Better Program, Stronger Community

AHEAD Project Improvement Consultation Report

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List of Abbreviation

AHEAD	Action for Health Development
CL	Commune Leader
CMEP2	Cambodia Malaria Elimination Project 2
DrPH	Doctor of Public Health
DVC	Deputy Village Chief
FP	family planning
GC	Group Chief
HHs	Households
IE&C	Information, Education and Communication
MCH	Maternal and Child Health
NGO	Non- Governmental Organization
NU	Nagasaki University
PHB	Promoting Health Behaviors
PSI	Population Service International
RCH	Reproductive and Child Health
RMNCH	Reproductive, Maternal, Newborn, and Child Health
SDGs	Sustainable Development Goals
USAID	United States Agency for International Development
VC	Village Chief
VHSGs	Village Health Support Groups
VHVs	Village Health Volunteers
VMW	Village Malaria Worker
WASH	Water, Sanitation and Hygiene

Executive Summary

This report is a product of the six-month consulting project under the agreement between the Action for Health Development (AHEAD), a local non-governmental organization (NGO) in Battambang, Cambodia, and the Doctor of Public Health (DrPH) program, Interfaculty Initiative in Planetary Health, Nagasaki University (NU), Japan. The project aimed to support AHEAD in improving their project implementation while providing a valuable opportunity for the NU DrPH students to apply knowledge in the real world and grow as professionals. The project was conducted from April to September 2024.

Cambodia has significantly improved its economy and health, as seen in the graduation from low-income country status to lower middle-income country and its sharp decline in under-five mortality from 120 per 1,000 live births in 1996 to 23.7 in 2022, meeting the SDG target of 25. Yet, it still faces various challenges, including the poverty risk due to vulnerable employment, unmet family planning needs, and the rising burden of non-communicable diseases. In this context, AHEAD is committed to improving people's health in rural communities in Battambang and Pailin provinces. They are implementing community-based health promotion projects, including Promoting Health Behaviors (PHB) and Cambodia Malaria Elimination Project 2 (CMEP2).

AHEAD has faced challenges with low male participation in its projects, particularly in family planning (FP) and malaria programs. The consulting project aimed to identify the underlying causes of this low engagement and provided feasible and effective recommendations. Through the literature review and AHEAD's document review, the NU DrPH team identified potential factors that influenced male participation in health promotions and came up with four key themes: project design, community engagement, time constraints, and motivation. To further investigate the factors that were most influential and could be modifiable, the team conducted fieldwork in Battambang and Pailin provinces from September 1 to 18, 2024, including 38 interviews and group discussions with 117 stakeholders (i.e., villagers, village health support groups (VHSGs), village authorities, government officers, and AHEAD staff) and direct observation in health promotion sessions.

AHEAD exhibited excellent communication skills, flexibility, and coordination in organizing and conducting health promotion sessions, significantly contributing to the project's success. The NU DrPH team acknowledged the relevance of the issue of male participation; the fieldwork uncovered that the problem is not just poor attendance but rather that appropriate individuals were not effectively invited. The project takes a closed invitation system due to the limited number of participants per session. Villagers claimed not to be able to attend without a direct invitation and felt an obligation to attend if invited by village authorities; their motivation did not matter. The recruitment of participants heavily depended on Village Health Volunteers (VHVs) and VHSGs, some of whom were also village authorities. Their selection processes were not organized and often fell into a convenient invitation. This could cause repeated involvement of individuals already knowledgeable about the subjects, even though they understood participant eligibility criteria of age, experience with FP methods, etc. Many potential participants, especially men, are overlooked due to the timing of home visits by VHVs/VHSGs.

The NU DrPH team recommends two strategies to improve the recruitment process for AHEAD projects. First, the use of visual tools such as village maps is proposed to help identify target households, track participation, and streamline efforts by avoiding duplication. Applying the concept of "Visualization" or "Mieruka," this approach will also facilitate better coordination with the stakeholders, ensuring effective outreach to villagers. Secondly, recognizing and rewarding successful VHVs and VHSGs through regular meetings is suggested as a non-monetary incentive to improve motivation. This approach will allow for sharing of best practices among them, fostering greater recruitment efficiency while maintaining low implementation costs.

Acknowledgments

We would like to express our sincere gratitude to Dr Moul Vanna, Executive Director of AHEAD, for offering us an invaluable learning experience, providing essential insights and information, and for her coordination and warm hospitality during our fieldwork in Cambodia.

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1. INTRODUCTION

Project background

This consulting project was conducted from April to September 2024 as part of the Doctor of Public Health (DrPH) curriculum in the Interfaculty Initiative in Planetary Health at Nagasaki University (NU), serving both as a professional engagement and a valuable learning opportunity. While the Action for Health Development (AHEAD), as a host organization, requested improvement suggestions, they also generously provided a platform for us, the NU DrPH students, to apply our knowledge in a real-world setting.

The DrPH Practicum is a short-term in-service training where students, during their first-year summer term, engage with a host organization, e.g., an international organization, a government agency, an NGO, or a private business. During the practicum, students identify a specific issue faced by their partner organization that can be addressed within a short timeframe. They apply their first-year coursework knowledge to devise solutions and achieve measurable success in addressing the issue. The practicum helps students refine critical skills in problem-solving, coordination, negotiation, and communication and serves as a foundation for their project exercise in the second and third years.

The collaboration offered the AHEAD time to review its project implementation from an external perspective and explore areas for improvement. Therefore, the project was an opportunity for growth and development for both parties and was conducted in a way that balanced the goals of educating the DrPH students and improving AHEAD's projects.

Country background

Cambodia, a Southeast Asian country covering 181,035 sq km, is bordered by Thailand, Laos, Vietnam, and the Gulf of Thailand. Forty-seven percent of the land is used as rice fields and croplands, with forests accounting for 42%[1]. The population is 15.6 million, of which 51.3% are women[2]. Cambodia is relatively homogenous regarding religion and language, with most Cambodians being Buddhist (97%) and speaking Khmer (95%)[2]. Urban areas are growing rapidly due to migration for employment and education[2]. Literacy rates have improved significantly over the past decade, with more than 90% among young people and 70% among older women, though 40% of the population still lacks primary education[2].

Since the 1993 democratic election led by the United Nations Transitional Authority in Cambodia, the country has had a constitutional monarchy ruled solely by the Cambodian People's Party as parliamentary majority[3]. Cambodian society is hierarchal, and at the village level, village authorities hold significant power over villagers through patron-client relationships[4]. Their roles include monitoring the population, managing conflicts, and controlling resources like lands; they are respected but somewhat feared by villagers[4].

In the last few decades, Cambodia has made significant strides in economic and health development. Cambodia graduated from a low-income status in 2015 to join the lower middle-income category with a GDP per capita of $1,857 in 2023[5]. Life expectancy has risen from 56 years in 1995 to 69.9 in 2022, and under-five mortality has sharply declined from 120 per 1,000 live births in 1996 to 23.7 in 2022, meeting the SDG target of 25[5]. The fertility rate also dropped from the peak of 6.3 births per woman in 1984 to 2.3 in 2022[5]. Malaria cases decreased to less than 10,000 in 2020, and no malaria deaths have been recorded since 2018[6].

However, they have still faced a lot of challenges. Due to the vulnerable employment conditions in agriculture and/or informal sectors, many people are living in poverty or could fall into poverty at any time and are excluded from social protection[7]. More than a million people have crossed the border to seek better

employment opportunities and wages, mainly in Thailand[8]. Unmet needs for family planning is 12%, high among teenage wives at 14% compared to 1% among those aged 45-49[9]. Children in rural areas are more stunted than those in urban areas (25% and 17%, respectively)[9]. Migrants and forest goers remain at high risk for malaria, contributing to continuous malaria transmission[10]. One in seven women experienced violence committed by intimate partners within 12 months[9]. The burden of non-communicable diseases is rising; three of the top four causes of death include stroke, ischemic heart diseases, and cirrhosis of the live[11].

