cm target, and it also appears that one needs to participate at medium or high level to achieve this threshold [16 of 17 to achieve the target at 12M had either a medium (M) or high (H) participation rate].

For the **aerobic fitness data**, 3 participants achieved a 10% gain within 3 months, two of which had a high overall participation rate and one had a low overall participation rate. The single participant achieving the 10% gain within 6 months had a low participation level while of the four achieving a 10% gain within 12 months, two had high participation, one had medium participation and one had low participation levels. This would suggest that one has a greater chance of reaching this threshold if one completes the full 12M programme, and it also is unclear that participation level [high/medium/low] impacts on attainment of this threshold [one of the four achieving the threshold after 12M had a low participation rate].

The **self- reported physical benefit data** relates to data computed from surveys at 3M, 6M and 12M where participants were asked if they felt they had achieved a physical benefit in the recent period of football activity. The 12M data shows that 96% of participants reporting that they obtained a physical benefit during the 12M period of the initiative – this is high but unsurprising given the nature of the initiative here. This may suggest that participants self-rate the physical benefits that they obtain from football more highly than the above objective data with thresholds would suggest.

When we combine those achieving a 5% weight loss, a 10% improvement in aerobic fitness and a 3cm reduction in WC, we have 18 participants out of 36 available participants [50%] achieving at least one of these benefits. All 18 of these participants had self-reported a physical benefit. The breakdown of participation rates for these 18 participants is 10 high, 6 medium and 2 low, and a further analysis of the 18 participants who achieved this benefit is shown in Table 7.13 below.

Table 7.13: The breakdown of the participants who achieved the physical benefit by participation level

Category	N	Number achieving Benefit	%
Low	6	2	33%
Medium	15	6	40%
High	15	10	67%
Total	**36**	**18**	**50%**

Consideration was given to the above information and it was felt that rather than apply a 50% percentage to all participants in the overall population regardless of participation, it would be better to segment the population of 123 participants by participation level when extrapolating the physical benefit to all. This was viewed as being important as otherwise one could be viewed as seeking to overclaim benefits for those with low participation levels. This led to the following extrapolation being applied in the Value Map [see Table 7.14 below].

Table 7.14: An overview of how benefit was assigned to groups defined by participation and completion level

Participation Level & Completion Level	Number in Population	% achieving Physical Benefit	Extrapolated Number of Participants Achieving Physical Benefit
Low Full	14	33%	4.62
Medium Full	43	40%	17.20
High Full	18	67%	12.06
Low 3M	17	23%	3.91
Low 6M +9M	27	28%	7.56
Medium 6M+9M	4	33%	1.32
Total	**123**		

Impact for Those who Did Not Achieve the Physical Benefit

While the above analysis shows the positive physical benefit for participants arising from participation in FC, a question arises as to what happened to those who didn't achieve the physical benefit. To address this, further analysis of the data revealed in Table 7.15 below.

Table 7.15: Analysis of those who didn't receive physical benefit by participation level

Category	Significant Benefit (% Achieving Physical Benefit Above Threshold & Self-Report Physical Benefit	Insignificant Change (Not achieving benefit or decline outside thresholds and/or not self reporting physical benefit)	Significant Decline (% Achieving Physical Decline above Threshold & not reporting physical benefit)
Low	2/6 = 33%	61%	6%
Medium	6/15=40%	54%	6%
High	10/15=67%	27%	6%
Total	**18/36=50%**	**16/36=42%**	**2/36=8%**

Table 7.15 above shows the participants who were deemed to have achieved the physical benefit as well as the distribution of those at each participation level who did not achieve this benefit. At an overall level, 50% achieved the physical benefit as defined earlier, 42% achieved an insignificant change and 6% experienced a significant physical decline [note that there were just two of the 36 participants in this category and with a very small sample size, it was decided to average this percentage (6%) to all subgroups].

Table 7.16: Allocation of physical decline to groups defined by participation and completion level

Participation Level & Completion Level	Number in Population	% achieving Significant Decline	Extrapolated Number of Participants Achieving Physical Decline
Low Full	14	6%	0.84
Medium Full	43	6%	2.58
High Full	18	6%	1.08
Low 3M	17	6%	1.52
Low 6M +9M	27	6%	1.62
Medium 6M+9M	4	6%	0.24
Total	**123**		

In summary, while the information in the earlier ToCs suggests that participants experience a physical benefit from FC, the data here has revealed a small proportion of participants who experienced a physical decline beyond the threshold limits and the value map was this adjusted to incorporate this negative physical outcome for the participants.

7.2.1.6 Mental Health Benefits for Participants

For the mental benefit that participants referred to in the ToC validation focus groups, the following indicators and thresholds were arrived at as shown in the extract below from the Value Map [see Figure 7.10 below].

Improved mental health/ well being	Mental health TO BE INCLUDED A CHANGE OF 10% IN THE ROSENBERG SELF ESTEEM SCALE IS REQUIRED AND Mental Health via SELF REPORTED SURVEY AT 12M (MUST HAVE REPORTED A MENTAL BENEFIT)

Figure 7.10: Value Map extract; Mental health benefit for participant stakeholder group

The RSE scale was used to assess the self-esteem of participants. Generally, changes over time in values on scales, such as this, are assessed on a group basis using parametric statistical tools. However, due to the initial small sample size in this study, coupled with the segmentation of the participant stakeholder group according to participation and completion levels, changes in scale values were assessed over time at an individual level. Therefore, the threshold of 'meaningful change' at an individual level assigned for this evaluation was guided by that identified using the Warwick Edinburgh Mental Well-Being Scale (WEMWBS) whereby a change in the standard error of measurement [SEM; 2.77; 4.9%] at an individual level was deemed significant[133]. As per the WEMWBS scale, the reliability of the RSE scale has been well established and therefore a small SEM was assumed. Also, given the smaller potential change in the scale value in the RSE scale [RSE 30 units; WEMWBS 56 units] the research team decided to heed on the side of caution and set the **threshold of a 10% increase in the measure of self-esteem** as meaningful in this evaluation.

This shows that two main metrics [the RSE scale and self-reported mental benefit which participants answered in surveys at 3M, 6M and 12M] were used to measure the attainment of the mental benefit. Note that the self-esteem scale consists of a 10-item scale with each item having four possible answers from 'Strongly Disagree' to 'Disagree' to' Agree' to 'Strongly Agree'. Some of the items in this scale were reverse coded and this led to a final scale which should be between 0-30; values of less than 15 are said to represent problematic low levels of self-esteem, and scores between 15 and 25 are said to be in the normal range. Some summary statistics of this indicator across all time points are reported in Table 7.17 below.

Table 7.17: The Cronbach's Alpha and average value of the self-esteem indicator at B, 3M, 6M and 12M as well as the participant representation at each time point

	Baseline [n=70]	**3M [=67]**	**6M [n=46]**	**12M [n=47]**
Cronbach's Alpha	0.884	0.873	0.84	0.89

Average Value	21.5	21.4	21.4	22.1

Note that the Cronbach's alpha values shown above represent a measure of the internal reliability of this scale to the data and as all the values are above 0.7, we can say that this scale is a good fit for this data at all time intervals. The average [mean] values of self-esteem shown above are largely constant for each of the time periods but this does not mean that all participants had a largely constant level of self-esteem over this period. For the SROI, individual level data was then generated using the 10% threshold and is reported in Table 7.18 below along with the self-reported mental benefit.

Table 7.18: An overview of the number and percentage who achieved the defined threshold for mental benefit at 3M, 6M and 12M as well as the participation level of those achieving the defined threshold for mental benefit

	3M [n; %]	**6M [n; %]**	**12M [n; %]**	**Participation Level 3M**	**Participation Level 6M**	**Participation Level 12M**
≥10% Rise in Self-Esteem	9/42; 10%	9/34; 26%	12/39; 31%	H,L,M,H,L H,H,H,H	H,L,M,H,M L,L,H,H	H,L,H,M,H,L M,H,H,M,L,M
Self Reported Mental benefit	33/66; 50%	21/44; 48%	42/47; 89%			
Overall Benefit			12/39; 31%			H,H,H,H,H M,M,M, M, L, L, L

Table 7.18 shows that the percentage of participants achieving improvements in self-esteem as measured by the RSE scale varied from 21% after 3 months to 31% after 6 months. It also shows the participation levels of those who achieved this benefit and it doesn't appear clear from this that one needs to be a high or medium participator to attain this mental benefit – this would be consistent with the focus group discussions which found that this benefit can be achieved by those who play irregularly as well as regularly. The self-reported mental benefit data from surveys suggests that participants are far more likely to self-report a mental benefit after 12M even though the self-esteem data suggests that many have attained some mental benefits at 3M and 6M.

When we combine those achieving the self-esteem threshold with those who also self-reported a mental benefit at 12M, we found that 12 of 39 participants [31%] achieved this mental benefit outcome; a breakdown of this benefit across levels of participation is detailed in Table 7.19 below.

Table 7.19: The breakdown of the participants who achieved the mental benefit by participation level

	N	Number achieving Benefit	Percentage achieving Benefit
Low	9	3	33%
Medium	18	4	22%
High	12	5	42%
Total	**39**	**12**	**31%**

While it is expected that a higher proportion of those with high participation rates [42%] would achieve the mental benefit, it is surprising that those proportionally more of with low participation rates [33%] achieve a mental benefit compared to those with medium participation rates [22%]. This may be due to the sample sizes involved with are relatively low and the approach adopted when extrapolating mental benefits to the wider population of 123 participants was to pool medium and low participants together [at an average of 26% attainment rate – half way between the low and medium rates above] and to also apply an adjustment for those who did not complete the full one year of the programme. This led to the extrapolation as per Table 7.20 below being applied in the Value Map.

Table 7.20: An overview of how benefit was assigned to groups defined by participation and completion level

Participation Level & Completion Level	Number in Population	% achieving Mental Benefit	Extrapolated Number of Participants Achieving Mental Benefit
Low Full	14	26%	3.64
Medium Full	43	26%	11.18
High Full	18	42%	7.56
Low 3M	17	16%	2.72
Low 6M +9M	27	16%	4.32
Medium 6M+9M	4	21%	4.00
Total	**123**		

Impact for Those who Did Not Achieve the Mental Benefit

As per the analysis of the physical benefit earlier, consideration was also given to those who didn't achieve the mental benefit. To address this, further analysis of the data revealed in Table 7.21 below.

Table 7.21: Analysis of those who didn't receive mental benefit by participation level

Category	Significant Benefit (% Achieving Mental Benefit Above Threshold & Self-Report Mental Benefit	Insignificant Change (Not achieving benefit or decline outside thresholds and/or not self reporting mental benefit)	Significant Decline (% Achieving mental decline above Threshold & not reporting mental benefit)
Low	26%	74%	0%

Medium	26%	74%	0%
High	42%	58%	0%
Total	**12/39=31%**	**27/36=69%**	**0/39=0%**

Table 7.21 above shows the mental benefit percentages from Table 7.20 to the left and it shows that of those who failed to achieve the mental benefit, none had experienced a significant decline in mental health [to qualify for this, participants needed to have experienced a decline in the self-esteem score of greater than 10% and to have not self-reported a mental benefit]. This was impacted by the findings in the 12M surveys where a large majority stated that they had experienced a mental benefit (42/47=89%). As all of the percentages to be applied to our subgroups are thus 0%, this led to the extract in the Value Map as per Table 7.22 below.

Table 7.22: Allocation of mental decline to groups defined by participation and completion level

Participation Level & Completion Level	Number in Population	% achieving Significant Decline	Extrapolated Number of Participants Achieving Mental Decline
Low Full	14	0%	0
Medium Full	43	0%	0
High Full	18	0%	0
Low 3M	17	0%	0
Low 6M +9M	27	0%	0
Medium 6M+9M	4	0%	0
Total	**123**		

In summary, while the information in the earlier ToCs suggests that participants experience a mental benefit from FC, the data was investigated to see if any participants had experienced a mental decline beyond the threshold limits and this revealed that no participant fell into this category.

7.2.1.7 Social Benefit for Participants

An increase in social health was the third benefit that participants referred identified in the ToC and the following indicators and thresholds used in this evaluation for this outcome is shown in the extract below from the Value Map [see Figure 7.11].

Improved social health	Loneliness via the UCLA loneliness scale TO BE INCLUDED A CHANGE OF 10% IN THE LONELINESS SCALE IS REQUIRED AND social Health via SELF REPORTED SURVEY AT 12M (MUST HAVE REPORTED A SOCIAL BENEFIT)

Figure 7.11: Value Map extract; Social health benefit for participant stakeholder group

The UCLA scale was used to assess the self-esteem of participants. As per self-esteem above, generally, changes over time in values on scales, such as this, are assessed on a group basis using parametric statistical tools. However, due to the initial small sample size in this study, coupled with the segmentation of the participant stakeholder group according to participation and completion levels, changes in scale values were assessed over time at an individual level. Therefore, the threshold of 'meaningful change' at an individual level assigned for this evaluation was guided by that identified using the Warwick Edinburgh Mental Well-Being Scale (WEMWBS) whereby a change in the standard error of measurement [SEM; 2.77; 4.9%] at an individual level was deemed significant[134]. As per the WEMWBS scale, the reliability of the UCLA scale has been well established and therefore a small SEM was assumed. Also, given the smaller potential change in the scale value in the RSE scale [RSE 60 units; WEMWBS 56 units] the research team decided to heed on the side of caution and set the **threshold of a 10% increase in the measure of loneliness** as meaningful in this evaluation.

As per the mental benefit assessment, two main metrics [the UCLA loneliness scale and self-reported social benefit which participants answered in surveys at 3M, 6M and 12M] were used. Note that the UCLA loneliness scale used was a 20-item scale, and some of the items in this scale were reverse coded and this led to a final scale which should be between 20-80; values of 20-34 indicated a low degree of loneliness, values between 35-49 indicated moderate degree of loneliness, 5-64 indicated a moderately high degree of loneliness, and values from 65-80 indicated a high degree of loneliness. Some summary statistics of this indicator across all time points are reported in Table 7.23 below.

Table 7.23: The average value of the loneliness indicator at B, 3M, 6M and 12M as well as the participant representation at each time point.

	Baseline [n=71]	**3M [n=61]**	**6M [n=41]**	**12M [n=44]**
Average Value	29.2	28.5	27.4	28.2

The average [mean] values of loneliness above show a fall in values at all subsequent time periods after the baseline data. For the SROI, individual level data was then generated using the 10% threshold and is reported in Table 7.24 below along with the self-reported social benefit.

Table 7.24: An overview of the number and percentage who achieved the defined threshold for social benefit at 3M, 6M and 12M as well as the participation level of those achieving the defined threshold for social benefit

	3M [n; %]	6M [n; %]	12M [n; %]	Participation Level 3M	Participation Level 6M	Participation Level 12M
10% Fall in Loneliness	10/38; 26%	13/32; 41%	18/38; 47%	H,H,H, M,M, M,M,M,L,L	H,H,H,H,M M,M,M,M,M L,L	H,H,H,H,H,H H,M,M,M,M M,M,M,L,L,L
Self Reported Social benefit	22/66; 33%	17/44; 39%	34/47; 72%			
Overall Benefit			14/38; 37%			

Table 7.24 above shows that the fall in loneliness gets bigger for those who participate for longer periods in the FC initiative – this reduced loneliness as a result of the FC initiative is consistent with the feedback at the focus group sessions which spoke repeatedly about the social connections formed during their time playing football. In terms of links to participation, there is no obvious trend of those achieving social benefit needing to have high participation [those on medium participation are also achieving this benefit in equal measure].

When we combine those achieving the loneliness threshold with those who also self-reported a social benefit at 12M, we found that 14 of 39 participants [38%] achieved this social benefit; a breakdown of this benefit across levels of participation is detailed in Table 7.25 below.

