ReBUILD Consortium

Research for stronger health systems post conflict

Learning from the experiences of health workers in conflict-affected Cambodia to improve motivation and retention: analysis of life histories

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The ReBUILD Research Programme Consortium is an international research partnership funded by the UK Department for International Development.

ReBUILD is working for improved access to effective health care for the poor and for reduced health costs burdens in post-conflict and post-crisis countries. We are doing this through the production of high quality, policy-relevant research evidence on health systems financing and human resources for health, and working to promote use of this evidence in policy and practice.

ReBUILD is implemented by a partnership of research organisations from the UK, Cambodia, Uganda, Sierra Leone and Zimbabwe.

- Liverpool School of Tropical Medicine, UK
- Institute for Global Health & Development, Queen Margaret University, Edinburgh, UK
- Cambodia Development Resource Institute, Cambodia
- College of Medicine and Allied Health Sciences, Sierra Leone
- Makerere University School of Public Health, Uganda
- Biomedical Research and Training Institute, Zimbabwe

Cover photo credit: Medical staff and patient at 16 Makara hospital, Preah Vihear province, Cambodia. Photo courtesy of Chhor Sokunthea / World Bank

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Acronyms

ANC – Antenatal care

CBHI – Community-based health insurance

DFID – Department for International Development (UK Aid)

GMIS - Government Midwifery Incentive Scheme

HC – Health centre

HEF – Health equity fund

HRH – Human Resources for health

HW – Health worker

IDI - In-depth interviews

IST – In-service training

NGO –Non-governmental Organisation

OD- Operational District

OS – Medical assistant

PHD – Provincial Health Department

PMTCT – Prevention of mother-to-child transmission (of HIV/AIDS)

ReBUILD - **Re**search for **BUILD**ing Pro-poor Health systems during recovery from political and social conflict

SOA – Special Operating Agency

UNTAC – United Nations Transitional Authority in Cambodia

WHO – World Health Organisation

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Executive summary

Background

Cambodia endured more than three decades of civil war and armed conflict, which finally ended in 1999, leaving a devastated health system and society. Coherent human resource for health (HRH) policies are needed to address the challenges faced in recruitment and retention of health workers, particularly in post-conflict countries. In Cambodia, there are remaining challenges in providing equitable healthcare for all due in part to the current HRH incentives, which drive an unequal distribution of the health workforce between urban and rural areas. There is therefore an urgent need for evidence based research that is policy driven and relevant to guide the Ministry of Health to effectively plan, manage and utilise its valuable human resources.

Methods

To document the evolution of incentives for health workers post-conflict and their effects on HRH and the health sector and to derive a recommendation package for retention of rural health workers from a health worker's perception, a qualitative study involving in-depth interviews with health workers was conducted by ReBUILD in 2014. 23 public sector health workers of different cadres, working in four regions, were interviewed. The study used a life history approach to explore health workers' experiences over time, including their decision to join the health professional workforce, the choices they made in taking jobs, their satisfiers/dissatisfiers, their experience of conflict, and their perceptions of the effectiveness of different policy measures in the post-conflict period. These themes were analysed taking gender, urban/rural and cadre of health professional differences into account.

Findings

The reported reasons for having joined the health professions show a similar profile to other areas where this research was carried out (Sierra Leone, Zimbabwe, northern Uganda). They included a sense of personal calling and the desire for social respect, the influence of other people, economic factors, gender roles, gaining work experience or entering as a volunteer, and as a response to demand in the market. Avoiding conscription was however unique to Cambodia – perhaps a reflection of the distance from the conflict and its duration in parts of the country. The role of gender expectations was also more clearly articulated in this (largely female) group than in other ReBUILD countries.

Training experiences reflect the conflict-affected environment, with some experiencing short initial training because of the urgency of re-establishing the health workforce, and others interruptions in training. Access to in-service training now appears to be reasonably equitable across the genders and also giving some priority (at least for short courses) to staff in rural areas.

In terms of career trajectory, the lure of their home area is strong for many participants, perhaps especially for women, and there was a sense of seeking stability after turbulent times. While salaries are low, they can enable access to other benefits, including private practice, training and social recognition. Avoidance of politics and additional duties is a factor influencing career choices for some (more explicitly in our Cambodian health staff than for the three other countries).

In relation to motivation, personal development plays an important role, as for other countries, alongside a pride in serving your community and country. Community links are important not just for personal satisfaction but also security, during difficult times. As with the other ReBUILD countries, the need to take on additional tasks in difficult circumstances can also be motivating and a source of professional pride.

Salary levels are generally not satisfactory, and do not cover basic living costs, especially those of children's education (and particularly for those in rural areas which lack good schools). Delays in getting on payroll, the absence of pay during probation periods and poor career progression opportunities and systems are also demotivating factors. Participants talk openly about corruption in relation to promotion opportunities. Working conditions and basics such as transport remain problematic for some, despite improvements in recent years. Workloads have reportedly increased, though some improvements in how that workload is managed are also reported.

The fear of being sued is a problematic aspect which has not arisen in the other ReBUILD countries – it presumably reflects the more developed health care market in Cambodia, and the more widespread private practice.

The conflict-affected context was mainly problematic but did throw up some opportunities, such as rapid learning of skills in surgery. As with other countries, harrowing tales of personal and family suffering were shared, and resilience demonstrated in coping and surviving. In the post-conflict period, participants identify gains for the health system and recall a sense of purpose in rebuilding, but also challenges such as rising prices and, for some of the cohorts (older staff who had worked for a long time but whose initial training was shorter and therefore less respected later on),, being overtaken by newly trained staff

As in many low income and fragile contexts, health worker remuneration is a very complex mosaic of salaries, allowances, top-ups, fee sharing, and private practice and informal sources. Managers in Cambodia seem to be relatively tolerant of dual practice in order to retain staff. Many recent policies aim to provide top-up payments to health staff and there is some evidence that overall this has improved the efficiency of the health districts but discussions are underway about reducing the fragmentation of pay and incentives as part of strengthening government leadership and accountability.

Incentives to work in rural areas are not substantial – some reported that training opportunities are prioritised for those working in rural areas and accommodation is sometimes provided, but in other ways terms and conditions are similar, and rural areas face the disadvantages recorded in many studies – higher costs of living, lack of opportunities for private practice, and worse conditions for families, amongst others. Staff suggest rural allowances, preferential access to training, provision of accommodation, clinical mentoring, and improved transport and working conditions as amongst the priority areas for attracting and retaining staff in rural areas, alongside local recruitment.

Conclusion

This study adds to our understanding of health workers' experiences of conflict and post-conflict periods and what can motivate them to stay in service during these challenging times. Developing a sense of mission and service can be particularly powerful during times of stress – staff can cope with difficult working conditions if they are supported by teams, families and communities. In the longer term, as the sector recovers, basic needs become more important and if the public sector is unable or unwilling to pay enough for health workers to provide for their families, then more flexible arrangements are needed, as illustrated by this case study. There also need to be more specific, funded and consistently implemented policies to retain staff in rural areas, such as allowances to reflect higher living costs for some items and reduced income generating opportunities.

Introduction

ReBUILD is a six year research project funded by the UK Department for International Development (DFID). The ReBUILD research programme focuses on health system development in post-conflict countries, to help governments understand how to make or recreate and sustain fair health systems. Countries included in the study are Sierra Leone, Uganda, Cambodia and Zimbabwe. It aims to understand how to strengthen policy and practice related to health financing and how different health financing strategies affect the poorest households. It also seeks to understand how different innovations in human resource management and opportunities for reallocating roles among health professionals can lead to improved access to health care.

A situational analysis conducted in 2011 in Cambodia led to proposals for research being developed in three main areas:

1. Health financing, with a focus on access and payments by poorer households
2. Health workers incentives and
3. Decentralization and contracting

These studies were conducted by the ReBUILD Team based at CDRI (the Cambodian Development Research Institute), with support from Queen Margaret University in Edinburgh and the Liverpool School of Tropical Medicine. The main goal of the health workers' incentive project is to understand the post-conflict dynamics for health workers and ultimately, how to achieve and maintain incentive environments for them to support access to affordable, appropriate and equitable health services. Researchers conducted in depth interviews with health workers to explore their perceptions on this subject, the findings of which are the focus of this report.

Rationale

Health worker attraction, retention, distribution and performance are pivotal factors in ensuring that health systems are efficient in providing accessible health service and effective coverage for all. In both developing and developed countries, failure to attract and retain health workers in remote, rural areas has created a geographic imbalance in the health workforce and challenges the aspirations of achieving equal access to health for all. This is an even greater challenge in post-conflict countries, where the health systems and the livelihoods of health workers have been severely disrupted. In addition, the World Health Organisation's (WHO) 'Increasing Access to Health Workers in Remote and Rural Areas, Through Improved Retention' report (WHO, 2010) identified research gaps and highlighted the need for evidence based research to be carried out in low-income countries. Research is needed to fill the dearth of compelling evidence on issues surrounding the maldistribution of the health workforce in rural versus urban areas in the developing world.

Global policy recommendations have been developed by WHO to assist decision-makers seeking to address rural attraction and retention issues. The recommendations cover the four main categories of education, regulation, financial incentives, and personal and professional support (WHO 2010). Improving the attraction and retention of skilled health workers in remote parts of Cambodia is essential to ensure the gains made in health outcomes in recent decades are maintained (So & Witter, 2016).

The research programme developed a conceptual framework (Witter et al. 2012), which aims to investigate the linkages between contextual factors, personal attributes and policies, and to understand how these have influenced HRH outcomes in the post-conflict period. The life history/in depth interview method was chosen as one component because it allows for an exploration of the

personal perspective of the health workers. If successful, it can illuminate how personal factors interlink with a changing context and a dynamic policy environment, how these are perceived at the service delivery level, and how they change over time.

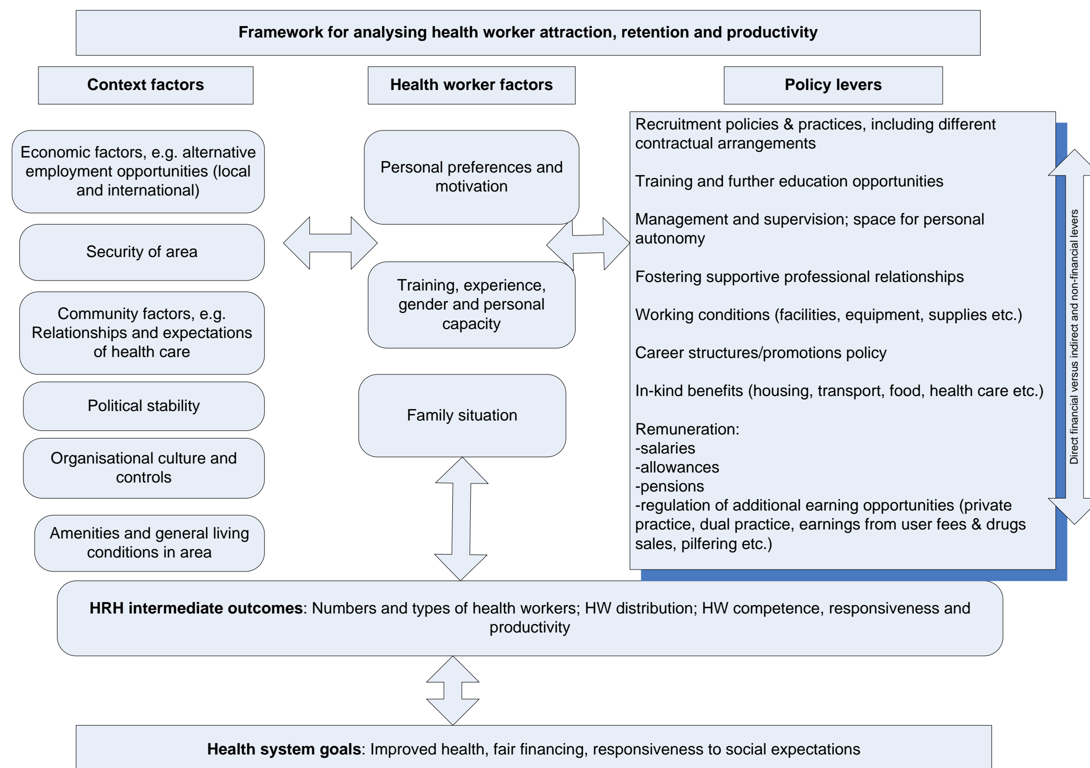

Figure 1 Conceptual framework, HW incentive research

Objectives of the sub-study

The objectives of this sub-study were:

1. To explore the overall perceptions and experiences of health workers before, during and after conflict
2. To identify health workers' motivating and demotivating factors and coping mechanisms
3. To understand health workers' views on the post-conflict evolution of incentives for health workers and factors which would encourage or discourage them from staying in post and being productive in remote areas
4. To deduce recommendations for effective approaches to retain health workers in hard-to-reach areas to support access to rational and equitable health services

This sub-study was conducted in four countries (Cambodia, Sierra Leone, Uganda and Zimbabwe) and was complemented by other research tools, including a health worker survey, routine HR data analysis, stakeholder mapping, document review and key informant interviews. Two earlier reports were published which analysed documents and key informant interviews for this project in Cambodia (So and Witter, 2016) and analysed HRH and other data to understand the impact of policies on district efficiency in Cambodia (Ensor et al. 2016). Please see these and the ReBUILD webpages (www.rebuildconsortium.com) for further background on the project and programme. As well as

providing the basis for recommendations for Cambodia, the findings will also feed into comparative cross-country analysis.