To address these health issues, Cambodia's health system established a specialized administrative unit for health called the Operational District (OD) in 1995[12]. It includes a referral hospital, health centers, and health posts to suit the population, ensuring that health services reach every corner of the country. However, access to high-quality health services is limited due to a shortage of medical personnel and geographical and economic barriers.

Host organization

Action for Health Development (AHEAD) is a Cambodian not-for-profit, non-partisan, and non-governmental organization focused on community-based Primary Health Care and other health interventions. It is governed by a Board of Directors responsible for policy, with an Executive Director and Management Team handling day-to-day operations. AHEAD follows various policies, including personnel, financial, child protection, and conflict of interest, all reviewed periodically. Its mission, vision, and goals are follows.

Mission: To improve the health and quality of life for all Cambodians by partnering with the government and communities to enhance the accessibility, quality, and sustainability of primary health care. It also aims to empower communities and health providers with the skills and capacity for self-management, promoting values like dignity, justice, and accountability.

Vision: Sustain health and quality of life for all.

Goals: Improve health status for individuals, families, and vulnerable groups, especially in poor and underserved communities in Cambodia.

To achieve its mission, AHEAD is committed to several health-related projects, including two main projects: Promoting Health Behaviors (PHB) and Cambodia Malaria Elimination Project 2 (CMEP2).

PHB is a community-based health promotion program led by Population Service International (PSI) in Cambodia and funded by the United States Agency for International Development (USAID). It aims to alter health behaviors among rural Cambodians through education utilizing behavioral change theory, such as family planning (FP), maternal and child nutrition, tuberculosis prevention, water sanitation and hygiene (WASH), and non-communicable diseases. The project started in October 2019 in four districts in Battambang and Pailin provinces and will continue until March 2025. The current focus areas are FP and maternal and child health nutrition.

CMEP2 is a government-led project supported by USAID President’s Malaria Initiative. It targets people at high risk of malaria, such as migrants, seasonal workers, and forestry workers, and provides malaria education, prevention measures, rapid blood testing, and referral support. AHEAD supports and supervises government officials (e.g., staff in health centers and health posts) to conduct sessions effectively. The project is conducted from March 2022 to July 2026 in Battambang and Koh Kong provinces.

After several years of the project's implementation, AHEAD realized that some of its implementation targets were difficult to achieve despite the measures taken, one of which was low male participation in health promotion sessions. To solve this problem, we, NU DrPH students, became involved.

2. PROJECT OBJECTIVES AND STEPS

The NU DrPH team set the following objectives to investigate the causes of low male participation in AHEAD and to recommend strategies to increase male participation in AHEAD outreach health activities.

- To identify and analyze the role of the stakeholders involved
- To assess AHEAD's project implementation
- To identify possible causes of low male participation
- To recommend potential strategies to overcome the cause

To achieve the objectives, we took the following steps:

1. Justify the issue through desk review and literature review
2. Analyze the root causes of the issue and develop a framework
3. Analyze the situation surrounding the issue through fieldwork
4. Discuss the findings and make recommendations

3. DESK REVIEW AND FRAMEWORK

This section describes the first two steps, issue justification, root cause analysis, and framework to inform the following fieldwork.

Desk review

AHEAD's two major projects, the PHB and the CMEP2, have established gender-specific objectives for various markers. Based on the annual reports of both projects for the fiscal year 2022-2023, there are substantial disparities in achieving the targets set for male participants in these indicators. For example, In the CMEP2 project, 769 people participated in the education campaign in the Smach Meanchey district. Of these, 294 were male, and 475 were female, though the project exceeded its overall target by increasing female participation. In the PHB, only 68% of the target for male attendance in individual sessions and 60% in couple sessions for FP activities in Battambang province was achieved. Although there was some progress in male participation under the PHB project in the next year, it did not meet the target significantly.

In many low- and middle-income settings, men control women and children's access to health services, significantly impacting their health outcomes. Women often live within patriarchal systems that limit their control over socio-economic and health decisions, relying on men not only for financial support but also for permission to access health care. This highlights the need to involve men as informed participants in health services, including those traditionally aimed at women, such as reproductive and maternal health. Though contraceptives are often targeted at women, men typically make decisions about family size and their partner's use of contraceptives.

The impacts of male involvement in health have been examined for decades in developed and developing countries. Its positive influences on health status are widely recognized, such as child development[13], prenatal health behaviors[14], depression during the perinatal period[15], and mother-to-child HIV transmission[16]. Therefore, it is reasonable to recognize low male participation in the AHEAD projects as an issue and try to take action to solve it to ensure the impacts of the projects.

Problem statement

Male involvement in health-related decision-making is crucial for the success of public health interventions. However, AHEAD has identified low male participation in their outreach activities, particularly in PHB FP and malaria projects. This lack of male engagement would hinder the organization's efforts to improve the overall health of the local population.

Hypothesis

We hypothesized that male participation was influenced by:

1. Project design
2. Community engagement
3. Time
4. People's motivation to join

This hypothesis was developed using findings from previous studies that explored factors related to male involvement in health and participation in community health programs, especially in contexts similar to the AHEAD projects but not limited to them.

Project design

In a study to promote male involvement in maternal and child health activities in the Iringa region of Tanzanian, Maluka et al. (2020) found out males are reluctant to participate in maternal and child health (MCH) activities because most of the maternal and child health programs are directed to women[17]. The study participants requested the project team to provide them with key messages that should be delivered to the community, particularly to men. This same finding was reported by Walston et al. (2005) that men were not specifically targeted in these programs, while other programs focus on specific target groups selected on the basis of their occupation[18]. The authors emphasized that some sole-method choices for birth spacing, such as the pill, IUD, or injection, could help maintain men's passive participation in family planning. Alternatively, promoting condoms as a dual method will help foster husband-wife sharing of responsibility for birth spacing and protect both from infection. Previous studies also emphasize how a women-oriented environment for reproductive and child health (RCH) services—with its predominance of female clients and service providers exclusively focusing on women militates against the involvement of men in RCH. All these studies underscore the importance of project design in ensuring high male participation in health activities provided by project teams.

Community engagement

Maluka et al. (2020) underlined the importance of engaging male gatekeepers, particularly religious and community leaders[17]. Their study highlighted that religious and community leaders are highly respected in the community. They have the power to convey health information to men and women alike. This corresponds with the findings of Lusambili et al. (2021) that targeted information sessions for men on reproductive, maternal, newborn, and child health (RMNCH) are a major facilitator to effective male engagement, particularly when delivered by male authority figures such as church leaders, male champions, and teachers[19]. They also confirmed that men were more receptive to messages from influential male leaders in the community, such as church leaders, male champions, and teachers. The advice from these authority figures was reported as impactful in promoting male involvement in Kenya. Effective community engagement is key to ensuring that authorities play an active role in getting males to participate in RCH activities at the community level.

Time

The importance of targeting male education sessions at home early in the morning, as this is typically when men are at home prior to taking on tasks outside the homestead, was emphasized by Lusambili et al. (2021)[19].