Table 7.25: The breakdown of the participants who achieved the mental benefit by participation level

Participation Level	N	Number achieving Benefit	%
Low	9	1	11%
Medium	18	8	44%
High	11	5	45%
Total	**38**	**14**	**37%**

It is noticeable in Table 7.25 above that those on medium and high participation levels are much more likely to achieve the social benefit than for those on low participation which again is as expected. This led to the following extrapolations being made for the wider population of 123 participants which included an adjustment for those who did not complete the full one year of the programme; Table 7.26 below is an extract from Value Map.

Table 7.26: An overview of how benefit was assigned to groups defined by participation and completion level

Participation Level & Completion Level	Number in Population	% achieving Social Benefit	Extrapolated Number of Participants Achieving Social Benefit
Low Full	14	11%	1.54
Medium Full	43	44%	18.92
High Full	18	45%	8.10
Low 3M	17	6%	1.02
Low 6M +9M	27	6%	1.62
Medium 6M+9M	4	30%	1.20
Total	**123**		

Impact for Those who Did Not Achieve the Social Benefit

In line with the analysis of the physical and mental benefit earlier, consideration was also given to those who didn't achieve the social benefit. To address this, further analysis of the data is detailed in Table 7.27 below.

Table 7.27: Analysis of those who didn't receive social benefit by participation level

Category	Significant Benefit (% Achieving Social Benefit Above Threshold & Self-Report Mental Benefit	Insignificant Change (Not achieving benefit or decline outside thresholds and/or not self reporting social benefit)	Significant Decline (% Achieving social decline above Threshold & not reporting social benefit)
Low	11%	84%	5%
Medium	44%	51%	5%
High	45%	50%	5%
Total	**14/38=31%**	**22/36=64%**	**2/38=5%**

Table 7.27 above shows the mental benefit percentages from Table 7.25 to the left and it shows that of those who failed to achieve this social benefit, just two had experienced a significant decline in social health [to qualify for this, participants needed to have experienced an increase in the loneliness score of greater than 10% and to have not self-reported a social benefit]. This was impacted by the findings in the 12M surveys where a considerable majority stated that they had experienced a social benefit [34/47=72%]. As the sample sizes experiencing a social decline were very small, the overall percentage of 5% is applied to all groups here in the extract in the Value Map shown in Table 7.28 below.

Table 7.28: Allocation of social decline to groups defined by participation and completion level

Participation Level & Completion Level	Number in Population	% achieving Significant Decline	Extrapolated Number of Participants Achieving Social Decline
Low Full	14	5%	0.7
Medium Full	43	5%	2.15
High Full	18	5%	0.9
Low 3M	17	5%	0.85
Low 6M +9M	27	5%	1.35
Medium 6M+9M	4	5%	0.2
Total	**123**		

In summary, while the information in the earlier ToCs suggests that participants experience a social benefit from FC, the data here has revealed a small proportion of participants who experienced a social decline beyond the threshold limits and the value map was adjusted to incorporate this negative social outcome for the participants.

7.2.1.8 Increased Injuries Outcome for Participants

The validation focus group discussions revealed that an adverse outcome [increased injuries] existed as a result of participation in The FC initiative [see Figure 7.3]. Consequently, the surveys at 3M, 6M and 12M asked participants if they had experienced adverse outcomes and to categorise such an outcome as minor, moderate or major. Table 7.29 below details the findings from those surveys.

Table 7.29: The number and representation of participants who experienced injury [minor, moderate, major] at 3M, 6M and 12M

Increased Injuries	3M [n;%]	6M [n;%]	12M [n;%]
None	38 (57%)	30 (71%)	16 (34%)
Minor	27 (40%)	12 (29%)	28 (60%)
Moderate	2 (3%)	0 (0%)	3 (6%)
Major	0 (0%)	0 (0%)	0 (0%)
Total	67 (100%)	42 (100%)	47 (100%)

Table 7.28 above shows that there are a considerable percentage of participants who reported either a moderate or a minor increased injury from participating in the FC initiative. Notably, this trend is more pronounced in the 12M data; this data has been analysed further by participation level and the findings are detailed in Table 7.30 below.

Table 7.30: The number and representation of participants who experienced injury [minor, moderate, major] at 12M according to participation levels

	Minor	Moderate	None	Total	% Minor	% Moderate
Low	7	0	3	10	70%	0%
Medium	14	3	6	23	61%	13%
High	7	0	7	14	50%	0%
	28	**3**	**16**	**47**		

Table 7.30 above shows some surprising patterns such as it appears that low participants are more likely to attain a minor adverse outcome [70%] than medium [61%] or high participants [50%]. Further, it shows that those on medium participation levels have a 13% chance of a moderate injury compared to 0% for low and high participants. Overall, these results are inconclusive in terms of establishing a clear link between participation levels and adverse outcomes and the decision was thus made not segregate adverse outcomes by participation level. However, Table 7.28 does show that there is a greater chance of 12M participants getting a minor or moderate injury [total 66%] compared to those at 3M [43%] and while the percentage at 6M is surprisingly lower at 29%. Therefore, we have apportioned the difference between low [43%] and high [66%] for medium in the value map. This led to the extrapolation as per Table 7.31 below being applied in the Value Map.

Table 7.31: An overview of how adverse outcome was assigned to groups defined by completion level

Participation Level & Completion Level	Number in Population	% experiencing Adverse Outcome	Extrapolated Number of Participants with an Adverse Outcome
Full	75	66%	49.50
3M	17	43%	7.31
6M +9M	31	55%	17.05
Total	**123**		

Note that consideration was given to those who did not experience this adverse outcome of increased injuries – and it was felt that those that avoided getting injuries did not need to be broken into separate groups for additional analysis. The benefits that such participants get is thus viewed as avoiding the negative costs associated with acquiring injuries – this will be shown later in this report.

7.2.2 Measuring Outcomes for Volunteer Coordinators

The ToC for VCs [see Figure 7.4] revealed three outcomes and no adverse outcomes which were measured via a self-reported survey at 12M. Surveys [generated on Qualtrics] were administered via the FC gatekeeper to all VCs via their WhatsApp group which asked them whether they experienced

each of the three outcomes identified. Four VCs completed the survey and all four experienced all of the outcomes identified. For the purpose of the evaluation it is assumed that all 6 coordinators experienced the all three outcomes. Table 7.32 below illustrates how this was entered into the Value Map.

Table 7.32: The Value Map extract of the measurement approach to assessing outcomes for volunteer coordinators

Outcome	Measurement Approach
Improved Self Worth/ Self Esteem	Survey at 12M asking if they experienced the outcome
Improved Social Connection	Survey at 12M asking if they experienced the outcome
Reduced Stress	Survey at 12M asking if they experienced the outcome

As all of the volunteer coordinators were viewed as having achieved the three outcomes, no discussion was needed for those who may have failed to achieve these outcomes.

7.2.3 Measuring Outcomes for Community Partners

The ToC for CPs [see Figure 7.5] revealed two outcomes [both positive] which, as per VCs, were measured via a self-reported survey at 12M. Surveys [generated on Qualtrics] were administered via the FC gatekeeper to both CPs via email; both CPs completed the survey and both experienced both outcomes. Table 7.33 below illustrates how this was entered into the Value Map.

Table 7.33: The Value Map extract of the measurement approach to assessing outcomes for community partners

Outcome	Measurement Approach
Increased revenue stream to 'Pitch Fund'	Survey at 12M asking if they experienced the outcome
Improved Self Worth/ Self Esteem	Survey at 12M asking if they experienced the outcome

As both of the community partners had achieved the two outcomes, no discussion was needed for those who may have failed to achieve these outcomes.

7.2.4 Measuring Outcomes for Significant Others

A self-reported cross-sectional survey design was used to assess outcomes which had been validated in the ToC for this group and participants were recruited via snowball sampling. The FC gatekeeper mediated the administration of questionnaires [Qualtrics link] to VCs via WhatsApp and at 12M, members of the SO stakeholder group were simply asked whether they experienced the three

outcomes identified in the ToC [see Figure 7.6]. Some 13 SOs completed the survey. Notably, there was more success in reaching this SO group via survey than previous data collection methods used in this evaluation [5% representation]; by Step 4 in the SROI process, some 11% of this stakeholder group contributed to the measurement the outcomes which satisfies the first SROI principle, involve stakeholders [see Table 6.1]. Table 7.34 below illustrates how this was entered into the Value Map.

Table 7.34: The Value Map extract of the measurement approach to assessing outcomes for significant others

Outcome	Measurement Approach
Improved Partner & Family Dynamic / Relationship	Survey at 12M asking if they experienced the outcome
Improved Mental Health/Well Being/Happiness	Survey at 12M asking if they experienced the outcome
Improve Family Physical Health	Survey at 12M asking if they experienced the outcome

While these three outcomes were arrived at after consultation with a sample of SOs in the ToC validation focus group [see Section 7.1.3.4], it was felt that such benefits would not apply equally to all types of participant but that they would vary in line with the participation level of the participant. In addition, given that more of the participants attained a physical than a mental or social benefit, it was decided, for consistency, that the attainment rate for SOs would follow a similar path. It was also felt that these benefits would not apply to participants who had not completed a full year of the programme. Therefore, for the participants who had a medium participation level and who completed 6M or 9M, zero benefit was applied. This was viewed as an appropriate approach to avoid being seen to over claim for benefits for this stakeholder in keep with the fifth SROI principle [see Table 6.1]. These considerations led to the extrapolation below for the various benefits to the SOs.

Table 7.35: Apportionment of benefits to SOs by participation and completion level

Participation Level & Completion Level	Number in Population	% achieving 'Improved Family Physical Health' Benefit	% achieving 'Improved Family Mental Health' Benefit	% achieving 'Improved Partner & Family Dynamic' Benefit
Low Full	14	0%	0%	0%
Medium Full	43	20%	10%	10%
High Full	18	50%	30%	30%
Low 3M	17	0%	0%	0%
Low 6M +9M	27	0%	0%	0%
Medium 6M+9M	4	0%	0%	0%
Total	123			

These above percentages are consistent with the experience of the participants and these led to extrapolated numbers of SOs attaining each of these respective benefits in the Value Map.

Note that consideration was given to significant others who did not achieve the above benefits but it was decided that no 'negative' outcome would apply here – this was based on an analysis of the physical, mental and social benefits for participants which showed that only very small proportions of participants had achieved 'negative' outcomes i.e. outcomes below that of the threshold in the reverse direction - 6%, 0% and 5% respectively. Given that a conservative approach was adopted to the allocation of benefits to significant others [see Table 7.35 above], it was felt that a similar approach to 'negative' outcomes would see zero 'negative' outcome for this stakeholder.

7.3 Valuing Outcomes

Valuation methods are seen as the hardest part of any SROI calculation because they involve complex techniques for monetizing diverse aspects of social benefit. This complexity is linked to the difficulty in valuing intangible outcomes such as increases in self-esteem and reduced stress, and in many cases, indirect methods using proxy market goods are used to gauge the value people place on such benefits. For the various outcomes described in Section 7.2, the initial intention of the research team was to host workshops with stakeholder groups as 12M to a) ascertain the relative importance of outcomes, b) value the most important outcome according to stakeholders and c) use the information from a) and b) to calculate the relative value of each outcome. However, for a number of reasons the research team decided to include specific questions pertaining to value and relative importance in the 12M questionnaire, namely;

- the difficulties experienced in organising the ToC validations workshops due to a spike in COVID 19 cases and the unavailability of stakeholders due to logistical reasons and/or COVID 19,
- the probability of getting a higher response rate and therefore stakeholder input to these metrics, and
- the view of our independent consultant who named the advantage of having each outcome individually valued rather than capturing the relative importance of each and using a ratio method to calculate value.

Therefore, at 12M, all stakeholders were invited to complete the survey [generated on Qualtrics] that was administered via the FC gatekeeper on WhataApp and email. Each stakeholder group was asked a) whether they experienced the outcome and b) to place a financial value (from €0- €10,000) on each of the outcomes they experienced from their direct or indirect involvement in the FC initiative. They

were asked to consider this value either as a direct benefit from having this outcome or as an opportunity cost [an estimate of how much they would be willing to pay to avoid not achieving this outcome]. Examples of the questions asked via survey for the participant stakeholder group for both experience and valuation of outcomes at 12M are presented in Figures 7.12-7.15 below.

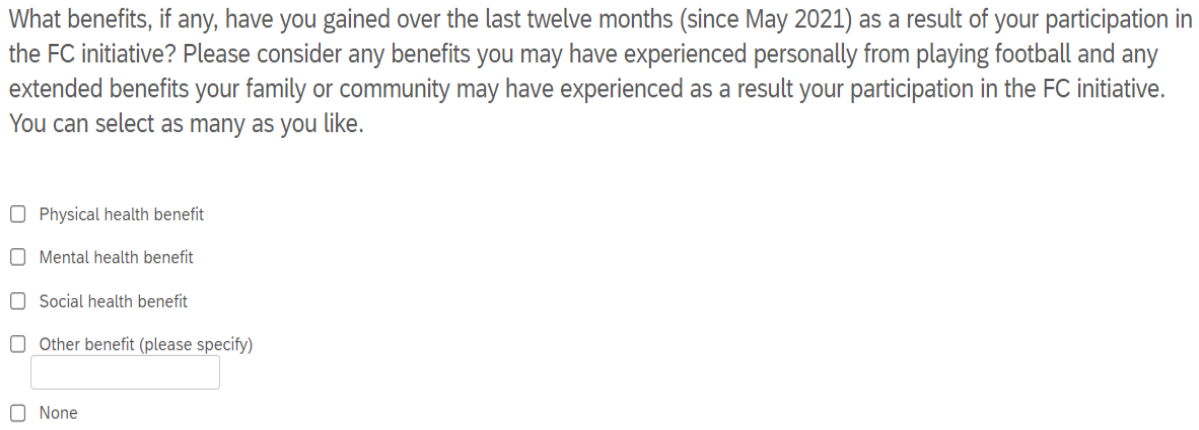


Figure 7.12: A screenshot of the question asking participants whether they experienced any benefit as a result of participating in the FC initiative

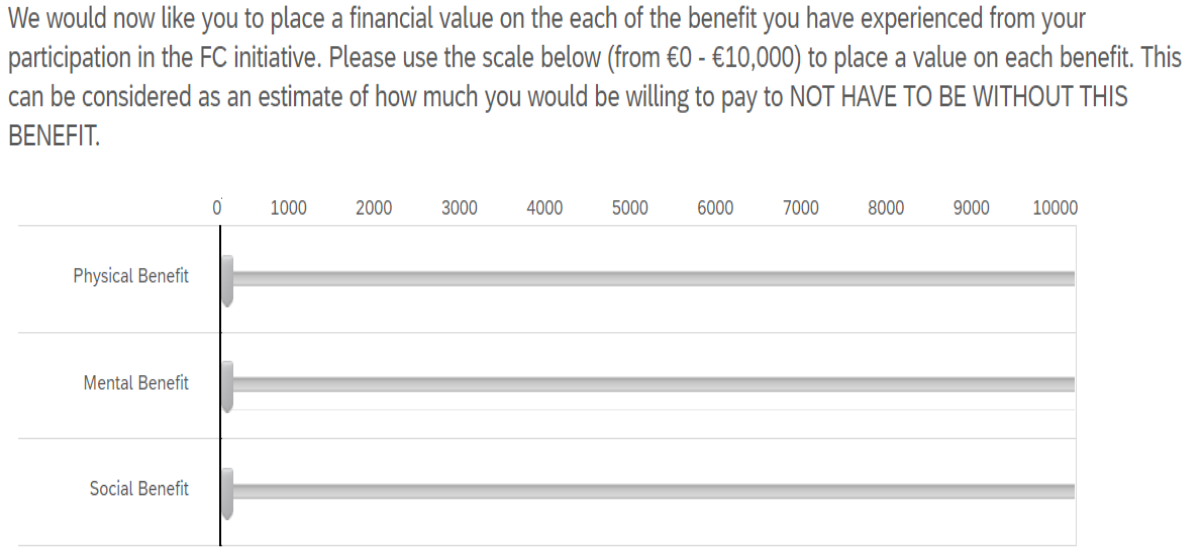


Figure 7.13: A screenshot of the valuation question for benefits asked of the participant stakeholder group at 12M