Research methods

Study design

This was a qualitative study involving in-depth interviews with public health workers, reflecting on their careers.

Study sites

This study was conducted in six provinces across four regions. Provinces were selected purposively to obtain a range of conditions – some were urban, while most were rural; they included provinces with high external investment and low; and representing the different ecological regions of the country (Table 1). The research team used the updated administrative records from the MoH to assess the characteristics of selected provinces, Operational Districts (ODs) and Referral Hospital (RHs). Rural and remoteness of the studied sites was indicated by the distance to the province, condition of road access and development potential through consultation with the commune database of 2012 which the team received from Ministry of Planning. The team selected one or two health centres (HC) from each OD by consultation with the Director of Provincial Health Department during the preliminary visit in mid-2013. In addition for selecting OD, RH and HC, the team consulted the updated database of health incentive schemes such as health equity fund (HEF), vouchers, community based health insurance (CBHI), and Special Operating Agencies (SOA) to get insight into the effects of those incentive schemes on the retention of health workers in rural and remote areas (Table 1).

Table 1: Characteristics of selected areas

Region	Province	Total ODs	Total RHs	Total HCs	Total population*	Characteristics***	Sample Site		
							OD	RH	HC
Plain	Phnom Penh	4	5	17	1,327,615	Urban; external support and fast growing area	1		
Plain	Kandal	8	6	94	1,265,280	Rural with long period of security; supported with health equity fund (HEF) in 2 ODs; user Fees & Government Midwifery Incentive Scheme (GMIS) for all ODs	2	2	
Plain	Kompong Cham	10	11	136	1,679, 992	Rural; supported with vouchers in 9 ODs; user Fees & HEF and GMIS for all ODs;	1	2	1

						contracting-in and-out in 2 ODs, Special Operation Agency (SOA) in 5 ODs			
Tonle Sap	Battambang	5	4	76	1,025,174	Rural; supported with vouchers in 3 ODs and User Fees & HEF for all ODs	2	2	1
Coastal	Kampot	4	4	50	585,850	Rural; supported with vouchers and HEF/Community based health insurance (CBHI) for 3 ODs, User Fees & HEF for all ODs	2	2	1
Plateau and Mountainous	Stung Treng	1	1	11	111,671	Rural; supported with user Fees and HEF	1	1	2
Total of the six provinces		32	31	384	4,315,590		9	9	5
Total for the Country**		77	90	1,004	13,395,682				

Source:

* National Institute for Statistics, 2009:p165, General Population Census of Cambodia 2008

** WHO (2012:p4), Health Service Delivery Profile Cambodia

***MoH Updated Administrative Records

Tool development

Tools were developed using a participatory approach between ReBUILD team members from the UK and Cambodia. A generic topic guide was produced by the UK Lead Researcher and was then adapted by the local team during a pilot and training exercise. It adopted a mainly chronological order for the sequencing of the questions. It looked first at the background of the health worker in terms of education and explored further the factors that influenced their career choices

The topic guide (see Annex 1 for tool) was designed to explore the following subjects:

- How and why they became health workers
- Their career path since they became health workers, and what influenced it during and after the conflict
- Their overall perception of their career in terms of motivating and demotivating factors before, during and after the conflict
- Challenges they face in their job and how they cope with them before, during and after the conflict
- Their career aspirations
- Their knowledge and perceptions of incentive policies during and after the conflict

- Recommendation for an effective retaining package for health workers in rural areas

Participants were requested to draw their career life lines while the interviewer simultaneously probed for more understanding and information at given points/events along the participant's career life-line.

Study setting and population

19 life histories/in-depth interviews were conducted with health workers in health care facilities. The majority were female (14; 5 male). 5 were based in Battambang; 6 in Kandal; 4 in Kompot and 4 in Strung Treng. The composition by cadre was: 4 doctors and one medical assistant; 8 midwives; and 6 nurses. Their age range was 24-53 (Table 2).

The original intention was to have 36 in-depth interviews (IDIs) with health workers in each of 6 ODs: 6 interviews per province (one nurse, one doctor and one midwife at the referral hospital and the same for one health centre per province). A long standing in the health services or a minimum age of 30-55 years was set for selecting the health workers from the staff list of RH and HCs in order to understand changes over time. However, because of labour unrest after the national election in July 2013, staff in Phnom Penh were unwilling to be interviewed. Health managers were also reluctant to share staff lists with the research team. The health manager therefore appointed the workers who were present at the workplace at the time of interviews to meet the research team. The interviews with those heath workers were conducted between August and December 2013.

Table 2 Breakdown of staff interviewed

#	CODE	PROVINCE	AGE	EDUCATION	GENDER
1	BB_IDI.1	Battambang	45	Doctor	Female
2	BB_IDI.2	Battambang	40	Doctor	Male
3	BB_IDI.3	Battambang	48	Med Asst.(OS)	Male
4	BB_IDI.4	Battambang	39	OS and nurse	Female
5	BB_IDI.5	Battambang	26	Primary nurse	Female
6	KC_IDI.6	Kandal	52	Prim midwife	Female
7	KC_IDI.7	Kandal	43	Secondary midwife	Female
8	KC_IDI.8	Kandal	50	Secondary midwife	Female
9	KC_IDI.9	Kandal	24	Secondary midwife	Female
10	KC_IDI.10	Kandal	47	Secondary nurse	Male
11	KC_IDI.11	Kandal	29	Primary Midwife	Female
12	KP_IDI.12	Kompot	42	Doctor	Male
13	KP_IDI.13	Kompot	38	Secondary nurse	Female
14	KP_IDI.14	Kompot	40	Sec nurse	Female
15	KP_IDI.15	Kompot	31	Primary midwife	Female
16	ST_IDI.16	SteungTren	29	Secondary Midwife	Female

17	ST_IDI.17	SteungTren	29	Primary nurse	Female
18	ST_IDI.18	SteungTren	53	Primary Midwife	Female
19	ST_IDI.19	SteungTren	38	Doctor	Male

Data collection

Data was collected using an open topic guide (see annexes). The interviews were recorded, after gaining informed consent from the participants, and were conducted in a location selected by the respondent that they deemed as private and comfortable. Interviews took 1-2 hours.

Analysis of transcripts

The data was analysed using the thematic framework approach. Interviews were transcribed verbatim for thematic analysis, which was carried out by one of the researchers. Transcripts were read several times to get an overall picture and then recurring themes were identified. A coding framework was generated and agreed upon between team members. The codes were refined through the use of constant comparison within and between codes to ensure that they accurately reflected the material. Correlations were then identified between the different themes and attributes of each participant (e.g. gender or cadre) before being grouped into the broader overall themes. The coding framework went through a number of draft phases as emerging themes that epitomised the central themes were identified and incorporated into the original framework to develop a final coding framework. Individual transcripts were then coded using NVIVO.

Finally, themes were charted and cross-tabled to help data comparison, highlighting a pattern of relations within the responses to allow interpretation. Each individual theme was then summarised and findings were then synthesised across the main themes, noting patterns and gender differences. The other members of the team provided feedback on the initial results of the analysis and on the draft of the report.

Research ethics

Ethical approval was obtained from National Ethics Committee for Health Research in Cambodia and the Liverpool School of Tropical Medicine prior to the commencement of the study (spring 2012). Informed consent was sought from the participants, assuring of confidentiality and anonymity of the information collected. There are ethical issues with regards reporting on interviews done with specific respondents who can be easily identified. To address this, findings are reported using codes without names or any details that would enable individuals to be easily identified.

Research limitations

As stated above, in some of the study sites, particularly in the provinces, the intended numbers and cadres of health workers were not met by this project, and the sampling was more pragmatic than intended. One major constraint was that high level cadres, especially doctors but also midwives and nurses, are always very busy so finding the opportunity to interview them was difficult. In addition, there were some concerns from managers relating to the elections which meant that researchers could not select from staffing lists but had to work from those present in facilities on their arrival. As no respondents were obtained from Phnom Penh, the perspective is dominated by staff serving in more rural provinces. A final limitation to mention is that the accounts of the participants span both conflict and post-conflict periods, so it is not always possible to separate these out in the themes.

Findings

The findings start with an exploration of health worker experiences during and after the conflict – how it affected them and also their perceptions of systemic effects. We then present their career trajectory – why they joined the sector, their experiences of training, their subsequent job choices and perceptions of their career. Themes related to pay and remuneration are explored, along with their perceptions of incentive policies in the post-conflict period. We conclude with their recommendations for policies to retain and motivate staff, especially in rural areas which are most challenging to staff.

1. Context of conflict

1.1. Situation during the conflict

1.1.1.Effect on Health workers

Several health workers reported security problems as a barrier to attend work particularly during the conflict.

> *"When I first came here, I was assigned to work at maternity unit to assist in delivery, to provide ANC services… etc. You know it was very difficult at that time. It was difficult for me to traveling at night. It was high risk of arresting by Khmer Rouge. We didn't not know who was who all solider. Bad fear really… [ ] … My husband does a business in Battambang province, he wanted me to stay together with family in Battambang because working here is very life threatening during the war time." (BB_IDI1)*

Workers were sometimes threatened by soldiers if they perceived that they had not been attended quickly:

> *"…soldiers coming to hospital for service and when we could not provide them service or medicine as fast as what they wanted, sometime they shot to the air or they threatened us." (KC_IDI 10)*

However, some participants reported that being health staff was protecting them as combatants were respecting them.

> *"…we did not have any fear of Khmer Rouge but gun holders (Vietnamese and, yes, our soldiers) in late 1980s; we didn't know who was who. Gun holders could do almost anything at that time; but they did not harm us when they knew we were health staff. (KD_IDI8)*

Some health workers perceived the conflict as an opportunity to learn new professional skills such as war surgery.

> *"…we were able to have real practice with the patients. We learn theories, and practice. During that time, they taught skills about the war, to help in the war, but now, they focus more on helping ordinary people." (BB_IDI3)*

> *"…at that time I was the only expert. Working at that time, I faced a lots of trauma [traumatology] experience." (KD_IDI10)*

During the crisis workers were sometimes paid in kind such as food or other non-monetary items.