Motivation

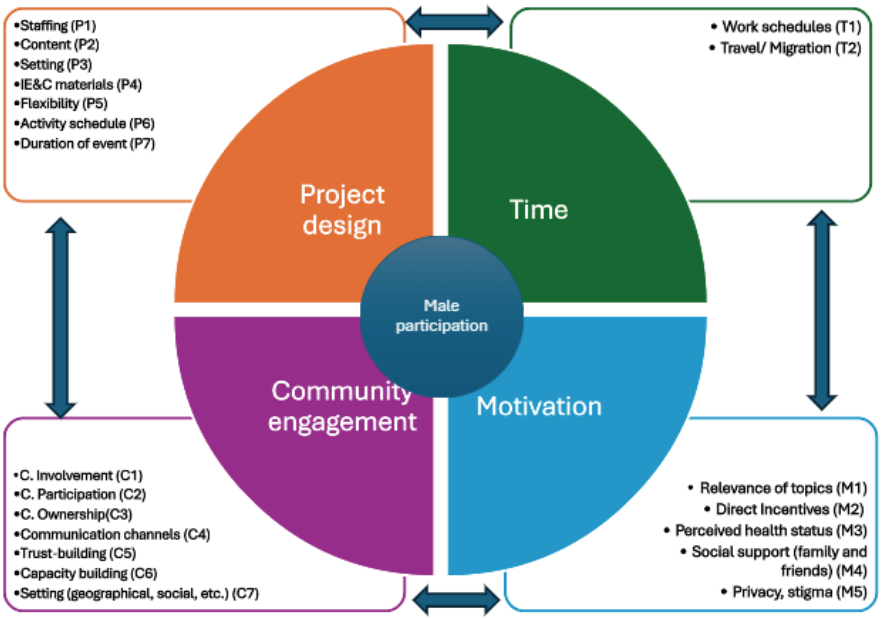
According to Lusambili et al. (2021), offering men a small stipend after attending community meetings may motivate them to participate in RMNCH initiatives[19]. They found out that transportation costs may be a barrier to attending RMNCH health activities, which is compounded by the challenge of balancing informal jobs and prior commitments with attending gender-sensitive community seminars. This may imply that men, who are the financial providers for their families, have to choose between losing their income and attending sessions. Stipend may be one method of encouraging them to participate in community meetings as it may be used for transport costs as well as allocated toward the purchase of household essentials. A study conducted in Nigeria by Adelekan et al. (2014) also listed motivation from their wife (87.6%) as one of the factors that could facilitate men's involvement in family planning activities[20]. The others include government policy regarding men's role in FP (30.7%), more FP clinics (65.2%), and adequate sensitization for men (85.2%).

Based on findings from the above studies and previous activity reports of AHEAD, we hypothesized that Male participation in the AHEAD outreach activities is influenced by the four themes identified above. Consequently, these elements that constitute our hypothesis dovetailed into the conceptual framework developed by the team to understand the causal factors of the problem and proposed recommendations to AHEAD for consideration to solve the problem that underpins the project.

Conceptual Framework

As part of efforts to achieve the project objectives and successfully test our hypothesis, we developed a conceptual framework shown below focusing on the four main variables used in formulating the project hypothesis.

Figure 1 Conceptual Framework of male participation in the AHEAD projects



Project design

We reviewed attributes of the project design and implementation and how that affects or has the tendency to affect community members' participation in general and male participation in particular. We considered AHEAD staffing norms regarding the number of staff assigned per session and whether there is gender consideration in assigning them to specific sessions based on the cultural and social context of each community. This might encourage or discourage males from participating. The suitability and friendliness of the information, education and communication (IE&C) materials also play a key role in ensuring participants are at ease and willing to participate. The level of project flexibility to fit into communities` demands, such as canceling, rescheduling, change of venue, time, and special consideration for some events and situations, all contribute to the status of participation, especially among males who are predominately busy people in settings such as Battambang and Pailin. With respect to AHEAD's practice in the community, session schedules and session duration are critical in ensuring high participation. We, therefore, see an intersection between the time management of community members and the session schedule by AHEAD in this regard. This is because project flexibility is required to balance the right timing and project goals. Lastly, the content of the sessions is a huge determining factor of participation. As discussed under motivation, how the community members perceived AHEAD activities to address their health needs will determine whether or not they will join the sessions. It is, therefore, imperative to have content that fits each village. Through the series of meetings and interviews with Dr Vanna and Project Manager from AHEAD, as well as the reports and data shared from AHEAD, we tried to explore the staffing and workload of staffing. Together with the result of the literature review of academic papers, we included the following elements in "Project design": Staffing, Content, Setting, IE&C materials, Flexibility, Activity schedule, and Duration of the session, in the context of AHEAD.

Community engagement

As all the projects provided by AHEAD are community-based, the manner and process of engaging communities to accept, involve, and participate in these projects are very critical. The team is of the opinion that adequate and effective community engagement has the potential to increase male participation in all AHEAD community health promotion activities. Based on this premise, community engagement was identified as a key variable in both our hypothesis and framework. We aimed to explore how much communities, particularly opinion leaders, are involved in planning and supporting AHEAD activities at the community level. One of the fundamental requirements to achieve project deliverables is effective communication with communities considering community structures, culture, and tradition. Regular and effective communication, together with appropriate community entry and engagement, significantly contribute to trust building and project ownership that translate to achieving project goals and key performance indicators. From the literature review of academic papers and guidelines from WHO, we included the following elements in "Community Engagement"; Community Involvement, Community Participation, Community Ownership, Communication Channels, Trust-Building, Capacity building, and Setting (geographical, social).

Time management

Since most males in Battambang and Pailin are engaged in farming and other income-generating activities, they are often busy and have very little to no time to spare for other events that do not contribute to their livelihood. They are mostly involved in farm work, working in the forest, or frequently migrating to neighboring countries for greener pastures. This affects both their availability in the community and the amount of time they can have for AHEAD health promotion sessions. Therefore, AHEAD must engage them to understand the right timing for them to participate in the activities and how long they can participate in each activity to possibly achieve a win-win situation. Through the series of meetings and interviews with Dr Vanna and the Project Manager from AHEAD and reports by AHEAD, we included the

following elements in “Time”: The work schedule of community members and the travel/migration of community members.

Motivation

We also identified motivation as a key pillar of increasing and sustaining the interest and participation of community members, including males, in community-based health activities. In our context, motivation refers to anything monetary, or otherwise, that acts as an incentive to illicit the interests of males and induces them to participate in AHEAD health promotion activities at the expense of others, including their routine economic activities. We identified direct incentives, relevance of the topics discussed during AHEAD health promotion sessions, social support, and the perceived health status of participants as some of the key determinants of motivation to participate in the sessions. We further established that this kind of motivation is double-stranded. Motivation that can be provided by the project (AHEAD) and that which is solely dependent on the community members, for instance, how the project activities align to their health needs and well-being in their opinion. At least one is required to improve male participation, even though both are desired to achieve optimum results. From the literature review of academic papers, we included the following elements in “Motivation”; Relevance of topics, Direct incentives, Perceived health status, social support, privacy, and stigma.

4. SITUATION ANALYSIS

Method

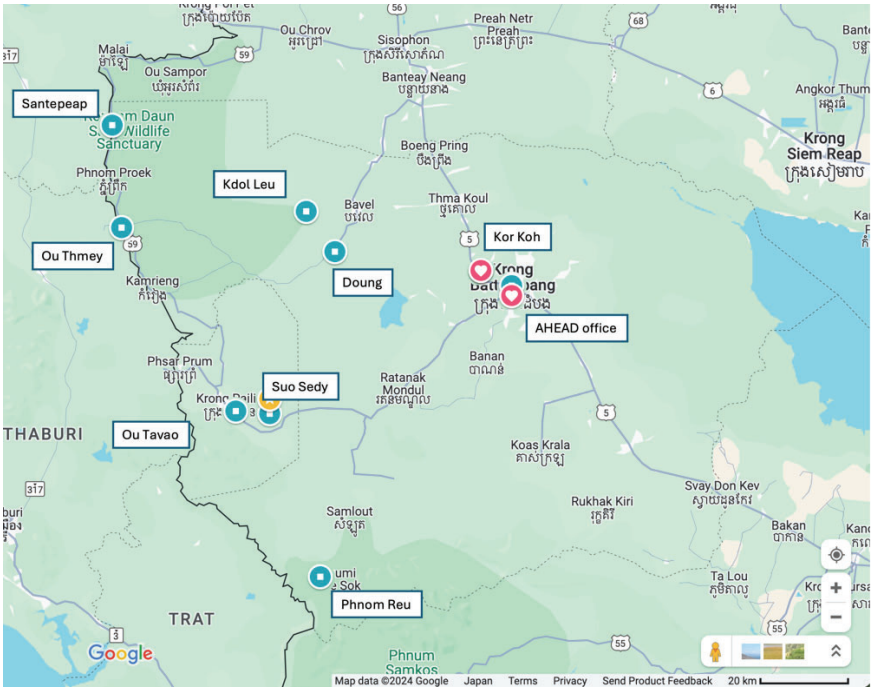
Based on the conceptual framework above, we determine where, from whom, what kind of information, and how we would obtain it.