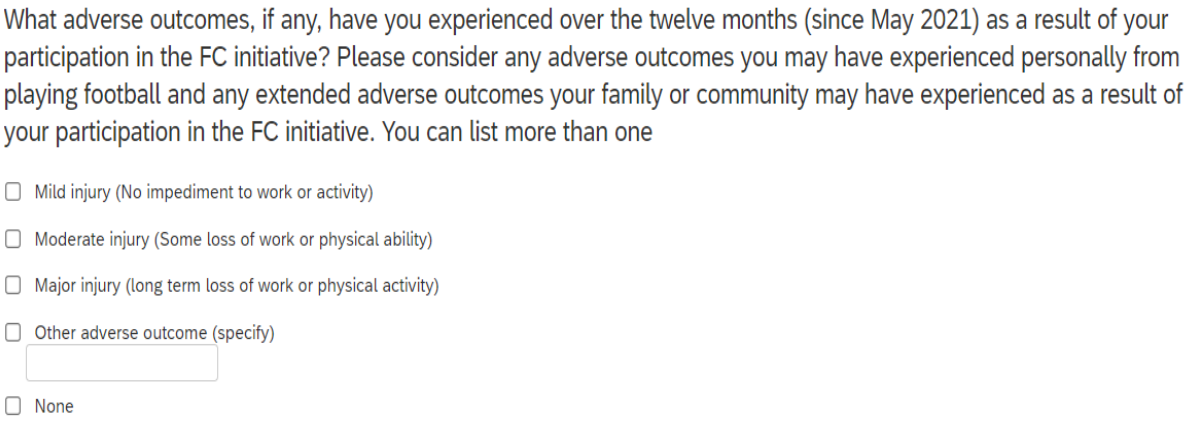


Figure 7.14: A screenshot of the question asking participants whether they experienced adverse outcomes as a result of participating in the FC initiative

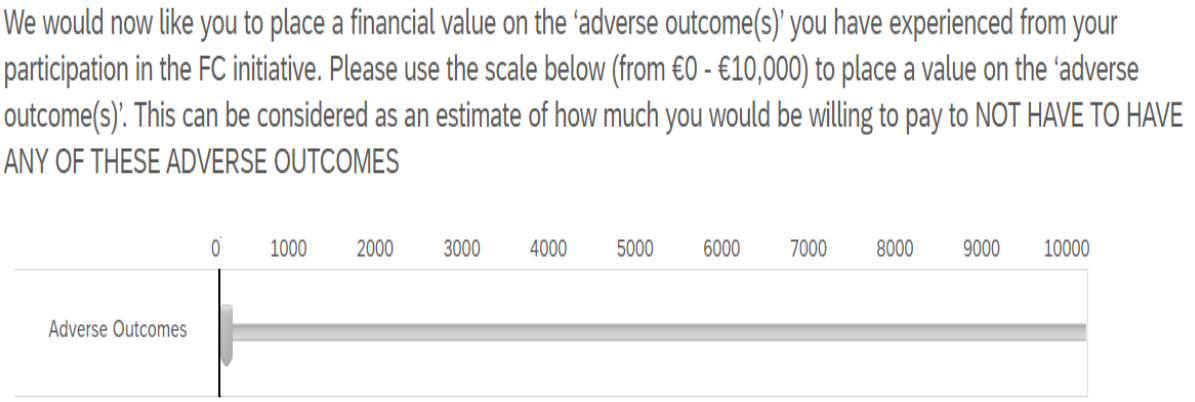


Figure 7.15: A screenshot of the valuation question for adverse outcomes asked of the participant stakeholder group at 12M

The research team do acknowledge that by adopting this approach, the relative importance of each outcome was determined by the value placed upon that outcome i.e. Step 6 of the SROI methodology 'Rank Outcome for Each Stakeholder Group' [see Figure 6.1] was in fact completed via the valuing process [Step 5]. However, in order to be true to the SROI approach, and to ensure methodological rigour, the relative importance of outcomes was asked of each stakeholder as per Figure 7.16 below [an example of that used for the Participant stakeholder group].

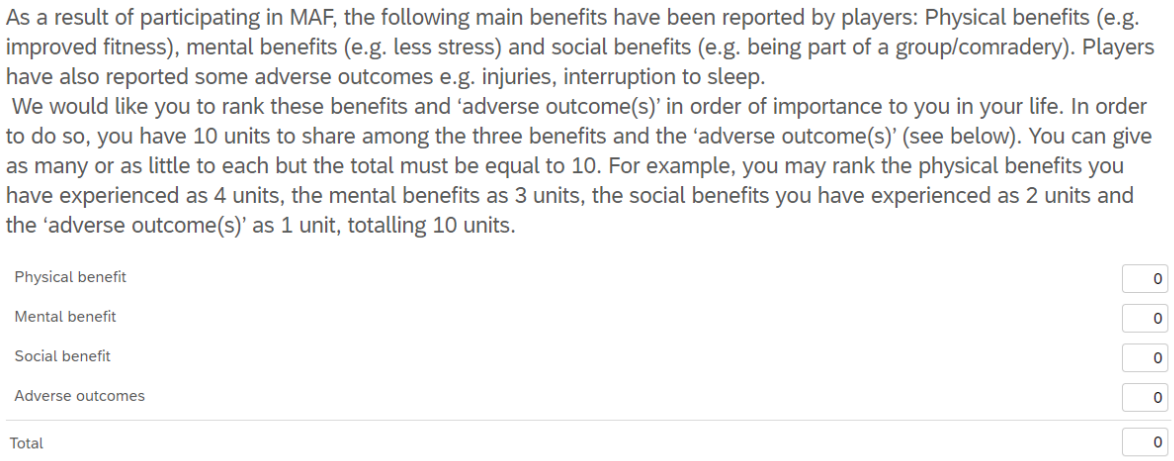


Figure 7.16: A screenshot of the question asking participants the relative importance of the outcomes they experienced as a result of participating in the FC initiative

Notably, and not surprisingly, the relative importance assigned to outcomes was reflected in the value given to them in the previous questions.

7.3.1 Valuation of Outcomes for Participants

In this section the valuation of benefits [see Section 7.3.1.1] and adverse outcomes [see Section 7.3.1.2] will be presented separately.

7.3.1.1 Valuation of Benefits for Participants

Table 7.36 below details the valuation of the three benefits for the participant stakeholder group [improved physical, mental and social health] segmented participation and completion level.

For the valuation of physical benefits, 29 participants [24% of the population] completed the valuation question in the 12M survey and this data was analysed by participation level to reveal that 10 participants had a high participation with an average value of €5,529, 11 participants had a medium participation with an average value of €5,280, and 8 participants had a low participation with an average value of €3,718. It was expected that those with higher participation levels would assign a higher average value to these benefits and the values are shown in the Table 7.36 below which leads to a total value of this physical benefit of €224,288. To further aid the Value Map analysis, it was

found that for those at 3M, the percentage achieving at least one of the three thresholds for this benefit was 23% (4 of 17 participants) while for those at 6M, the percentage was 41% (9 of 27 participants). 9M percentages were not available so these were aggregated with the 6M percentages.

For the valuation of mental benefit, 74 participants [60% of the population] completed the valuation question in the 12M survey; a breakdown of these replies by participation level found that 17 participants had high participation with an average value of €4,569, 41 participants had medium participation with an average value of €5,014, and 16 participants had low participation with an average value of €3,787. The lower average valuation for participants with low participation levels was expected here. Apportioning was applied to those who part completed the full programme, and this led to a total value of the mental benefit of €135,255.

For the valuation of social benefit, 74 replies [60% of the population] were also available and the breakdown of the valuations by participation level found that 17 participants had a high participation with an average value of €3,090, 41 participants had a medium participation with an average value of €3,795, and 16 participants had a low participation with an average value of €2,536. The lower average value for low participation levels compared to medium & high participation levels was expected here. The total value of the social benefit is shown below to be €111.985.

Table 7.36: The valuation of physical, mental and social benefits for participants according to participation level and completion level

Participation Level & Completion Level	**Low Full**	**Medium Full**	**High Full**	**Low 3M**	**Low 6M +9M**	**Medium 6M+9M**	**Total**
Number in Population	14	43	18	17	27	4	123
Physical Health Benefit							
% achieving Physical Benefit	33%	40%	67%	23%	28%	33%	
Average Value	3,718	5,280	5,529	3,718	3,718	5,280	
Total Value of Benefit	**17,177**	**90,816**	**66,680**	**14,537**	**28,108**	**6,970**	**224,288**
Mental Health Benefit							
% achieving Benefit	26%	26%	42%	16%	16%	21%	
Average Value	3,787	5,014	4,569	3,787	3,787	5,014	
Total Value of Benefit	**13,785**	**56,057**	**34,542**	**10,301**	**16,360**	**4,212**	**135,255**
Social Health Benefit							
% achieving Benefit	11%	44%	45%	6%	6%	30%	
Average Value	2,536	3,795	3,090	2,536	2,536	3,795	
Total Value of Benefit	**3,905**	**71,801**	**25,029**	**2,587**	**4,108**	**4,554**	**111,985**

7.3.1.2 Valuation of Adverse Outcomes for Participants

It was decided when measuring the increased injuries not to segment by participation level but to just segment based on whether participants had completed a full or part of the programme [see Section 7.2.1.8 above]. For the valuation of the adverse outcomes, 27 participants [22% of the population] completed the valuation question in the 12M survey and all placed values on minor and moderate injuries [no one reported a major injury]. Notably, all 27 respondents had suffered minor injuries, of which 3 had suffered a moderate injury. With the very small sample size for those with moderate injury, it was decided to pool all 27 replies together which led to an overall average value of €1,858 being applied to all participants who suffered either of these adverse outcomes [see Figure 7.14 above for how the question was asked]. Note that the values for this outcome are shown as a negative value in the extract from the Value Map below, and a total negative value of €137,232 is extrapolated for the participant population for this outcome.

Table 7.37: The valuation of the adverse outcomes [minor and moderate injuries] for participants according to completion level

Completion Level	Number in Population	% experiencing Adverse Outcome	Average Value from surveys	Total Value
Full	75	66%	-1,858	-91,971
3M	17	43%	-1,858	-13,582
6M +9M	31	55%	-1.858	-31,679
Total	**123**			**-137,232**

7.3.2 Valuation of Outcomes for Volunteer Coordinators

As per the ToC for the VC stakeholder group [see Figure 7.4 above] only beneficial outcomes were identified. For the valuation of these benefits, 3 VCs [50% of the population] completed the 12M survey which led to average values of €4,423, €5,552, and 5,027 for increased self worth/ self-esteem, increased social connection and reduced stress respectively. This led to the extrapolated valuations in the extract from the Value Map presented in Table 7.38 below.

Table 7.38: The valuation of the benefits for volunteer coordinators

Benefit	N	Proportion Achieving this Benefit	Average Value	Extrapolated Total Value
Increased Self Worth/ Self-Esteem	6	100%	4,423	26,538
Increased Social Connection	6	100%	5,552	33,312
Reduced Stress	6	100%	5,027	30,162
				90,012

7.3.4 Valuation of Outcomes for Community Partners

Two outcomes were determined for the two community partners [see Figure 7.5 above] and both of these partners completed the 12M survey. The average values for these benefits of €2,486, and €3,739 respectively which led to the extrapolated valuations in the extract from the Value Map in Table 7.39 below.

Table 7.39: The valuation of the benefits for community partners

Outcome	N	Proportion Achieving this outcome	Average Value	Total
Satisfaction of having a Secure and Reliable Tenant	2	100%	2,486	4,972
Increased Self Worth/Self-Esteem	2	100%	3,739	7,478
Total				12,450

7.3.3 Valuation of Outcomes for Significant Others

Three outcomes were identified by the SO stakeholder group [improved partner and family dynamic / relationship, improved mental health/well being/happiness and improved family physical health] as being beneficial [see Figure 7.6]. The extent to which these benefits were achieved by the respective SOs was deemed to be linked to the participation level of the participant. In this regard, in the absence of detailed data on SOs, it was decided to apply similar percentage attainment of benefits to SOs as was applied to participants assign zero benefit for low level participation and 10% for medium level participation. For those with a high level of participation, 50% was assigned for the physical benefit [improved family physical health] and 30% for the other two outcomes identified. 80% benefit for full participation. All SOs consulted in Section 7.2 were partners of high participators. However, the research team decided to adopt a conservative approach to assigning value to SOs whose partner

participated in the FC initiative on a fortnightly basis [medium participation level] given the likelihood of the ripple effect on SOs and their families i.e. they wouldn't benefit from the full value. We also adopted a conservative approach with respect to SOs whose partner participated in the FC initiative on a weekly basis [high participation level] to ensure that the overall value assigned to this stakeholder group was meaningful relative to the participant stakeholder group [who received the direct benefit].

At 12M, a total of 10 valuation survey responses were received [8% of the population]. With a small number of responses, it was not possible to compute average values for each outcome for those with varying levels of participation so it was decided to use the average value of all 10 surveys when extrapolating the benefits to the population of SOs. As can be seen from Table 7.39 below, the average value attributed to the improved partner and family dynamic / relationship was €3,765, the average value for the improved mental health/well being/happiness was €5,019 and the average value for the improved family physical health was €4,937. The extrapolated total value of benefits for this stakeholder group according to participation and completion levels is €36,521, €48,684 and €86,891 respectively.

Table 7.40: The valuation of the benefits for significant others

Participation Level & Completion Level	**Low Full**	**Medium Full**	**High Full**	**Low 3M**	**Low 6M +9M**	**Medium 6M+9M**	**Total**
Number in Population	14	43	18	17	27	4	123
Improved Partner and Family Dynamic/Relationship							
Average Value	3,765	3,765	3,765	3,765	3,765	3,765	
% achieving Benefit	0%	10%	30%	0%	0%	0%	
Total Value of Benefit	**0**	**16,190**	**20,331**	**0**	**0**	**0**	**36,521**
Improved Mental Health/Well Being/Happiness							
Average Value	5,019	5,019	5,019	5,019	5,019	5,019	
% achieving Benefit	0%	10%	30%	0%	0%	0%	
Total Value of Benefit	**0**	**21,582**	**27,103**	**0**	**0**	**0**	**48,684**
Improved Family Physical Health							
Average Value	4,937	4,937	4,937	4,937	4,937	4,937	
% achieving Benefit	0%	20%	50%	0%	0%	0%	
Total Value of Benefit	**0**	**42,458**	**44,433**	**0**	**0**	**0**	**86,891**

7.4 Determining the Materiality of Outcomes for Stakeholders

Prior to finalising the respective outcomes for each of the stakeholders, it was considered at the outset that each of these outcomes should pass a materiality test. This includes a detailed review of all information collected to ensure that the final outcomes and their values presented by each stakeholder group gives a fair picture of the programme's impact. For each stakeholder group, the various outcomes were assessed for materiality based on the:

- Relevance of the stakeholder group in the context of the model and value creation,
- Relevance of the outcomes to the stakeholder group, other stakeholders and society, and
- Significance of the outcomes and value experienced by each stakeholder group.

Using this approach, all outcomes determined by the stakeholders were deemed material with the exception of the adverse outcome ['Reduction in Personal Time'] identified by the CP stakeholder group; when pressed to value this adverse outcome, the stakeholders assigned a value of €0 which is an insignificant therefore deeming the outcome 'immaterial'.

7.5 Determining and Valuing Inputs for Each Stakeholder Group

In an SROI study, inputs are viewed as the resources necessary for the activity or the resources used in the creation of the activity, and this can include money, time, volunteer hours and in-kind resources. For the assessment of inputs for the FC initiative, a consolidated income and expenditure account was obtained from the FC gatekeeper [see Appendix 11]. This shows that the game fees [charged at €5 per game with two games weekly and an average of close to 30 players at each session] led to income of €12,855 which was sufficient to cover all costs associated with the FC initiative [including the Pitch Rental [€7,215] and overheads] and left a surplus for the period of review of €3,194. This consolidated set of accounts also highlights the voluntary nature of the FC initiative with the governance and labour costs being provided for free. This information was considered along with information gathered during the ToC validation focus group sessions with all stakeholder group the participants to arrive at the inputs for this SROI [see Table 7.41 below]. Note that we have sought to insert opportunity costs [minimum/living wage rates] for volunteer time when computing input costs rather than insert a zero value.