> *"At the beginning it was very hard. I paid in rice, but later they calculated into cash." (KD_IDI6)*

> *"At that time no bonus fee or service fee for that, we were only given a big bunch of Khmer Noodle and "Lort" dessert and shared together. There was nothing during 1980." (KD_IDI7)*

Some participants told stories about families being decimated during the Khmer Rouge regime with members being taken away and disappearing and other dying of diseases.

> *"My family had six members; and after Khmer Rouge, only three member left. My father was taken for education and never returned. My sister and brother died of malaria." (KD_IDI8)*

Low or no salaries at all left some workers needing support which was often provided by their colleagues.

> *"I had a very poor staff; she did not have money to pay for food. I supported her since. We were in very bad condition. We made some money in the hospital to support her and her child."* (KD_IDI6)

1.1.2. Effect on health system

Stories told by participants show the great resilience of these health workers who despite operating in extremely adverse conditions were still attending work.

> *"At that time, there was no new motor car like now; I tried to push motor to Stung Keo. When we arrived, we injected vaccine to people. There was a man run to slash us. We tried to run to escape without wearing shoes… How struggle we were!"* (KP_IDI13)

> *"In one time, there was a person who injured hand with the debris of the bomb, came to knock my door, but I could not dare to open it during the fighting time. After for a while, the fight was calm, I opened the door and I treated his hand injury."* (BB_IDI1)

Working conditions were very difficult: staff shortages causing very high workloads and long working hours.

> *"…at that time I was the only expert. Working at that time, I faced a lots of trauma experience. [] At the time, we had to work 8 hours per day but I work 24 hours sometime. It was very tired. It seemed that was no working hour at that time."* (KC_IDI10)

> *"I was responsible for at least 60 children, especially at night time. There were two halls and I had to run back and forth. There were many sick children here during the UNTAC time. A few NGOs worked here." (BB_IDI2)*

> *"During K5* [bush areas in Thai border cleared and sometimes land mined to facilitate their defence] *era I could not find free time even though it was night. The patients were transferred from the frontlines to district hall and hospital. They needed perfusion and blood test. When it was too busy with K5 patients, I did not care much about my maternal duty. We had to work around the clock. Worse of all, there was shell bombed onto the hospital. It was from the East side of the river. I had to find bunker near to the steps. It was horrible*" (KD_IDI6)

Access to health service during the peak of the conflict was severely reduced, increasing the risk of for instance pregnant women going all through their pregnancies without an antenatal check-up:

> *"Before, some pregnant women don't have her baby check from the very first month till the ninth. They would come only when the baby is about due to, these cases happened a lot in 1979, 81, 82, to 1985."* (KD_IDI7)

Infrastructure was insufficient during the conflict when health care needs were higher.

> *"At the beginning it was terrible. The hospital at PrekPnov had only one or two beds and there*

were a lot of patients who got malaria, diarrhoea, and so on. The road was often very bad. It was not really safe, some of the sounding area, Khmer Rouge pass by very often." (KD_IDI6)

Scarce medical staff available to attend the general population was sometimes further constrained by the needs of these workers in the frontline:

"…there was lack of medical staff, but government required to send medical officers to the frontline." (KD_IDI8)

Doctors were trained through short courses which had serious implications in terms of quality of care:

"…there were a lot of malaria cases, amputation cases etc. So we highly needed medical care professional who was trained from three months and went to work right away." (KC_IDI10)

1.1.3.Coping strategies

Working close to colleagues made them feel more secure as this nurse reported.

"I had a colleague and we worked together through thick and thin. Initially, in 1986 there was a campaign on PEV [vaccination]; we had to take oxcart through the forest. Once when the oxen were shuffling Khmer Rouge guerrillas chased us." (KD_IDI8)

Abscondment was sometimes the only choice when workers were obliged to take up work in dangerous situations.

"I had one friend. She studied with me in 1997. At that time, it was not integrated yet, but they sent her to work in Borvel commune, Battambang. She asked hospital director to stay in hospital, but he didn't allow. Thus, she decided to stop working." (KP_IDI12)

"*In the previous time, there were two or three midwives staff, but they all got experience in Pol Pot regime and they stopped working. They stopped by themselves. There were only three included me."* (ST_IDI18)

Going back to farming or other unskilled work was the preferred option for some of participants.

"…because they wish to move and work on their farm was better then worked for government with very small pay and high risk of Pol Pot's attacks." (ST_IDI18)

Families were reunited when the conflict started to slow down. At that time community networks played an important role in recovering the perception of safety to go to work.

"Three years later, my husband came to live with me in Morng Reuseey. The most important, we needed to have a strong commitment not to change our profession, and our work here becomes easier, we have good neighbours who we can live closely with them, and we don't have much ambitious to change to work in other places." (BB_IDI1)

1.2. Post conflict situation

1.2.1.Health workers

Nationalism and willingness to reconstruct the country was reported to have helped health workers to contribute to rebuild the health system. While participants acknowledge the contribution of NGOs they frequently remark that this happened under the leadership of the government which contradicts some of the literature criticizing poor aid coordination in the early stages of the post conflict:

*"We could get by with that because we loved this country, and the government also tried to help a lot. We had to struggle together to survive, after the war, that's my idea. At that time, we could struggle because first, because of government's help, and second, the NGOs helped us on buildings, all of these building, but it was also under the leadership of the government. And as we know it that the war posed a lot of problems for us, and we had to stand together. "(*BB_IDI3)

People were very aware of the strategy used by Pol Pot to disintegrate Cambodian society and were clear about the need to reconstruct the very fragmented society left by the conflict:

"We can't blame the government, as we could see, we went through wars, and look at other countries about 50 years ago. They faced the same problem. We have to stand together, or else they will take advantage of us. It's not individual problem, it's society's. We could not blame the government as we're developing, and we could not go directly there, or we'll destroy the society like Pol Pot. We have to do it step by step, that's what I think." (BB_IDI3)

1.2.2.Health system

In the immediate post conflict period, resources started to become more available with foreign professionals staffing health services and drugs and equipment becoming more available:

"We were happy with works and foreign doctors were also called to hospital around 1-2 am at night. There were lots of donated medicines and volunteer doctors from France and Belgium came to help us." (BB_IDI2)

However, increased security triggered return of local population to their home areas but also foreign aid workers, which made access to affordable housing more difficult for the local population:

"For the new comers now, they may not be able to rent house in the main road because it is very expensive, and they did not earn income, yet receiving the government salary. Thus, they have to rent the house that is far away from the main road, they can do any private clinic, they may depend on the income from the government salary and user fees, it is not sufficient to cover their living costs. Therefore, the main problem is the accommodation." (BB_IDI1)

In the early post conflict, increased demand due to population returning to their home places, together with a precarious situation in terms of staff availability, made things difficult for health workers as this male doctor reported.

"During UNTAC [United Nations Transitional Authority for Cambodia] time, it was integration phase. There were few of health workers, only one or two physicians at PHD level. Now we have more than 10 doctors. I had heavy work load at that time, I was responsible for at least 60 children, especially at night time. There were two halls and I had to run back and forth. There were a many sick children here during the UNTAC time. A few NGOs worked here. For example, the World Vision often transferred sick children here. We also had to provide service to the resettlement people (immigrant) who were located in both O Taki and O Sanday. There was no HC close to their home at that time. We were full of patients in our provincial hospital. There were many sick children from Ratanak Mondul district at that time." (BB_IDI.2)

Staff who joined the workforce during the conflict were poorly trained, most often through accelerated courses:

"During 1991-1994, there was so much difficulty. It was due to there weren't any skilled of health workers. There were only two skilled health workers per ward. Mostly, the skilled of health workers

were from the primary nurse education. Staffs who worked with me were mostly ordinary staff who got further training for 6 months such as primary nurse training."(KP_IDI14)

Participants reported that after the conflict they started to have colleagues who were previously working for the army joining the workforce and offering health services in local government facilities:

"…commune infirmary was run by a male medic who left military status and served in health sector in their communes." (KD_IDI8)

The situation seems to have improved since 2000 when support for infrastructure rehabilitation allowed for rehabilitating health services in more remote areas:

"…it was much better since 2000. Meanwhile, health centres have been renovated or built. Previously, it was terrible!" (KD_IDI8)

"I am not sure when the building was built. It was made around 2007 or 2010 or 2011. In the previous time, the consultations for pregnant women were in an old wooden building." (ST_IDI18)

Drugs and equipment availability also started to improve as soon as the conflict was over:

"For the equipment, it is better than before; there are a lot of changes. [ ] Now, we have drug called Magnesium which is used for pregnant women who has got convulsion." (ST_IDI18)

Training of staff changed the focus at the end of the conflict moving from conflict related skills to general care:

"During that time, they taught skills about the war, to help in the war, but now, they focus more on helping ordinary people." (BB_IDI3)

Some of the staff joined NGOs after the conflict as salaries and work conditions were comparatively better than in government-run services. However, some NGOs started to face economic problems after the initial emergency phase:

"I've work with NGOs since 1998 because in here, they've supported some equipment… [ ] …But now, the NGO has become financially weak, and they've reduced their support, but the level of financial support received is enough for us to survive." (BB_IDI3)

1.3. Current situation

Participants reported having seen improvements in the availability of drugs and material.

"For the equipment, it is better than before; there are a lot of changes." (ST_IDI.18)

"Now, we have drug called Magnesium which is used for pregnant women who has got convulsion. In previous time we had no Magnesium…" (ST_IDI.18)

It was also suggested that increased availability of staff within some cadres (e.g. midwives) in the last years is having a positive impact on workload as this female primary nurse suggests.

"Nowadays, midwives are not as busy as before because there are many midwives now. Before, we were alone, so it was difficult. Sometimes, I rode back home, but because there was an urgent meeting, I had to return to the health centre; it was difficult." (BB_IDI.5)

This is being reflected in shorter shifts as this 53-year old midwife reported.

"Nowadays, we start at 8h00 AM but when we are in SOA I think that it was not 8h00 it was 7h00" (ST_IDI.18)

However, participants reported about the poor skills of workers that were trained during the conflict as this female secondary nurse suggested.

"During 1991-1994, there was so much difficulty. It was due to there weren't any skilled of health workers. There were only two skilled health workers per ward. Mostly, the skilled of health workers were from the primary nurse education. Staffs who worked with me were mostly ordinary staff who got further training for 6 months such as primary nurse training." (KP_IDI.14)

People living in rural areas started to move to either more urbanised settings or abroad which is having an impact on the overall economy as this older female doctor reported.

"…in the last two years, more and more people migrate to work in Thailand, especially young people. As people in this district survive by growing rice, but in the last few years, the products of rice were not productive, people have to migrate to work in Thailand, and this leads this district become quiet. People here survive by growing rice; we don't have any factory or industry yet." (BB_IDI.1)

After the conflict workers were integrated in the civil service and were supposed to adopt a more structured service organization. However, the account of some participants suggest great flexibility from the management as reported by this male medical assistant.

"After we were accepted in the civil servant framework, we changed to a week per turn. And there are on duty, 24h. The truth is that's out of the law, illegal. We have to work 8 hours a day, but that's we have to do to be able to run this hospital." (BB_IDI.3)

2. Decision to join the medical profession

Reported reasons for having joined the health professions included intrinsic motivation and the desire for social respect, the influence of other people, economic factors, gender roles, avoiding conscription (during the conflict period), gaining work experience or entering as a volunteer, as a response to demand in the market and to avoid having to study in a foreign language (as was needed at some periods for other subjects).

1.1 Intrinsic motivation and desire for social recognition

Many participants reported that they always wanted to become a health professional

"It is my conscience since I was a child I wished to be a doctor, [when I was a child] *I was playing as* [if] *I* [was] *a doctor. I like this profession~~al~~ very much." (BB_IDI.1)*

"I chose this career because I like it since I was young." (KC_IDI.9)

Humanitarian principles were among the most frequent motivators reported by participants, particularly referred as "helping the community" or "helping others", even sometimes beyond other common motives such as the economic. While participants didn't refer to religious motives, compassion is among the basic principles of the most prevalent religion in Cambodia (Theravada Buddhism) which could also explain this.