Identified stakeholders included:

- Villagers
- Village Health Volunteer (VHV), Village Malaria Worker (VMW)
- Village Health Support Group (VHSG)
- Village chief (VC)
- Healthcare providers
- Provincial Health Department
- District Health Department
- AHEAD staff

To meet the stakeholders, we selected villages from the districts that AHEAD projects covered, based on the proportion of males participating in AHEAD sessions in the last six months, the geographical location, the type of AHEAD health promotion session, and the numbered and gender of staff assigned per session. Within the limited time available for the fieldwork, we selected eight villages in four districts in Battambang and Pailin provinces (Figure 2). The characteristics of the villages are shown in Appendix 1. In the villages, we observed five FP couple sessions, two FP male sessions, and one Malaria session.

Figure 2 Map of the observation sites (villages) and AHEAD office.



(from Google Maps.(2024) [Screenshot of Cambodia] Retrieved from http;//www.google.com/maps)

All the stakeholders outlined above were engaged and involved in the information-gathering process. We used various qualitative methods, such as focus group discussions and interviews, to obtain the information required to understand the stakeholders` interaction and involvement in AHEAD`s projects. Based on the conceptual framework, we prepared interview guides for each stakeholder, which were adjusted to extract meaningful information during the fieldwork period. We interviewed villagers separately from other stakeholders to encourage them to speak freely. We had 39 information-gathering sessions with 117 total attendance (Table 1, Table 2).

Table 1 Qualitative methods used during the fieldwork

Information gathering methods	**Count**
Focus group discussion	1
Individual interview	19
Group interview	17
Workshop	1
Meeting	1
Total	39

Table 2 Number of informants attending information-gathering process

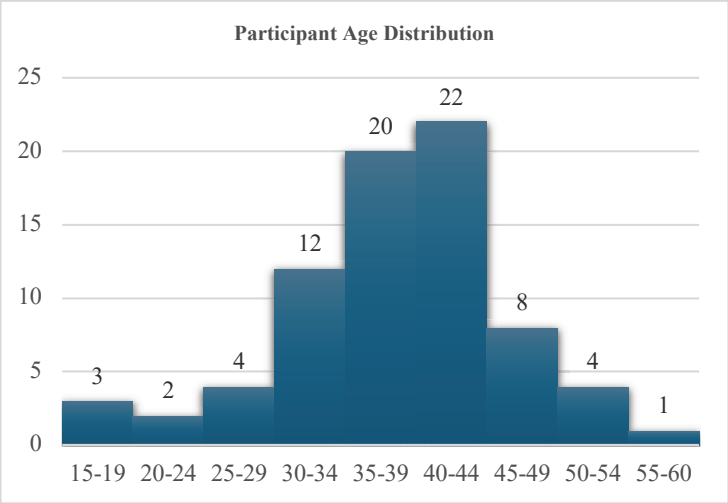
Informants	**Female**	**Male**	**Total**
Villagers participating in the observed sessions	23	34	57
Villagers who have never participated in AHEAD sessions	7	3	10
VHVs/ VMWs/ VHSGs	3	2	5
VCs/ Deputy VCs/ Group Chiefs	2	7	9
Healthcare providers (Health center staff, officers)	1	4	5
PDH/ OD officers	2	2	4
AHEAD staff	11	16	27
Total attendance	49	68	117

Findings

In this section, we describe the findings by categorizing the information obtained from beneficiaries (i.e., villagers) and providers (other than villagers) and by four themes in the conceptual framework. Each informant is represented by the letters B (beneficiary) or P (provider) and number.

According to the AHEAD session roster sheets, 76 villagers participated in seven FP sessions. Participation in the first two FP couple sessions was unbalanced; the number of couples did not reach the target, and some female participants joined without their husbands. Five participants did not meet the age criteria. The age distribution, including non-eligible participants, is shown in Appendix 2. Although they are within the age criteria, the distribution is skewed towards the older age groups.

Figure 3 Age distribution of the participants in seven FP sessions observed



Finding from the provider side

Project Design – How is the FP session conducted?

AHEAD is working as the implementation team for the PHB project, led by PSI Cambodia and funded by USAID. Based on behavior change theory, the educational sessions for villagers, a core of the project, were developed through discussions with stakeholders, including AHEAD and community members, on the activity type, its modality, the materials used, and the duration (P12). There are two types of family planning sessions: male sessions and couple sessions. The men's sessions aim to provide information to men who typically have less access to family planning resources. The couple's sessions offer a platform for discussion, addressing the fact that family planning is often seen as a woman's responsibility and rarely discussed between spouses (P12). There are some differences in the materials and activities used in the two sessions due to their different aims and targets.

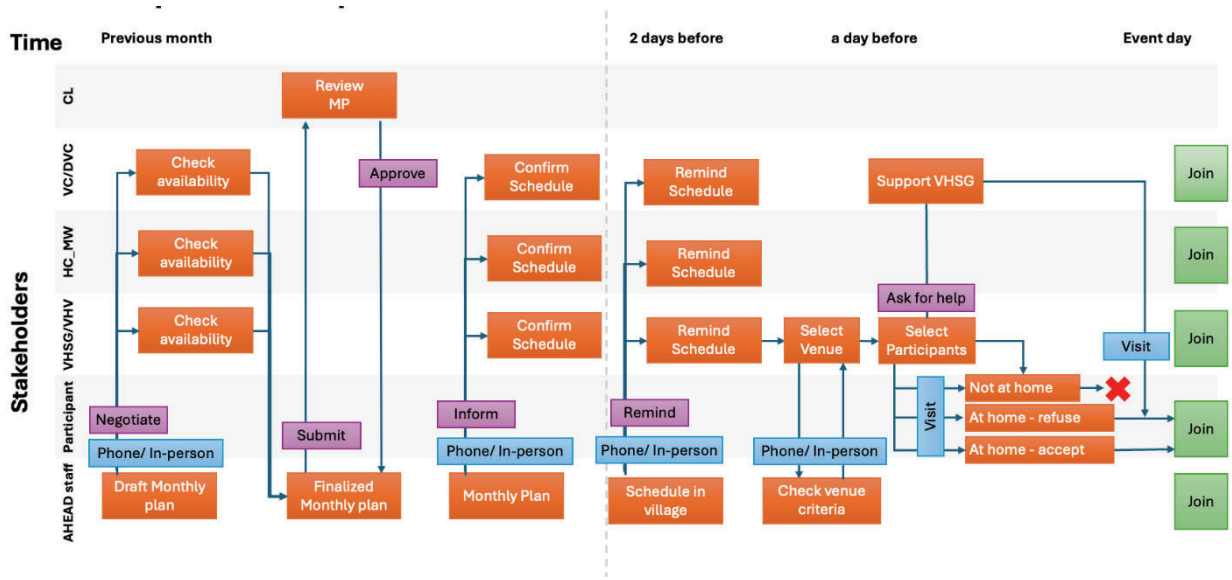
Table 3 The characteristics of FP sessions

		Male session	Couple session
Target		12 Male at the age of 15-49 years old	5 couples at the age of 15-49 years old (reproductive age)
Session	Icebreaking	Football kick while Q & A	Question cards (e.g., What did you feel when you first met your partner?)
	Lecture	Importance of family planning with video and flipcharts	
	Discussion	True and False question – Decision making, gender violence	
	Information	Modern contraceptive methods Contact information Cards with football goal motif	Modern contraceptive methods Contact information Pink pamphlet
Duration		40 – 50 minutes, no longer than 60 minutes	
Providers		1-2 VHSG/ VHV, 1 AHEAD staff	1-2 VHSG/ VHV, 1 Midwife in HC, 1 AHEAD staff

Session Preparation

The 5-year PHB project plan is divided into annual, quarterly, and monthly plans. Each AHEAD ground staff member is responsible for developing monthly plans and executing educational sessions in their designated districts. The following figure describes the session preparation process from AHEAD drafting the monthly plan to the session starting in a village. In this process, commune leaders (CL), VC / deputy VC (DVC), VHV/ VHSG, villagers, and AHEAD ground staff members are involved (P11, 12) (Figure 4).