Table 7.41: Description and value of the input costs per stakeholder group for the duration of the evaluation period [see Appendix 11 for full details]

Stakeholder	Description	Input Cost
Participants	Cost of pick-up games	12,885
Volunteer Coordinators	General Overheads	557
	IT Costs	406
	Marketing / Social Media	200
	Committee Costs	360
	Labour Costs[1]	6,750
Community Partners	Labour Cost[2]	510
Significant Others	No costs were incurred[3]	0
Total Cost		**€21,668**

1 VC labour estimated as 1.5 hours/week * 50 weeks * 2021 [€15.00] * 6 volunteers
2 CP labour estimated as 1 hour/week * 50 weeks * 2021 National Minimum Wage [€10.20]. Two volunteers shared this responsibility and collectively they gave 1 hour/week
3 Based on focus group and interview discussions, no costs were considered to be incurred by this stakeholder group

Note that almost all of the values in Table 7.41 above were extracted from the consolidated accounts [see Appendix 11] given by the FC gatekeeper and the pitch rental costs has been excluded here as it is a cost that is funded from the fee income of €12,885 and is not incurred by any stakeholder in addition to the fee income collected. Other costs such as general overheads, IT costs and marketing were felt by the research team to be material costs as these need to be paid in order for the FC initiative to operate as it did during this period.

In relation to volunteer time commitments, it was found in the ToC validation focus group that neither the VCs nor the CPs placed a financial value on their volunteering time for the FC initiative and this is confirmed in the accounts supplied by the FC gatekeeper [see Appendix 11]. Nonetheless, in line with SROI methodology, we have allocated opportunity costs to the time commitments of these two stakeholder groups; for the CP stakeholders we have used the national minimum wage rate [drawn from www.citizensinformation.ie] as the rate for volunteer time to reflect the role of this stakeholder group; as 'unskilled' workers they enabled FC members access to the facility which took approximately 1 hour of their time weekly. From discussions with the VC stakeholder group, we estimate that a total of nine hours per week of VC time [an average of 1.5 hours per week per VC] for the FC initiative to operate as it does and given the 'skilled' nature of the VC role, a value of €15/hour was assigned.

7.6 Discounting Outcomes

In this section, the values of the outcomes identified in Sections 7.3.1-7.3.4 will be discounted according to principles of deadweight [see Section 7.6.1], displacement [see Section 7.6.2], attribution

[see Section 7.6.3] and drop off [see Section 7.6.4]. This is to avoid over claiming by only being seen to claim the value that FC has created [see Section 7.6.5].

7.6.1 Deadweight

Deadweight is defined as 'What would have happened without the activity?' This can be calculated in three possible ways – use existing research, use a comparison group, or ask the stakeholders.

The period of this evaluation [May 2021-May 2022] coincided with the partial lifting of Covid-19 restrictions which were in place for much of the year leading up to the start of this evaluation. It has been well reported in literature that Covid-19 had a negative impact on many health outcomes – for example, the 2021 Healthy Ireland survey[135] found that mental health and social connectedness declined through the Covid-19 pandemic. However, the following Heathy Ireland survey (2022)[136] found that general health levels remained at similar levels to that reported in 2021; two-thirds (66%) of those that viewed themselves as overweight or obese stated that they were trying to lose weight.

The analysis of the data collected at B from the FC participants[137] [see Section 5.0] suggest that the men who signed up to participate in the FC initiative represent an 'at risk' group in terms of cardio-vascular disease. For example, only 31.1% of participants stated that engaged in ≥4 days of 30 minutes of moderate PA/week, marginally higher than the national Irish average [30][138]. It is probable that low PA levels underpinned the low aerobic fitness of this group; some 76.7% had very poor-fair aerobic fitness levels. In addition, 73.9% of men were classified as overweight [60%] or obese [13.9%] based on BMI measures, which is again higher than the national average [70%]. Indeed, the waist circumference measure, arguably a more powerful predictor of cardiovascular risk for men, 37% were in the high-risk (≥ 94cm), and 30% in the very high-risk (≥102 cm) categories.

In short, existing research was inconclusive in terms of establishing thresholds that would have happened for this cohort of men in the period of the evaluation in the absence of the FC initiative being available. The majority of the evidence reviewed does suggest that this group are 'hard to reach' and were not likely to improve their health behaviours despite the lifting of Covid-19 restrictions. Furthermore, as stated in Section 7.2.1.1 above, a comparison-control trial was not possible or ethical to establish for this evaluation. Therefore, it was felt that decisions on deadweight and other discounting variables would best be informed by reviewing the extensive discussions which had taken place with each set of stakeholders [see Section 7.1 above].

7.6.1.1 Analysis of Participant Deadweight

For the purpose of this evaluation, the research team consulted with the participant stakeholder group [as per Step 2; see Section 7.2.1 above] to determine deadweight and a subset of the findings that are relevant to discounting outcomes is presented in Appendix 12. While one may suspect that some of this group may have engaged in additional activities in the absence of football being available, it was evident from those who were interviewed that football had been part of their life since childhood and that were clear about their desire to play football [for some, before they got too old and couldn't].

> ***"I love playing football in any capacity, whether that be five on five on a smaller pitch versus 11 on a full-length pitch or in the case of*** **[named site location]** ***7 v 7 or eight v eight, occasionally."*** **RA3**
>
> ***"And obviously I love playing football. So you know it's, it's something that I've done all my life, and it's just something that I really enjoy you know I like, I love playing the game ….It's beyond a social thing, you know for me it's, it's kind of you know, it's kind of a, not to get too 'arty farty' but it's kind of a form of expression almost you know it's something which is accepted within the male sphere, you know, does being kind of a form of expression, almost."*** **RA5**
>
> ***"…but I want to, really wanted to play a bit of football before I got to the point where well, I'm going to be more useless on the pitch then I am now. While, I can still move a bit, pass a bit, you know, and I think this is that last few years that I'm going to get as much enjoyment out as possible, you know…. The itch is still there, you know, you're just trying to keep paying a little bit longer."*** **IRR1**

For many, the attraction of FC was that it offered a membership model that they could commit to when available and that it was available to them in their locality.

> ***"So, coming from the outside*** **[having lived abroad],** ***it was, I wasn't wishing to join up to tennis club or something, it was something that, I didn't have to sign up as a member, I could come and go as I please, so it was nice having that." RA9***
>
> ***"…a bit of a gap in terms of the sport*** **[referring to their locality]…"** **RA2**
>
> ***"Whereas, it was, there just didn't seem to be any anything. I looked into a couple of clubs and they weren't really interested in you unless you knew someone or whatever, so it was like whatever that is, I thought, not going to bother with that."*** **IRR4**

Many men also spoke of the important of being part of a team/group that is not always available to them in other forms of exercise/sport.

> ***"*[spoke of living in London]… And *one of the first things I did when I arrived over in London was to seek out a kind of a team that I got to join just to kind of keep myself busy, keeping us all fit, meet new people, that kind of thing. So it's something that I've been kind of looking out for, for a couple of years actually since coming back from London".*** **RA5**

> ***"I have used other substitutes. I would have taken up the piano, done, yoga, meditation, this kind of stuff and that's, that's served me well, but there's something about being in a group dynamic certainly for me is I think."*** **RA9**

The SOs confirmed much of the data reported by participants in that they were motivated to play due to their love of football, team sports and the flexible model developed by the FC initiative.

> ***"…he used to play before*** **we moved to [named FC site]** ***over 10 years ago…. he's played it, as a five, you know, five-a-side the Astro football for as long as I know. And though I know*** **[named partner]** ***since 2005 and he's played it, like every week, like, nearly every week since. Once or twice a week he used to play in*** **[named a previous location]** ***because that's where he's from on a Friday night and he used to play on Tuesday night over in, I think, near at the racecourse in, I can't remember the name of it. But he's played there, there as well and he loved it. But we moved out here. It was a bit of a trek for him, and it was just a bit awkward…. He missed it here. Yeah, I could see that he missed it." SO2***

> ***"He really missed, he missed this football terribly over the last two lockdowns. I think he's getting a great buzz out of it. I think football has really boosted his confidence. He's enjoying meeting new people and his skills, so he tells me, is improving as well. I think he likes playing, he likes sports that has a team, has team aspects to it." SO1***

> ***"… which is fantastic but at the same time there's people like*** **[named participant]** ***who have maybe jobs that don't suit, or don't have the time to commit, but want to have that bit of training or that bit of, like the social aspect of it, so it's great that they can just, you know, come in and out of it." SO2***

In brief, 83% of those men interviewed, explicitly stated that their participation in the FC initiative could not be replaced by other forms of exercise while all spoke of their love of football as a motivation to be active. These discussions led the research team to decide on deadweight percentages for the various outcomes of the participants as per Table 7.42 below.

Table 7.42: An overview of the deadweight [%] for participant outcomes along with the rationale for same

Outcome	Deadweight	Source and Rationale
Improved Physical Health	5%	For almost all of those interviewed, activities other than football were of little interest and thus it is very unlikely that physical benefits would occur without the FC initiative
Improved Mental Health	5%	Almost all participants interviewed didn't get the same satisfaction out of other activities than they got from football making it highly unlikely that mental benefits would have arisen without the FC initiative
Improved Social Health	10%	The interviewed participants referred to the benefits of meeting new people through the FC initiative and the benefits of the social dynamic – and did not feel that this could be easily obtained elsewhere
Increased injuries	10%	Participants referred to the competitive nature of football as an attraction and this does make it less likely that increased injuries would be obtained if the FC initiative did not exist

Note that the above deadweight discount percentages were applied to all categories of participant in the Value Map i.e. participants who had low, medium or high participation levels were all given a 5% deadweight discount for the physical benefit and equally a 10% rate was applied to all participant categories for the social benefit. This decision was made as there was no evidence in the interview discussions that the deadweight discounts would likely differ across participation levels.

7.6.1.2 Analysis of Deadweight for Volunteer Coordinators, Community Partners and Significant Others

For the remaining stakeholders [VCs, CPs and SOs], a similar approach of consulting with each group was employed to arrive at deadweight percentages.

With respect to the VCs while they may have engaged in other activities in the absence of organising and playing football games, it was evident from those interviewed that organising football games had been a consistent part of their life and their first choice in what they wanted to give their time to.

> ***"When I got involved it was quite well organized. I was already kind of involved ..just, in the past. When I was younger, I organized 5-a-sides for my own peer group for about 12 years before I left*** **[the country]*, so I was kind of, I was doing that at home anyway. So, it was just to be, just, it was almost natural just to get involved in the coordinating side of things." VC1***

"I mean I've totally forgot, but I did the exact same thing **[referring to VC1's comment above in terms of organising football games]** *when I was in my early 20s as well, in my teens and early 20s as well. Yeah. So yeah, that's a good point. So maybe it's just inbred in us." VC2*

*"***In [named location of FC site]** *there's different things like Toastmasters there's, you know, Junior Chamber and lots of different things that I think in some way, I'd like to get involved in. But, if I could pick anything to do of a Monday, a game of football would trump anything as long as I can do it. It's what I want to do." VC3*

With respect to CPs, it is evident that not all tenants are as reliable as the FC initiative in terms of being respectful to the pitch and the volunteers and in making advance payments.

"So, it's available to anybody to rent, obviously under certain conditions….. I have to say they are, they [the FC initiative] are very good insofar as that they do, initially from the, from the get-go. The organisers were very good at making sure everyone fulfilled all the rules because there is a real issue with, like shoes, right shoes and say on the pitch because it's completely different to a soccer pitch. So that has been no problem. ….. and also adherence to the rules around respect for the pitch and respect for us actually as well because they're very good at going off for the right time…" CP1

" The payments, probably there was a hiccup somewhere along the line there that got sorted out very quickly ….. and it **[the astroturf pitch]** *happens to facilitate the GAA club or the soccer clubs who want to rent, but this group, have been a very consistent group, and it has evolved into being a very solid group" CP2*

The deadweight applied to the SOs was considered in light of that applied to the participants given that their outcomes were dependant upon the participants involvement in the FC initiative. A summary of the percentages applied with a rationale for the respective decisions is given in Table 7.43 below.

Table 7.43: An overview of the deadweight [%] for VCs, CPs and SOs outcomes along with the rationale for same

Stakeholder	Outcome	Deadweight	Source and Rationale
Volunteer Coordinators	Improved self esteem	10%	The VCs that were interviewed [see Section 7.2.1] were also participants and so the volunteer benefits that arose from arranging & coordinating games were inextricably linked to being able to experience the participant experience [and to make this available for others]. They are a group with skills which could be applied to other contexts but given their love of football as participants, similar percentages [10%] are applied for all benefits in this group as were applied to participants.
	Improved social connection	10%	
	Reduced stress	10%	
Community Partners	Satisfaction of having a Secure and Reliable Tenant	40%	The CPs that were interviewed [see Section 7.2.1] had a strong relationship with the FC initiative as a stable customer in terms of usage and payment for the astroturf facility – and indeed the improved self-esteem is linked to the positive relationships developed with the FC initiative volunteers, and it was acknowledged that less time is needed to monitor the facility due to this strong relationship. However, it is acknowledged that the astroturf facility could likely be leased to alternative clients if the FC initiative did not exist and a higher deadweight percentage of 40% is this attributed to the benefits for the CPs.
	Improved self worth/ self-esteem	40%	
Significant Others	Improved partner & family dynamic/relationship	15%	The SOs that were interviewed [see Section 7.2.1] did not believe that relationships would have improved as they had without the FC initiative being in place. Nonetheless, it is possible that some of the benefits for this stakeholder may have been achieved through the participants taking up some new activities after the Covid-19 lockdown period which coincided with the start of this evaluation. This is accounted for in the 15% to not overclaim for the FC initiative influence in driving these outcomes. The 15% rate was applied to all three benefits cited by this stakeholder group.
	Improved family physical health	15%	
	Improved mental health/well being/happiness	15%	

7.6.2 Displacement

This is defined as 'an assessment of how much of the outcome has displaced other outcomes. For example, if our activities prevent people experiencing the same changes somewhere else, we should take account of this'. For example, a project to reduce crime by improving street lighting may just move crime to a different neighbourhood, or a project to reduce flooding in an area by improving drainage may displace the flooding further downstream. The outcomes referred to in Section 7.1 above are viewed as net positive changes [apart from adverse outcomes] and it is difficult to see how any of the outcomes could have been displaced for the four stakeholders that were analysed.

Indeed, some 83% of the **participants** that were interviewed [14/17; see Section 7.1.2] explicitly stated that they couldn't replace playing football with other sports/forms of exercise because they wanted something competitive.

> ***"I much prefer doing it*** **[playing football]** ***than going to the gym because it's competitive. I'm a pretty competitive person and I find myself probably doing a multiple*** **[of volume of exercise]** ***in a game of football, than I would if I went to the gym for an hour." RA4***
>
> ***"I'm no good at gyms and things that you do on your own. I'm quite competitive and I wanted that. So I wanted some competitive sports." RA8***
>
> ***"I would be somebody who, who would have gone to the gym…I didn't get the same satisfaction out of the gym that you know a lot of people other people seem to get like you know I just, I don't get the point in doing a thousand burpees or, you know, 100 squats or whatever like you know. I want the competitive edge you know… I want to go back and play matches and it's not because I want to win a trophy it's because I want to fucking get stuck in and, you know, and all that type of stuff and I think you need that kind of a, you need that outlet like" IRR2***

In short, these quotes suggest that playing football with the FC initiative was the unique offering these participants wanted and that other activities were not getting displaced as they were of little interest to them. The unique circumstances of the FC initiative starting up after the relaxation of Covid-19 restrictions meant that participants were largely unable to participate in other activities before FC resumed and thus no activities were displaced when FC resumed in May 2021.

