



RESEARCH PROTOCOL

National Survey preceded by a Qualitative Study on

**CORRUPTION AND ITS SOCIO-ECONOMIC IMPACTS ON THE
HEALTHCARE SECTOR**

In the 6 provincial Capitals of Madagascar

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PRESENTATION FILE for the SOCIO-ANTHROPOLOGICAL STUDY ON CORRUPTION AND ITS SOCIO-ECONOMIC IMPACTS on the HEALTHCARE SECTOR in MADAGASCAR

« TSABOY NY GASY » Project

Funding : EUROPEAN UNION

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ACRONYMS

CA	Community Agent
CSO	Civil Society Organisation
DHO	District Healthcare Office
DMT	District Management Teams
DHR	District Hospital of Reference
EIDHR	European Instrument for Democracy and Human Rights
HF	Health Facility
LB	Live Birth
MCH	Maternal and Child Health
MPH	Ministry of Public Health
N	Number
PCC	Primary Care Center
PNC	Prenatal Consultation
RHC	Regional Hospital Center
RHO	Regional Healthcare Office
RRHC	Regional Hospital of reference
SDG	Sustainable Development Goals
TI-IM	Transparency International - Initiative Madagascar
UHC	University Health Center
UHCV	Universal Health Coverage
UNICEF	United Nations International Children’s Emergency Fund
USAID	United States Agency for International Development

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Executive Summary

“The Tsaboy ny Gasy project aims indirectly to establish greater transparency and best practices in the field of healthcare, with the purpose of contributing to the Malagasy right to social justice, as well as obtaining significant public policy reforms in relation to healthcare. As such it will positively contribute to reaching the SDG priority targets which the country aims to reach by the year 2030.” (TI-IM, Concept note for the Tsaboy Ny Gasy Project)

As part of the « Tsaboy Ny Gasy » Project (Literally: Heal the Malagasy people), Transparency International - Initiative Madagascar plans to undertake a national survey of 3300 individuals, preceded by a qualitative study. The aim of this research is to identify the different types of corruption affecting the healthcare sector and their socio-economic impacts. The results will be used to advocate with the Malagasy state to press it to honour its commitments regarding healthcare for all. Moreover, this evaluation will be a point of reference by which to measure corruption in the healthcare sector.

Users will be surveyed on the basis of their experiences while using healthcare facility services (HF). The survey will be conducted at a household level and in part in the vicinity of healthcare centers. Following a random sampling method, individuals were stratified in groups obtained by segmentation that was proportionate to attendance rates at the HFs by region. The questionnaire will be drawn up after cross-documentation with analysis of the qualitative study material, which entails the detection of different forms of corruption. It will be carried out individually in the local dialects and it will be administered, in part, via mobile phone, using the KoBo application which allows a direct transfer of data to an in-house database. Processing and interpretation will be done on PSPP (following a method and an analysis plan yet to be developed).

The study will be conducted in full consideration of ethics in research involving humans, including explanations on the investigation, request for consent, and respect of rights including the right to withdraw, as well as confidentiality of the data collected.

I. Study Context and Scientific Rationale

I.1. The Malagasy healthcare sector

For Madagascar, a low-income country,¹ whose system has been extremely weakened by successive political crises,² the achievement of Sustainable Development Goals (SDGs) N°3 on "good health and well-being" remains a major challenge. Persistent difficulties relating to good governance are one of the primary reasons for the non-achievement of these objectives.^[1]

A healthcare system struggling to achieve "good health and well-being" for all

The country has achieved only one third of the progress expected, notably with regard to maternal and child health (MCH).³ Indeed, health development indicators have made modest progress towards the Sustainable Development Goals.⁴ Maternal mortality⁵ stood at 353 maternal deaths per 100,000 live births (LB) in 2015.^[2] WHO estimates that one third of Malagasy parturient deaths are related to complications during pregnancy and childbirth.^[3] Infant mortality is around 26 out of every 1000 newborns within the first month of life, while 62 out of every 1000 children die before the age of five.

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An unequal health system

According to the Ministry of Health,⁶ 8% of Malagasy nationals benefit from health coverage and 41% of household expenditure is allocated to healthcare. Other sources report that the current health insurance schemes cover "only a small part of the population (less than 1%) and are financed by investors, or self-financed by contributions ranging from 10 to 40%." **Error! Bookmark not defined.** Economic disparity is further compounded by gender inequality.⁷ According to USAID, the health authorities are under-developed and growing weaker. **Error! Bookmark not defined.**

Public health work in Madagascar identifies barriers to biomedical care such as the geographical isolation of the home from healthcare facilities. Indeed, "over 60% of the Malagasy population lives more than 5km from a healthcare center, often (...) without roads or any other means of communication." **Error! Bookmark not defined.** In a country with "a high proportion of individuals who can neither read nor write," **Error! Bookmark not defined.** misunderstanding of the benefits of biomedical care is also a hindering factor.