Figure 4 The preparation process of AHEAD sessions



1. Developing a monthly plan

Following the annual and quarterly plans, AHEAD ground staff members choose target villages in their designated districts, decide on the number of sessions and modality, and draft the budget plan. They then negotiate the plan with the three role players in each village by phone or in person and make some adjustments. Once they have finalized the monthly plan, the AHEAD members submit it to the commune leaders for approval. The approved monthly plan is shared among the stakeholders.

2. Executing education sessions

The AHEAD members remind the three role players of the session two or three days before the session day by phone or in person (P1, 2, 9-11, 17, 18). Schedule changes may occur depending on the availability of the midwife and VHV/VHSG. Once the schedule is confirmed, the VHVs/VHSGs select a venue for the session. The AHEAD members check whether the venue accommodates the activities, especially for the "ball game" in the male session. The VHVs/VHSGs start inviting participants around the venue by visiting their households. They make several visits if needed or ask VCs/DVCs for help to invite participants to ensure the minimum required participation.

Participant Selection

The participant selection followed a closed invitation system, targeting villagers aged 15-49. Participants included five couples for the FP session and twelve males for the male session. VHVs and VHSGs are responsible for identifying eligible participants; some apply additional criteria, like those with limited health knowledge or economic vulnerability (P10). Including previous participants with experience using modern contraceptive methods enhances knowledge-sharing among new participants (P12). Proximity to the venue was another criterion used to ensure accessibility for participants (P10, P13) because transportation support for the participants is not included (P13). Providers also noted that while inviting to tuberculosis sessions was not difficult because it targeted all villagers, FP sessions focus on specific targets, facing difficulties securing attendance from especially working-age men (P9).

Setting - Venue

In addition to the space fitting for each session, the venue is selected based on accessibility, favoring locations on main roads (P9). Some venues were chosen because they had not previously hosted sessions, offering an opportunity to reach different villagers (P11). The venue location may also be decided or changed with input from the participants, prioritized proximity to their homes (P13). It was noted that individuals living farther from the main roads were more likely to be absent, possibly due to migration or economic factors (P17).

Session Scheduling

Although the session schedule was agreed upon and confirmed by the providers in the previous month, it can be changed according to the provider's and participant's availability (P13). Sometimes, sessions are rescheduled, or the session time is changed a few hours before the session starts at the participants' request to accommodate their daily commitments (P13). The extent to which such changes have occurred, and in particular cases where postponement has happened due to a lack of participants, is not recorded (P12). Delays in starting the session often led to participants leaving, as villagers were conscious of time commitments (P1). Some couples, particularly those with conflicting responsibilities, left due to these delays (P1).

Contents, Materials, and Resources

The educational materials used in the sessions were collaboratively developed with input from various stakeholders (P12). Some providers modified the session, allocating more time for the interactive components for participants with some knowledge and experience than for first attendees (P11, P12). They expected this adjustment to enhance the participants' understanding and retention. They also noted that the content could be redundant and benefit from revision to eliminate overlapping information (P12).

Provider Roles and Involvement

AHEAD staff, VHSG members (VHSG), and health center midwives facilitated the FP sessions. Their roles were clearly defined, though there was inconsistency in their involvement and execution of

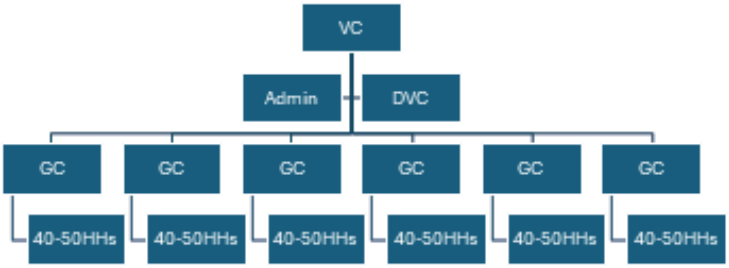
responsibilities (P12). Providers noted that training and capacity-building efforts were beneficial, particularly for VHSG members. However, a newly trained VHSG did not fully engage in the session due to nervousness during her first post-training session (P13, P14). During the fieldwork, some providers expressed shyness due to the presence of external observers (i.e., the NU team), which influenced their ability to carry out tasks effectively (P4, P13, P14).

Community Engagement

Social structure, Leadership, and Community bond

The hierarchical social structure within the village played a crucial role in ensuring community participation. There is a transparent chain of command from village chiefs to households (Figure 5) (P6,7-10, P17). The village authorities are responsible for the village registration and villagers' welfare, including the arrangement of hospital visits and medical costs for sick villagers (P6, 9, 10). In some villages, village authorities also serve as VHSGs (P1, 10, 17).

Figure 5 Governance structure in a village from the interviews



VC: Village chief, DVC: Deputy Village chief, GC: Group chief, HHs: Households

Village chiefs and authorities were instrumental in extending invitations and motivating attendance at health promotion events (P1, P10). They emphasized the strong sense of community and the close-knit relationships among their residents, facilitating effective communication and coordination (P1, P2). Their long-term presence in the village also contributed to their ability to engage with the community and encourage participation in health-related activities (P9, P19), represented by the words, "I know them, and they know me" (P10). Invitations from trusted individuals, particularly village chiefs or other local leaders, were met with greater responsiveness from community members (P1). In some cases, household dynamics affected participation, as illustrated by the example of three younger men who were unable to attend due to their fathers' work-related restrictions (P9).

Communication and Coordination

VHVs or VHSGs are responsible for inviting participants, often visiting households, to explain the session details, including topic, timing, and duration (P1, 2, 10, 13, 14, 18, 21-23). In some cases, multiple visits were necessary to ensure participants were at home during the invitations (P2, 13, 14). While there was no formal strategy for inviting participants, personal visits were prioritized to ensure engagement (P1, P9). Some providers negotiated with villagers about their working schedule to ensure their availability for the session date and time (P10, 18). The use of phone calls is limited, only the cases they have already met and informed and to confirm the attendance (P1, 2, 18). Passing the invitation among villagers is not always preferred because it may degrade the seriousness of the invitation, which impacts future invitations as well (P18).

Time

Some villages have more migrants and seasonal workers than others. In one village, a significant portion of the working-age population (20s-40s) worked in Thailand, leaving children with grandparents (P6). In another village, around 80% of villagers worked locally, with the remaining 20% employed outside the village (P9). Due to the small landholdings, families could manage their farms without hiring seasonal workers, relying on family labor instead (P17). Some villagers are committed to daily workers, like porters; middlemen connected farm owners with workers, though no formal contracts were used in these arrangements (P2, P3). As mentioned, when VHVs and VHSGs visit to invite villagers, they often find them absent from their homes.