> ***"And, you know, because you, you literally had nothing to do*** **[during Covid lockdowns]** ***rather than try and keep yourself motivated to go for a bit of a run on your own and that's hard, hard to do you know."*** **IRR4**

"I'm not a big fan of running, and to be honest with you…But I found that I was more likely to run while I was playing football. I find it harder to run when the football is being off **[during the pandemic and at the time of consultation]***. That, that could be me, it could be, lack of moral fibre, backbone but it's just the best reality of it."* **RA2**

"I mean I notice it now after four months of not doing it **[playing football].** *I've definitely yeah, put on the 'Covid stone' or a couple of stone probably, and so that's a big factor physically, and I definitely could be probably in worse shape of my life now after probably having not played since, maybe November December. And yeah, I'm not a fan of going out running some people don't mind doing that. I'm not huge fan of it, so yeah, I haven't been doing a huge amount, kind of, I don't have so many alternatives, I guess."* **RA4**

"Whereas, in the last five months when I haven't had the football to go to, you know, that's **[healthy behaviours]** *all just dropped away. Then, you know, my diet has gone become terrible, you know, I don't drink as much water, not getting any exercises at all really…"* **RA7**

The participant experiences were confirmed by the SOs; it's evident that their partners are not likely to take up another sport [unless it was a team sport] or form of exercise.

"I think he likes the idea of being sporty..it wouldn't be naturally in him, to be honest with you. But he really missed, he missed this football terribly over the last two lockdowns. He's not into the running, we've tried, … he finds it very difficult." SO1

An alternative lens to consider this issue of displacement would be to ask if the astrotruf facility was not allocated to these football participants at the allocated times on Monday and Wednesday, would it be available to other participants who might be able to obtain similar benefits. In this regard, the FC gatekeeper did discuss with the research team that the impetus for the introduction of the FC initiative was when he saw an unused astroturf facility at times [9 pm – 11 pm] on Monday and Wednesday evenings. The facility would be in popular use in an urban area with hockey as the primary sport being played there but the use after 9 pm on the weekdays when the FC initiative takes place was not evident at the outset of the FC initiative. The discussions with the CPs also alluded to the reliability of FC as a tenant for the astroturf facility – other requests were made to use the facility at these timeslots for special occasions such as birthdays/parties but these would be ad hoc requests and unlikely to generate anything like the stable income flow generated through the FC initiative. Such ad hoc arrangements could lead to some possible physical, mental and social benefits being obtained by alternative participants but these would likely be limited to low participation levels which the above analysis has shown leads to much less benefits compared to participants who play football for a longer time period of up to 12M. Furthermore, given the need abide by certain rules in order to maintain the pitch and the risk of damaging the pitch via groups not used to or respectful of these rules, the hourly pricing of the pitch is set to discourage such ad hoc bookings.

"I mean, that pitch can't survive without financial money. It's nice to facilitate people, everyone. I actually think his thing* [the FC initiative] *is good yeah, but it is financial. Yeah, that'd be the driver…we don't tend to rent it ad-hoc, by the hour, we'd want a bit of supervision up there…. We don't really do ad hoc bookings, I mean it's a €80 an hour for an ad-hoc book, so that puts people off anyway." CP2

With these considerations in mind, estimated displacement percentages were arrived for the various outcomes of the stakeholders as per Table 7.44 below.

Table 7.44: An overview of displacement [%] by individual outcome and its rationale for each stakeholder group

Stakeholder	Outcome	Displacement	Source and Rationale
Participants	Improved Physical Health	10%	For almost all of those interviewed, they couldn't replace playing football with other sports/forms of exercise because they wanted something competitive
	Improved Mental Health	10%	Mental benefits may be available for other activities but FC appeals to a cohort of men who are unlikely to avail of alternatives to football
	Improved Social Health	10%	None of the alternatives to FC in the locality offered the same social experience for these participants – football was a form of common language which united people from a variety of backgrounds together
	Increased injuries	10%	Ps referred to the competitive nature of football as an attraction and it is viewed that increased injuries are much more likely from football than from alternative activities in the locality
Volunteer Coordinators	Improved self esteem	10%	The VCs were a group who were not engaged in other voluntary activities at the start of the programme (largely due to Covid) and thus the volunteer time did not displace any activities when Fc started. A rate of 10% was viewed as appropriate for this stakeholder as they were viewed in the same vein as participants given that all also played FC regularly.
	Improved social connection	10%	
	Reduced stress	10%	
Community Partners	Satisfaction of having a Secure and Reliable Tenant	40%	The CPs did acknowledge that the astro facility could likely be leased to alternative clients if MAF did not exist and this it can be viewed that a higher displacement percentage of 40% should be attributed to the outcomes for the community partners
	Improved self worth/self-esteem	40%	
Significant Others	Improved family dynamic/relationship	15%	The SOs that were interviewed felt that football was an activity that improved their partner's mental health and that this had spin off benefits for the household. It was viewed that these benefits would be very unlikely to arise from other activities given the profile of the participants and thus a 15% was applied to all three benefits cited by this stakeholder
	Improved family physical health	15%	
	Improved mental health	15%	

7.6.3 Attribution

Attribution in an SROI is defined as 'Who else contributed to the change?' In this evaluation, a number of steps were taken to help with the identification of attribution for participants. As stated in Section 7.3 above, in the participant surveys at 3M, 6M and 12M they were asked if they had experienced benefits such as physical, mental and social benefits [see Figure 7.12 above]. The answers to this question led to the physical [see Table 7.13], mental [see Table 7.19] and social benefits [see Table 7.25] as cited by the participants. In addition, the quotes used in Section 7.6.2 [Displacement] also referred to a cohort of participants who weren't into other activities such as the gym for physical exercise. In fact, it was specifically football which offered a unique mix of physical and social benefits which weren't available from other activities. This suggests that attribution levels would be low for the participants.

Notwithstanding the wording of the above question on benefits, participants were also asked the extent to which other activities may have contributed to the benefits obtained from the FC initiative at 3M, 6M and 12M [see Figure 7.17 below for that which was asked at 12M].

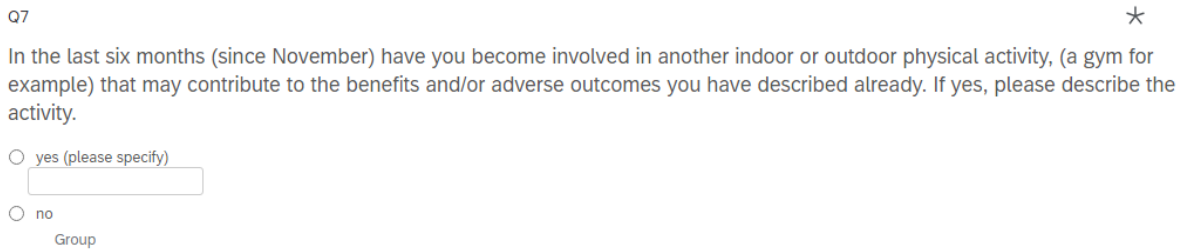


Figure 7.17: A screenshot of the attribution question for participants at 12M

The results to this question found that 28 of 68 participants had engaged in additional activities at 3M (41%), 12 of 44 participants had engaged at 6M (27%) and 19 of 47 participants had engaged at 12M (40%). This suggests that other activities may have at least partly contributed to some of the benefits achieved and prior to arriving at final attribution figures, it was decided to see how participation levels may have impacted on the additional activities undertaken at 12M [see Table 7.45 below].

Table 7.45: Additional activities of participants across levels of participation at 12M

	Participation level			
	Low	**Med**	**High**	**Total**
Additional Activities	7	10	2	19
No Additional Activities	3	13	12	28
Total	10	23	14	47
% of Additional Activities	**70%**	**43%**	**14%**	**40%**

This analysis shows a trend of levels of participation in the FC initiative being inversely related to additional activities. This might seem surprising at first glance but is perhaps understandable in that it may explain how some low participation people are achieving benefits such as physical benefits.

This analysis was incorporated into the attribution decisions that were made for the various outcomes of the participants as per Table 7.46 below.

Table 7.46: An overview of the attribution [%] for participant outcomes along with the rationale for same

Outcome	Attribution	Source and Rationale
Improved Physical Health	30% [low], 20% [medium] and 10% [high]	These percentages are consistent with the participation data and while the percentages for attribution are smaller than for those engaged in additional activities, consideration was also given to the wording of questions which did specifically say 'as a result of participation in the FC initiative'.
Improved Mental Health	15% [low], 10% [medium], 5% [high]	For mental benefits, a similar trend across participation levels but lower attribution percentages as these are viewed as being less likely to be linked to additional activities [unique benefits of football not easy to replicate]
Improved Social Health	15% [low], 10% [medium], 5% [high]	Similar to mental benefits with trends across participation levels and linked to the unique social atmosphere of men playing football which is not easily replicated with other activities
Increased Injuries	15% [3M], 5% [6M or 9M]	For this outcome, the attribution percentage is not linked to participation but instead a 10% rate is applied to all categories [as there is no clear rationale in interviews linking adverse outcomes to participation levels]

A similar approach to the assessment of attribution was taken for the other stakeholders and the decisions arrived at are shown in Table 7.47 below.

Table 7.47: An overview of the attribution [%] for VCs, CPs and SOs outcomes along with the rationale for same

Stakeholder	Outcome	Attribution Percentage	Source and Rationale
Volunteer Coordinators	Improved self esteem	30%	These percentages reflect two considerations: on one hand, the effort of the VCs in running the FC initiative was not work that was shared with any other person or activity (implying low attribution) but on the other hand, these were also participants who were getting mental and social benefits from being a participant and thus a high 30% was applied here as it was viewed that there could be some duplication in these benefits for this stakeholder.
	Improved social connection	30%	
	Reduced stress	30%	
Community Partners	Satisfaction of having a Secure and Reliable Tenant	15%	The effort of the CPs to the successful running of FC was not work that was shared with any other person or activity [apart from two weeks of the year when these partners were on holidays] and thus a 5% attribution was deemed appropriate for all outcomes for this stakeholder
	Improved self worth/self-esteem	15%	
Significant Others	Improved family dynamic/relationship	15% [low], 10% [medium] and 5% [high]	Similar rates of attribution were applied to the benefits for SOs as was applied to the participants. This meant higher overall percentages for the physical health benefit than for the other benefits
	Improved family physical health	15% [low], 10% [medium] and 5% [high]	
	Improved mental health	15% [low], 10% [medium] and 5% [high]	

7.6.4 Drop Off

The last of the discounts to be considered is 'drop off' and this considers the reduction of the outcome after the intervention has been implemented. In this regard, the following points were considered:

- On the one hand, it was noted that, at the time of writing, the FC initiative is going strong [since the relaxation of restrictions post Covid-19 in May 2021] and is expected to continue

delivering social value for many years to come. In addition, a review of the extensive data gathered in earlier parts of the SROI confirmed that almost all participants interviewed have a real love of football as an activity and plan to continue to play as long as their bodies will allow them to do so. While it is certainly the case that benefits will not continue beyond one year for participants who have low participation levels or for those who have not completed a full year of the programme, we do feel that participants at medium and higher participation levels can be expected to continue to be able to enjoy benefits of FC for many future years. In addition to the data sourced during the SROI evaluation, the research team consulted with the FC Founder who has all participation data since the end of the evaluation period in May 2022. According to the FC records, from May 18th, 2022 to October 1st, 2023 [Year 2 post evaluation] drop off for medium and high participants combined is only 14%. Indeed, this continuation of benefits for many future years also applies to the benefits for VCs and CPs in particular as these stakeholder groups have high participation rates and are viewed as being fully committed to FC.

- However, on the other hand, the key question when considering drop off was not how long the outcomes will last when the activity is ongoing but rather how long the outcomes would last if the activity (FC) ceased to exist. The consensus in this regard is that benefits would likely cease to exist quickly in the absence of FC and the best estimates in this regard would be that benefits would last for up to six months after completion of the FC activity. For example, it was felt that social benefits for participants which were developed during the FC activity would continue for a period afterwards as participants used the social network developed during FC to continue social friendships and relationships afterwards. However, the Value Map dictates that drop off is accounted for in a full year and doesn't capture the shorter period of six months. Therefore, in keeping with our conservative approach this evaluation, the research team decided that all benefits [positive and negative] would cease to exist upon completion of the FC initiative. For this reason, the duration of this FC initiative was set at one year [year of the evaluation only] and this meant that drop off considerations did not apply to this SROI evaluation in the subsequent years i.e. no benefits were being attributed to FC after year one of the programme.

7.6.5 Mitigating Against Over-Claiming

The fifth SROI principle [Do Not Overclaim] requires us to ensure that we only claim the impact that is due to involvement in the FC initiative. Therefore, in this evaluation the following was done to mitigate against over-claiming:

- Stakeholders [or data received from stakeholders] were consulted at all stages of the evaluation [see Figure 6.1 above]. Therefore, they were central to defining, valuing and determining the relative importance of material outcomes.
- The research team recognised that all stakeholders did not experience outcomes equally and segmented by creating subgroups according to participation and completion levels; account for the differing experiences between subgroups ensured against over-claiming for those who experience outcomes less.
- Stakeholder data was used to validate the independence of outcomes, thereby ensuring against over-claiming via double counting benefits to stakeholders.
- Stakeholder data underpinned the discounting of values as per Sections 7.6.1-7.6.4 above.
- Throughout this evaluation, the research team adopted a conservative approach and in particular with respect to assigning benefit to SOs [see Section 7.3.3] and when discounting values [see Sections 7.6.1 – 7.6.4].
- All data reported in this evaluation was collected during and are specific to period of the evaluation only [see Figure 7.1].

8.0 Final Social Return On Investment Calculation

The SROI model [shown in the Value Map] determined on the basis of the above details that the SROI of FC was that **€17.60 of social value was created for every €1 invested in FC.**

A breakdown of this calculation across the four stakeholders and for the various outcome measures is shown below in Table 8.1.

Table 8.1: Components of the final SROI calculation

Stakeholder	**Outcome**	**Total Benefit (current year cash flow)**
Participants	Improved Physical Health	153,999
	Decline in Physical Health	- 22,523
	Improved Mental Health	116,019
	Decline in Mental Health	0
	Improved Social Health	82,221
	Decline in Social Health	-13,705
	Increased Injuries	- 100,042
Volunteer Coordinators	Improved self esteem	19,346
	Improved social connection	24,284
	Reduced stress	21,988
Community Partners	Satisfaction of having a Secure and Reliable Tenant	1,521
	Improved self esteem	2,288
Significant Others	Improved family dynamic/relationship	24,482
	Improved family physical health	53,433
	Improved mental health	32,636
Total Value of Benefits		381,366
Total Value of Inputs		21,668
Social Return on Investment		17.60

Table 8.1 above shows that the total value of the benefits from FC amount to €381,366 which is over 17 times the value of the inputs (€21,668) thus giving an SROI of €17.60. It is clear from this table that a large part of the total value is created by the participants even allowing for the negative value assigned to some of the outcomes for this stakeholder. This breakdown across the four stakeholders is highlighted further in Figure 8.1 below.