This research also argues that the costs (both direct and opportunity⁸) of healthcare visits exacerbate the inequality of access to care.^[4] Aside from the fact that patients have to pay for the costs of

1 158th place out of 188 countries according to Human Development Index ranking.

2 Unicef, 2015.

3 Taking into account both the health of the woman during pregnancy, labour, childbirth until post-partum and the health of the newborn and the child under 5 years.

4 Information Fédérale – Madagascar Fiche Pays – 2018 02 FR.

5 Maternal mortality is defined as death occurring during pregnancy or within 42 days of labour.

6 2018

7 USAID, 2018

8 Working hours of patient and accompanying persons who are relieved from difficult tasks or work in the fields, and whose transportation costs, meals, etc. are covered

equipment and consumables that are supposed to be free, unmotivated and unsupervised health workers⁹ also impose additional payments.¹⁰

Additionally, there are inadequate allocation of healthcare personnel and frequent shortages of inputs¹¹ in certain areas.**Error! Bookmark not defined.** Moreover, private institutions and private doctors are well-established at the community level, thanks namely to religious service providers operating in rural areas and poor urban areas.**Error! Bookmark not defined.**

Sociocultural factors limiting the access to biomedical care

A socio-anthropological study revealed that the use of MCH care is limited due to problems accessing information. Disparity in implementing actions that impact access to services such as the inadaptability and / or unavailability of services^[5], is also underlined.

Even more recent multidisciplinary research¹² has identified other socio-cultural factors limiting access to biomedical care. It noted how cultural protection rites such as confinement or "Mifana"¹³ were given priority, postponing first aid for the newborn (for example: vaccination at birth). In addition, lack of understanding of messages also hinders use of such medical care. Furthermore, the lack of awareness of the burden is based on local conceptions of diseases, which at times do not allow for the development of powerful awareness messages within the context of establishing control and prevention. Finally, healthcare centres have a poor image, specifically due to the high cost and unavailability of care services.^{[6] [7][8] [9]}

A therapeutic landscape valuing traditional care-givers

This work¹⁴ also highlights the importance that the Malagasy accord to traditional healers and midwives as a barrier to biomedical care. Indeed, the latter play a significant role in the delivery and care of newborns. Although matrons¹⁵ can only attend births that are more than 5km from the healthcare center if necessary,¹⁶ many women come to see them to give birth. Perinatal follow-ups concerning development of the pregnancy are also carried out at this level. Additionally, the territorial inadequacy of medical staff accentuates social inequalities and serves to maintain the activities of traditional midwives.^[10] These matrons¹⁷ are also known for their availability and flexibility in terms of payment, further reinforcing their proximity to the local people.^[11] In fact, according to the Alma-Ata conference in 1978, WHO recommended including traditional care givers in the primary care program. As in many African countries, Madagascar has also officially opted to combine biomedicine and traditional medicine in its healthcare policy. This desire to include these categories of activities, which

9 By the District Management Teams (DMT).

10 According to preliminary research done in 2018 by Humanity & Inclusion.

11 Drugs and materials to dispense care (syringes, dressings, waste management and sterilization equipment).

12 Comprising three components: anthropological, epidemiological and economic.

13 Literally: staying warm, a post-partum tradition whose primary goal is to protect the internal organs from the cold-induced disease called "sovoka". Later, this period was advised by older women to their offspring so that they could recover strength and protect themselves from lower back pain.

14 In public, epidemiological and anthropological health and health economics.

15 In the local language: reninjaza.

16 "According to a tacit agreement between the medical profession and the body of matrons, it is said that the matrons should only accommodate women who will give birth and who live more than 5kms from a healthcare center, if the need arises." (Genderlinks) Also reported by health professionals in previous studies on childbirth (NeoVac, 2016).

17 Men and Women

the Ministry of Health classifies as part of the informal sector, has been moreover reiterated in the design and promotion of UHCV.^[12]

Conditions contributing to corruption

Although corruption in the healthcare sector is still poorly documented, the difficulties in accessing care, specifically the low availability of healthcare personnel, long waiting times and high cost of healthcare visits (including opportunity costs) are among the situations that contribute to the corruption we will investigate. Moreover, it would be interesting to delve even deeper into certain misperceptions, particularly the perceived high cost of healthcare services. Furthermore, previous studies among others,^{[13];[14]} have shown that patients mainly use healthcare centres for emergencies. The primary results of the survey on healthcare in Madagascar conducted during the first phase of the Tsaboy ny Gasy project in 2017, showed the perceived lack of commitment to healthcare on the part of the State. Patients reported on the consequences of failures in healthcare provision, from misdiagnoses to neglect in treatment. The analysis of these results would benefit from a larger study population.