Motivation

Villagers often appreciate health promotion events like vaccination campaigns (P9). Health center staff observed that more educated and wealthier individuals were more likely to engage in health promotion activities, while men showed less interest in family planning than women (P3). They reported that men often perceived contraception as a women's issue, making their involvement in family planning discussions difficult (P3). Incentives such as monetary rewards or souvenirs were suggested to encourage attendance at health promotion sessions (P1, P10). Requests were made to increase the number of sessions to provide more opportunities for community engagement (P1, P9).

Finding from the beneficiaries' side

As far as we explored qualitatively, 24 out of 67 participants were found to be attending the session multiple times. The breakdown of participation frequency is as follows: eight people participated for the second time, thirteen for the third time, and three for the fourth time. Regarding contraception, 12 out of 30 women reported using modern methods. The number of repeaters and contraceptive users must have been higher as we began systematically asking these questions to respondents a few days after the survey started. So, these figures should be referred to just for reference.

Project design

Staffing, Contents and Setting

The sessions facilitated by AHEAD appeared to inspire participants' interest in health topics. After the session observation, one participant openly asked questions, particularly related to gynecological issues. Attendees expressed appreciation for the sessions, with almost all respondents indicating they did not feel uncomfortable discussing topics like family planning with members of the opposite gender, as they recognized the importance of shared understanding between men and women. Additionally, most participants reported feeling at ease regardless of the instructor's gender. Many participants showed a strong interest in learning more about various health issues, including how to react to a snake bite or injury, non-communicable diseases, and children's diseases (B17-18, B23, B55-61). Especially the strong request was heard from several farmers because they faced the death of colleagues because of snake bites.

Setting- Eligibility of Participants

Among the female participants, at least 40% were already using modern contraceptive methods prior to attending the session (B6, B34-41, B43, B44-52). Additionally, at least 36% of the total number of participants had attended multiple times. The number of attendances ranged from two to four sessions (B8-16, B20-31, B51-52, B55-58).

AHEAD session can be beneficial for those who have limited access to health services. From the interview, it was found that most of the session participants had good access to health services and stated there were no geographic or financial barriers. This implies that AHEAD's sessions are delivered to people who are

easier to access. Nearly all respondents indicated that they had access to health services, including private clinics or referral hospitals in their living area (B34-41, B42-52, B46-47). Some individuals mentioned possessing medical assistance cards for low-income households, but when they were in a hurry, they preferred to seek care at private clinics, indicating that they had a choice in where to receive medical attention depending on their situation (B23-25). However, our visit might compromise the site selection to the rather urban area; further investigation about sight selection should have been planned beforehand.

Community engagement

Social structure, Leadership, and Community bond

Participation in the sessions was largely influenced by the invitation process led by village authorities. All participants had been personally invited by the village authorities, and those who did not attend were mostly the individuals who had not received an invitation. A small number of invitees were unable to attend due to work commitments despite the invitation (B1, B32). The people who received the invitations seemed to live in convenient or easily accessible locations. Most participants lived near the venue, which facilitated their attendance. Some participants were relatives of VHSG members (B33). In two sessions, attendees included men who worked together (B20-25, B55-58). In one session, several couples who were relatives were present (B44-52).

Perception Gap with the Village Authority regarding Community bonds

A villager mistook the current VC as DVC or VHV, although she sometimes talks with the current VC (B19). The villager stated that she is busy and not very interested in the event held in the community. Some villagers expressed dissatisfaction to an interviewer from NU regarding perceived favoritism by the village authorities, such as inviting only a selected group of people favored by the VC while excluding others. They also mentioned that authorities did little to assist villagers facing sickness or financial hardship (B4)

Setting- Obedience to the Village Hierarchy

The invitation from the village authority was the most influential factor in determining participation. The flow of information was one-directional, from the village authority to the villagers (B7, B54). It appeared challenging for villagers to express dissatisfaction to the authorities if they were not invited to the session (B4, B7, B42-43, B54).

Communication channels – Communication for invitation

Most villagers preferred face-to-face communication with village authorities (B44-52, B55-61). If the intended participant or their family was at home when the village authority visited, they were able to receive the invitation (B2-3). However, if no one was home, it became difficult to convey the session details. Invitations were typically communicated verbally, not through written documents. Only one villager mentioned that it would be more convenient to receive invitations by phone. However, there was no phone network that covered the entire village, and the VC did not know the villagers' phone numbers (B54)

The timing of the invitation was usually one day before the session, which most villagers preferred. Agricultural workers, in particular, have unpredictable schedules due to weather and other factors, making it difficult to schedule far in advance. As a result, they preferred receiving invitations just one day prior (B55, B58). Many villagers also noted that if invited too far in advance, they tended to forget about the event.

While many villagers owned mobile phones, these were not utilized for information distribution within the village (B54). When asked about their primary use of mobile phones, the majority of respondents indicated

purposes such as communication with family, work, and friends (including social networking services), as well as for viewing the news and entertainment like TikTok and YouTube. Only one respondent answered he receives the information from the commune through the mobile phone as he has a role as a contract teacher (B55).

Time

Men working as day laborers, particularly porters and employed agricultural workers, found it difficult to take time off from work to attend sessions (B1, B4). In contrast, men who were self-employed or had more flexible work schedules reported that it was easier for them to find time to participate in the sessions (B17-18).

Several non-participants stated that even if they received an invitation from the village chief, they were unable to attend because taking day-off time-off work would result in losing a day's wages, which would put financial difficulties on their households (B4).

Motivation

Throughout the interviews and group discussions, the most influential factor for participation was the invitation from village authorities. Individual motivation did not appear to be a significant bottleneck or driver for attending the sessions.

Relevance of topics

Through the interviews, villagers demonstrated a curiosity about health-related topics. Many participants had limited formal education and thus appreciated the opportunity to attend face-to-face educational sessions (B18). Some respondents mentioned being mindful of their diet to prevent non-communicable diseases (B17,18). Almost all respondents stated that they did not visit clinics solely for health check-ups and seek healthcare only when they are ill or injured. Almost all respondents had access to healthcare services and stated that, depending on the situation, they choose from options such as private clinics, public health centers, referral hospitals, and pharmacies.

Perceived health status

It was observed that there was no significant difference between participants and non-participants regarding self-rated health and preventive health behaviors such as tobacco and alcohol. Most respondents who could recognize the intension of self-rated health through the interpretation by translator rated between 7 to 10 but some answered they cannot understand the question. Almost all respondents stated that they smoke and only drink alcohol occasionally, such as at community events.

From officers at the provincial and district levels

From the perspective of government officials, in general, people's health has improved, access to hospitals and health centers has become easier, and vaccination and facility delivery rates have increased (P5, 16, 24, 26). They also appreciated NGOs' collaborations, including AHEAD, to support people in improving their health knowledge (P5, 16, 24-26). However, they still see problems with labor migrants, seasonal workers, and health awareness among males (P5, 24, 26). They also stated that the increase in non-communicable diseases needs to be addressed in recent years (P5, 16).

Local government officials have recognized the difficulty in reaching labor migrants and seasonal workers (P5, 24, 26). They see this as a problem, as they experience, for example, cases where they do not receive antenatal check-ups, go into labor and deliver on the way to a health facility (P26). Previously, they have approached the seasonal workers on farms to provide health education (but did not mention continuity) (P24). The approaches to labor migrants include mass gatherings during major holidays when labor migrants come back to their hometown, such as New Year (P5).

5. DISCUSSION

This consultation work aimed to find solutions to the low male participation in the AHEAD health promotion sessions. An extensive document review and literature review confirmed the relevance of the issue and identified factors that could influence male participation. The three-week fieldwork further provided information from providers, participants, and the external party (i.e., NU team and translators) viewpoints, which were critical to deeply understanding the situation surrounding the AHEAD projects and developing feasible and actionable solutions.