"For me, medical profession is not main source of income; I do it because I want to help people with what I know because these days, I don't rely on the salary for the living." (BB_IDI.3)

"I have to help the poor people that use the public hospital service. If it is just because of such a salary, I won't work!" (KP_IDI.12)

"I learnt that doctor had good income and respect from people in the community. I can also help people." (BB_IDI.1)

"I like medical field myself, and most important is that I want to help people." (BB_IDI.2)

"Reason for choosing this career because I love it and can help people in my community" (KD_IDI.7)

Social recognition and respect was mentioned as a motive to join the medical profession. Some viewed that recognition was earned through their support to vulnerable groups in their communities:

"In this district there are minority groups. They respect medical staff and they need respect from us too." (ST_IDI.19)

1.2 Influenced by other people

Families played an important role in decisions to join – both directly by suggesting the profession, or indirectly, through family illness or family circumstances which made the health profession an attractive one. Friends were less frequently reported as influencers.

1.2.1 Family

From the accounts of several participants, the decision about joining health sector professions is not necessarily an individual choice but one that is made by the family as a whole. Some referred to the father as the main contributor, but others referred to brothers and sisters who, working in the health sector themselves, pushed their siblings to start working as volunteers which is reported as the entry point to the health workforce for many of the interviewees.

"I didn't like this subject but my father likes it. I started to like it since I studied about it and working on it." (KD_IDI.11)

"…my mother was always encouraging me to study hard; that's why I can succeed." (KC_IDI.9)

"Actually, I didn't want to study this skill. According to my family, as I am a woman, they didn't want me to go faraway from home. So, they suggested to me for applying an exam in order to become a teacher or a midwife. I passed both exams. However, we thought that the salary for teachers is too little. On the other hand, midwife can be better, so I decided to become a midwife." (KP_IDI.15)

"At that time, my older sister worked with Mr.xxxxxx, the chief. She brought me to work at xxxxxxx Hospital… [ ] …I was a volunteer because I was not qualified."(KD_IDI.6)

Having close relatives with health problems was reported to have motivated the decisions to apply for health studies either to provide them care directly or to avoid having to pay for it:

"The reasons that I decide to apply this job because I like it. None of my family members is doctor or nurse; but because of my father has high blood pressure, I can measure the blood pressure, inject, and treat him at home. All in all, I love this job." (BB_IDI.5)

"Actually I am interested in this field because when I was a student, my brother was often sick. We spent a lot of money to take care of him. My relatives mostly are teacher and soldier. Thus, I thought that no one could help us besides ourselves." (KP_IDI.12)

Staying close to the family was important, particularly for female participants who sometimes even chose their profession to ensure they were close to their relatives. In this specific conflict this may have acquired even more importance as during the Khmer Rouge government people were often taken away from their home environments and sometimes families were separated as a strategy to disintegrate social networks. As a reaction, being near their home place probably represented an even stronger desire.

"According to my family, as I am a woman, they didn't want me to go far ways from home. So, they suggested to me for applying an exam in order to become a teacher and a midwife." (KP_IDI.15)

1.2.2 Friends

Some male participants mentioned having discussed their choice with friends

"I consulted with my friend for choosing the subject of study and we decided to choose medical study..." (BB_IDI.2)

1.3 Economic

Decisions are also based on economic perspectives. The prospect of earning a good salary was an incentive for many to join a health profession:

"I learnt that doctor had good income…" (BB_IDI.1)

"…good income from being a nurse." (BB_IDI.4)

Sometimes, families advise their children to choose a health profession as these are better paid than others:

"…they suggested to me for applying an exam in order to become a teacher and a midwife. I passed both exams. However, we thought that the salary for teachers is too little. On the other hand, midwife can be better than. So, I decided to become a midwife." (KP_IDI.15)

Some participants, particularly these with more economic problems and hence in urgent need to earn a salary, reported having selected their health profession according to the time required to complete the studies as this secondary midwife reported:

"Actually, I wished to become a Medical Assistant, but it took longer time for study [than midwifery]*; and my family was very poor (laugh)… [ ] …I spent shorter time* [than medical assistant] *for completing my study and then go back to work and take care of my family." (KD_IDI.8)*

1.4 Gender role

Gender roles influenced the decision to join a health profession of several female participants particularly as it is seen as a suitable area for women.

"Working in this kind of profession is suitable for me as a woman" (KD-IDI.7)

One participant who is a female medical doctor reported that her husband, following traditional Cambodian gender roles assigned to women, pushed her to stop working as a doctor and go back home to take care of the family while he would, assuming also traditional Cambodian roles for men, be the breadwinner for the family. However, she refused.

> *"I come to work here alone, my husband does a business in Battambang province. I worked here alone, he insisted me to stop working and come back, and he would work to support the family. I replied that I am not stop working, even though he would request me to separate, I don't stop working, because I have studied since I was young until I completed my medical doctor degree…" (BB_IDI.1)*

However, in this regard, women who refuse to assume exclusively their traditional roles cannot reject them altogether. They have to fulfil them on top of their professional roles as this midwife reported.

> *"I got married in 2008. My husband occupation is fishery. Now, I have a son. With a couple of lives* [under my responsibility]*, I have many tasks that I must do every day. However, there is no matter* [choice] *for me, I do my housework after I finish my official job. Whenever we get free time we must do housework. Furthermore, I had my mother-in-law who helped me but now, she can't help me at all since she became ill." (KP_IDI 15)*

Families sometimes advise children, particularly daughters, to take health studies based on the availability of education facilities close to their place of residence, to avoid them having to move away from the home place.

> *"Actually, I didn't want to study this skill. According to my family as I am a woman, they didn't want me to go far (a)ways from home. So, they suggested to me for applying an exam in order to become a teacher and (or) a midwife." (KP_IDI.15)*

Normally women were not sent to dangerous areas during the conflict, although sometimes administrative mistakes lead to female professionals being sent to the front line, as this nurse commented:

> "At that time, by accident, my name was typed very straight forwards by missing the word "Ms." at the begging of my name. As a result, I was assigned to work here, in xxxxxxx, where the civil war was still going on with Khmer rouge." (BB_IDI.1)

1.5 Avoiding conscription

Another reason to choose a health discipline among men was to avoid being recruited by the army which was a particularly attractive choice before the end of the conflict

> *"The reason why I chose the medical area because in the past, there was war, and we were better off to be doctor than to be soldiers going out to war." (BB_IDI.3)*

> *"I chose the job which allowed me to get away from entering into military service..." (KC_IDI.10)*

1.6 Work experience (e.g. networking, volunteering, etc.)

Medical staff often start their health work experience as volunteers before they complete their pre-service training

> *"At xxxxx Hospital, I was a volunteer because I was no qualified." (KD_IDI.6)*

But even for volunteering sometimes they need to pull strings to be hired.

> *"When the hospital was established, it was announced for volunteer medical staff. Because I knew the 18 village chief well, my father asked for my name as volunteer." (KC_IDI.10)*

Some started their careers working for NGOs (e.g. Red Cross). NGOs offered good support to health workers with accommodation, financial support for utility bills etc, which given the relatively precarious economic situation of young professionals, represented an important incentive:

> *"At the first time in 2004, I was a contracting staff [temporary contract]. I was supported by Cambodia Red Cross at beginning. They rented a house and other stuff for me. They helped me pay for electricity and water utility… [] That is the reason why I could work in health centre. Otherwise, I could not continue working here." (KP_IDI.15)*

1.7 Identifying need and/or gap

Others decided based on their perceived labour market demand for specific disciplines and specialities:

> *"I studied general medical doctor* [lung diseases] *because* [there are] *only a few of doctors in this field." (BB_IDI.2)*

1.8 Language

One participant mentioned that some of the available choices to study were provided only in foreign languages (e.g. Russian or Vietnamese) which influenced his decision to choose Medicine:

> *"I decided to register to take exam medical course and engineering. At that time, I loved those two majors! I took medical course exam first. Moreover, at that time, engineering University was controlled by Soviet and Vietnam which I am required to learn these two language which I think it should be very difficult for me. Then I decided not to take engineering exam. The medical exam result was released and I passed it." (KP_IDI.12)*

3. Training

In the life histories, after probing reasons for joining the profession, the discussion moved to experiences of training.

3.1. Initial training

During the immediate post-conflict and due to an increasing demand for health services there was urgent need for health workers. Students coming out of high school were trained for three months as basic health attendants and recruited to work in the newly established health facilities:

> *"…because there was no proper government system yet, new staff had to be recruited to work at the new established hospital to rescue* [treat] *patients. There were a lot of malaria cases, amputation cases, etc. So we highly needed medical care professionals who were trained from three months and went to work right away. During the time, I studied for three months and then I got the job." (KC_IDI10)*

3.1.1. Source of funding

Some of the participants reported having been funded by government scholarships.

"…for government framework, I received it since I joined in 1996. It was government funded." (BB_IDI.3) male

"I had to try to study because it is scholarship…" (KP_IDI.12) male

Other participants reported having funded their tuition with loans and others reported having had to work to fund their studies. From their accounts, it seems that students need to pay a fee to sit exams which is the cause for some of them having to secure funding.

"…some loan from xxxx microfinance Co.Ltd. to support our studies, especially during my exam." (KC_IDI.9) female

"I serve the treatment service and sell some stuff. I didn't get certificate yet at that time, but I started to run that clinic because I didn't have money to have exam." (BB_IDI.4) female

One female participant reported not having been able to obtain a scholarship. There is some evidence from the interviews that women found it harder to access funding for training.

"I never got "bourse" [scholarship]…." (KP_IDI.13) female

Some participants reported having to work while studying part-time to top up their earnings with other jobs and be able to cover their needs.

"After I got married with my wife, I didn't study in fulltime. I can come back home and earn some money." (BB_IDI.2)

3.1.2.Experience of training

Some participants reported having got their training disrupted by forced movements imposed by the Pol Pot's regime[1], some of them having to re-train after that.

"I have received training but it was just short time before we were forced to the city at the beginning of Khmer Rouge era. So, I had to train again for fulfil the requirement." (KD_IDI.6)

It was reported by some of the participants that they were already working in technical (health professional) positions before they got into formal training.

"Well, I used volunteer term of job because I was not properly trained as a midwife or nurse yet at that time. I was then told by the chief of district hospital that there was recruitment of student for Russia Hospital." (KD_IDI.8)

3.1.3.Source of funding for in-service training

Many participants referred having got trained in different areas related to their professional roles.

"I frequently travel to attend short training courses, particularly on surgery subject." (KC_IDI.10)

Participants referred to either NGOs or multilaterals as the source of funding for continued training.

"Marie Stopes teaches us in Khmer." (KD_IDI.7)

[1]http://www.psc.isr.umich.edu/pubs/pdf/rr05-582.pdf

"…Global Fund round 8-9 trainings…" (KD_IDI.8)

"Ministry of health requested us to attend those training course but our NGO partners sponsored on that." (ST_IDI.16)

3.1.4.Experience of in-service training

The three cadres included in this study reported having had access to continued training. There are no substantial differences in access to continuous training between male and female participants (e.g. both genders reported having attended continuous training).

During the immediate post-conflict some health workers were trained on-the-job by Vietnamese tutors but often they did not get any accreditation.

"…I had another responsibility as an anaesthetist. We learnt this skill from the Vietnamese expert. This course was not organized by Ministry of Health so I did not have the certificate. I only got the knowledge on anaesthesia but I had a secondary nurse degree." (KC_IDI10)

Some participants reported that staff working in rural areas get more opportunities to access short course in-service training.

"Government staff in rural areas get more chance to attend training course than government staff in urban areas." (ST_IDI.16)

The three cadres included in this study reported having had access to IST although midwives seem to have more opportunities for short trainings than doctors and nurses. Men and women seem to have similar access to IST.