1.2. The State towards universal health coverage

The State has expressed its desire to invest in improving conditions of healthcare access for Malagasy citizens, notably by signing the Abuja declaration in 2001. Effectively, it committed to dedicate at least 15% of its annual budget to the healthcare sector up until 2015. In actual fact the budget allocated by the state to healthcare was equivalent to only 5.6% of the State budget. Although the 2018 Budget Act notes the desire to improve access to healthcare for all, the budget allocated to the social sector represents only 6.9%. "Even though Article 19 of the Malagasy Constitution guarantees access to 'free public healthcare', this commitment is not, as things stand, respected by the State," (TI-IM). Moreover, the sector is still marked by a dependence on fluctuations in external financing. "As for public spending, healthcare is not a priority, which partly explains the precariousness of the sector," (TI-IM).

Despite the funds available for public health, with a limited ability to mobilize the taxpayer-adherent, the Malagasy Government intends to continue the launch of Universal Health Coverage (UHCV) this year, which has been the subject of discussions with its partners since 2015.**Error! Bookmark not defined.**

II. The Study Framework

II.1. The Tsaboy Ny Gasy Project

TI-IM and its expertise in the Tsaboy Ny Gasy Project

Transparency International is "the largest civil society organization fighting corruption". Transparency International - Initiative Madagascar (TI-IM) is its national section. It is engaged mainly in the land sector, natural resources, transparency of public finance and local governance. It undertakes concrete actions aimed at reducing corruption throughout the Malagasy territory.¹⁸ TI-IM has proven expertise in the production of:

- Studies and reports highlighting corruption-generating mechanisms;
- Advocacy work with authorities to implement reforms
- Targeted communications in the media to inform the population
- Also establishing "collaborative action with other civil society actors, State audit institutions, institutions and the private sector."

TI-IM is expanding its area of expertise to the healthcare sector, based on a preliminary survey carried out in September 2017 by the citizen movement Wake Up Madagascar and the organisation Liberty 32. After submitting a proposal to the European Union in accordance with the EIDHR,¹⁹ TI-IM obtained funding to head up a project to fight against corruption in the healthcare sector in Madagascar.

II.1.1. Objectives

The *Tsaboy Ny Gasy* Project aims to ensure that citizens can fully benefit from their social and economic rights, especially their rights to healthcare, by fighting against corruption in the healthcare sector in Madagascar.

Its specific goals are to, firstly, develop advocacy for increased state involvement in the provision of accessible healthcare services. It also aims to fight against corruption in the healthcare sector in Madagascar.

II.1.2. Expected Results

The project results will be considered accomplished when public opinion²⁰ is informed about the impact of corruption in the healthcare sector and takes action against it.

This project will also introduce measures to accompany reform of public policy and of the legal framework governing the health sector, in favour of universal access to health services.

Finally, the barometer developed for this project will be a point of reference by which the impact of corruption in the healthcare sector in Madagascar can be measured on an annual basis.

II.1.3. The Project's Target Participants

The *Tsaboy ny Gasy* Project has two different targets. Given that the diagnostic phase is based primarily on the experiences and perceptions of users of healthcare services, they are therefore the first

¹⁸ The association is present in three regions: Atsimo Andrefana, Boeny et Diana.

¹⁹ European Instrument for Democracy and Human Rights.

²⁰ With a focus on women

participants. With respect to advocacy, this will mainly target the state and public and private healthcare actors, in order to lobby for their commitment to guaranteeing "health for all". Support is also proposed to ensure that the Malagasy healthcare system is more transparent and accessible to all Malagasy citizens. As a result, all levels of the care structure will be involved in this project.

II.2. Aims of the Study

This combined study corresponds to the first phase of the *Tsaboy Ny Gasy* project, whose main objective is to establish a diagnosis of the different forms of corruption existing in the healthcare sector in Madagascar and to assess its socio-economic impacts.

Secondly, based on user experience, this research will identify the factors limiting access to healthcare services caused by the weak commitment of the State to the healthcare sector in Madagascar.

II.3. Expected results of the study

This research will establish a typology of corruption cases in the healthcare sector in Madagascar. Analysis of the collected data will allow for the development of a system to classify the complex reality of the cases of corruption in this sector. Considering regional specificities, the study will identify the circumstances in which cases of corruption are rare or non-existent, as well as corruption "hotspots" with which users of the national health system may be confronted. The socio-demographic profiles of the citizens most affected by corruption will be established and known.

In addition, the effectiveness of anti-corruption measures will be analysed, in order to formulate an effective and adequate proposal to counter corruption in the healthcare services.

Furthermore, the evidence of the different forms of corruption and its impact on the socio-economic life of the Malagasy population will support advocacy actions targeting the State.

Finally, this study, and specifically the resulting barometer, will become a reference point for the annual measurement of the impact of corruption in the Malagasy healthcare sector.