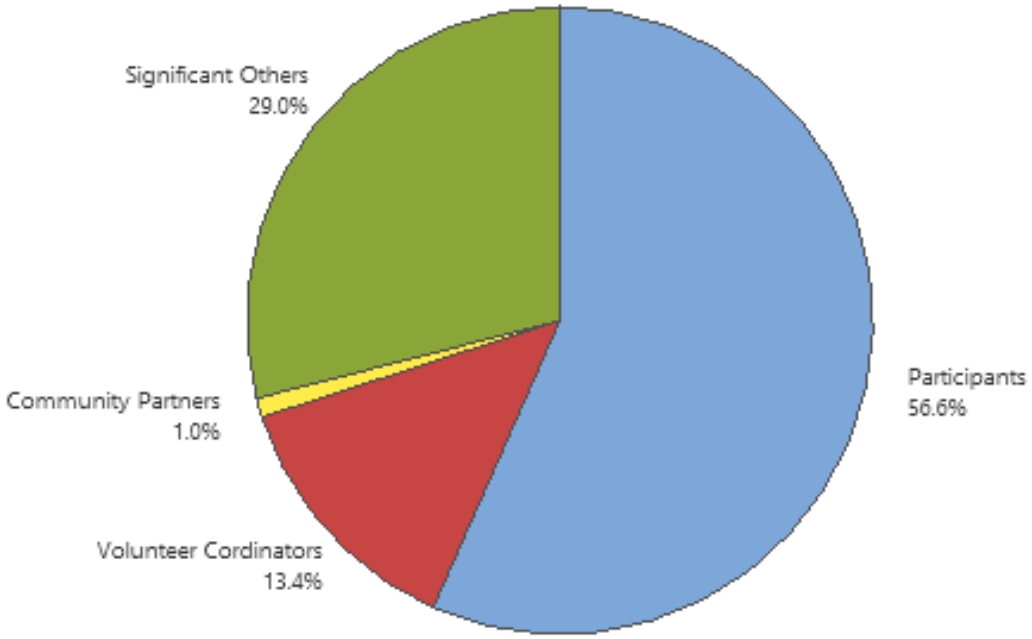


Figure 8.1: Pie chart of the distribution of total value from the FC initiative by stakeholder group

This diagram shows that participants [the main stakeholder in this SROI] account for almost 57% of the total value created in this SROI followed by SOs with 29% and VCs with 13%. Within each stakeholder group, the following comments can be made:

- For **participants**, the majority of benefits are obtained from the physical benefit from the FC initiative (61% of total) followed by mental benefit (54% of total) and social benefit (32% of total). Increased injuries are a negative 46% of the total benefit for this group. This finding is consistent with the data collected where a greater proportion of participants experienced a physical benefit than for a mental or social benefit and these benefits have taken into account the participation levels so that higher amounts are allocated to those who participated more and vice versa.

- For **significant others**, the benefits here of a better family relationship, improved family physical health and improved mental health contribute to the 28% of total value created; these benefits are shared relatively equally between the three benefits (family physical health, family dynamic and improved mental wellbeing. In short, it is evident that there are spin off benefits for an entire family when the male partner takes up an activity such as football and engages regularly in this activity which has been reported elsewhere in literature.
- For **volunteer coordinators**, the additional benefits that these receive beyond playing, such as improved self-esteem and reduced stress, account for 13% of social value created. The relatively high percentage for this small cohort is linked to their high levels of investment in FC.
- **Community partners** are an important stakeholder group but as there are just two of these involved in FC, it is unsurprising that they account for a small 1% of the total value created by FC.

8.1 Sensitivity and Scenario Analysis

The SROI model includes professional judgements and assumptions, which means that the final reported SROI of €17.60 for every €1 invested could be over or understated. The authors of this report are confident in the approach taken to measuring and valuing outcomes as outlined in previous sections. However, it is important to understand how vulnerable the final assessment is to changes in logic and different ways of assessing valuation. For this reason, sensitivity and scenario analysis was performed; this is a process that involves considering different valuations than those used within the Value Map to assess the robustness of the final SROI value. Both types of analysis were used on variables for which the authors felt there was reasonable scope for variability in the model and over which the practitioner had to use careful judgement.

For sensitivity analysis, different variables were altered one at a time to see the impact on the SROI calculation; the following variables were selected to be tested:

- A 10% fall in participants attaining a physical benefit
- A 10% fall in participants attaining a mental benefit
- A 10% fall in participants attaining a social benefit
- An increase in the opportunity cost of volunteer time to €20

While sensitivity analysis is useful at isolating the impact of individual variables separately, scenario analysis examines the impact of changing a number of variables at the same time. This can lead to a range of best and worst case outcomes which can be used to guide decision making. For this SROI, it was decided to conduct a number of scenarios as follows:

- A 10% fall in participants attaining physical, mental and social benefits
- A 20% rise in Deadweight for participants for all benefits
- A 20% rise in Deadweight for significant others for all benefits
- A 20% rise in Attribution for participants for all benefits
- A 20% rise in Attribution for Significant Others for all benefits
- A 20% rise in Displacement for participants for all benefits
- A 20% rise in Displacement for Significant Others for all benefits
- A 20% fall in the valuations attributed to all benefits from surveys
- An extension of benefits to significant others with medium participation levels
- An extension in the programme to last one year after the completion of FC (with a 50% dropoff in benefits)

The impact of varying these assumptions on the final SROI values is shown in Table 8.2 below.

Table 8.2: An overview of the sensitivity and scenario analysis of key variables in the SROI calculation

Variable Tested	Base Case	New Case	Rationale	New SROI
% of Participants Achieving Physical Benefit *(A 10% Fall)*	*Participants* 33% Low, 40% Medium, 67% High	*Participants* 23% Low, 30% Medium, 57% High	The physical benefits measurements were based on an analysis of objective and subjective data; however, it is acknowledged that an extrapolation of sample data to the population of 123 was involved.	15.87
% of Participants Achieving Mental Benefit *(A 10% Fall)*	*Participants* 26% Low, 26% Medium, 42% High	*Participants* 16% Low, 16% Medium, 32% High	The mental benefits relied on a subjective self-esteem scale as part of its measurement and extrapolation of sample data results was applied to the population of 123 participants	15.79
% of Participants Achieving Social Benefit *(A 10% Fall)*	*Participants* 11% Low, 44% Medium, 45% High	*Participants* 1% Low, 34% Medium, 35% High	The social benefits measurements were based on a self rated loneliness scale as part of its measurement and extrapolation was also applied to the population of 123 participants	16.48
Change in value of opportunity cost of Volunteer Time	€15.00 (minimum wage rate)	€20	The volunteers are a well educated group and possess strong IT and financial skills for coordinating FC and these skills are likely to command a higher rate than the minimum wage if they were offering this as a paid service	15.94
% of Participants Achieving Physical, Mental and Social Benefits *(A 10% Fall for all)*	Varies by level of participation as shown earlier	10% fall in benefit rate for each of these benefits for all types of participant	The extrapolation of sample results to the population of 123 participants introduces a sampling risk for all of these benefits	14.61
Deadweight % for Participants	5% Physical 5% Mental	25% Physical 25% Mental	Notwithstanding that the data suggested low deadweight percentages for the participant benefits, these benefits occurred at a time post Covid restrictions	15.52

(a 20% Rise)	10% Social 10% Injuries	30% Social 30% Injuries	which make it possible that they could have developed new interests at this time	
Deadweight % for Significant Others ***(a 20% Rise)***	15% for all benefits	35% for all benefits	The sample size of significant others at data collection was smaller than that of participants (a harder to reach group) and this introduces a greater chance of sampling error, and it is also possible that the benefits described by the SOs may have arisen from other activities due to the relaxation of Covid restrictions	16.40
Attribution % for Participants ***(a 20% Rise)***	Varies for different benefits and across participation levels as shown above	20% rise in all attribution percentages for participants	While percentages given earlier are linked to the data gathered from the participants, it was felt prudent to allow for the possibility that other factors post Covid could have contributed to the benefits reported earlier.	15.24
Attribution % for Significant Others (*(a 20% Rise)*	Varies for different benefits and across participation levels of participants as shown above	20% rise in all attribution percentages for SOs	As above – to allow for the possibility that other factors may have contributed to the benefits obtained by SOs.	16.45
Displacement % for Participants ***(a 20% Rise)***	10% Physical 10% Mental 10% Social 10% Injuries	30% Physical 30% Mental 30% Social 30% Injuries	While our data suggests that FC activities did not displace other activities, it is considered prudent to allow for this possibility in the analysis.	15.39
Displacement % for Significant Others ***(a 20% Rise)***	15% for all benefits	35% for all benefits	As above – to allow for what is considered a worst case scenario for displacement of SOs.	16.40
A 20% fall in all valuations derived from surveys	Various Values for different benefits and across participation levels	20% fall in the value attributed to all valuations	It was considered prudent to allow a 20% degree of variation in survey estimates of value and in this case, a 20% less than expected assumption was made.	14.08
Extension of Significant Others Benefits for those with	Physical (20%) Mental (10%) Family Dynamic (10%)	Physical (30%) Mental (20%) Family Dynamic (20%)	Low levels of benefits were assumed for the significant others for medium participants; however, it is acknowledged that these could be higher	19.30

Medium Participation				
Extension of Programme to last one additional year for all benefits for all stakeholders	1 year programme	2 year programme with 50% dropoff	As stated earlier in the report, it is expected that benefits of the programme will last for up to six months after completion of FC and in this regard, it is possible that certain FC benefits could last up to one year after completion of FC particularly the social benefits of FC.	26.14

The results of this sensitivity and scenario analysis shows that the final SROI figure is quite robust to changes in various factors – the SROI figure is shown to vary from €14.08 to €26.14 in the above analysis. This analysis has looked at worse case scenarios rather than best case scenarios (apart from the last two rows of the above table) as it was felt prudent to test the robustness of the high SROI value to downside risks in the analysis. In short, this analysis (sensitivity and scenario analysis) suggests that for every €1 invested in FC, between €14.08 and €26.14 in social value is created – a strong endorsement of the value being created by this initiative.

9.0 Limitations

Despite the extensive work that was undertaken for this SROI, it is important to acknowledge that the work has some limitations which could be the subject of further research.

The data collection approach primarily involved consulting stakeholders to assess what changed for them and all outcomes in the TOCs were verified by the stakeholders. Despite this, it is acknowledged that alternative approaches such as having a control group to compare against the FC group over this time period [May 2021 - May 2022] would have been beneficial in assessing the discounts to apply at the end of the analysis. However, as stated in Section 7.2.1.1 above it was neither practicable or ethical during the Covid-19 pandemic to randomise participants and recruit a control or 'comparison group in waiting' for this evaluation. However, this will be considered in future evaluations.

We were pleased with the engagement of all stakeholders with the research team throughout this process and this was a strong endorsement of the loyalty within the FC initiative that has been generated by the FC gatekeeper. This led to high amounts of participants, VCs and CPs being available on multiple occasions for data collection. By contrast, it was more challenging to capture the views of the SO stakeholder group as they were the only stakeholder group not directly in contact with the FC initiative. Notwithstanding that, focus group discussions and survey responses were received from some of these [11% representation in total]; the limited number of sample respondents from this stakeholder is acknowledged as a limitation [it did mean that average values for different levels of participant could not be used for this stakeholder]. To mitigate for this limitation, every effort was made to avoid overclaiming for the benefits attained by this stakeholder group.

It may also be argued that the exclusion of participants' 'dependants' as a stakeholder group is a limitation given the evidence in the literature of the impact an active parent [and particularly father] has on health promoting behaviours of their off-spring. Again, as per Section 7.2.1.1 it was not practicable to do this in May 2021 given the Covid-19 restrictions and the likelihood of getting this through the University Ethics Committee was minimal. However, this stakeholder group will be considered in future evaluations.

The majority of the data collected by the research team from stakeholders to allow the determination of changes was done through online focus group discussions and surveys. This method was deemed to be the most accessible to all stakeholders particularly as the initial part of data collection [prior to

baseline] came at a time of continued Covid-19 restrictions in Ireland. Such focus group discussions come with a risk of the social desirability bias and less vocal participants not feeling comfortable to share their views. In order to mitigate this risk, an explanation was given at the start of each focus group about the purpose of the exercise and the desire to understand the changes caused by the programme, including and most importantly the negative ones. Moderator bias is also a risk with focus group data collection, and this risk was mitigated by adopting an open-question discussion guide [see Appendices 2-9] and the lead author of this evaluation is experienced in focus group data collection as this is a common method used with stakeholder engagement in normal organisational operations. When arriving at indicators and determining the incidence of the outcomes, the focus group data was triangulated with objective data and the participant outcomes had a mix of subjective and objective indicators. However, objective data was not sourced for the other stakeholders and this the reliance on subjective data sources when assessing these outcomes is acknowledged as a limitation.

The SROI was undertaken by the research team who were completing their first SROI evaluation and this comes with the risk of them not fully recognizing or appreciating the negative outcomes or potential for negative outcomes. In order to mitigate this risk, all members of the research team completed the SROI training by Quality Matters prior to the completion of data collection. In addition, extensive discussions took place with all stakeholders and when professional judgement was required, a conservative approach was taken. The research team also consulted with an accredited SROI evaluator from Quality Matters throughout this evaluation [and indeed their training] to discuss assumptions, decisions made and the SROI process applied to this analysis. The analysis of data also includes a risk of subjective bias although this was considered to be effectively mitigated, as the research team operated separately from any members of the FC initiative [apart from the FC gatekeeper who was a constant source for the team].

While our approach to assessing the materiality of outcomes takes sufficient account of the ‘relevance’ portion of the materiality check it can be said that the ‘significance’ portion of the materiality check is not adequately explored. Our approach does not adequately take into account the deadweight, attribution or displacement percentages of the outcomes which could potentially lead to overclaiming, as a highly valued outcome which occurs to a great extent may be, for example, attributed to another activity and would therefore not be significant. In future research, with respect to materiality, the significance of the outcome will be assessed in line with data from stakeholders regarding the deadweight, attribution and displacement of the outcomes.

While deadweight has been considered in this report, our approach is not fully aligned with SROI guidance and standards as it is too similar to attribution i.e. whether other activities contributed to the outcomes experienced by stakeholders. Deadweight is the amount of an outcome that would have occurred anyway, even had the activities under analysis not been run and this will be accounted for in future research by the use of a comparative control group.

Our approach to displacement is also not entirely without its limitations. While we considered displacement from the point of view of 'other activities that were displaced' for the participant due their participation in the FC initiative consideration was not given to unintended negative consequences of what participation displaced. While the impetus to request the pitch initially [in 2017 was as result of seeing it unused from 9-11pm, perhaps since then, another group may be displaced from using it who would receive an equal or greater benefit from doing so. In future research, the issue of displacement will be explored with all stakeholders with a particular focus on unintended consequences.

10.0 Conclusions

This project aimed to evaluate the FC initiative at one site using a SROI framework to assess feasibility for scale up. It is evident from both the findings of the analysis [€17.60] as well as the sensitivity and scenario analysis [€14.08 to €26.14] that the social value returned from this volunteer-led, community based initiative is substantial. In fact, when compared to other sports clubs or community-based projects the findings from this report would indicate that the social return from the FC initiative is exemplary. In 2019, Na Fianna, a Gaelic Athletics Association (GAA) club in Dublin returned a social dividend of €15 per €1[139] invested while an exercise-based programme for individuals with COPD in Ireland returned a social value of €10-€22[140] per €1 invested. As a result of these findings, plans are underway to scale the delivery of the FC initiative across multiple sites for the benefit of population health.

Furthermore, in keeping with the eight SROI principle, 'Be Responsive', the research team will present the findings of this report to all stakeholder groups at the end of year social gathering for the FC initiative in 2023.

11.0 Appendices

Appendix 1 Physical Activity Readiness Questionnaire (Par-Q)

The Physical Activity Readiness – Questionnaire [PAR-Q] is a sensible first step to take if you are planning to increase the amount of physical activity in your life.
For most people, physical activity should not pose any problem or hazard. PAR-Q has been designed to identify the small number of adults for whom physical activity might be inappropriate or for those who seek advice concerning the type of activity most suitable for them.
Common sense is your best guide to answering these few questions. **Please read them carefully and check the YES or NO opposite the question if it applies to you.**

		YES	NO
1.	Has your doctor ever said that you have a heart condition and recommended only medically approved physical activity?	□	□
2.	Do you have chest pain brought on by physical activity?	□	□
3.	Have you developed chest pain at rest in the past month?	□	□
4.	Do you lose consciousness or lose balance as a result of dizziness?	□	□
5.	Do you have a bone or joint problem that could be aggravated by the proposed physical activity?	□	□
6.	Is your doctor currently prescribing medication for your blood pressure or heart condition (diuretics of water pills)?	□	□
7.	Are you aware, through your own experience or a doctor's advice, of any other reason against your exercising without medical approval?	□	□

If you answer yes to one or more of the above questions you should consult your doctor before undertaking physical activity. It is your responsibility to do so.