"…in relation to technical training, I got it. There is many such as the training on birth flue, emergency rescue, the equipment and material management and other training on some diseases. It is frequently in relation to material and equipment management, nursing file management etc. Mostly the training is focused on nursing care and the longest time for the training is a week. I just came back from a week training course on the equipment caring at the school of Khmer- Japanese friendship." (KC_IDI.10) male nurse

"There are many different training. There are a lot of trainings conducted for the maternity section." (KD_IDI.6) female midwife

"During I was working here, I received several trainings/refresher trainings since 1999, the OD director assigned me to be a chief of mother and child health program, so I received several trainings/refresher trainings, including training on nutrition, birth spacing, training associated to mother and child health. Then, I transferred my knowledge and skills to the midwives. The longest training that I attended in 2004, was the training on "Emergency Obstetric Care" in Japanese Hospital in Phnom Penh, It lasted for 3 months, I learned to do a surgery in that training as well." (BB_IDI.1) female doctor

Some older participants reported that in the past there was no on-job training available as this 42 years old male doctor referred.

"When I have started my work, there was no on job-training." (KP_IDI.12)

4. Career trajectory

4.1. *Posting*

From the reports from some participants it seems that the system tries to post staff at their place of origin.

> *"I had a contract in which said who come from what province to be back to the province." (ST_IDI.18)*

In fact, some participants signed a training bond agreement when they accepted the scholarship to cover their pre-service education, committing themselves to go back to work in their home area.

> *"After completing high school, I applied for vacancy to study medical assistant at University of Health Science from 1985-1990. All students got scholarship from the government and yes, we promised to go back our province to work after completing the medical assistant courses." (BB_IDI.2)*

However, after the conflict many new health centres were opened. Several participants reported having been transferred to take positions in these new centres.

> *"They hadn't found a post for me yet! Then there was new health centre, I was transferred to work there." (KP_IDI.13)*

Participants reported that rural and remote areas lack some basic services what makes them unattractive. Staff having been sent to unattractive areas sometimes absconded or just refused to move to their new position.

> *"It is difficult when they live in the rural area. It is difficult for them to staying, not many things to buy in rural area and etc." (KP_IDI.12)*

> *"I remember one staff that was sent to work in OD with me, but I saw only the name, but not in person." (BB_IDI.4)*

4.2. Future career plans

4.2.1. Reasons for career plan

Several participants expressed their intention to stay in their current positions for the rest of their career. They are planning though to add more activities mostly to increase their current income.

> *"I think I would continue this professional, and at the same time, I would do other private business, but I will continue it until I retire." (BB_IDI.3)*

Some workers reported not to have pursued progression in their career to avoid extra workload and having to deal with political networking. Some also reported being satisfied with their present position and considered they had provided enough contribution to the health care system already.

> *"…the more you become higher the more time and resource that you have to allocate for political attachment or networks or doing extra administrative work for others!! That is just create another workload for me that I did not wish to get higher position than what I had now." (KD_IDI.6)*

> *"I was offered but I did not accept it [a promotion] for more workload. In short, [as] the Head of Maternal and Child Health, I play an important role in reporting to the Operational District level." (PD_IDI.6)*

From other workers' accounts can be perceived a desire to be stable after the conflict, which is understandable taking into account the upheaval of the Pol Pot's regime. Being close to families and remaining satisfied with a government job are reported as a strong incentive not to move jobs.

> *"I never thought leaving any longer. Moreover, my kids grow up and I may live with them to pursue their study." (KD_IDI.6)*

> *"I do not plan to change my job or workplace because it is my home here. I will always do the government job." (KP_IDI.15)*

> *"I think I would continue this professional, and at the same time, I would do other private business, but I will continue it until I retire." (BB_IDI.3)*

Some reported planning to move to other activities out of the health sector such as farming after getting enough resources.

> *"I just have the plan, but I don't have yet the activity and capital. I just set the plan. I am going to do agricultural sector." (KP_IDI.12)*

Younger female participants expressed their intention to return to their home places after completing their studies to reunite with their families.

> *"After completing my study, I will come back here because it is my home place. My relatives and friends also feel happy to have me back, I think. So that I can help my people here." (BB_IDI.5)*

5. **Overall perception of career**

5.1. Motivating factors

5.1.1.Personal

5.1.1.1. Being near home

Being able to earn some income without having to move around was reported by female participants as an incentive and a source of job satisfaction which is probably related to the caring role that women normally have in Cambodia

> *"I like and want to work in this sector. I wish to help people and of course, can get some income from my profession and I do not need to travel from one place to another as business women in my village do." (KC_IDI.9)*

In the same regard, being near their home place was perceived as a motivating factor

> *"I like my job because it's near my house, so I continue staying here." (KD_IDI.7)*

5.1.1.2. Satisfaction about role and responsibility

Older staff who worked during the end of the conflict or the immediate post-conflict had to take responsibilities beyond scope of their professional category which was not only perceived by them as something to feel proud about but it was also recognized by their managers as this secondary nurse says:

> *"I have a lot of experience; I am not exaggerating. At that time, we had no clinician, therefore health staff became clinicians. Because of my comprehensive experience for example to do*

amputation, breast tumour operation while I was not a surgeon, so when the supervisor from ministry came here to see us, they decided to motivate staff to go for training." (KC_ISI10)

Some participants expressed their satisfaction with the work, particularly when during the post conflict conditions improved as a result of international cooperation.

"We were happy with works and foreign doctors were also called to hospital around 1-2 am at night. There were lots of donated medicines and volunteer doctors from France and Belgium came to help us." (BB_IDI.2)

The impact that the work has on their professional, personal and emotional skills was reported as a source of job satisfaction.

"I have changed a lot since I work here. It reduces my fear, I have improved my communication skills, many customers know me, more confident and my mistakes are also reduced." (ST_IDI.16)

In this regard, assuming responsibilities in different areas of speciality was reported as satisfactory by some participants.

"I was the director of children unit, I didn't hold only children unit task, but also was responsible for AIDS programme and worked as inspector in health centres. I held AIDS programme 1998-2000." (KP_IDI.12)

Some participants expressed their satisfaction about the positive impact that their work is having on the health status of the communities they are serving.

"The good thing about working here is that most of pregnant women now don't face what we called bleeding. Since 1980, 81, 82, daily, there was a case of seizure, those women I helped were bleeding, there were 3 out of 10. However, now there aren't many cases." (KD_IDI.7)

Some participants expressed their gratitude to the government and a sense of nationalistic pride as source of satisfaction.

"We could get by with that [problems] because we loved this country, and the government also tried to help a lot." (BB_IDI.3)

5.1.1.3. Pride in skills and competency

Career progression and being an expert in a specific area were reported as motivating factors by some participants.

"I love my job, that's why I am coming (Chuckling). Though the paid isn't much, I just work because I am specialized in this field already." (KD_IDI.7)

Being able to train others was reported as a source of satisfaction.

"Our workplace also accepts new interns who just graduate from school. They can improve their knowledge and get work experience which is different from their study." (KC_IDI.11)

5.1.1.4. Helping my family

Being able to help relatives was reported as a motivator for health workers who could take care of their sick relatives.

"I love this job. In addition, I'd like to treatment my father who has a blood pressure. He is not well sometimes. He usually has neck pain." (BB_IDI.5)

5.1.1.5. Job security

While most participants reported investing time in private practice they keep their government post as it is perceived to be more secure and also a means to attract patients to their own clinic.

"It is difficult to judge between my salary and clinical [private] salary which one is more important; however, income from clinic is more than salary, but take government job is also important for my job security and more people know me." (KP_IDI.12)

5.1.2. Organisational

5.1.2.1. Professional relations (with colleagues and supervisors)

Personal and professional relationships were reported as a source of satisfaction by some participants.

"First I have friends, I have good working colleagues, I have good neighbours as we live with each other long times in this areas, they become as our relatives." (BB_IDI.1)

Getting support from superiors was also a source of motivation for some workers.

"Nowadays, I receive the support from my director, to help, to motivate and to support me. He had never accused me, even I made something wrong. So, this helps me to commit to work here." (BB_IDI.1)

"…my supervisor encourages me to stay. Once in a while he asks if I am ok." (KD_IDI.6)

Good relations with colleagues were considered as a source of job satisfaction.

"Our co-workers get along well with each other. We don't have any conflicts. I think that conflict of interest always happens in every working place. There is no conflict beside that." (KC_IDI.9)

5.1.3. Community

Community attachment was reported as a source of satisfaction but also the security attached to them was highlighted as an important factor which makes particular sense in a post conflict environment.

"I also know many villagers here, and they also know me. Therefore, I feel secure living here, so I decided to stay." (KD_IDI.7)

5.1.4. Working environment

Having the necessary resources to work was reported as a motivator which is the reason why some participants work for NGOs where working conditions in this regard are better than government facilities.

"I've worked with NGOs since 1998 because in here they've supported some equipment…" (BB_IDI.3)

5.2. Demotivating factors/challenges

5.2.1.Personal

5.2.1.1. Skill gaps relative to task and personal confidence

One older participant reported that patients prefer to be attended by younger staff who are perceived to be better prepared than their seniors. This is maybe related to the fast-tracking which occurred in training health professionals during the early stages of the post conflict, which was reported by some to be of poor quality.

"It is difficult due to our age and experience. We don't get much trust from the customers. Customers always blame to the hospital to let young midwives and less experience to treat them, especially when the problem happens." (KC_IDI.11)

5.2.1.2. Perceived unfair pay structure

Salaries, even for the highest cadres, seem insufficient to cover living expenses, as this male doctor suggested.

"For example, the salary is 600 thousand riels [148$ as per official Aug 2014 rates[2]]. *If new staff is single, it should be enough; but if staff is married, I think he/she will need more than 600 thousand riels to support their family. 600 thousand riels if we use that money to spend daily expenses, it is not enough! [ ] … Thus, the proper salary should be over 300$... [ ] …Spending for my children's study, it is about 100$ to 160$ per month. For electricity expense is not regular, but it is around 200$. The total expenses are about 400$ per month."* (KP_IDI.12)

The same doctor suggested that better salaries have the potential to improve staff performance.

"In Kuntha Bopha hospital [private not for profit paediatric hospital], just doctor's salary is $ 1200 and specialist doctor's salary is $2400. Thus, work performance is very good and smooth!" (KP_IDI.12)

This other senior female doctor suggested that particularly junior staff face problems to cover even their basic needs.

"With 100$ per month, they have to eat less, we could not eat noodle soup that costs 5,000 Riels per time, rather they can eat only rice with cheaper food two times per day." (BB_IDI.1)

This female nurse also suggested that covering the needs of their children was not easy for her.

"I have one son and one daughter. I bought expensive milk powder for my children. I spent too much on my children!" (BB_IDI.4)

Several participants mentioned the cost of children's education as a major economic burden, as this female secondary midwife reported.

"Currently, I've got less than 100$, just got 320000 Riels [79$ as per Aug 2014 official rates]. *Before it was not a problem, but now my daughter is going to college, so it's difficult now since we need to spend more. Have to pay for school fees, if including this, it is even more difficult on a really limited budget." (KD_IDI.7)*

[2] http://www.xe.com/currencytables/?from=KHR&date=2014-08-24

Other expenses, while not essential, are perceived as (culturally) necessary as this 31 years old female primary midwife suggested when she reported expenses to attend a wedding together with these for food and education.

"Children need to go to school and we need to spend on food. It is barely enough. There are some wedding invitations for some other months. There are a lot of expenses." (KP_IDI.15)

Some participants reported having to change their initial plans in regard to their children's education due to its high cost, particularly when it is in Phnom Penh, as this 53 years old female midwife suggested.

"Now, I sent my daughter to learn medical field as Midwife in Stoeng Treng province… [ ] …I want her to be a doctor but I can't because we spend a lot of money and stay in Phnom Penh... Staying in Phnom Penh we will spend a lot of money." (ST_IDI.18)

Some participants reported having to sell assets and get help from relatives to pay for their children's education as government remuneration is not sufficient to cover it.