III. Methodology

This combined research, involving application of social science methodologies to healthcare and development, has two components: a qualitative study and a survey. In the first phase, source interviews²¹ will be conducted with individuals who have experienced corruption during their use of healthcare services. For the second phase, surveys will be carried out with users of health facilities (HF) and at a household level in the provincial capitals of Antananarivo, Antsiranana, Fianarantsoa, Mahajanga, Toamasina and Toliara.

III.1. Documentation

A brief literature review (see references in appendix) was conducted to complete analysis of the material in the qualitative study, in order to develop the instrument for the national survey. This documentation covers official documents published by state institutions and non-governmental organizations on public health in Madagascar. It also concerns the research carried out to explain the contexts and factors limiting the use of care services, including perceptions of the biomedical healthcare sector by the Malagasy population. Finally, it also includes the review of rare documents on corruption in the healthcare sector (including the results of the project's first survey).

III.2. A Qualitative Study

An inductive methodology²² will be adopted to highlight the different forms of corruption experienced in the healthcare sector. This first phase uses socio-anthropological approaches with a specific focus on qualitative study techniques.²³ During interviews, interviewees will be asked semi-structured, non-leading questions.

III.2.1. Qualitative Study Population and Inclusion Criteria

In order to be considered for this study, source individuals must have experienced circumstances which they consider to be linked to types of corruption, during their visits to healthcare facilities. Their experience must also have had a measurable negative impact on their situation, notably: impoverishment, personal debt and / or refraining from further use of healthcare services, a deterioration in their health and / or incidentally, a negative experience and perception of healthcare services. Although in qualitative research, the focus is not on representation in the study population, we will strive to include individuals with different types of care needs²⁴ (the majority of whom have no social healthcare coverage). Although their relatives may be included with caution, healthcare workers who have used healthcare services will not be included in this study.

21 A budgetary restriction does not allow us to conduct this qualitative study at the level of the six provincial capitals. The study area is therefore limited here to Antananarivo since the interviews must be conducted face-to-face.

22 Working from data collected in the field, without preconceived ideas or a hypothesis to prove.

23 Interviews, observations and a focus group.

24 Ideally, from different provinces, different occupations (since we still need to determine a relevant measure of the socio-professional category).

III.2.2. Method of Recruitment

Given that corruption is a sensitive topic and that the testimony involves an element of whistleblowing, selection of source individuals may be challenging.

For interviewees, the use of an "opportunistic sample" (depending on opportunities) therefore seems appropriate. To do this, the TI-IM team and supporters of the association were mobilized to enlist relatives who have experienced cases of corruption in the field of healthcare. In addition, recruitment of individuals who have testified their experiences via the *Tsaboy Ny Gasy* Facebook (page might also be considered).

III.2.3. Study Methodology: Source Interviews

The interview will be conducted individually as a detailed face-to-face discussion, following an interview guide [Appendix B]. It will focus on an interviewee's experience using healthcare services when he/ she felt they had been victim of some form of corruption. This interview will paint a picture of what interviewees consider to be cases of corruption. A fact sheet on the socio-demographic characteristics of the interviewee will also be completed at the end of the interview, subject to the agreement of the interviewee.

III.2.4. Methodology for processing and analysis of material

The word-for-word transcripts of all the interviews will be encoded on the 11th or 12th edition of the Nvivo software.²⁵ For the final analysis,²⁶ descriptive tables of the socio-demographic data of the study population will also be created, in order to establish the factors leading to corruption.

A codebook will subsequently be written to encode the material on Nvivo. This will highlight the main themes, presented as our main results, and develop our main lines of analysis. The material will be analysed using "grounded theory" and triangulation. This methodology aims to create knowledge based on data collected in the field. For triangulation, there will be an overlap between analysis of the qualitative material and interpretation of the results, as well as the documentation.²⁷

The transcript will be used to illustrate the results (trends) of the national survey.

25 Specialist software for treating material in qualitative studies (cannot be substituted for investigators' analysis).

26 With the quantitative data.

27 An analysis of comments left on the project's Facebook page will be added to this, along with other considerations.

III.3. National Survey

Based on the previous analysis, this second phase of the study will attempt to quantify the number of users who have experienced/ been victims of corruption during visits to healthcare facilities. The survey will also analyse the socio-economic impacts of corruption on the healthcare sector.

III.3.1. Sampling

The survey will be carried out simultaneously in the six provincial capitals over the course of 15 days by 60 interviewers. Taking these projections into account, it is possible to interview 3300 individuals/ households. Stratified random sampling is therefore preferred in order to facilitate the organisational optimization of the survey.

Defining the Parent Population

The survey seeks to analyse the socio-economic impacts of corruption on healthcare center users. According to data collected by the Ministry of Public Health in 2018, users of healthcare facilities represent 61%²⁸ of the population in the six provincial capitals, or 6 069 966 individuals concerned by this survey.