Participation in physical activity as part of the evaluation of Football Cooperatives' Malahide Astro Football is done entirely at your own risk.

	YES	NO
I have read, understood and completed this questionnaire	□	□

Participant Date of Birth: _____ [PLEASE PRINT]

Participant Mothers' Maiden Name: _____ [PLEASE PRINT]

Date: _____/_____/_____

Appendix 2 Participant Topic Guide – Initial Consultation - Step 2

Context:

- Statement of Ground rules' that include:
  - right to pass/not to contribute,
  - allowing space for all to speak if they wish,
  - allowing for differences of opinion and
  - confidentiality i.e. participants must keep reflections shared on the day private and are not to discuss the details of the discussion after the focus group with anyone.

- Setting:
  - Allow participants the opportunity to participate in the comfort of their own home as opposed to requesting a neutral venue. Some people may prefer to speak from the comfort of their own home and feel they can be more honest using Zoom than face to face. And it may be more practicable.
  - Ensure that the internet capacity at both ends will enable the full Zoom call.
  - Ensure that there is no one else present at either end to ensure confidentiality and privacy.
  - Ensure the space around the researcher that is visible to your research participant is welcoming and calming.

Guide for Questioning:

Area 1: Motivation
- Please tell me what motivated you to participate in FC.
  Prompts: Prompts/nudges to join (self, friends, work colleagues, partner/spouse)
  Why FC and not other types of football?
  What did you hope to get/achieve by participating in FC?

Area 2: Experience
- Please describe your experience of participating in FC
- What was it about FC that you participated frequently?
  - Environment, people, set up, outcomes

Area 3: Outcomes
- What do you believe are the outcomes that you have achieved from participating in FC?
- Did your expectations match outcomes achieved?
- Ripple effects on other aspects e.g. lifestyle behaviours, new friendships, volunteering/community engagement
- Describe any outcomes you may have seen others (family, community) get from your participation in FC.

Prompts to remember:

- Questions starting with Why, What, How, Explain, Describe rather than closed questions
- Questions exploring feelings – it's really important to pay attention to statements such as "I feel that…" – this is a thought not a "feeling". If they say "I feel that…."
- Perhaps a response could be "I am hearing you telling me what you think". As you say this how are you feeling?

Other general questions include:

- And what might that mean to you?
- I don't quite understand, can you please explain that to me?

Appendix 3 Volunteer Coordinator Topic Guide – Initial Consultation – Step 2

Context:

- Statement of Ground rules' that include:
  - right to pass/not to contribute,
  - allowing space for all to speak if they wish,
  - allowing for differences of opinion and
  - confidentiality i.e. participants must keep reflections shared on the day private and are not to discuss the details of the discussion after the focus group with anyone.

- Setting:
  - Allow participants the opportunity to participate in the comfort of their own home as opposed to requesting a neutral venue. Some people may prefer to speak from the comfort of their own home and feel they can be more honest using Zoom than face to face. And it may be more practicable.
  - Ensure that the internet capacity at both ends will enable the full Zoom call.
  - Ensure that there is no one else present at either end to ensure confidentiality and privacy.
  - Ensure the space around the researcher that is visible to your research participant is welcoming and calming.

Guide for Questioning:

Area 1: Motivation
- Please tell me what motivated you to volunteer in FC.
  Prompts: Prompts/nudges to join (self, friends, work colleagues, partner/spouse)
  Why FC and not other types of football?
  What did you hope to get/achieve by volunteering in FC?

Area 2: Experience
- Please describe your experience of volunteering in FC
- What was it about FC that you volunteered frequently?
  - Environment, people, set up, outcomes

Area 3: Outcomes
- What do you believe are the outcomes that you have achieved from volunteering in FC?
- Did your expectations match outcomes achieved?
- Ripple effects on other aspects e.g. lifestyle behaviours, new friendships, volunteering/community engagement
- Describe any outcomes you may have seen others (family, community) get from your participation in FC.

Prompts to remember:

- Questions starting with Why, What, How, Explain, Describe rather than closed questions
- Questions exploring feelings – it's really important to pay attention to statements such as "I feel that…" – this is a thought not a "feeling". If they say "I feel that…."
- Perhaps a response could be "I am hearing you telling me what you think". As you say this how are you feeling?

Other general questions include:

- And what might that mean to you?
- I don't quite understand, can you please explain that to me?

Appendix 4 Community Partner Topic Guide – Initial Consultation – Step 2

Context:

- Statement of Ground rules' that include:
  - right to pass/not to contribute,
  - allowing space for all to speak if they wish,
  - allowing for differences of opinion and
  - confidentiality i.e. participants must keep reflections shared on the day private and are not to discuss the details of the discussion after the focus group with anyone.

- Setting:
  - Allow participants the opportunity to participate in the comfort of their own home as opposed to requesting a neutral venue. Some people may prefer to speak from the comfort of their own home and feel they can be more honest using Zoom than face to face. And it may be more practicable.
  - Ensure that the internet capacity at both ends will enable the full Zoom call.
  - Ensure that there is no one else present at either end to ensure confidentiality and privacy.
  - Ensure the space around the researcher that is visible to your research participant is welcoming and calming.

Guide for Questioning:

Area 1: Motivation
- What was your motivation for being associated with FC?

Area 2: Experience
- Please tell me what you know about FC
- What is your experience of FC?

Area 3: Outcomes
- What do you believe are the outcomes of FC?
- Describe any outcomes you may have experienced yourself or observed in others or your community of FC.

Prompts to remember:

- Questions starting with Why, What, How, Explain, Describe rather than closed questions
- Questions exploring feelings – it's really important to pay attention to statements such as "I feel that…" – this is a thought not a "feeling". If they say "I feel that…."
- Perhaps a response could be "I am hearing you telling me what you think". As you say this how are you feeling?

Other general questions include:

- And what might that mean to you?
- I don't quite understand, can you please explain that to me?

Appendix 5 Significant Other Topic Guide – Initial Consultation – Step 2

Context:

- Statement of Ground rules' that include:
  - right to pass/not to contribute,
  - allowing space for all to speak if they wish,
  - allowing for differences of opinion and
  - confidentiality i.e. participants must keep reflections shared on the day private and are not to discuss the details of the discussion after the focus group with anyone.

- Setting:
  - Allow participants the opportunity to participate in the comfort of their own home as opposed to requesting a neutral venue. Some people may prefer to speak from the comfort of their own home and feel they can be more honest using Zoom than face to face. And it may be more practicable.
  - Ensure that the internet capacity at both ends will enable the full Zoom call.
  - Ensure that there is no one else present at either end to ensure confidentiality and privacy.
  - Ensure the space around the researcher that is visible to your research participant is welcoming and calming.

Guide for Questioning:

Area 1: Experience
- Please tell me what you know about FC.
- What is your experience of FC?
- Were you a factor in prompting person to join or maintain attendance?

Area 2: Outcomes
- What do you believe are the outcomes of FC?
- Describe any outcomes you may have experienced yourself or observed in others or your community of FC.

Prompts to remember:

- Questions starting with Why, What, How, Explain, Describe rather than closed questions
- Questions exploring feelings – it's really important to pay attention to statements such as "I feel that…" – this is a thought not a "feeling". If they say "I feel that…."
- Perhaps a response could be "I am hearing you telling me what you think". As you say this how are you feeling?

Other general questions include:

- And what might that mean to you?
- I don't quite understand, can you please explain that to me?

Appendix 6 Participant Workshop Schedule – Validation Focus Group - Step 3

Time	Purpose	Lead Facilitator
8.10	Facilitator introductions & statement of purpose of the research. Ask permission to record.	
8.15	Participant introductions – who they are (name) one statement about their experience of the FC initiative (what they get from it)	
8.22	Facilitator explanation of purpose of focus group. "The story of your experience as players" and the why, how and what of that. Four headings, Environment, Participants, Impact, Outcomes	
8.25	(10 min) facilitate discussion on Environment and participants. Share the draft ToC. That can be guided to focus on what appeals to them about the environment and what about them make the FC initiative a good fit for their lifestyle. Facilitators can take notes and seek further input, if required	
8.35	(20min) ask them to explore a) what impact their participation in games has had on them and b) outcomes gained (consider adverse outcomes too). Facilitate a discussion on same. Take notes. Near the end, or if progress stalls the impact and outcomes of the draft can be shared. Participant can be nudged to speak but facilitators should not try to prompt.	
8.55	Review the main points and give a brief summary of the impact and outcomes noted. Explain that the points they raised will be complied into a newer draft which they will have the chance to verify and approve via email over the coming week/10 days. Thank participants and ask if any significant others would like to help, they can contact [name facilitators].	
9.00	Closing round- Thank participants ask each to say " Playing in the FC initiative is……"	

Appendix 7 Volunteer Coordinator Workshop Schedule – Validation Focus Group - Step 3

Time	Purpose	Lead Facilitator
9.00pm	Welcome and thank participants, Remind about role as Coordinators for this group. Facilitator introductions and ask participants to introduce themselves (see below)	
9.03	Participant introductions – who they are (name), role in FC and one or two statements about why the do what they do to make the FC initiative happen on a weekly basis (as a volunteer)	
9.08	Facilitator overview of research to date: 4-6 Slides detailing Aim & Objs, SROI Methodology with timelines, Audit of that completed to date, preliminary findings to date. Purpose of workshop and what a TOC is and why it's relevant to SROI methodology. Describe TOC headings, Environment, Participants, Impact, Outcomes	
9.13	Ask the focus group to discuss (5 minute max) the why of their involvement. What factors led to them being coordinators, why they do this role here and not elsewhere, what is unique about the FC initiative. The environment they have created. These are the environmental factors. After 5 min, they will then be asked to summarise this into key words for the ToC. When these are agreed by the focus group, they are noted and entered into a blank ToC word doc.	
9.20	The group next discuss (5 min) the What, of their involvement. What are their roles and how do they do them? What works and what could be improved. What they bring as a group and individually to the table to help run the FC initiative. After the 5 min discussion, They then summarise the volunteer profile factors and when consensus is reached these words are written down	
9:28	The group are then shown the draft version of the TOC, environment and participants slides and they are compared and if needed adjusted, this can be done in real time on the shared screen.	
9.35	The group are then invited (10/15min) to discuss the impact of their participation as coordinators both +/- and the outcomes achieved. These can be hard to differentiate so the facilitator will provide an example as a player, Impact =fitness/weight loss. Outcome= Improved CV health, lessened Heart disease risk.	
9:50	The group are then asked to populate the Impact and outcome sections of the blank ToC and are shown the draft ToC. There is then a chance to swap, change or omit entries.	
10.00	The group are shown the 'final' version of their ToC and should agree on its validity. This may be a rough version but the words and connections should be correct.	
10.05	Thanks from T&S for participation, remind about value and rank of outcomes in May. Ask for a closing remark from all. Close	

Appendix 8 Community Partner Workshop Schedule – Validation Focus Group - Step 3

Time	Purpose	Lead Facilitator
6.00	Welcome and thank CPs. Remind about purpose of Focus group 'To hear about the role and duties of the CP, the impact personally and professionally of the role and the outcome of those impacts',	
6.05	Participant introductions- Name, length of time they have been involved with FC, their role and duties	
6.10	Brief outline of role explained and the personal professional separation.	
6.13	CP invited to discuss what impact they have experienced, for them as a volunteer for their club and personally. May need to steer back to CP experience in general.	
6.25	Review findings and show the Draft ToC, discuss. Note new or removed impacts	
6.30	Turn discussion to Outcomes. Again, emphasis on participant not partner	
6.40	Review and show draft ToC, compare and note final outcomes agreed	
6.45	Thank participants. Closing round "having FC involved in the community means……."	
6.50	Finish, Timing approximate	

Appendix 9 Significant Other Workshop Schedule – Validation Focus Group - Step 3

Time	Purpose	Lead Facilitator
9.00	Welcome and thank participants. Introduce facilitators. Remind about purpose of Focus group 'To hear about the FC initiative ripple effects into their family life'	
9.05	Participant introductions- Name, length of time SO has been playing, what they have noticed most in their SO since playing	
9.10	Brief outline of findings so far. While physical may have been seen as biggest anticipated it appear that the players get both social and mental health benefits.	
9.13	Participants invited to discuss what impact they have experienced, not their partners. May need to steer back to participant experience.	
9.25	Review findings and show the Draft ToC, discuss. Note new or removed impacts	
9.30	Turn discussion to Outcomes. Again, emphasis on participant not partner	
9.40	Review and show draft ToC, compare and note final outcomes agreed	
9.45	Thank participants. Closing round "having my SO playing football means……."	
9.50	Finish, Timing approximate	

Appendix 10 Baseline Participant Survey

Please note that this was adapted as per Table 7.4 at 3M, 6M and 12M to capture participant experiences of changes in behaviours observed and benefits and/or adverse outcomes gained over the study period.

A. ABOUT YOURSELF

1. **Please state your date of birth** _____[day/month/year]

2. **Please state your mother's maiden name** _____

3. **Which of the following best describes your ethnic background?**

(Please tick **one** box only)

White (Irish, Irish Traveller, Any other white background) ☐

Black or Black Irish (African, Caribbean or Any other black background) ☐

Asian or Asian Irish (Chinese or Any other Asian background) ☐

Mixed / multiple ethnic groups ☐

Other ☐

If 'other', please specify _____

4. **Please state your nationality** _____

5. **Which of the following best describes your level of education?**

(Please tick **one** box only)

Primary education only ☐

Some or completed secondary education ☐

Some or completed third level education ☐

6. **Which of the following best describes you?** (Please tick **one** box only)

Married / cohabiting ☐

Widowed ☐

In a relationship and not cohabiting	□
Separated /divorced	□
Single	□

7. Who lives in your household? (Please tick **the relevant boxes**)

I live alone □ Partner □ Children □ Parents □

Friends □

8. What is the total number of people in your household including yourself and any children

(Please circle **one** number)

1 2 3 4 5 6 7 8 9 10

9. Which of the following best describes you? (Please tick **one** box only)

Employed (full time i.e. 30+ hours)	□
Employed (part time i.e. less than 30 hours)	□
Self-employed (working alone)	□
Self-employed (and employing others)	□
Unemployed and looking for work	□
Looking after home/family	□
Retired from paid work	□
Unable to work due to long term illness/disability	□
Not in paid work for other reason	□
Full time Student	□

10. How well would you say you yourself are managing financially these days? Would you say you are:

Living comfortably	□
Doing alright	□
Just about getting by	□

Finding it quite difficult	□
Finding it very difficult	□
Prefer not to say	□

11. Which of the following best describes how you found out about Malahide Astro Football? (Please tick **one** box only)

Word of Mouth	□
Newspaper/Media/Social Media	□
Local service/club	□
Family	□
Health Professional	□
Other	□

If 'other', please specify _____

12. What is your primary motive for participating in Malahide Astro Football? (Please tick **one** box only)

To improve my fitness or to stay fit	□
To integrate into my community	□
To release stress	□
Love of competitive football	□
Health reasons	□
Other	□

If 'other', please specify _____

13. What is the approximate time it takes you to travel from your home to the Malahide Astro Football venue?

_____hrs _____ mins

14. How would you rate your ability TODAY to play recreational football? (whereby 1 is very poor and 10 is excellent)

1 2 3 4 5 6 7 8 9 10

B. ABOUT YOUR HEALTH

15. In general would you say your health is:

Excellent □

Very good □

Good □

Fair □

Poor □

16. The following questions are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, how much?

	Yes Limited A lot	**Yes Limited A little**	**No, Not Limited At All**
Moderate activities such as moving a table, pushing a vacuum cleaner, bowling or playing golf.			
Climbing **several** flights of stairs.			

17. During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities <u>as a result of your physical health</u>?

	Yes	**No**
Accomplished less than you would like.		
Were limited in **the kind** of work or other activities.		