"At the time, I sold everything for their [children's] studies. But I could send them to Phnom Penh while [as] *I had some money from savings… … They all study in Phnom Penh. During that time, I did not have enough money to pay for school fees. Fortunately, my younger sister lives in Phnom Penh, therefore I put all of them at my sister's house with food support from my sister who is working at Phnom Penh port. She supports some. I also support them some." (KC_IDI.10)*

The situation is even more difficult when workers are located in more remote or rural areas where good quality education services are not available.

"I have two children. The son is in grade 11, and the girl is in grade 6. The son goes to school in Battambang because there are many problems here and the education sector here is weak. Well that's normal for the rural area so I let him go." (BB_IDI.3)

5.2.2.Organisational

Some workers reported delays in starting to get their salaries after first appointment which adds to the already difficult conditions they face, particularly during their first professional experience.

"My husband paid for the renting house due to I had no salary yet." (BB_IDI.1)

In addition, workers during the probation period do not receive a salary.

"Oh! When on probation, I didn't get salary. When I became staff, I got 180 thousand [44$]*." (BB_IDI.5)*

Some participants reported being afraid of contracting diseases as this midwife reported.

"…my job is full of high risks of infection with deadly diseases." (KD_IDI.8)

5.2.2.1. Limited opportunity for promotion and/or corruption

The process to obtain the salary increases that all workers are entitled to was reported as irregular and arbitrary which is perceived negatively by health workers.

“Getting a promotion of salary, it is irregular. Sometimes, it depends the accountant introduce [help] us to complete the request form. I don’t remember about the how many times per year! When they introduce us to fill the request form, they increase our salary, too. From “ ខ” to “ ក៏”. Just 2 ranks! Two ranks. After you graduated OS and doctor.” (KP_IDI.12)

“I don’t know the reason, but some staff receives the increase and some don’t.” (BB_IDI.3)

Some participants reported that despite having claimed the salary increases they are entitled to their applications were not successful.

“I always write to request the increasing salary rank 3, 4, or 5 times per month but they never approve.” (BB_IDI.4)

Corruption and lack of transparency were blamed for irregularities in salary increments as this young female nurse reported.

“If we want to eliminate the corruption, OD should have clear salary rank like how many increasing per month [year?]*. Some staff had no salary rank* [increment?] *until now. Like me, I got the salary rank only twice until now* [since 2001]*. I never got increasing salary. I don’t know why?” (BB_IDI.4)*

5.2.2.2. Working condition/equipment

Some participants reported that despite some improvements in the last years, lack of equipment and drugs represent a barrier for providing good quality services, which - together with deficiencies in skills in some cadres and new emerging pathologies - cause inefficiencies such as unnecessary referrals as this female secondary midwife suggested.

“In addition, it is challenging since we lack modern medical equipment, though there are lot of them have already been put in [place]; there is still not enough because a lot of new diseases have emerged. I am picking up an example of my area of working; to illustrate, during delivering the baby, some women couldn’t deliver so we need an equipment to help her out, but the equipment is not up to date [adequately maintained?] so we need to send her to the more expertise doctor, then they said why didn’t you use the equipment. Moreover, the professionalism in using the equipment is still limited. Sometimes, even the medicines and other medical materials aren’t enough, and there hasn’t any technological advances yet.” (FD_IDI.7)

5.2.2.3. Lack of transportation/access

Lack of transport was reported as an issue to do outreach which, together with poor road infrastructure, leave some areas with no services for several months during the rainy season.

> "*We have difficulty in our work and we have no transportation to remote villages. We give up for 3 or 4 month if it is in rainy season. We can't go in rainy season. The communication road is in very bad condition." (ST_IDI.18)*

Some workers reported having to pay transportation from their own pockets as this female OS/nurse suggests.

> *"I asked my boss that it is better if you didn't invite me to join that meeting because I had to spend my own money over the per diem." (BB_IDI.4)*

5.2.2.4. Lack of support from colleagues/low capacity and performance

Some participants reported assuming responsibilities from superior cadres beyond their scope of practice and not getting fair recognition for it, as this female OS (Medical Assistant) reported. The fact that she mentions that her superior has less education than her is probably to do with the intensive (fast-track) medical training programmes provided immediately after the conflict.

> *"I am OS, but the responsibility is like doctor's task. I always do instead of him. For pride, he always gets. For fault, I always get instead of him! …In reality, my task is more than director's task. Honestly, my boss has less education background than me, so I am responsible all everything includes insurance and report including management, meeting, and reporting." (BB_IDI.4)*

Some participants reported that in rural areas is more difficult to get positive reinforcement from managers either in kind or just as an appreciation.

> *"My hospital is different from other. In Phnom Penh, working environment is full of encourage active staffs. This workplace never gives the incentive like appreciate certificate to active staffs." (BB_IDI.4)*

5.2.2.5. Multiple task/burden/workload

Some participants reported an increase in workload during the last years.

> *"For the patients, since 2011 or 2012, there's a big difference, about twice the increase, like if we had 50 patients in the past, we have about 150 now." (BB_IDI.3)*

> *"I feel depressed sometimes. Because lacking of staffs, I had to accommodate about 60 patients per day." (BB_IDI.2)*

However, it was also suggested that some adjustments on task allocation as well as provision of additional staff have been made to control the increasingly high workload.

> *"I was in charge all tasks, however PMTCT was just transferred in 2011. Really heavy workload for me." (KD_IDI.8)*

> *"I had many tasks to do, particularly during I had been working alone. But now there are a few* [more] *nurses, we help each other so it is not really too hard." (KP_IDI.15)*

"Before, I do everything, delivery, paediatric care and treatment, perfusion, injection, surgery etc. Now, I do only cyst surgery, traffic accident injury, quarrel injury etc." (KC_IDI.10)

More availability of staff is nowadays allowing workers to distribute their time and organize shifts to do other things.

"My work place here is different from the office in Phnom Penh who has day and night midwives. Here we work all together both day and night, 24 hours. We exchanged with each other in case having lunch or someone have something to do in urgent. We just inform the time we go and return and when we come back we can work as usual." (ST_IDI.16)

5.2.2.6. Staff shortage/not staying (attrition)

Staff shortages cause high workloads for health workers but also this situation push them to assume different roles which are sometimes beyond their professional scope, as this secondary nurse reported:

"…there are some health centres that complain such as Kroch Chhma district where there are 5-6 staffs, therefore, an individual plays three or four roles and responsibilities. Even myself who is not hospital director but I have many job responsibilities as chief of service management, staff management and hospital management for example, after doing surgery." (KC_IDI10)

Some managers complained that besides their managerial duties they have to do clinical work as there is not enough staff.

"However, there was urgent case, too. When there was meeting, I had to treat patients and control staffs at the same time like managed signature, etc." (KP_IDI.12)

5.2.2.7. Lack of accommodation

Not having accommodation was perceived as an important source of dissatisfaction and one posing an economic strain on staff coming from other areas.

"Like other staff, we didn't have accommodation from the stage. I was lucky that my friend's parents allowed me to stay with them… …It was difficult for the new staffs. Many come from other province and had to rent accommodation. It is really difficult for them. Some already went back to their hometown after completing their probation period. We did not have accommodation for new staff." (BB_IDI.2)

Some participants reported that in the absence of government accommodation workers have to rent privately. This female doctor reported that renting accommodation in areas more accessible for patients seeking private care (e.g. close to main roads) was easier in the past but that nowadays workers looking for renting affordable accommodation have to do it in less accessible areas which reduces their business potential.

"The main problem for the newcomers is the accommodation. It is hard to find the accommodation now, when I first came here I could rent a house along the main road so that I do my private clinic. For the newcomers now, they may not be able to rent house in the main road because it is very expensive, and they did not earn income, yet [even when] receiving the government salary. Thus, they have to rent the house that is far away from the main road, [and] *they can't do any private clinic, they may* [have to] *depend* [exclusively] *on the income from the government salary and user*

fees, [which] *it is not sufficient to cover their living costs. Therefore, the main problem is the accommodation." (BB_IDI.1)*

5.2.3.Community

5.2.3.1. Fear of litigation

Some participants reported that after many years performing functions that were beyond their professional scope due to lack of skilled cadres they had now to stop to avoid legal problems as this secondary nurse reported:

"...I do surgery for more than 30 years but now we have the law, if there is a patient who is under surgery and dies, we are questioned about the degree. [] …who would like to take the risk? it does not mean that we do not care about the patient but in some situation we have to refer [patients] to bigger and higher capacity [services] *than us because surgeon is afraid and the anaesthetist is also afraid. Therefore, we have to be careful." (KC_IDI10)*

Fear of litigation was referred by several participants as a threat to their professional practice. They reported that in order to solve this problem they need to inform patients about the difficult conditions in which they have to provide services to avoid them going to court in case of problems.

"We discussed in our unit to find the cause which make the problem happen. Sometime we find that the cause was also come from the customers themselves. Thus, our solution was giving advice to them and make them know what the real cause was. All problems happened here we can deal with it without facing in the court." (ST_IDI.16)

Workers that are sued, even for having failed to refer a patient during an emergency, may end being arrested as this secondary midwife reported.

"Sometimes, it is in a rush that we couldn't send them to the experts on time. That's when they bring it to the court that we failed to send them on time, so midwives will have to face the law, possibly could lead to arresting. This is what I am afraid of; they didn't consider our difficulties, our limited technological advance equipment, but suddenly arrest or sue us." (KD_IDI.7)

Even it was suggested that professionals who have the duty to perform surgery are concerned with being sued.

"…when any patient dies due to surgery; surgeon has to face with investigation made by the supervision team, therefore surgeon feel afraid of taking risk…" (KC_IDI.10)

One female nurse reported having decided not to practice privately to avoid being sued as she would not be able to afford the compensation in case of legal problems.

"...if there is danger [problems] *in my clinic, I have no money to compensate. For example, inject someone and then he is in danger, I have not 10 thousand dollars to compensate, I got just 30 thousand riels!" (BB_IDI.4)*

5.2.3.2. Political pressure on staff

Some participants reported having been under pressure from their superiors in relation to their political affiliation.

"Talking about political party, I have no link to any party, but I was accused by my former director. I think regarding politic, a people, a HCW, has its own right to make decision. The policy of any political party, that is good, it will be interested. We live here therefore; we know who does a good job and bad job." (KC_IDI.10)

6. Sources of income

6.1. Salary

Salaries reported by doctors are not reliable or adequate as most of them reported receiving too low salaries (e.g. 120,000 riels) when compared with that reported from lower cadres.

"Nowadays, my salary, money on my duty is about 100 or 130 thousands riel[3]." (KP_IDI.12)

"In 2008, I received around 500 thousand riels! That salary is still the same." (BB_IDI.3)

Among nurses the salary reported is more consistent, amounting to an average 350,000 riels.

"Salary! Now, my salary is increased. This month salary is 360 thousand." (BB_IDI.5)

"…salary is about 400 thousand." (KP_IDI.13)

"I get 420,000 riels as net salary." (KP_IDI.14)

"…it is around 280,000." (ST_IDI.17)

Midwives reported earning a similar amount than nurses.

"Currently, I've got less than 100$, just got 320000 Riels." (KD_IDI.7)

"I got 330,000 riels in July and 380,000 riels in August and September." (KC_IDI.9)

"I got 390,000 riels per month." (ST_IDI.16)

Many participants reported that their government work does not cover their needs but that they use it to attract patients to their private practice as this male medical assistant suggested.

"For my farm land, I have 7 hectares, and other people have more than that, and they have other business as well! …For me, medical profession is not main source of income; I do it because I want to help people with what I know because these days, I don't rely on the salary for the living. I just work to get the extra income… [] …It's more like another source of income" (BB_IDI.3)

6.2. Allowances

Some of the allowances mentioned by participants were "health risk", "night shift", "field trips", "attending trainings", "guard", and "duty".