Mode of sampling and selection of individuals

The primary selection criterion for individuals in this study population is attendance at a healthcare centre. Geographic divisions were additionally made to give a representation of cases of corruption experienced in the health sector by the Malagasy population in the six provincial capitals. The number of individuals per stratum (n = 6) is therefore concomitant and is intended to be representative of the number of healthcare facility users for each site. Determining the size of the sampling also takes into account the optimization of time and human resources management previously cited.

During roll-out, in each household visited, the investigators will prioritize decision-makers and those in charge of healthcare decisions²⁹ as interviewees. Finally, no member of the medical staff will be eligible for this study.

²⁸ Doubts have been raised on the method for calculating this rate. If it was calculated in relation to the number of consultations or treatments and not in relation to the number of users, this rate can be revised downwards.

²⁹ Responding to the main criterion: user of healthcare facilities.

Size of the survey population

The parameters for calculating sample size are based on the number of HF users by provincial capital, which was obtained according to the respective attendance rates obtained in 2018 by the Ministry of Public Health. Based on the percentages of HF users and taking into account the optimal threshold (3300 individuals to be surveyed), the following samples are obtained for each site.

Table 1. Calculating sample size by area

	Total population	Attendance rate at HF	Number of HF Users	% of HF Users	Samples
Antananarivo Analamanga	3 726 274	87 %	3 239 374	53 %	1 761
Antsiranana Diana	827 644	94 %	780 744	13 %	424
Fianarantsoa Haute Matsiatra	1 533 189	34 %	515 663	8 %	280
Mahajanga Boeny	841 916	53 %	442 006	7 %	240
Toamasina Atsinanana	1 494 775	27 %	396 614	7 %	216
Toliara Atsimo-Andrefana	1 535 464	45 %	695 565	11 %	378
Total for the six regions	9 959 262		6 069 966		3300

For this survey, we need to include 3300 individuals. This sample size with a desired accuracy level of 95% gives a confidence level of +/- 2%. Calculating the daily quota of seven questionnaires on average per investigator leaves a certain margin for the total number per region to be completed within the time allotted.

III.3.2. Method of collection and administration of the survey

Any user having visited a HF on one or more occasions, who is not a member of the medical staff, and is living in the surveyed areas, will be invited to participate in the study until the desired number is obtained.

Recruitment of the survey population will be carried out directly at household level. The administration phase will be concomitant with the user's consent to participate in the survey. The questionnaire will be administered individually face-to-face in the dialect understood by the interviewee. The interviewer will ensure that the survey is administered in a safe environment for the interviewee.³⁰

While carrying out the study, investigators should take care to integrate and respect the defined diversity criteria: including gender, age, occupation, education level, number of people in the household or dependents. To accomplish this, filter questions will also be developed during the creation of the questionnaire. Any person who has closely accompanied or taken care of a deceased person following an identified form of corruption will also be included in the survey (to avoid memory bias: the death must have occurred in 2018). As to the question of traceability³¹ and desired fluidity in data collection, the questionnaires will be carried out using mobiles, thanks to the KoBo³² mobile data collection application. Responses will be collected directly on mobile and sent to a TI-IM database.

III.3.3. Results compilation and interpretation

The database compiled via Kobo will be saved directly onto an Excel spreadsheet. Flat sorting and descriptive analysis under PSPP are also planned.

The interpretation will be carried out in such a way that data is able to describe different forms of corruption, corruption hotspots as well as the profiles of those most affected.

This analysis plan will be developed and refined at a later date. The variables to be explained will be the experience(s)³³ of a situation related to corruption,³⁴ the form(s) of corruption experienced, the situations contributing to these forms of corruption, the profiles most affected by corruption as well as the socio-economic impacts of corruption in the healthcare sector.

The main judging criteria are:

Determinants of corruption (factors and circumstances conducive to corruption)

Proportion of users most affected by corruption, by profile

Proportion of users whose health condition was impacted

Proportion of individuals with relatives who have died as a result of a situation they experienced, such as corruption / neglect

Proportion of users who have been impoverished / had to go into debt due to an incidence of corruption

Proportion of users who have abandoned any use of health services (therapeutic wandering) after having been the victim of a form of corruption (whether they took part or not)

Proportion of users who have abandoned any use of health services (non-use and / or alternative methods) after having been the victim of a form of corruption (whether they took part or not)

Proportion of users who did not agree to participate in a form of corruption.

³⁰ Since the survey will be conducted at the household level, the questionnaire will not be carried out in a public place. A discreet place without anyone else being able to hear these answers will be privileged. However, it is likely (due to the harvest season) that the survey may be conducted in the fields. In this case, all precautions (eg isolation) will be taken to ensure the privacy and freedom of speech of the interviewee (s).

³¹ Plausibility and daily monitoring.

³² This application is both an input method and temporary data storage until the mobile has access to a connection point

³³ Different from exposure or a situation that was witnessed.

