THE COPING STRATEGIES OF RURAL DOCTORS IN PORTUGUESE SPEAKING AFRICAN COUNTRIES (PSAC)

In Portuguese-speaking African countries* (PSAC), as in many developing countries, public sector doctors and nurses invest in a multiplicity of income-generating activities to complement the low salaries and produce other incomes.

These activities can be considered as part of each individual's strategies of health personnel to cope with the often extreme discrepancies between social, economic and professional expectations and real-life situations. Given the importance of private practice as one of the income supplementation strategies of government officials, this paper sets out to explore the type of such side activities, and their distribution and differences between urban and rural settings.

Population and methods

The results of one first study[2] based on a self-administered questionnaire in a sample of 14 doctors of PSAC[3] who were following an international post-graduate course in public health in Portugal were triangulated with the results of an earlier qualitative survey based on semi-structured interviews to 68 doctors of PSAC[4,5]. The respondents were selected following a purposive sampling strategy in order to ensure that at least two doctors from the following sectors of each country were represented: private practice, military, university and other training institutions, each level of public sector health care management and provision.

The study also analysed the results of a third survey based on semi-structured interviews with 25 health personnel in southern Mocambique[6] in 1997 and the preliminary results of a later study done in PSAC, about the different activities of doctors working at the public sector.

All interviewees are government employees.

Results

The first[7] and the second[8] studies, allow us to identify and summarise the different type of individual strategies mentioned under three headings:

1. Extra-income from non-medical (commercial and agricultural) sources;
2. Extra income directly related to professional medical activities; and
3. Support by the family.

Source of income			Principal Activity/ Strategy	Secondary Activity/ Strategy
Non medical	Farming		0	8
	Commerce		0	10
Medical	Clinical	Public	56	14
		Military	8	0
		Extra sessions in casualty and emergency	0	3
	Teaching	University	8	6
		Nursing colleges	1	2
		Private tuition	0	1
	Punctual premiums and per diems	Incentives from project/ NGO/international co-operation	5	7
		Supervisions	0	1
		Consultancies	0	1
	Private medical practice		5	36
	Private pharmacy		0	1
	Private practice within public facilities		1	0
	Presents from patients		1	2
Social support	Family		0	3

Table I. Sources of income mentioned by the respondents (second study)

As we can observe in Table I, which summarises the results of the second study, although most still considered their government job their principal activity, 36 report an income generating activity through private practice.

In this study, of all the activities, the ones of primary economic importance from the principal activity are:

- public sector medical care (n=56)
- military sector medical care (n=8)
- university teaching (n=8)

The activities with more importance from the secondary activity, are:

- private sector medical care (n=36)
- commercial and agricultural activities (n=18)
- public sector medical care (n=14)
- incentives from project/NGO/international co-operation (n=7)
- university teaching (n=6)

In urban settings, we find similar strategies in the different studies; in special consultancies at public hospitals, private clinics and fee-for-service schemes, performed individually or in groups, normally with the sharing of the financial supplement by the doctor with the rest of the health personnel under his supervision. Coping strategies are less individualistic, there is stronger team work and the doctor has a stronger leadership role and is more active than the other health personnel.

Another individual strategy adopted, in urban areas, in this case, by nurses[9], are home visits, also called "clandestine clinics"[10], where the nurses accept patients at home or go to their house. This individual coping strategy of the nurses seems to be a mix between allopathic medicine and traditional medicine.

In rural areas, according to non-medical health professionals[11], coping strategies are not so directly related to professional activities as in the case of the doctors. There are many ways of reducing the effects of low income, without using much of the time of the principal activity, using mainly family help. The most important are agriculture, young of animals, as well as recourse to small commercial activities.