The AHEAD sessions demonstrated effective use of resources and flexibility in its operations. The dynamic, motivated, and professional staff contribute to the project's success. Educational materials were collaboratively developed with stakeholders, ensuring relevance to local needs. The staff also displayed flexibility in organizing sessions, adjusting the schedule to suit participants' working hours, changing time and venues upon request, and tailoring educational content to the specific characteristics of the participants within their discretion. This adaptability helped to increase participation and engagement in the sessions.

Communication was a strong point of the project, with the AHEAD staff, village authorities, and VHVs/VHSGs using face-to-face methods to inform beneficiaries about session schedules, ensuring accurate information delivery and encouraging involvement. The project followed standardized procedures and respected the social structure of the communities, which can help smooth coordination. Task distribution was well-organized, involving health center staff, VHSGs, and AHEAD staff, which contributed to the project's overall efficiency and success.

What is the fundamental issue?

We acknowledged that according to AHEAD's annual report, the number of male participants in AHEAD's health promotion sessions had not reached the target. The significance of men's involvement in health and health status is widely recognized, so AHEAD's awareness of the problem is appropriate. However, the fieldwork revealed that the issue was not just the low level of male participation but rather that the right individuals were not being invited, and the invitation process itself was ineffective.

Upon reviewing the number and characteristics of participants in the eight sessions we observed, we noted that the first two sessions had fewer male participants. However, many attendees had previously participated in AHEAD sessions, were already knowledgeable about family planning, had their needs met, or had relatively easy access to information, including through health centers. Such participants' characteristics may not be ideal for achieving the project’s ultimate goal: improving family situations and health outcomes through spreading the knowledge of family planning and altering people’s behaviors. Therefore, rather than solely addressing the issue of low male participation, it is important to focus on how best to invite the most appropriate beneficiaries to these sessions in order to achieve the project’s objectives.

How to Invite the Right Person in the Right Way?

The findings revealed that the invitation to beneficiaries heavily depends on VHVs and VHSGs. The AHEAD staff claimed to have communicated the participant eligibility criteria to the VHVs and VHSGs, and both groups demonstrated a clear understanding of those criteria. However, in practice, the actual participants sometimes differed from the expected target audience, such as when the number of participants did not meet the target or when individuals who had already attended multiple sessions participated again.

Additionally, individuals who had never attended an AHEAD session stated that they were not invited and thus did not participate. The number of participants per session is limited, and invitations are not announced to the entire community but are extended by VHV and VHSG through home visits. Indirect methods, such as phone calls, are not only unavailable but also seem to be less preferred. It is argued that

directly speaking with potential participants helps clearly convey the invitation. These visits typically occur the day before the session and during which adjustments to the participant's schedule for the following day are negotiated. Most people who were visited agreed to these adjustments and attended the session the next day.

However, this approach excludes individuals who are not at home during the visit. This is particularly true for men, who are often absent during home visits due to their work. VHV and VHSG reported addressing this by visiting early in the morning or late in the evening or by making multiple visits. However, this would place a significant burden on them. When asked how they select households to visit, most replied that they know the villagers well, but no clear criteria were provided.

We believe the key issue lies in " I know the villagers well." The villages we observed had a population of around 800, with approximately 200 households. While village leaders may have access to basic household data, such as family size or the number of children, do they also know details such as how these families earn their living or their knowledge of health and family planning? Who knows what, and to what extent?

VC, DVC, GC, VHV, and VHSG each likely possess different pieces of information. By bringing together and sharing this information, we may identify new individuals to approach or find more effective ways of engaging with them—things that might not be clear to VHSG members acting alone. We believe a system that facilitates information sharing and enables VHSG to connect with the right individuals is necessary.

Migrants and seasonal workers

There are two types of residents that the AHEAD team finds challenging to approach. The first group consists of seasonal workers who temporarily settle in the villages, and the second group comprises migrant workers who live in the villages but work abroad, such as in Thailand, returning only during major holidays like New Year's. For the latter group, it would be unnecessary to stretch the current capacity of the AHEAD to accommodate them. Government initiatives, such as large-scale vaccination campaigns, appear to be held and may be a more appropriate approach than the current AHEAD project design.

On the other hand, this approach could be effectively applied to seasonal workers. While their temporary residence does impact local healthcare services, their stay of 1–2 months limits the direct benefits of educational interventions to the community’s health, as they are likely to move before long-term effects can take hold. However, by addressing these individuals on a broader scale, the AHEAD can contribute to improving health beyond the immediate community over time. This more detailed outreach aligns with the AHEAD’s mission, and, given the NGO’s agility compared to government bodies, it is a valuable area where the NGO can make a meaningful contribution.

We must admit that our observations represent only a small portion of the overall project and recognize that our presence may have influenced the behaviors of those involved in the observations. A thorough analysis of the project’s participant registration database is crucial for gaining a more accurate picture.

6. RECOMMENDATIONS

Based on insights gathered from our observations, we propose two specific recommendations that are expected to be effective and feasible, regardless of the attributes of VHV and VHSG. Those recommendations seek to modify the AHEAD staff's approach toward VHV and VHSG to enhance participant recruitment and ultimately maximize the project's effectiveness.

1. Visualization of Target Areas and Invited Villagers

The first recommendation involves using maps to identify areas within a village where the residents who are expected to participate live. This will also allow the AHEAD team and the village side to visualize which households have been approached and which residents have already participated.

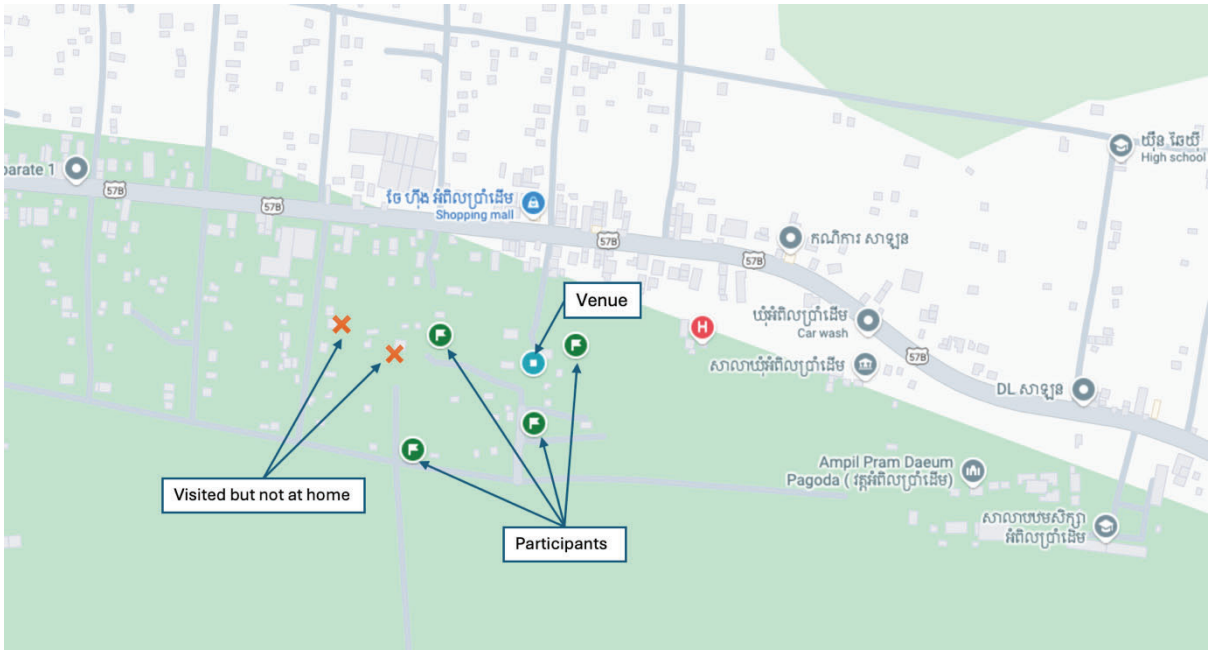
"Visualization," or “Mieruka” in Japanese, is widely adopted across various industries as an effective business improvement tool. It was first introduced in 1998 by Wataru Okamoto of Toyota Motor Corporation under the concept of "visualizing the state of production maintenance activities"[21]. Visualizing activities clarifies unseen issues. It extends beyond simple data presentation; it drives improvement activities based on the insights gained from that data. In organizations, sharing information about employee tasks and progress enhances overall unity.