³⁴ Whether care was or was not received, a delay in receiving care or an error in diagnosis.

The secondary judging criteria are:

Proportion of reported cases by particular location

Proportion of individuals having reported corruption

Proportion of individuals needing legal services after the experience of a situation related to corruption

Proportion of users aware of forms of corruption

Proportion of users aware of the mechanisms / procedures for reporting and combating corruption

III.4. Zoning

In the provinces, healthcare facilities will be randomly selected, with only those in urban and suburban areas³⁵ which are functional being considered. In order to better ensure the representation of interviewees,³⁶ interviewers will interview those who live 10km, more than 5km and less than 5km from the healthcare centers.

For each site, at least one UHC and one RHC will be included in this study to determine the perimeter of the survey.

For Tulear I (city) in particular, the concentration of fokontany means that the surroundings of all PCCs will be considered, while respecting the previous determination of the survey area.

For Antananarivo, since neither the proximity of the home to the healthcare facilities nor the locations necessarily determine the choice of the user, two possibilities are open to the investigators:

1. Interview results and leads generated through *Tsaboy Ny Gasy's* Facebook page will help to identify the healthcare facilities to select. In this case, users will be questioned when leaving these places. However, the main risk is the project's disclosure (due to the presence of investigators) to local health authorities.
2. The neighbourhoods will be selected at random with equal integration of different types: "low" neighbourhoods, business district, town center, shopping district, and residential neighbourhoods. We will also consider central neighbourhoods and suburban neighbourhoods.

Follow up measures

In cases where there are not enough interviewees, a change of perimeter (around another healthcare facility) or neighbourhood is possible.

Faced with a feasibility issue: investigator insecurity, problem of geographical accessibility (more than a 2 hour walk oneway), the following perimeter/ fokontany in the list already selected will be considered as a replacement.

³⁵ For reasons of feasibility.

³⁶ But also in order to demonstrate that physical distance is not the main barrier to access to healthcare (evidence which has long been supported by public healthcare actors).

III.5. Practical terms of the study

In order to ensure quality in the research process, investigators will be organised as follows.

III.5.1. Planning the Survey

The interviews for the qualitative study will take place from 14th to 18th March 2019. The survey, meanwhile, will be carried out from 1st to 21st April 2019 (for 15 working days). A detailed schedule will be developed per site, using maps marking the perimeters of the survey as well as the randomly selected list of fokontany and neighbourhoods.

III.5.2. Tools

The interview guide for the qualitative study will address open questions that can freely retrace experiences that are perceived to be related to a form of corruption.

The questionnaire will be developed subsequently, following analysis of the qualitative material. It will include a fact sheet describing the socio-demographic data of users including gender, age, marital status, occupation and any other criteria to categorize his profile. A plausible way to measure the socioeconomic level of the household / individual will be determined. A qualitative question will be added to the questionnaire in order to highlight perceptions of healthcare facility users.

III.5.3. Language

The interviews will be conducted, transcribed and analysed in “Malagasy ofisialy.” The surveys on the other hand, will be carried out in the local dialects, before being standardised in French.

III.5.4. Storage

Interviews will be recorded on dictation machines only, with the consent of the informants and / or their legal guardian in the case of minors.

Quantitative data will be sent at the end of each day by investigators via the KoBo application. The automatically saved data will be sent as soon as the investigators' smartphones are connected. They will be stored in the Excel database in the TI-IM computer³⁷ allocated to this study. The database clearing will be completed using a cleaning script yet to be developed, to allow missing and inconsistent data to be verified as the field survey progresses.

A unique identifier in the form of a code will be assigned to each interviewee in order to facilitate data management but especially to guarantee the anonymity of those interviewed.

³⁷ With two back up copies.

IV. Ethical Considerations

Measures will be implemented in order to ensure respect of ethical considerations when conducting a study³⁸. For each site/interview, we will proceed as follows:

IV.1. Courtesy Visits

They will be systematically carried out with each local authority in public health (Regional Health Office, medical inspectors, managers and directors of healthcare centres / hospitals), fokontany presidents or mayors of the six provinces. The objective of these visits is not only to notify of our presence, but also to gain permission to go out in the field, and to acquire information about the service providers. In order not to reveal and bias our investigation, the reasons for this study will be presented as relating to the evaluation of accessibility of healthcare services.

An introduction letter will be presented and referred to the authorities as a mission statement but also to justify our visit to their levels.

IV.2. Explanation of Study Procedures and Conditions for Participation

An oral explanation supported by the descriptive background note for the study (in local dialects) will be provided for each person interviewed. Before the survey is conducted, everyone will receive clear and precise oral information on the aims of the study, the expected results, the practical details (questionnaire and mobile entry), the management of data confidentiality and their right to refuse to participate in the study. After being informed and once their understanding of the survey is well established, individuals will be invited to participate freely in the study without any compensation.