18. During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities <u>as a result of any emotional problems</u> (such as feeling depressed or anxious)?

	Yes	**No**
Accomplished less than you would like.		
Didn't do work or other activities as **carefully** as usual.		

19. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework). (Please tick **one** box only)

Not at all	□
A little bit	□
Moderately	□
Quite a bit	□
Extremely	□

20. These questions are about how you feel and how things have been with you **during the past 4 weeks.** For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks –

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Have you felt calm and peaceful?						
Did you have a lot of energy?						
Have you felt downhearted and low?						

21. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities?

All of the time	□
Most of the time	□
Some of the time	□
A little of the time	□
None of the time	□

C. ABOUT YOUR PHYSICAL ACTIVITY

22. In the past week, on how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your breathing rate?

This may include sport, exercise and brisk walking or cycling for recreation or to get to or from places, but should not include household work or physical activity that may be part of your job.

(Please tick **one** box only)

Never	1 Day	2 Days	3 Days	4 Days	5 Days	6 Days	7 Days
□	□	□	□	□	□	□	□

D. ABOUT YOUR LIFESTYLE

23. How many portions of fruit and/or vegetables (including pulses, salad, vegetables, fruit juices and fresh, dried and canned fruit) did you eat yesterday? (Please tick **one** box only)

None	1	2	3	4	5	6	7+
□	□	□	□	□	□	□	□

24. Do you currently smoke cigarettes, cigars, a pipe or use chewing tobacco?

(Please tick **one** box only)

Never Smoked	□
Former Smoker	□
Current Smoker (not every day)	□
Current smoker (daily)	□

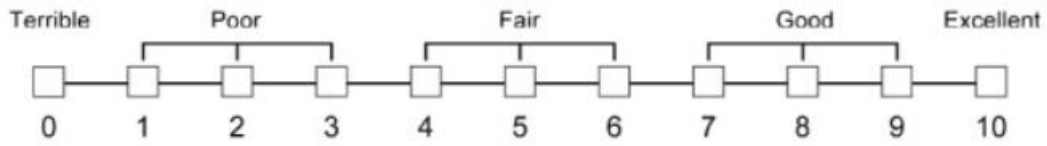
25. **Thinking back over <u>the last 4 weeks</u>, how many days in a typical week did you have any kind of drink containing alcohol?** (Please tick **one** box)

Everyday	□
5-6 times a week	□
3-4 times a week	□
Twice a week	□
Once a week	□
2-3 times a month	□
Once a month	□
Never	□

26. The following question refers to your overall sleep quality for the **<u>majority</u>** of nights in the **<u>past 7 days only</u>**.

Please think about the quality of your sleep **<u>overall</u>**, such as how many hours of sleep you got, how easily you feel asleep, how often you woke up during the night (except to go to the bathroom), how often you woke up earlier than you had to in the morning and how refreshing your sleep was.

During the past 7 days, how would you rate your sleep quality overall? (Please mark **one** box only)



E. ABOUT YOUR SENSE OF SELF

27. Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

	Strongly Agree	Agree	Disagree	Strongly Disagree
On the whole, I am satisfied with myself				
At times I think I am no good at all				
I feel that I have a number of good qualities				
I am able to do things as well as most other people				
I feel I do not have much to be proud of				
I certainly feel useless at times				
I feel that I'm a person of worth, at least on an equal plane with others				
I wish I could have more respect for myself.				
All in all, I am inclined to feel that I am a failure.				
I take a positive attitude toward myself.				

F. ABOUT YOUR SOCIAL HEALTH

28. The following statements describe how people sometimes feel. For each statement, please indicate how often you feel the way described by circling one of the responses below. Here is an example:

How often do you feel happy?

If you never felt happy, you would respond "never"; if you always feel happy, you would respond "always."

	Never	Rarely	Sometimes	Always
How often do you feel that you are "in tune" with the people around you?				
How often do you feel that you lack companionship?				

How often do you feel that there is no one you can turn to?				
How often do you feel alone?				
How often do you feel part of a group of friends?				
How often do you feel that you have a lot in common with the people around you?				
How often do you feel that you are no longer close to anyone?				
How often do you feel that your interests and ideas are not shared by those around you?				
How often do you feel outgoing and friendly?				
How often do you feel close to people?				
How often do you feel left out?				
How often do you feel that your relationships with others are not meaningful?				
How often do you feel that no one really knows you well?				
How often do you feel isolated from others?				
How often do you feel that you can find companionship when you want it?				
How often do you feel that there are people who really understand you?				
How often do you feel shy?				
How often do you feel that people are around you but not with you?				
How often do you feel that there are people you can talk to?				
How often do you feel that there are people you can turn to?				

Thank you for taking time to complete this questionnaire

Appendix 11: Consolidated Income and Expenditure Account for the FC initiative for the period 17 May 2021 to 16 May 2022

	Totals	Description
Revenue		
Game Fees	12,855	Fees from Pick up games
Other Income	618	Christmas raffle income
Total Revenue	**13,473**	
Cost of Sales		
Pitch Rental	(7,215)	
General Equipment	(341)	Footballs, bibs, pumps, medical kit
Marketing / Social Media / Photography	200	
IT Costs	(406)	Google drive subscription; game portal fees
Governance Costs (financial, audit, legal)	0	Financial accounts provided on voluntary basis;
Total Cost of Sales	**(8,162)**	
Gross Profit	**5,311**	
Overheads		
Labour Costs	0	All game/site coordination provided on voluntary basis
Research	(582)	SETU data collection for Health Impact study
Charity Donation	(618)	Malahide Lions Club donation from Christmas raffle donation
Committee	(360)	Meetings, expenses, subsistence
General Overheads	(557)	Public liability insurance; LHT (light, heat & telephone) costs
Total Overheads	**(2,117)**	
Surplus Profit/(loss)	**3,194**	

Appendix 12 Evidence in Support of 'Deadweight' and 'Displacement' Discounting of Participant Outcomes

It's evident that participants had a love of and a long-standing relationship with the game of football as a player:
"And so, I thought, well, look, I really want to get back playing football because I may have, you know, playing at a semi decent level, I, I, I might only have a couple more years." RA1
"…there's a vast majority are, you know, I suppose. You know ex-players who just play because they just love playing football." RA1
"Well, like, not to get too cheesy or too nostalgic but it all stems from like a childhood of playing football you know having an older brother…. developing a thirst for not only playing football but also for learning, learning about different people about how they communicate on the pitch, maybe or about the style of play how to, how to work best with people." RA3
"I love playing football in any capacity, whether that be five on five on a smaller pitch versus 11 on a full-length pitch or in the case of [named site location] 7 v 7 or eight v eight, occasionally." RA3
"…football is a huge thing for my mental health, like it's like extremely important." RA3
"And obviously I love playing football. So you know it's it's something that I've done all my life, and it's just something that I really enjoy you know I like, I love playing the game ….It's beyond a social thing, you know for me it's, it's kind of you know, it's kind of a, not to get too arty farty but it's kind of a form of expression almost you know it's something which is accepted within the male sphere, you know, does being kind of a form of expression, almost." RA5
"[speaking of the pandemic], *I can deal with almost everything except for the schools being closed and the football being off…*" RA5
"I kind of travelled a bit as well [lived abroad]…. *Everywhere I go, I went over to the UK for a couple years. Everywhere we go I tend to make friends and contacts via social soccer."* RA6
"…it just it [playing football] *doesn't feel like exercise to me, you know. I just think, you know, it takes no effort whatsoever. It just it's you go out and you get, I get lost in the game and, you know, and it just never feels like exercise. That's why football is probably the only form of exercise that I actually stick with…… it's just you, and the ball, and anybody else playing.* *And, you know, nothing else exists for an hour or however long you're doing. But that's, you know, that's a big draw."* RA7
"[When considering going back playing after the lockdown] *Although I am looking forward to the social element, but it is actually the football part that I'm looking forward to most, you know, getting back to scoring goals."* RA7
"I've always been a football player actually, so for me it's quite simple." RA8
"[when speaking about joining the FC initiative] *So, really, really, really that, primarily just being able to play football again and enjoying the competitive element for me. It's been exactly what I wanted it to be in terms of getting that competitive element, but in a, in a friendly way."* RA8
"So, I've played football from a very young age, probably seven, eight. Years ago, I was captain of [named club] *football team. I played junior level in the Ireland team."* RA9
"[when speaking of playing football] *You're in flow, you know, you're playing an hour and a half, you've forgotten about everything and just at that time you're not thinking about the past or the future anything like that you're just in the present"* RA9
"…but I want to, really wanted to play a bit of football before I got to the point where well, I'm going to be more useless on the pitch then I am now. While, I can still move a bit, pass a bit, you know, and I think this is that last few years that I'm going to get as much enjoyment out as possible, you know…. The itch is still there, you know, you're just trying to keep paying a little bit longer." IRR1

"…for me that the friend is the football. So I think it's I mean I just, I think it's for the majority of men across the world, you see a football in the park and you're thinking kick it, kick it you know, that's what you want to do …" IRR1

"I've one, I've one lad [son] *who's just, I bring him to a playground. Right.*
And he any, any he brings a football with him, and he won't go on the swings, and he won't go on the slide, he just, he actually wants to play football in the playground right. That was me as a kid…. I'm obviously a type right I'm some kind of personality type [that loves football]" IRR2

"I always played football at underage and adult football and, you know, probably levels got worse and worse but, you know, always, always played." IRR2

"I'd also a couple of years before I'd been living overseas, in New Zealand. I am back in Ireland about two years and over there I would have played, living over there for eight years, and I would have played 11-a-side football over there. And then like, when I was younger, I would have played a bit." IRR4

"It's sort of clinging onto the last ability, playing football. That's really what it feels like. But not in a desperate way … not in a kind of do you not know what age you are? …it's actually really appropriate, probably, it's probably the best you can be [at the age you are]… People are there, they're enjoying the dream, but they know the reality.." IRR3

It's evident that for most of this group, 'football' cannot be replaced by another sport/form of exercise:

"I tried my hand at tennis and squash and anything to keep me fit [but due to business in his life] I was kind of driving past the tennis and squash club, you know it just, it ceased to be something that fit into my life seamlessly" RA2

"…primary motivation would have been that need to get some exercise, and it's, you know, playing football was, is enjoyable, it's fairly straightforward game. Anyone can kind of try their hand at it, and it's a sport that you know you, the more you play, the better you get, you know, unlike tennis and golf, when I found the inverse, true." RA2

" [describes business of life with small kids] …you know, you have to kind of fit your own discretionary leisure time around a fairly you know, demanding schedule. There's only so many hours in the day, so when you get when you get an option of football on a Monday, or Wednesday, or the occasional game on a Friday night on a monthly basis. It just means you can pick and choose around your schedule, so it lends itself to that. Whereas if it was, you know, do you fancy a game of tennis? Yeah, when can you play? You know, trying to get, when you've got a fewer number of people trying to agree a time that suits everyone is much more difficult." RA 2

"I much prefer doing it [playing football] than going to the gym because it's competitive. I'm a pretty competitive person and I find myself probably doing a multiple [of volume of exercise] in a game of football, than I would if I went to the gym for an hour." RA4

"So, coming from the outside, it was, I wasn't wishing to join up to tennis club or something, it was something that, I didn't have to sign up as a member, I could come and go as I please, so it was nice having that." RA9

"I'm no good at gyms and things that you do on your own. I'm quite competitive and I wanted that. So I wanted some competitive sports." RA8

"And I'm not a particularly, I'm not fond of running anyway. I think I've always liked football and competitive stuff, certainly the social element of it, it's easy enough to, to find a few fellas play ball it's fairly universal. So, a running club didn't really appeal to me it was, I'm just more into football really." RA9

"I would be somebody who, who would have gone to the gym…I didn't get the same satisfaction out of the gym that you know a lot of people other people seem to get like you know I just, I don't get the point in doing a thousand burpees or, you know, 100 squats or whatever like you know. I want the competitive edge you know… I want to go back and play matches and it's not because I want to win a

trophy it's because I want to fucking get stuck in and, you know, and all that type of stuff and I think you need that kind of a, you need that outlet like" IRR2
"You know I'm not a good golfer right, but I played golf last week because we were allowed [due to lifting of pandemic restrictions]. And you know I was absolutely useless. And the reason I was useless was, it wasn't the competition... I mean like I need that competitiveness." IRR2
"I started going to the gym, and I got into the gym, and I never really done the gym my life, …so CrossFit gyms is like trying to turn fitness into a sport right. .. I'm not into this so I'm a sceptic on this right. And, and I got into it for a while, and then I just kind of said like, this is just, like, this is fucking nonsense like this is … you know I'm competing against, you know, let's say, you know, some guy who's twice your weight trying to, trying to lift something heavy or some girl who's half your weight trying to do pull ups and like, it's just, you know, I just, I recognized when I went there and I went there for about five years like doing all this stuff like this wasn't something I did for 12 weeks or something right, I got into it. But at the end of it I was like, this is, this is actually nonsense and all I want to do is, you know, play a match, try score a goal, try win, beat your man" IRR2
It's evident that for some men, being part of a team or group is key to their engagement in sport:
"[spoke of living in London]… And *one of the first things I did when I arrived over in London was to seek out a kind of a team that I got to join just to kind of keep myself busy, keeping us all fit, meet new people, that kind of thing. So it's something that I've been kind of looking out for, for a couple of years actually since coming back from London".* RA5
"I always played in organized teams from like college onwards from there. *And I've lived in a few different countries and always taken part in, in teams there"* RA8
"I have used other substitutes I would have taken up the piano, done, yoga, meditation, this kind of stuff and that's, that's served me well, but there's something about being in a group dynamic certainly for me is I think." RA9
It's evident that for some men, there wasn't an alternative sport for them to engage in in their locality:
"…a bit of a gap in terms of the sport…" RA2
"Whereas, it was, there just didn't seem to be any anything, I looked into a couple of clubs and they weren't really interested in you unless you knew someone or whatever, so it was like whatever that is, I thought, not going to bother with that." IRR4
It's evident that, in the absence of the football games during the Covid-19 restrictions, exercise in other forms was not happening for most men:
"I'm not a big fan of running, and to be honest with you…But I found that I was more likely to run while I was playing football. I find it harder to run when the football is being off [during the pandemic and at the time of consultation]. *That, that could be me, it could be, lack of moral fibre, backbone but it's just the best reality of it."* RA2
"I mean I notice it now after four months of not doing it [playing football]. *I've definitely yeah, put on the 'Covid stone' or a couple of stone probably, and so that's a big factor physically, and I definitely could be probably in worse shape of my life now after probably having not played since, maybe November December. And yeah, I'm not a fan of going out running some people don't mind doing that. I'm not huge fan of it, so yeah, I haven't been doing a huge amount, kind of, I don't have so many alternatives, I guess."* RA4
"[speaking of the pandemic] But the that's the thing I've been looking forward to is the football coming …. It's not a push for me to have to go a lot of time for me personally with the fitness. It's hard for me to push to get out of the door off the couch and do a five K. But I don't have to push myself to go and play football and I'll run 5k, 10k football and I won't notice this. It's different when you gotta push yourself off the couch to go out on a windy night and difficult to define exactly why there's a big

difference between the two but it's just maybe just different people, different people in different ways." RA5
"… and just trying to get the kick of the ball again we get the competition going. To get the skill levels to improve, it will be poor quality on the first night anyway. The outlet as well, just to deal with the monotony that is life for the moment [during the pandemic] *and not exercising much with my knee and then I haven't been exercising much because of a family situation."* RA6
"Whereas, in the last five months when I haven't had the football to go to, you know, that's [healthy behaviours] *all just dropped away. Then, you know, my diet has gone become terrible, you know, I don't drink as much water, not getting any exercises at all really…"* RA7
"I'm not doing as much exercise" IRR3
"And, you know, because you, you literally had nothing to do [during Covid lockdowns] *rather than try and keep yourself motivated to go for a bit of a run on your own and that's hard, hard to do you know."* IRR4

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