From the point of view of the patients, strategies adopted by health personnel are not only directly related to the activity developed by health professionals, but also with the drug deviation from the public sector and with the payment from the patients to health personnel of a financial

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Reasons	Frequency of reason for the principal economic activity		Frequency of reason for the secondary economic activity		Frequency of reason for the third most important activity	
	rural (n=9)	urban (n=35)	rural (n=4)	urban (n=21)	rural (n=2)	urban (n=11)
To face the cost of living	4	23	1	17	1	6
To educate one's children	2	13	3	9	1	3
To support the extended family	5	18	4	12	2	4
As an insurance against the uncertainties of life	1	9	1	4	0	2
As an insurance for old age	4	8	2	3	0	2
For material reasons	2	3	0	2	0	0
To be rich	3	1	1	1	0	1
To ensure an adequate lifestyle	0	4	0	1	0	0

Table II. Reasons given for the importance of the three principal professional activities (second study)

Goods purchased with one month's salary	Median (range)	Median urban	Median rural	n respondents
% spent on house rent	14 (0-1666)	12	30	21
Number of colour televisions	1/10 (1-1/1000)	1/10	1/10	35
Kilograms of rice	50 (1-400)	18	75	35
Number of chickens	7 (1-50)	5	13	35
Kilograms of cow's meat	10 (0,5-40)	10	14	34
Number of eggs	120 (3-2500)	100	178	30
Kilograms of powdered milk	8 (0-20)	7	9	20
Litres of cooking oil	20 (1-33)	10	22	23

Table III. Purchasing power of doctor's public sector income (second study)

Source of income	Percentage of overall income from this source			
	Average (n)	Median	Median Urban Drs	Median Rural Drs
Public sector salary	27,1 (40)	10	10	55
Private practice income	52,5 (40)	58	65	0
Bilateral co-operation	0,3 (31)	0	0	0
International co-operation	10,3 (33)	0	0	0
Local NGOs	7,9 (31)	0	0	25
Family support	6,1 (32)	0	0	0
Gifts from patients	0,3 (31)	0	0	0
Salary of spouse	20,0 (40)	1	1	9

Table IV. Percentage of a doctor's income that depends on the various sources (second study)

supplementation in order to be assisted more quickly.

Respondents are asked to give their reasons for engaging in their various side activities. As we can observe in Table II, the outstanding reasons are "to face the cost of living", "to support the extended family", and "to educate one's children".

On the other hand, for urban doctors, facing the cost of living and for rural doctors, supporting the extended family, are the first reason to complement the principal activity. We can also verify that, in urban settings, doctors face the problem of the high cost of living and at the same time, the reduction of the number of persons directly dependent on his income.

Table III gives an idea of the purchasing power of the public sector salaries of the interviewed doctors. Interviewees estimated the time a family of two could survive on their public sector salary at seven days.

The situation appears better in the rural areas, because of the lower cost of living as compared to the urban areas. All the answers, with the exception of the house rent, have a lower median in rural areas, which confirmed the higher cost of living in urban areas.

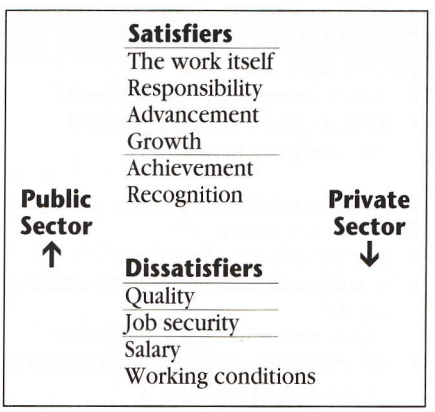

Figure 1. Herzberg's Two Factors Theory

We can also observe that the public sector salary still provided most of the income of rural doctors (median 55%), but in the urban areas, has marginal importance (median 10%) and private practice had become of paramount importance (median 65%) (Table IV).

In Table IV, we can also verify that local NGOs have for rural doctors a greater importance, as a source of income, than for urban doctors.

Private practice in all its forms is considered very rewarding financially.

Conclusions and recommendations

Present attempts at reforming the health care sector in Africa often fail to respond to the aspirations of government health personnel for acceptable salaries and working conditions[12].

As a result each individual develops unique strategies to cope with this financial predicament.

Family may sponsor some. Others derive additional income from teaching, commercial or agricultural activities. The most important source of additional income, however, is directly related to professional medical activities.

In rural areas, the public sector salary still provides most of the income of doctors, but has marginal importance for those in the urban areas and private practice has become of paramount importance.

We find differences between medical coping strategies and non-medical coping strategies, in rural areas. Doctors practise activities directly related to professional activities, but non-doctors work in agriculture as well as resorting to small commercial activities.

We also find differences in relation to the type of strategies adopted by doctors, between urban and rural areas. Doctors in urban areas adopt coping strategies related mainly with private practice, while in rural areas, complementary activities to public sector are connected to local NGOs.

Coping strategies in urban areas are