IV.3. Informed Consent Form

Once it is ensured that the interviewees understand the study and its broad outline, they will be asked to sign a consent form (the content of which will also be explained). This form will clearly mention: their authorisation and freedom to participate in the study or not, without compensation, but also to stop at any time.

IV.4. Confidentiality and Respect for Anonymity

The methodology is designed to avoid any form of stigmatisation. Thus, measures will be taken to respect the anonymity of individuals and the confidentiality of the information collected. The data collected will be systematically anonymised (the entry of socio-demographic data will not contain the names or information that allows direct identification of participants). Data storage will be on the investigators' local computers and transferred to the project sponsors at the end of the study. Access will be password protected and the transfer will take place via secure server, or directly, to the project's protected hard disk.

Finally, any legitimate request for access to the data is to be preceded by a formal request to the sponsors. Only investigators and sponsors will have access and it is their responsibility to ensure that there is no other use, other than for purposes authorised by the sponsors.

³⁸ According to the principles published by Global health training and HI

V. Study Schedule

This schedule describes the different activities during the two phases of the study with the respective implementation periods.

	March				April				May				June				July			
	Mars				Avril				Mai				Juin				Juillet			
	S1	S2	S3	S4	S1	S2	S3	S4	S1	S2	S3	S4	S1	S2	S3	S4	S1	S2	S3	S4
Documentation																				
Drafting of research protocol																				
Researcher recruitment																				
Training researchers and investigators																				
Organisation of field logistics																				
Exploration phase																				
Qualitative study																				
Creation of interview guides																				
Pre-testing of interview guides																				
Recruitment of participants																				
Interviews																				
Processing and Analysis of data																				
Probationary phase																				
Quantitative study																				
Design of questionnaires																				
Pre-testing of questionnaires																				
Survey roll-out																				
Data processing (refining)																				
Data interpretation																				
Audit report on the different types of corruption and their socio-economic impacts																				
Development of a barometer to measure corruption																				
Etablissement d'un baromètre sur la corruption																				...

Figure 1. Study Schedule



**TRANSPARENCY
INTERNATIONAL
INITIATIVE
MADAGASCAR**

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01/04/2019

Subject : Introduction Letter – Tsaboy ny Gasy, a socio-anthropological study on the accessibility of healthcare facilities in the 6 provinces of Madagascar

Dear Sirs,

It is our pleasure to inform you that Transparency International-Initiative Madagascar (TI-IM) is currently implementing, with the support of the European Union, the Tsaboy ny Gasy project which aims to contribute to improving access to healthcare and the healthcare system for all Malagasy people. A preliminary household survey is therefore organised from 1st to 15th April 2019 in the six provincial capitals, with a defined sample of 6,000 people. We count on your collaboration to assist us in this effort focused on the public well-being and remain at your disposal for any questions.

For further information, please contact:

- Ketakandriana RAFITOSON, Executive Director TI-IM, krafitoson@transparency.mg, 034 08 463 16
- Erica JOELITIANA, CORSAN TI-IM Project Manager, ejoelitiana@transparency.mg, 033 04 829 19
- Hoby RAZAFIARIMANANA, National Research Consultant, hrazafiarimanana@transparency.mg, 032 81 475 53

Yours Sincerely,

The Executive Director

Ketakandriana RAFITOSON

Appendix B. Background Note

Title: A socio-anthropological study on the accessibility of healthcare facilities in Madagascar

Period : from March to April 2019

Date : / /2019

Site: Antananarivo, Antsiranana, Fianarantsoa, Mahajanga, Toamasina, Toliara

You are invited to participate in a socio-anthropological research action initiated by Transparency International - Madagascar Initiative (TI-IM) with the support of the European Union.

The objective of this study is to better understand the accessibility of healthcare services for the population of Madagascar's 6 provincial capitals.

Practical Terms of the Study:

If you agree to participate in this research, we ask that you sign a consent form. We will question you about your experience when using different levels of healthcare centres. We will also ask you questions about your socio-demographic and socio-economic profile.

Confidentiality:

All persons conducting this study commit to strictly respect your anonymity throughout its execution and when communicating the results. Your data will be given a code that will identify you because your first and last name will be deleted. There is nothing that will identify you outside the scope of the study. The publication of the results will not include individual data.

Right to Refuse:

You are entirely free to accept or refuse to participate in this study without any prejudice whatsoever. Signing the consent form does not take away your right to withdraw and leave the study at any time.

Cost/Compensation:

Your participation in this study is voluntary and therefore you will not be given any form of compensation in exchange.

If you have any further questions or need for information, we will be happy to provide you with answers.

For more information, you can contact the CORSAN Project Manager at TI-IM, Ms. Erica Joelitiana, ejoelitiana@transparency.mg

Appendix C. Consent Form

Title: A socio-anthropological study on the accessibility of healthcare facilities in Madagascar

I understand all the information that has been provided in relation to my participation in this study. I was able to ask questions and get satisfactory answers.