However, the amounts reported by participants were variable, depending on funding availability which is in turn linked to the presence and involvement of NGOs.

"It's not regular. The provident from allowance is not always the same. Sometimes there is a lot and sometimes there is less." (ST_IDI.17)

[3] 4,065 Riels = 1 USD in Aug 2014 http://www.xe.com/currencytables/?from=KHR&date=2014-08-24

“It depends on the support from the NGOs, trainings would not happen if we only depended on funding from the government.” (KD_IDI.18)

6.3. Top-ups

Some doctors said that their income from the Health Equity Fund (HEF) has improved in the last years as this male OS, reported but also that this funds are also contributing to improve the infrastructure and to incentivise other staff.

“Since we first created the user fees and HEF, we received at most 50 to 100 thousand riels. However, now, we could receive 300 to 500 thousand riels, the least is 300 thousand riels, and the most is 500 thousand riels. We could see the improvement since we have equity fund for the poor, and we have the fund to support the staff and some of it, we could use to improve the hospital. And it also helps us change the habit to work more, and have better ethics.” (BB_IDI.3)

Income from user fees for doctors amounts to around 380,000 riels per month.

“I also got some incentive from user fees which provided me some income in addition to my base salary: about, let say, I get 370,000-400,000 riels per month.” (BB_IDI.2)

For nurses, user fees are around 200,000 riels.

“the user fee which is about 200,000 riels.” (KP_IDI.14)

Reports from midwives about user fees is relatively inconsistent.

“I also get about 20,000 to 30,000 from user fees.” (KP_IDI.15)

“Beside my salary, I also got it but it is just a small amount 7000-8000 riels.” (KC_IDI.9)

Some participants reported sharing the user fees among the different members of the team.

“We have got money for birth service and we have got 6 thousand Riel for one case. It is not regular. Sometime we have got only two cases a month and sometime we have got 10 cases a month. We have shared altogether. The people go to get payment will get 5 thousand Riel and the rest is shared with director, deputy director and the people who provide services will get more.” (ST_IDI.18)

Participants mentioned two incentive programmes provided by NGOs: HSP2 and Pooled Fund.

“There are support from NGOs such as HSP2 and Pooled Fund.” (KD_IDI.6)

6.4. Private practice

Almost all doctors and most nurses and midwives, both men and women, reported having to work privately to top up their poor salaries. The most reported activities were private care and running pharmacies.

“I just try to take time to earn through extra job like injection in village.” (KP_IDI.13)

“Yes, I have. I have other private job besides doing this. I worked 8 hours per day in hospital. I can work [privately] at the end of the day or when there is no customer here…” (ST_IDI.16)

“I have a small pharmacy and examine some disease at home…” (KC_IDI.9)

Some reported working in areas out of the health sector.

"Some staffs have requested to take leave from the government officer to feed duck to earn money to support his two children study at the university, because the government salary is low, and not enough to support his living costs." (BB_IDI.1)

Topping up salaries was a strong imperative, leading sometimes to very high workloads with great likelihood to impact on the quality of work as this older midwife reported.

"When I was at Prek Pnov I used to, in one night, deliver 20 infants. Hmmm…I do it because I work for money to support livelihood." (KD_IDI.6)

Some participants reported being aware about the fact that running a private pharmacy is illegal. It was suggested that there is flexibility from authorities as they know that salaries are low and health workers need to cover their needs - as this male doctor, who beside his government work runs a private clinic and a pharmacy, reported.

"I work as a government officer and I also can earn beside that by doing my own business (private clinic). My business is doing in a good way I am not cheating or corrupt my customers. I can say that we serve for poor and rich patients; that's why our customers always come to my clinic… [ ] …I just focus on my work and make my Pharmacy running. Yes, this illegal by law but we didn't care about it because we cannot survive with our salary" (BB_IDI.2)

One older midwife reported having been doing abortions privately in the past but she decided to stop for religious and moral reasons, and now she provides other type of care in addition to running a business.

"My kid told me that I could make lots of money if I go there. I don't want to, I don't want to do anything. I am getting old. Before her death, my mother told me not to practice abortion any longer (laugh). She told me to follow Buddhist dharma for the future life… [ ] *…Now I make my living from running a grocery (laugh) and I privately inject the patient at their home for little income. So, in total I make about 50,000 to 100,000 Riel. We cannot depend on the income from the hospital.*" (KD_IDI.6)

Doctors and nurses did not provide consistent information about how much they earn from private practice. From the reports from midwives, the average income from private care is around 75,000 riels.

"…providing home care for which I can make about 50,000 to 100,000 Riels." (KD_IDI.8)

"…I privately inject the patient at their home for little income. So, in total I make about 50,000 to 100,000 Riel." (KD_IDI.6)

6.5. Other sources of income (business, agriculture, trading, etc.)

Besides private care the most common activities reported by participants were related to farming. One reported having a salt production business.

"The extra income such as raising animals and producing salt are only to support our base salary." (KP_IDI.14)

Some participants reported working for the government, practicing privately and working in other sectors.

“Nowadays, I’ve received support from NGO because to survive, we have to take two steps at a time. That’s normal, and I used to work with NGOs, and plus the income from government. We have to do that, and secondly, we also do farming to support ourselves. To live here, we have to do that.” (BB_IDI.3)

7. Experiences and perception of incentive policies for rural areas

Participants reported that there are monetary and non-monetary incentives to retain workers in rural areas.

“I just know that ministry of health tries to strengthen human resources as many as they can and promote them to work in the rural/ remote areas. On other hand they have incentive such as money on birth delivery; midwives in rural areas get this incentive more than midwives who work in the urban areas. Government staffs in rural areas also get more chance to attend training course than government staff in urban areas.” (KC_IDI.11)

While in theory workers accepting to be posted in rural areas are entitled to get free accommodation, it was suggested that this is often not the case. It was also mentioned that economically there is no difference between urban and rural postings, which given the lack of opportunities in rural areas for private practice to top up their salaries makes these areas less attractive. This male doctor suggested that these accepting being posted in these areas do so because they have relatives who support them.

“There is already policy, but the practice is often different. For example, in the policy, it states that they will find place for staff who volunteer to work in rural areas to live, but in the practice it is not the same. Some staff often go and refer because he or she had support from their relative who is big guy out there to help them. You know there is no accommodation for staff in rural area. Salary is also same.” (KD_IDI.12)

However, it was also suggested that many workers are not well informed about their entitlements in terms of incentives as this male doctor and this female nurse reported when asked about their knowledge about policies for rural retention.

“I don't know much about policy, please asked my director, head of this PRH.” (BB_IDI.2)

“The government policy does exist but I feel that I have no much information about it.” (KC_IDI.10)

Participants working in remote districts reported that working in the capital involves more incentives than working in remote areas, as this female nurse, who seems not to be very happy with the support she gets in this regard, says:

“In Phnom Penh, working environment is full of encouraging active stuff. This workplace never gives the incentive like appreciation certificates to active staffs, but they blame staff… this always happened! If there is no bonus or incentive in money, it is fine to have just appreciation letter. But there are no [neither] *~~both~~ of them* [here]*.”* (BB_IDI.4)

8. General recommendations of health staff

8.1. Special allowance for rural areas

Providing incentives in rural areas was mentioned as a strategy with potential to retain workers in rural areas.

"I would suggest providing sufficient salary for those who work at health centre; they will not move to work in other places." (BB_IDI.1)

It was also suggested that making differences between different areas may help retaining staff.

"It should divide salary based on area." (BB_IDI.4)

In this regard one female nurse specifically mentioned a 50,000 Riels top up.

"*Ratanakiri and Mondulkiri* [two remote districts in the North East], *they have 50 thousand riel added over their salary. Area salary can help more. And it should have incentive or bonus added over main salary.*" (BB_IDI.4)

Apart from the amount to be paid, some participants suggested that getting what is already in place on time is important, as this midwife suggested.

"…money of birth services should pay in time." (ST_IDI.18)

One midwife suggested that health staff is comparatively worse off than these working in education.

"Health staff gets less salary than educational staff. The secondary school teachers, which the same grade as me, get about 500,000R while I get only about 400,000R." (KP_IDI.15)

In line with internationally accepted guidance one participant suggested that deploying staff to their home area may have potential to retain workers in remote areas.

"Based on experience in other countries, it is good that government provide the place to live for staffs that is far from workplace. Firstly, deploying them to work at their home village or commune; or otherwise, provide appropriate support to staffs who willing to work in rural area." (KP_IDI.12)

However, younger participants suggested that they would like to be deployed where there are more health needs. Partially they alleged humanitarian reasons ("help others") but also in that way they can get more exposure to different cases to acquire experience. In this regard deployment preferences should be taken into account.

"I want to work in the remote area which located further than here. They do need our help. I used to live in that situation so I know it. For me, I will ask my manager to work in Pong Reang. A health centre is just built there. It's about 6-7 Kilometres from here. I also think about that but I would feel happier if I had chance to help people to deliver their babies. I want to help them." (KC_IDI.9)

8.2. Accommodation

Accommodation was mentioned by most participants as necessary to attract and retain workers to more remote areas. Some mentioned that this should be particularly important for these that live far from the work place.

"…it is good that government provide the place to live for staffs that is far from workplace." (KP_IDI.12)

8.3. Training opportunities/capacity building

Improving equipment and access to training were also suggested as possible incentives to retain staff in more difficult areas.

"My request is to increase suitable amount of monthly salary, and more advance medical equipment and other related medical assistance and/or training." (KD_IDI.7)

More simple and affordable interventions include to match worker's skills with their job profile as this young midwife suggested.

"I would feel happier if I had chance to help people to deliver their babies. I want to help them. What I am working here is completely different from what I've learnt and what I wished to do. I want to deliver the baby." (KC_IDI.9)

In addition to access to formal training some participants suggested that government should get support from development partners to get specialists to train them in-service.

"…in other countries, they hire specialist from other developed countries to provide training to the local staffs. This can help to improve local staffs' clinical knowledge and skills…" (KP_IDI.12)

8.4. Improvement in the working conditions - equipment, drugs, and space

Providing enough equipment and clinical material was mentioned by several participants as necessary.

"I need enough materials such as gloves for medical doctors and assistants. It's sometime difficult for us to examine patients when we don't have it." (KC_IDI.9)

Some participants suggested that besides provision of new equipment there is need to ensure appropriate maintenance of the existing material as this female nurse suggested.

"…equipment is not sufficient either. For example, the Doppler in the pregnancy examination room has been broken for about 4 or 5 years so far and we need a new one." (ST_IDI.17)

Ensuring an adequate power supply to facilities was also recommended by these two participants working in Streng Tren, a particularly remote district in the North.

"We just concern about electricity, it's not available." (ST_IDI.17)

"We have no electricity when [since?] *this area was flooded and we have got only a time over a period of half month so I want an electricity machine and people who take care of machine."* (ST_IDI.18)

8.5. Local recruitment/more staff

In line with their complaints about staff shortages some participants suggested that ensuring appropriate staffing levels could help in attracting and retaining health workers surely linked with more "affordable" workload levels.

"…we want the more staff, firstly the staff that could come to help us, as many as possible!" (KC_IDI.10)

8.6. Adequate transportation

Some participants, particularly these working in more remote areas, suggested that transport is necessary for outreach activities as this 53 years old female nurse working in Stoeng Tren suggested.

"I want a motorbike to go to remote village." (ST_IDI.18)

Although not as feasible as other suggestions one participant working in a remote Northern district suggested that road infrastructure should be improved.

> *"…construction of rural roads." (ST_IDI.19)*

8.7. Local infrastructure

Having local services and infrastructure was mentioned as an important element of attraction as this male doctor suggested.