Applying this method will help make efforts to invite beneficiaries more efficient and effective. Specifically, visualizing which households have been approached and which residents have participated allows stakeholders to share this information and use it to make future recruitment effective, avoiding duplication to achieve the project goal for future sessions.

In practice, the method involves using an enlarged map (Figure 6) that clearly identifies buildings within the village. During the monthly planning process, the AHEAD staff identifies villages for the next month and negotiates with village stakeholders. When coordinating with VHV or VHSG, information on which residents should be invited is shared. The AHEAD staff use the map to communicate with them about essential details such as proximity to roads, location of health centers or health posts, and the residents' characteristics. Discussions will also focus on how to approach residents in specific areas. Village authorities, especially group chiefs, may have more detailed knowledge of smaller groups of residents. Leveraging this knowledge to share relevant information with VHV and other volunteers will ensure that the people most likely to benefit from the AHEAD sessions are effectively informed.

The map will also be used on the day of the session, and a debriefing session should be held with VHV and VHSG to review which households were approached, who participated, and any challenges faced in invitations. This process helps clarify which areas to target in future sessions and how to approach beneficiaries, leading to better planning. Further, this record will be useful in the monthly AHEAD meetings, helping staff discuss recruitment efforts, challenges, and solutions for each village. Visualizing information in this way will facilitate continuous improvement.

Figure 6 Example of the visualization of AHEAD session[22].



Google Maps. (2024) [Screenshot of Doung village, Thmor Kol district, Battambang province, Cambodia]. Retrieved from https://www.google.com/maps

2. Enhance the motivation of VHV/ VHSG

The second recommendation is to recognize VHVs/VHSGs who have consistently succeeded in bringing more appropriate participants to the sessions during AHEAD's regular meetings, and to provide opportunities for them to share their strategies with other VHVs/VHSGs. This would serve as a non-monetary incentive and a chance to boost self-efficacy for those being recognized, while offering an educational opportunity for those learning from the shared strategies. As AHEAD already conducts regular meetings across various professional levels and locations, and since face-to-face communication is already a key component, the implementation cost of this recommendation would be minimal, making it a feasible solution.

As a result of a series of observations and information-gathering activities, it became clear that the invitation activities of VHVs/VHSGs plays a crucial role. It requires significant effort to collect the participants for the session such as visiting households directly to explain about the sessions and adjusting visiting time to match the household's availability. However, even with their intensive effort, there is no guarantee that the necessary number of participants will be collected. Additionally, there is a rule that if the required number of participants is not reached, the session itself will be canceled. Therefore, it is understandable that VHVs/VHSGs prioritize gathering enough participants by inviting the "convenient people".

However, in exchange for inviting people who are easier to invite, negative phenomena were observed such as a higher proportion of the participants who have already attended multiple times or participants who currently using modern contraceptive methods. In other words, a trade-off exists between "gathering enough participants not to cancel the AHEAD's session" and "maximizing the number of appropriate participants." Given this situation, we further reviewed the academic papers and reports from NGOs. Based on them and considering the role and position of VHVs/VHSGs in AHEAD's session design as well as AHEAD's current policies and operational status, the above recommendation has been made.

7. LIMITATIONS

This consultation work, conducted in collaboration with the local organization AHEAD to tackle low male participation in health education programs, may have several limitations:

One significant issue was the potential impact of our presence as outside observers on the behavior of participants. This may have resulted in responses that didn't accurately represent their real attitudes or typical involvement in the sessions. Such an observer effect could have compromised the validity of our findings.

Secondly, our heavy dependence on verbal communication may have constrained our capacity to thoroughly investigate the deeper emotional or cultural factors influencing male participation. Verbal responses alone may not have adequately captured the participants' more profound thoughts or personal motivations.

Thirdly, our understanding of the broader context was impeded by restricted access to the project's data, including participant enrollment and attendance records. This lack of data made it challenging to thoroughly evaluate historical engagement patterns or obstacles encountered by the program.

Lastly, despite the assistance of interpreters, language and cultural differences may have resulted in misinterpretations or subtle meaning loss. The brief three-week fieldwork duration also constrained our capacity to establish stronger connections with the community or observe long-term participation trends.

While the practicum provided valuable insights, it's important to consider these limitations when interpreting the findings and proposing solutions to increase male participation in AHEAD’s health programs.

8. CONCLUSION

During the six-month consultation work with AHEAD, the NU DrPH team uncovered primary factors leading to minimal male participation in the organization's health promotion initiatives. These factors encompassed project design, a less organized invitation process, and community engagement. The fieldwork indicated that the problem extended beyond low attendance, highlighting an inconsistent and often ineffective process of inviting appropriate participants. Additionally, the presence of seasonal and migrant workers posed unique challenges that required specialized approaches. Despite these issues, AHEAD exhibited strong communication, flexibility, and coordination in implementing its interventions. To strengthen the program's effectiveness, the team suggested improving the visualization of target areas and enhancing volunteer motivation, which are practical recommendations that can be readily incorporated into AHEAD's current operations. These proposed changes are anticipated to bolster AHEAD's efforts and lead to more successful health promotion outcomes in the future.

9. APPENDIX

Appendix 1: The characteristics of villages selected

No	Community name	Health center	Operational District	Distance from health center	Session	Number of sessions	Number of male attendees	Number of female attendees	Proportion of male participation	Community Leader's gender	Poverty rate or economic indicators	Literacy rate
1	Kor Koh	Or Taki	Thmor Kold	15 km	FP Couple							
2	Ou Thmey	Pich Chenda	Sampov Loun	4Km	FP Couple	1	2	5	29%	Male	Farmer, Constructor	Medium
3	Tropang Prolett	Serey Meanchey	Sampov Loun	7 Km	FP Men	1	11	NA	99%	Male	Seller in Market	Medium
4	Suo Sdey	Kro Chab	Pailin	11Km	FP Couple	3	19	24	44%	Female	Farmer, Constructor	Low
5	Ou Tavao	Kro Chab	Pailin	21 km	FP Couple	1	2	15	12%	Male	Seller in Market	Low
6	Kdol leu	Kdol Tahen	Thmor Kol	4Km	FP Couple	1	2	9	18%	Male	Farmer, Migrants labor	Low
7	Doung	Ampelpram Deum	Thmor Kol	1Km	FP Men	1	10	NA	83%	Male	Farmer, Migrants labor	Low
8	Phnom Rey	Tasanh	Battambang	110 km	Malaria	6	132	74	56%	Male	Farmer, Forest goer	Low

Appendix 2: The characteristics and participation rate of the observed sessions

No	Village	Session	Invitation made by	Target	Couple	Female	Male	Not eligible	% of target Female	% of target Male
1	Kor Koh	Couple FP	DVC (M) (VHSG)	5 couples	4	5	3	4	100%	60%
2	Ou Thmey	Couple FP	VHSG (F)	5 couples	2	6	3	0	120%	60%
3	Santepeap	Male FP	DVC (M)	12 men			10	1		100%
4	Ou Tavao	Couple FP	VC (F) (VHSG)	5 couples	6	6	6	0	120%	120%
5	Suo Sedy	Couple FP	VHV (F)	5 couples	4	4	4	0	80%	80%
6	Kdol Leu	Couple FP	DVC (M) (VHSG)	5 couples	5	7	5	0	140%	100%
7	Doung	Male FP	VHSG (F)	12 men			12	0		120%
Total					21	28	43	5		

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