I understand that I can freely refuse to participate in this study and, if I consent to participate, that I can withdraw at any time without prejudice.

I was informed about the practical terms of the study, including the general subject matter and potential content of the questions that will be asked. I have also been informed of the use that will be made of the information I will share and the measures that will be taken to ensure my anonymity.

I agree to participate on a voluntary basis, and I understand that I will not receive any financial compensation for my participation in this study.

I have been informed that any information that could lead to my identification will be encrypted and I consent to the archiving of the answers I give to the questions that will be asked.

I agree to participate in the aforementioned study

Interview Code:

Date:

Antananarivo/ Antsiranana/ Fianarantsoa/ Mahajanga/ Toamasina/ Toliara

Legal guardian's Signature

Interviewee's Signature

Appendix D. Interview Guide

Reading of the memorandum, acknowledgements and request for consent	
Interview Code:	Date: /.... /.....
Investigator Code:	
Data Sheet	
<input type="checkbox"/> Female <input type="checkbox"/> Male	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Other, please specify	
Age	
Number of Children	
Educational Level or Qualifications	
Job Title	
Coverage of Healthcare Costs	
Criteria to be developed to measure the standard of living of the individual/house	
Individual / household	

Topic I. Representation of Healthcare Centres

Questions	Follow Up
- Can you tell us about healthcare in your community? in your city?	Introductory Question or "ice breaker"
- How do you find the accessibility of healthcare centres? Hospitals?	Which ones? Why? What are the criteria for being accepted for care at these health centres?
- In your opinion, what causes difficulties in accessing healthcare services?	Which difficulties? Why? For whom?
- Could you tell us about any solutions to these difficulties?	Why would these solutions be effective?

Topic II. Circumstances/ Difficulty of Access to Healthcare Services

1. Can you tell us about the circumstances in which you have used healthcare centres? Or did you accompany a relative?	Cause of use? When? Duration? Frequency? Reasons for the choice of services (healthcare facility, health worker, etc.) Were there any services you wanted to use but were unable to access for any reason?
2. Can you tell us about some of the situations that affected you when you used healthcare services?	Why? In which way?
3. Can you describe any situations that you did not appreciate when you used healthcare services?	Why?
4. Can you tell us about any difficulties or situations that have made it difficult for you to access healthcare services?	What obstacles? Solutions found? Abandonment? Consequences?

Topic III. Caregiver-Patient Relationships

- How did you feel about the reception you received at the healthcare centres? When exactly? By whom? Where? On what basis? In relation to what?
- How do you perceive the information with regards to the procedures in the healthcare facilities you have visited? Procedures for: payment, coverage of costs (consultation, care, surgery), separate payment for medication, appointment booking, payment of expenses (consultation, care and others). Where? Consequences?
- How do you find the waiting times at the healthcare facilities that you have attended? Considered as an obstacle? Why? Solution found?
- How do you find the availability of healthcare personnel towards you? During consultations? Request for information? During the treatment?
- How do you find making appointments with the care staff? Necessary? Facilitates access or makes it difficult? Why? Solution?

Topic IV. Perceived Forms of Corruption and Negligence

1. We would like to discuss with you what happened regarding the care that did not.../ when your relative passed away (related for inclusion in the study), can you tell us what happened? Detailed description and title to be recorded
What is this situation about: lack of resources? Negligence? Other explanation given?
Could this situation have been avoided? How? Or could the consequences have been minimised? Why?
Where? Who? How?
2. Can you tell us about the impact this situation/incident has had on your life? (if it is not the death of a loved one)
3. Do you think that what happened to you could happen to other people in the same facility? Common? Rare? Why?
4. Do you think that all of the expenses incurred at that time were justified? If yes/no, why?
How much should you have paid?

Topic V. Conscience (Awareness) of corrupt situations

1. Can you tell us about a situation where a medical staff member asked you for money that you felt was unjustified or irregular? (If not already described before) Can you describe this? When? Where? How? For which services? Reasons? Why do you think this should not be asked for? Did you accept? If yes/no, why? How would you describe this irregular request?
2. Can you tell us about a situation where you paid a health worker outside of the usual payment? (If not already described before) On what grounds? To have a service more easily/ to be favoured/ to benefit from more comfort/ not to queue/ to be taken care of.....

Appendix D. Interview Guide

- | | |
|--|--|
| 3. In your opinion, is the healthcare sector affected by corruption and in what forms does it occur? | Cite real-life examples if not previously mentioned
Cite observed situations
Cite description / perceptions
Ask to define corruption in the health sector
Who do you think is most concerned?
Where does corruption prevail? At what level? |
| 4. In your opinion, how can we fight these forms of corruption? | How? With what actions? With whom?
Already established or prospects?
What is their effectiveness? |

Thank you for your participation

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