> *"All in all, that area should have market, school, and better road. For example, he had family, so he needs school for their children." (KP_IDI.12)*

Discussion

The reported reasons for having joined the health professions show a similar profile to other countries where this research was carried out (Namakula et al, 2013; Wurie & Witter, 2014; Chirwa et al. 2016). They included intrinsic motivation and the desire for social respect, the influence of other people, economic factors, gender roles, gaining work experience or entering as a volunteer, and as a response to demand in the market. Avoiding conscription was however unique to Cambodia – perhaps a reflection of the distance from the conflict and its duration in parts of the country. The role of gender expectations was also more clearly articulated in this (largely female) group than in other ReBUILD countries. Gendered expectations and barriers were also articulated in linked case studies on progression in the health workforce in Cambodia and other ReBUILD countries (Witter et al. 2016a).

Training experiences reflect the conflict-affected environment, with some experiencing short initial training because of the urgency of re-establishing the health workforce, and others interruptions in training (Roome et al. 2014). Access to in-service training now appears to be reasonably equitable across the genders and also giving some priority (at least for short courses) to staff in rural areas.

In terms of career trajectory, the lure of their home area is strong for many participants, perhaps more so for women, and there was a sense of seeking stability after turbulent times. While salaries are low, they can enable access to other benefits, including private practice, training and social recognition. Avoidance of politics and additional duties is a factor for some (more explicitly in our Cambodian health staff than for the three other countries).

In relation to motivation, personal development plays an important role, as for other countries, alongside a pride in serving your community and country. Community links are important not just for personal satisfaction but also security, during difficult times. As with the other ReBUILD countries, the need to take on additional tasks in difficult circumstances can also be motivating and a source of professional pride.

Salary levels for health workers are generally not satisfactory, and do not cover basic living costs, especially those of children's education (and particularly for those in rural areas which lack good schools). Delays in getting on payroll, the absence of pay during probation periods and poor career progression opportunities and systems are also demotivating factors. Participants talk openly about corruption in relation to promotion opportunities. Working conditions and basics such as transport remain problematic for some, despite improvements in recent years. Workloads have reportedly increased, though some improvements in how that workload is managed are also reported.

The fear of being sued for malpractice is a problematic aspect which has not arisen in the other ReBUILD countries – it presumably reflects the more developed health care market in Cambodia, and the more widespread private practice.

The conflict context was mainly problematic in terms of the general challenges posed to health staff and the hardships they had to overcome, but did throw up some opportunities, such as rapidly learning of skills in surgery. As with other countries (Namakula and Witter, 2014), harrowing tales of personal and family suffering were shared, and resilience demonstrated in coping and surviving. In the post-conflict period, gains for the health system are recalled and a sense of purpose in rebuilding, but also challenges such as rising prices and, for some of the cohorts, being overtaken by newly trained staff (for older staff who had worked for a long time but whose initial training was shorter and therefore less respected later on).

As in many low income and fragile contexts, health worker remuneration is a very complex mosaic of salaries, allowances, top-ups, fee sharing, and private practice and informal sources (Bertone and Witter, 2015). Managers in Cambodia seem to be relatively tolerant in order to retain staff (So and Witter, 2016). Many recent policies aim to provide top-up payments to health staff and there is some evidence that overall this has improved the efficiency of the health districts (Ensor et al. 2016) but discussions are underway about reducing the fragmentation of pay and incentives as part of strengthening government leadership and accountability (Witter et al. 2016b)

Incentives to work in rural areas are not substantial – in theory, training opportunities are prioritised for those working in rural areas and accommodation is sometimes provided, but in other ways terms and conditions are similar, and rural areas face the disadvantages recorded in many studies – higher costs of living, lack of opportunities for private practice, and worse conditions for families, amongst others (Wurie et al. 2016). Staff suggest rural allowances, preferential access to training, provision of accommodation, clinical mentoring, and improved transport and working conditions as amongst the priority areas for attracting and retaining staff in rural areas, alongside local recruitment.

Conclusion

This study adds to our understanding of health workers' experiences of conflict and post-conflict periods and what can motivate them to stay in service during these challenging times, building on the wider body of evidence from ReBUILD and beyond and augmenting the themes in our conceptual framework. Developing a sense of mission and service can be particularly powerful during times of stress – staff can cope with difficult working conditions if they are supported by teams, families and communities. In the longer term, as the sector recovers, basic needs become more important and if the public sector is unable or unwilling to pay enough for health workers to provide for their families, then more flexible arrangements are needed, as illustrated by this case study. There also needs to be more specific, funded and consistently implemented policies to retain staff in rural areas, such as allowances to reflect higher living costs for some items and reduced income generating opportunities.

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Annexe 1 In-depth Interview Guide

Objectives: To explore health workers' and health managers' perceptions and experiences of the implementation of retention policies post-conflict.

A. Introduce the purpose of the study – its aims and scope
- Assure participant of confidentiality and how it will be maintained
- As for their consent to participate

B. Note details of participant.

1. Interviewee ID		6. Gender	Male ☐ Female ☐
2. Date of Interview		7. Age	
3. Name of RHs or HCs		8. # of children	
4. Province		9. Family members	
5. Title interviewee		10. Education	

Questions

I would like to understand about your life. Can you draw me a line, starting from birth and leading to the present day? What are the major events that you would put on it? Describe them to me.

As respondent starts to draw, follow the story with probing questions such as:

- When was that?
- Why did you do that?
- What did you enjoy about that?
- How did you manage in that situation?
- Where did you go next?

Open-ended questions to provoke discussion:

1. Tell me a bit about yourself? How did you come to work in the health field?
2. What kinds of jobs have you done in the past?
3. How did you get this job?
4. Describe what you do now
5. How long have you been working here?

6. How do you feel about your current job?

7. What do you like and dislike about it?

8. Are you planning to stay? What are your plans for your future career?

9. Do you do other jobs as well, or other activities to make money? Tell me about them

10. Tell me about the different kinds of pay which you receive (probe: salary; allowances; user fees; payments from patients; incentives for deliveries; private business etc.).

    a. Which ones are most valuable for you?
    b. Why?
    c. How do they change the way you work?

11. What are the main challenges you face in your professional life?
    a. How do you cope with them?

12. What sort of changes have you seen over your period of working?

13. Do you know about any policies to encourage health workers to stay in rural areas? Tell me about them

    a. Have they worked?
    b. What do you think about them?

14. What do you think is the most important thing for the government to do to get health workers to work and stay in rural areas?

Annexe 2. Coding Structure of IDI THEMES and SUB-THEMES: Cambodia

1. **Decision to join the medical profession**	1.1 Intrinsic Motivation_Personal movation 1.2 Other People *1.2.1. family* 1.2.1.1. Advice 1.2.1.2. Exerience of bad health *1.2.2. friends* 1.3 Social respect 1.4 Economic 1.4.1. Earning more 1.4.2. Poor should earn soon 1.4.3. Job opportunity/need for health workers 1.5 Working condition 1.6 Educational 1.7 Stay close to home 1.8 Avoiding conscription 1.9 Work experience (contact, volunteering etc) 1.10 Serving community 1.11 Identifying need and/or gap 1.12 Gender role
2. **Training**	2.1 Highest grade of general education 2.2 Initial training 2.2.1 Degree and location of training 2.2.2 Source of funding 2.2.3 Experience of training 2.3 Continued Trainings of higher degree 2.3.1 Degree and place of continued training 2.3.2 Source of funding 2.3.3 Experience of contined traning 2.3.4 Reasons for coming back 2.4 In service training opportunities (Short course or workshop) 2.4.1 Frequency 2.4.2 Type and content 2.4.3 Sponsors and/or organisor 2.4.4 Experience of IST
3. **Career trajectory**	3.1 Career trajectory 3.2 Reason for job choice 3.2.1 Self develop 3.2.1.1 Personal interest 3.2.1.2 Offered promotion 3.2.2 Posting and application (personal choice) 3.2.2.1 Some were bonded 3.2.3 Conflict/leadership 3.2.4 Family reasons and personal 3.2.5 Contacts 3.2.6 Studying 3.2.7 Good location 3.2.8 Staff Shortage and demand 3.2.9 Opportunity for private practice 3.3 Reason for not seeking and accepting promotion 3.3.1 Politics

	3.3.2 Too much work 3.3.3 Positive factors – e.g. commitment to current post 3.4 Future career plans 3.4.1 Reasons for career plan 3.5 Gender observation 3.6 Rural specfic observations
***4.* Overall perception of career**	4.1 Experience of career 4.1.1 Positive 4.1.2 Negative 4.2 Motivating factors 4.2.1 Personal 4.2.1.1 Satisfaction about role and responsibility 4.2.1.2 Opportunity for private practice 4.2.1.3 Impact of training on skill and competency 4.2.1.4 Helping my family 4.2.1.5 Earning money 4.2.1.6 Job security 4.2.2 Organisational 4.2.2.1 Good leadership 4.2.2.2 Team arrangement to allow stand by work 4.2.2.3 Professional relations (with colleagues and supervisors) 4.2.3 Community 4.2.3.1 Social status and recognition 4.2.3.2 Community attachment and service 4.3 Demotivating factors/Challenges 4.3.1 Personal 4.3.1.1 Separation of family 4.3.1.2 Skill gaps relative to task and personal confidence 4.3.1.3 Percieved unfair pay structure 4.3.2 Organisational 4.3.2.1 Limited Opportunity to practice (few clients) 4.3.2.2 Poor leadership 4.3.2.3 Limited opportunity for training 4.3.2.4 Limited opportunity for promotion and/or corruption 4.3.2.5 Working condition/equipment 4.3.2.6 Lack of transportation/access 4.3.2.7 Lack of support from colleagues/low capacity and performace 4.3.2.8 Multiple task/burden/workload 4.3.2.9 Staff shortage/not staying 4.3.2.10 Lack of accommodation 4.3.2.11 Restrict opportunity for private practice 4.3.2.12 Low income in relation to cost of living and children's education 4.3.3 Community 4.3.3.1 Poor security 4.3.3.2 Community practice/beliefs/education 4.3.3.3 Difficult access to health care for clients 4.3.3.4 Fear from being sued 4.3.3.4 Political pressure on staff

	4.3.3.6 Lack of trust from community
***5.* Context of conflict**	5.1 Pre conflict 5.1.1 Health workers 5.1.2 Health system 5.1.3 Coping strategies 5.2 Situation during the conflict 5.2.1 Effect on Health workers 5.2.2 Effect on Health system 5.2.3 Coping strategies 5.3 Post conflict situation 5.3.1 Health workers 5.3.2 Health system 5.3.3 Coping strategies 5.4 Current situation 5.4.1 Health workers 5.4.2 Health system 5.4.3 Coping strategies
***6.* Sources of income**	6.1 Salary (all comments related to salary) 6.2 Allowances (Per diem,) 6.3 Top-ups (NMIS, HEF, voucher, CBHI, SDG) 6.4 Private practice 6.5 Other sources of income (business, agriculture, trading, etc) 6.5.1 Personal 6.5.2 Family 6.6 Total income
***7.* Experiences and perception of incentive policies**	7.1 Incentive policies experienced/heard of including from rural areas 7.2 Payment (NMIS, HEF..etc) 7.2.1 Personal effects 7.2.2 Health system effects 7.3 Special Development Grants-SDG (Supply Side) 7.3.1 Personal effects 7.3.2 Health system effects 7.4 Salary uplift (increase) 7.4.1 Personal effects 7.4.2 Health system effects 7.5 Combination of all incentives 7.5.1 Personal effects 7.5.2 Health system effects
***8.* General recommendation**	8.1 Higher pay + more regular 8.2 Special allowance for rural areas 8.3 Accommodation 8.4 Children's education 8.5 Training opportunities/capacity building 8.6 Improvement in the working conditions-equipment, drugs, space 8.7 Local recruitment/more staff 8.8 Adequate transportation 8.9 Local infrastructure 8.10 Allowing private practice 8.11 National solidarity/greater commitment